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EVALUATION REPORT

CSC's Health Services

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Canada

SIGNATURES

EVALUATION OF CSC'S HEALTH SERVICES

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Don Head
Commissioner

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Date

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Brigitte de Blois
Director, Evaluation Division

.....
Date

CONTRIBUTIONS

Authors:

Kendra Delveaux, Senior Evaluation Manager
Colleen MacDonald, A/Senior Evaluator
Ashley McConnell, A/Evaluation Officer
Sheena Bradley, Evaluation Officer
Adam Crawford, Evaluation Analyst
Felicia Tse, Junior Evaluation Analyst

Evaluation Team Members:

Duyen Luong, Senior Evaluator
Hassimiou Ly, Senior Evaluator
Lysiane Marseille-Paquin, Evaluation Officer
Marcie McLean-McKay, Evaluation Officer
Tara Beauchamp, Evaluation Officer
Bertha May, Evaluation Officer
Donna Towns, Evaluation Officer
Elizabeth Loree, Junior Evaluation Analyst
Hortense Kambou, Junior Evaluation Analyst
Joel Ndayubaha, Junior Evaluation Analyst
Kossi Aziaba, Junior Evaluation Analyst
Kristen White, Junior Evaluation Analyst
Alex Lefebvre, Junior Evaluation Analyst

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EXECUTIVE SUMMARY

According to section 86(1) of the *Corrections and Conditional Release Act* (CCRA), CSC is mandated to provide essential health care, and reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community. [i]

Compared to the Canadian population, offenders demonstrate a higher prevalence of mental and physical health concerns. As well, CSC's offender population is aging. In 2014-15, 24% of federal offenders were 50 years or older and the number of offenders over the age of 50 at admission has risen over the last ten years. [ii] In 2014-2015, Health Services accounted for approximately 11% of CSC's total direct program spending. CSC's Health Services represent an important opportunity to address offenders' diverse health care needs throughout the continuum of care, which includes: intake, incarceration, and pre-release and community supervision.

The evaluation focuses on the relevance and performance of CSC's mental, clinical, and public health services. Evaluation questions examine the following areas: relevancy of CSC's health services, effectiveness and efficiency of the intake assessment process, offender access to care and services throughout incarceration, public health education and harm reduction, institutional mental health services, pre-release and community health services and the management and coordination of health services. Given the breadth and complexity of health services within CSC, the evaluation is organized into seven findings in focus for evaluation (FIFEs).

Evaluation Results:

Overall, the evaluation found that CSC's Health Services are relevant and meet the needs of federal offenders. Positive impacts were found regarding institutional mental health care where offenders' had a reduced likelihood of incidents, serious charges and involuntary segregation following treatment. Several key areas were identified for service improvements and recommendations were made to support decision makers with improving the efficiency and effectiveness of CSC's Health Services. Program managers responded to these recommendations. The major recommendations and their associated management responses are outlined below.

- ***Maintain productive relationships with partners who support individuals with mental health disorders.*** CSC is responsible for providing health services to federal offenders; there is an ongoing need for partnerships to effectively and efficiently deliver these services to offenders.
    - **In response:** CSC will strengthen partnerships to support the delivery of mental health services for federal offenders and will share information and practices related to mental health through the Federal Provincial Territorial Working Group on Health/Mental Health.
- ***Ensure offenders are referred to the appropriate mental health services.*** CSC has developed a *Mental Health Need Scale* to assess offenders' mental health need and determine the appropriate level of care required in accordance with its new refined model of mental health care (primary, intermediate, psychiatric hospital). The validity and reliability of this scale are yet to be assessed.
    - **In response:** CSC will assess the validity and reliability of the *Mental Health Needs Scale* and will strengthen the process for recording and maintaining offender level of need data.
- ***Adopt measures to support a continuum of health care for offenders during their transition from CSC Health Services to provincial/territorial health coverage. Specifically, obtaining health cards and payment for community health services.*** Procedures in obtaining provincial/territorial health cards vary across regions and depend on provincial/territorial health authority requirements. CSC may cover the cost of some medical expenses in the community if offenders are not covered by provincial/territorial health insurance or other provincial/territorial plans (e.g., disability benefits, drug plans).
    - **In response:** CSC will develop guidelines to obtain, track and store ID at intake; work with Canadian provinces and territories to determine how offenders can better access health care services and disability benefits following their release; and, clarify national guidelines regarding CSC payment for health services in the community.
- ***Increase the efficiency of health-related intake assessments processes.*** Health services intake assessment tools and processes are effective in identifying offender health needs; however, duplication of offender health information collected through intake assessment processes results in inefficiencies in assessing offenders' health care needs.
    - **In response:** CSC will eliminate the requirement for repeated administration of health assessments and unnecessary repetition of health information between assessment tools.

CSC will also ensure health referrals are appropriately recorded and monitored electronically.

- ***Ensure offenders have timely access to health education programs and harm reduction products.*** Health education programs, particularly those aimed at infectious disease, are associated with increased offender health-related knowledge and related behavioural changes (e.g., reduced risk-taking behaviours). Results of a review indicated that bleach was not always available as required in all CSC institutions and no recent data were available to confirm the accessibility of other harm reduction products (e.g., condoms).
    - **In response:** CSC will provide clear direction and accountability for delivery and tracking of health education programs; monitor the distribution of harm reduction products; and, address any identified accessibility issues.
- ***Continue to implement and report on the Chronic Disease Management Strategy.*** CSC has implemented policies, guidelines and strategies to address the special health care needs of women and Indigenous offenders. Additional support related to the chronic disease needs of older offenders is required.
    - **In response:** CSC will continue to implement the Chronic Disease Management Strategy and will report on progress against expected results to track and identify gaps in service.

This evaluation will assist CSC in improving the delivery of health services for all offenders across the continuum of care.

LIST OF FINDINGS

FINDING 1: NEED FOR HEALTH SERVICES
There is a continued need for delivery of clinical, public and mental health services to CSC offenders.
FINDING 2: ALIGNMENT WITH PRIORITIES AND FEDERAL ROLES AND RESPONSIBILITIES
CSC Health Services are aligned with federal government priorities. CSC is responsible for providing health services to federal offenders, but there is an ongoing need for partnerships to effectively and efficiently deliver services to offenders.
FINDING 3: EFFECTIVENESS OF HEALTH SERVICES INTAKE ASSESSMENT
The overall health services intake assessment tools and processes are effective in identifying offender health needs.
FINDING 4: EFFICIENCY OF HEATH SERVICES INTAKE ASSESSMENT PROCESS
Duplication of offender health information collected through CSC health services intake processes and tools results in inefficiencies in assessing offenders' health care needs.
FINDING 5: ACCESS TO CLINICAL, PUBLIC, AND MENTAL HEALTH CARE
CSC offenders have access to clinical, public, and mental health care to address their needs. The majority of offenders receive initial mental health services according to established time-frames; clinical health services are not tracked electronically. Health Services is in the process of implementing an Electronic Medical Record.
FINDING 6: ACCESS TO COMMUNITY HEALTH CARE SPECIALISTS
The provision of community health care specialist services for offenders for non-urgent care is subject to wait times in the community. CSC uses telemedicine (where provincial telemedicine programs are available) to address procedural issues associated with health care specialist appointments in the community. CSC does not systematically collect data regarding referrals to specialist services (in-person or telemedicine).
FINDING 7: TRANSFERS
Health services staff and offenders reported challenges to continuity of care and information sharing or documentation during transfers were identified. Inaccurate information sharing may be a result of incomplete documentation in the Health Services Transfer Summary forms.
FINDING 8: INFORMATION SHARING
Some CSC personnel reported a lack of understanding of the guidelines for sharing of personal health information, and the sharing of health information could be improved. There are opportunities to implement electronic medical records to enhance information sharing.
FINDING 9: HEALTH EDUCATION DELIVERY
CSC's health education programs and initiatives target many of the significant health needs of the offender population, but offender access to and voluntary participation in some programs is limited.

FINDING 10: IMPACT OF HEALTH EDUCATION AND HARM REDUCTION INITIATIVES
Health education programs, particularly those aimed at infectious disease, are associated with increased offender health-related knowledge and related behavioural changes (e.g., reduced risk-taking behaviours). Results of a review indicated that bleach was not always available as required in all CSC institutions, but no recent data were available to confirm the accessibility of other harm reduction products, such as condoms, dental dams, and lubricants.
FINDING 11: INSTITUTIONAL MENTAL HEALTH CARE OUTCOMESS
Institutional mental health care provided in CSC mainstream institutions and RTCs was associated with positive impacts on offenders' behavioural stability following treatment, such as reduced likelihood of incidents, serious charges, and involuntary segregation.
FINDING 12: LEVEL OF CARE BASED ON NEED
The Health Services Sector developed a *Mental Health Need Scale* to assess the level of mental health need and determine the appropriate level of care required in accordance with the new refined model of mental health care (primary, intermediate, psychiatric hospital). The validity and reliability of this scale have not been assessed, and electronic data on offender scale results have not been consistently recorded.
FINDING 13: REGIONAL COMPLEX MENTAL HEALTH COMMITTEES
Regional Complex Mental Health Committees have been established to assist and support institutions in providing an effective continuum of care to offenders with complex mental health needs. The degree to which funds were expended relative to those allocated at the regional level could not be accurately determined because funding was not fully tracked in the financial system.
FINDING 14: ROUTINE DISCHARGE PLANNING AND OFFENDER IDENTIFICATION
Processes to assist offenders in obtaining provincial health cards vary across regions and are dependent on provincial/territorial health authority requirements. Procedural challenges associated with assisting offenders to obtain provincial/territorial health cards exist (e.g., prerequisite for a birth certificate, fee requirements, releases to different provinces).
FINDING 15: PAYMENT FOR COMMUNITY HEALTH SERVICES
According to CSC policy, CSC may cover the cost of some medical expenses in the community if offenders are not covered by provincial/territorial health insurance or other provincial/territorial plans (e.g., disability benefits, drug plans) and have no personal means to pay. Medical expenses covered by CSC in the community vary across regions, which may be related in part to variations in provincial health coverage.

FINDING 16: COMMUNITY MENTAL HEALTH SERVICES AND CLINICAL DISCHARGE PLANNING
Community mental health specialists services provided to offenders were associated with lower rates of recidivism; whereas, clinical discharge planning services alone did not appear to have an impact. The number of offenders receiving clinical discharge planning services could not be determined due to inconsistencies in data recording; providing continuity of care is challenging when offenders who receive discharge planning services are released to locations with limited CSC community mental health staff.
FINDING 17: COORDINATION OF CSC'S HEALTH SERVICES
Following changes to the health services governance structure, there has been greater standardization and integration of health services.
FINDING 18: INFECTIOUS DISEASE TREATMENT: HEPATITIS C VIRUS
CSC expenditures for Hepatitis C Virus (HCV) medication more than tripled from 2013-2014 to 2015-2016 due to a new Canadian approved standard of care. New treatment is more costly, but has resulted in an increased cure rate for individuals with the disease, also reducing the risk of spread of HCV to others.
FINDING 19: HEALTH SERVICES FOR SPECIFIC POPULATIONS
CSC has implemented policies, guidelines and strategies to address the special health care needs of women and Indigenous offenders. Additional support related to the chronic disease needs of older offenders is required.

LIST OF RECOMMENDATIONS

RECOMMENDATION 1: MENTAL HEALTH DIVERSION

That CSC maintains productive relationships with partners who support individuals with mental health disorders.

RECOMMENDATION 2: EFFECIENCY OF HEALTH SERVICES INTAKE ASSESSMENT TOOLS AND PROCESSES

That CSC Health Services endeavour to increase the efficiency of health-related intake assessment processes by considering the following:

- Eliminating the requirement for repeated administration of health assessments;
- Optimizing and eliminating unnecessary repetition of health information between assessment tools; and,
- Ensuring health referrals are appropriately recorded and monitored.

RECOMMENDATION 3: ACCESS TO COMMUNITY HEALTH CARE SPECIALISTS

That CSC Health Services collect data on wait times to access selected specialists services for non-urgent care; and implement strategies (for example increased use of telemedicine where appropriate) if wait times exceed available Canadian benchmarks.

RECOMMENDATION 4: INFORMATION SHARING

That CSC Health Services improve the understanding of information sharing requirements and limitations, as elaborated in their guidelines, in accordance with privacy laws and other relevant legislation. That CSC Health Services improve timely access to relevant and accurate medical records for Health Care staff. These will be accomplished by:

- Finalizing the implementation of electronic medical records to improve accessibility and consistency of health information;
- Enhancing awareness of information sharing procedures and "need-to-know" principle among CSC personnel, including concrete examples of where and how the principle should be applied; and
- Conducting a review of information sharing issues identified in board of investigation incidents to contribute to existing lessons learned and to inform procedural/policy changes if necessary.

RECOMMENDATION 5: HEALTH EDUCATION AND HARM REDUCTION

That CSC Health Services ensure that offenders have timely access to health education programs and harm reduction products by:

- Providing clear direction and accountability for delivery and tracking of health education programs; and
- Monitoring the distribution of harm reduction products (bleach, condoms, dental dams, and lubricants) and addressing any identified accessibility issues.

RECOMMENDATION 6: LEVEL OF CARE BASED ON NEED

That CSC Health Services ensure offenders are referred to the appropriate mental health services by:

- Implementing effective management practices to ensure that current information on offender level of need is recorded electronically and that previous records are retained;

and

- Assessing the validity and reliability of the Mental Health Need Scale.

RECOMMENDATION 7: REGIONAL COMPLEX MENTAL HEALTH COMMITTEES

That CSC Health Services:

- Track nationally and report on activities and expenditures of funds released to regions through RCMHCs; and
- Provide information to institutional staff regarding the role of RCMHCs and identified best practices.

RECOMMENDATION 8: RELEASE PLANNING AND OFFENDER INDENTIFICATION

That CSC adopt measures to address challenges related to offenders accessing health care in the community by retaining or obtaining offender ID (including health cards); and to clarify the policy, guidelines and procedures pertaining to coordinating access to medication while transitioning to the community.

- Develop guidelines to support the retention of offenders' ID including health cards;
- Establish mechanisms to obtain key ID at intake; and,
- Clarify existing release policy related to the requirements for medication at release and provide consistent communications to staff.

RECOMMENDATION 9: ACCESS TO AND PAYMENT FOR COMMUNITY HEALTH SERVICES

That CSC improve access to community health services to ensure a continuum of health care for offenders during the transition to provincial/territorial health coverage, by:

- Improving partnerships with provincial and territorial health authorities to determine how offenders can better access health care services and disability benefits; and,
- Clarifying and communicating policies and procedures related to CSC's coverage (i.e., payment) for health services in the community and requirements for medication at release.

RECOMMENDATION 10: CLINICAL DISCHARGE PLANNING AND COMMUNITY MENTAL HEALTH SERVICES

That CSC:

- Review the model of community mental health service delivery to ensure that community mental health services are being provided to offenders with the greatest mental health needs.
- Ensure that clinical discharge planning activities are tracked in electronic information systems.

RECOMMENDATION 11: SPECIFIC POPULATIONS OF OFFENDERS

That CSC Health Services continue to implement the Chronic Disease Management Strategy, with reference to any special needs/requirements for older, women, and Indigenous offenders, and methods for tracking impacts.

MANAGEMENT ACTION PLAN OVERVIEW

In response to the recommendations identified throughout the evaluation, CSC has developed Management Action Plans to strengthen the provision of health services across the continuum of care. The Management Action Plans are summarized below, for a copy of a full plan, contact CSC's Evaluation Division.

MANAGEMENT ACTION PLAN FOR RECOMMENDATION 1:

- Strengthen partnerships and collaborative efforts in support of the delivery of mental health services to federal offenders by guiding the implementation of CSC's *Integrated Engagement Strategy*.
- Share information and practices relating to mental health through the Federal Provincial Territorial Working Group on Health/Mental Health and for consideration of the Heads of Corrections.

MANAGEMENT ACTION PLAN FOR RECOMMENDATION 2:

- Modify health services processes for health care requirements for 24-hour and 14-day assessments.
- Streamline health services intake assessment tools to reduce unnecessary repetition of physical health information.
- Review of mental health assessment tools to determine if they can be revised/streamlined to eliminate unnecessary duplication of information while maintaining effective identification of offenders with mental health needs.
- Implement a new electronic health information system to record information electronically on assessments and referrals.

MANAGEMENT ACTION PLAN FOR RECOMMENDATION 3:

- Implement a national approach to tracking offender referrals and services for selected community specialist services.

MANAGEMENT ACTION PLAN FOR RECOMMENDATION 4:

- Implement an Electronic Health Information System.
- Improve clarity and understanding of information sharing requirements and understanding of "need-to-know" principle (among all Health Services staff, and between Health Services and operations staff).
- Identify common issues and lessons learned, and best practices across Boards of Investigations, related to health related information sharing issues.

MANAGEMENT ACTION PLAN FOR RECOMMENDATION 5:

- The Regional Directors Health Services and the Director General Clinical Services and Public Health are responsible for ensuring that offenders have timely access to health education programs and harm reduction products.
- Streamline and integrate delivery of health education and awareness programs to facilitate delivery and tracking.
- Monitoring harm reduction product distribution.

MANAGEMENT ACTION PLAN FOR RECOMMENDATION 6:
• Conduct analysis to verify the validity and reliability of the Mental Health Needs Scale. • Strengthen the process for recording and maintaining offender level of need data.
MANAGEMENT ACTION PLAN FOR RECOMMENDATION 7:
• Implement a national approach to track and monitor outcomes associated with RCMHC activities in each region. • Ensure accurate recording of expenditures related to RCMHCs in CSC's financial system.
MANAGEMENT ACTION PLAN FOR RECOMMENDATION 8:
• Ensure the retention of offenders' ID (e.g., birth certificate, health card) at intake through the development of storage and tracking procedures. • Develop guidelines and procedures to ensure that offenders obtain ID at intake (e.g., birth certificate, health card). • Clarify existing release policy related to the requirements for medication at release and communicate the policy updates to staff.
MANAGEMENT ACTION PLAN FOR RECOMMENDATION 9:
• Improving partnerships with provincial and territorial health authorities to remove barriers to accessing health care and disability benefits. • Clarifying and communicating policies and procedures related to CSC's coverage (i.e., payment) for health services in the community and requirements for medication at release.
MANAGEMENT ACTION PLAN FOR RECOMMENDATION 10:
• Review CSC's model for community mental health services. • Ensure that clinical discharge planning activities are tracked in electronic information systems.
MANAGEMENT ACTION PLAN FOR RECOMMENDATION 11:
• Continue to implement CSC's Chronic Disease Management Strategy.

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LIST OF ACRONYMS

ADHD	Attention Deficit Hyperactivity Disorder
APEC	Aboriginal Peer Education Course
BBSTI	Blood Borne and Sexually Transmitted Infection
BOI	Boards of Investigation
CCC	Community Correctional Centre
CCRA	Corrections and Conditional Release Act
CD	Commissioner's Directive
CDP	Clinical Discharge Planning
CHIPs	Choosing Health in Prisons
CMH	Community Mental Health
CMHI	Community Mental Health Initiative
CMHS	Community Mental Health Services
CMT	Case Management Team
CoMHISS	Computerized Mental Health Screening System
CORR	Compliance and Operational Risk Report
CPO	Community Parole Officer
CRF	Community Residential Facility
CSC	Correctional Service of Canada
DBT	Dialectical Behaviour Therapy
ETA	Escorted Temporary Absence
FASD	Fetal Alcohol Spectrum Disorder
FIFE	Finding in Focus for Evaluation
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HCV	Hepatitis C Virus
HSPMR	Health Services Performance Measurement Report
IFMMS	Integrated Financial and Materiel Management System
IIS	Intensive Intervention Strategy
IMHT	Institutional Mental Health Team
IPO	Institutional Parole Officer
ISAPW	Inmate Suicide Awareness and Prevention Workshop
LTBI	Latent Tuberculosis Infection
MAP	Management Action Plan
MHNS	Mental Health Needs Scale
MHTS	Mental Health Tracking System
MMTP	Methadone Maintenance Treatment Program
MRSA	Methicillin-resistant Staphylococcus Aureus
NCMHC	National Complex Mental Health Committee
NHQ	National Headquarters
OHIS-EMR	Offender Health Information System-Electronic Medical Record
OMS	Offender Management System
OST	Opiate Substitution Therapy
OTN	Ontario Telemedicine Network
PEC	Peer Education Course
PSR	Psychosocial Rehabilitation
RAP	Reception Awareness Program

RCMHC	Regional Complex Mental Health Committee
RDHS	Regional Director of Health Services
RHQ	Regional Headquarters
RTC	Regional Treatment Centre
SIB	Self-Injurious Behaviour
SLE	Structured Living Environment
SMT	Suboxone Maintenance Treatment
STI	Sexually-Transmitted Infection
TB	Tuberculosis
TBS	Treasury Board of Canada Secretariat
TOR	Terms of Reference
WebIDSS	Web-Enabled Infectious Disease Surveillance System
WED	Warrant Expiry Date

1.0 INTRODUCTION

In accordance with the *Five-Year Departmental Evaluation Plan*, the Correctional Service of Canada (CSC) conducted an evaluation of health services. As per the Treasury Board Secretariat's (TBS) *Policy on Evaluation (2009)* and the *Policy on Results (2016)*, the evaluation focused on two core objectives: 1) the continued relevance of health services, including the need for health services offered as part of the continuum of care, and their alignment with departmental and government priorities, as well as federal roles and responsibilities; and 2) CSC's performance in delivering health services, as demonstrated through implementation, effectiveness, efficiency and economy.

CSC delivers health services throughout the continuum of care including intake, incarceration and pre-release and community supervision and focuses on the areas of: mental health, public health and clinical services. By delivering efficient and effective health services, CSC encourages offenders to take responsibility for their own health, promotes healthy reintegration, and ultimately contributes to safe communities.[iii] These objectives are aligned with four of CSC's corporate priorities:[iv]

- Safe management of eligible offenders during their transition from the institution to the community, and while on supervision;
- Effective, culturally appropriate interventions for First Nations, Métis and Inuit offenders;
- Effective and timely interventions in addressing mental health needs of offenders; and,
- Efficient and effective management practices that reflect values-based leadership in a changing environment.

The results and recommendations included in this evaluation report will guide CSC's senior management with future strategic policy and decision-making regarding CSC's health services.

1.1 BACKGROUND

Federal offenders experience many of the same health issues as the general Canadian population. However, compared to the Canadian population, offenders demonstrate a higher prevalence of mental health concerns (e.g., antisocial personality disorder, anxiety disorders, self-injurious behaviour) and physical health concerns (e.g., diabetes, cardiovascular conditions, HIV/AIDS, Hepatitis C).[v] Studies have indicated that individuals entering the correctional system already suffer from poor health due to risky lifestyle behaviours, such as intravenous drug use.[vi] Further, once they are incarcerated, an individual's health concerns may be aggravated.[vii] This may be attributed to a number of characteristics related to the institutional setting, such as shared accommodations, which may expose offenders to new physical health risks, and present opportunities for engaging in high-risk activities that may result in transmission of infectious disease.[viii] Moreover, CSC's offender population is aging. In 2014-15, 24% of federal offenders were 50 years or older compared to 45% of the Canadian population and the number of offenders over the age of 50 at admission has risen over the last ten years.[ix] With this general increase in the number of older offenders, CSC is likely to experience increased demand to address health needs attributed to aging, such as chronic conditions, cardiovascular conditions, and diabetes.[x]

Offenders require access to health services to meet their diverse health care needs throughout their continuum of care. Studies have shown that health services in institutions have positive impacts on offenders' health. One study demonstrated that prison health education had significant long-term effects on offenders' knowledge of the transmission of infectious diseases.[xi] Given that the majority of offenders will be released, their prevalent health concerns could have an impact on the communities in which they are released.[xii] As such, CSC's health services represent an important opportunity to address offenders' health needs.

1.2 POLICY AND LEGISLATION

The delivery of health services for Canadians is a shared responsibility between the federal, provincial and territorial governments. CSC is mandated through federal legislation and corporate requirements to provide health services for federal offenders. Section 86(1) of the *Corrections and Conditional Release Act* (CCRA) states that CSC is obligated to provide every inmate with "essential

health care; and reasonable access to non-essential mental health care that will contribute to the offender's rehabilitation and successful reintegration into the community."[xiii]

In addition to the CCRA, CSC is guided by a series of internal Commissioner's Directives (CDs) that support legislative obligations. CDs specific to health services include the following:[1]

CD 800 – Health Services: focuses on procedures related to health services delivery, including assessments occurring at intake, responsibilities during medical emergency situations, involuntary admission and treatment at Regional Treatment Centres and childbirth arrangements for pregnant offenders.

CD 843 – Management of Inmate Self-Injurious and Suicidal Behaviour: outlines procedures for assigning suicide watch observational levels, including screening for the risk of suicide, descriptions of high and modified suicide watch and mental health monitoring. Also included are procedures for the use of restraint equipment including reporting requirements, application to pregnant offenders and assessment and monitoring.

CD 578 – Intensive Intervention Strategy in Women's Institutions: provides procedures for Structured Living Environments (SLEs) including admission requirements, assessments, use of the therapeutic quiet room, discharge process and outreach support. The Secure Unit procedures are also presented, including rules and expectations, the role of interdisciplinary teams, treatment planning and movement.

1.3 PROGRAM DESCRIPTION

According to the *National Essential Health Services Framework*, health services are defined as physical and mental health services, which include health promotion, disease prevention, health maintenance, patient education, diagnosis and treatment of illnesses. In accordance with CSC's program structure, health services are delivered in three areas:[xiv]

1. Clinical Services: "assessment, diagnosis and treatment of acute and chronic physical illnesses."
2. Public Health: "services and resources on a variety of topics (mental health, wellness, infectious diseases, etc.) provided to inmates related to health promotion and education; disease prevention,

[1] A comprehensive list of CDs that involve a health related component can be found in Appendix A.

control and management of infectious diseases and discharge planning for community reintegration."

3. Mental Health: "assessment, intervention, treatment and support services and discharge planning provided to inmates with mental health needs in the areas of emotion, thinking and/or behaviour."

1.3.1 INTAKE ACTIVITIES

During the intake process, offenders undergo health needs assessments, screening and testing and intervention for immediate mental, clinical and public health care needs. Offenders are also provided with disease prevention initiatives along with health promotion and educational activities. Ongoing surveillance and analysis of offender health needs is initiated at intake and continues throughout incarceration.

1.3.2 INCARCERATION ACTIVITIES

As per CSC's mandate, essential health services are provided to offenders during incarceration. This includes ongoing screening and assessment as required, and various mental, clinical, and public health interventions. Disease prevention measures, health promotion and education, as well as surveillance and analysis of offender health needs, which were initiated at intake, continue throughout the incarceration period.

Mental Health Services: A range of institutional programs and services are available to address offenders' mental health needs. Primary mental health services consist of individual and group interventions (e.g., sleep hygiene, stress management, counselling), as well as crisis intervention as needed. Offenders who require intermediate mental health care may access high or moderate intensity levels of service, women offenders may also access the SLE. Offenders with acute needs that cannot be addressed within the institution may receive treatment at a RTC.

Clinical Services: Offenders are offered primary care (e.g., dental services, pharmacy services) and chronic disease management. Offenders also have access to community specialists if necessary. In addition, CSC offers infectious disease management including the opiate substitution therapy (OST) program which is made available to offenders with substance abuse problems.

Public Health Services: CSC provides a number of public health educational activities to address infectious diseases, such as the Peer Education Course (PEC), which aims to train offenders as peer counsellors and to provide information on infectious diseases. Offenders may also access harm reduction initiatives (e.g., needle exchange programs, bleach kits, condoms).

1.3.3 PRE-RELEASE AND COMMUNITY ACTIVITES

During pre-release, CSC provides routine discharge planning to prepare offenders for transitions in care, including release to the community.[2] Offenders with significant mental health needs may be referred for clinical discharge planning. This process aims to ensure that offenders receive continuity of care by establishing comprehensive plans and transitional services.

In the community, CSC offers essential physical health services for offenders residing in Community Correctional Centres (CCCs) where provincial coverage is unavailable. This may include appointments, dental care, eyewear, and/or equipment and medical devices. In some regions, CSC may provide additional coverage for medication. CSC provides limited community mental health services in select locations to provide support for offenders with significant mental health needs. These services are provided by mental health professionals, and may include monitoring and assessment, education, clinical accompaniment support, mobile services, and community capacity building.

[2] Transitions in care also include transfers between CSC institutions.

2.0 EVALUATION METHOD

2.1 SCOPE OF THE EVALUATION

The scope of the evaluation was determined through a number of activities aimed at identifying evaluation priorities, including:

- Pre-evaluation consultations with approximately 80 CSC key informants from National Headquarters (NHQ), Regional Headquarters (RHQ), institutions and the community. Consultations were conducted in person, by telephone or by videoconference.
- Site visits were conducted at Millhaven Institution and Joyceville Institution to gain a better understanding of the intake assessment process from health services staff members.
- Review of documentation including CSC priorities and risks as well as research, audit, evaluation, accreditation and other performance reports.
- Risk was assessed at the outset with mental health services representing the highest area of risk for the organization, primarily due to the direct link with corporate risk and priorities and the high sensitivity of this area.

The scope of the evaluation was further refined through ongoing consultations with the Office of Primary Interest (OPI), the Health Services Sector, and key stakeholders which assisted in organizing the health services evaluation into three periods: intake, incarceration and pre-release and community supervision. These three periods reflect the continuum of care provided to offenders by CSC and examines clinical, public and mental health services. A brief description of each period is provided below.

2.1.1 INTAKE

The evaluation questions related to intake concentrated on intake screenings and assessment tools, as well as specific health services interventions, health promotion activities, and access to health information. The continued need for CSC health services, alignment with government priorities and federal roles and responsibilities were also explored. Specific questions were included in regards to meeting the health care needs of women offenders, Indigenous offenders and older offenders at intake.

2.1.2 INCARCERATION

The evaluation questions associated with incarceration examined the integration and continuity of health care services, including any challenges or improvements with the new governance structure, health services planning and coordination, and gaps related to accessing health care professionals and health promotion activities. Specific questions were included related to meeting the needs of women offenders, Indigenous offenders and older offenders during incarceration.

2.1.3 PRE-RELEASE AND COMMUNITY SUPERVISION

The evaluation questions for pre-release and community supervision focused on routine and clinical discharge planning and community mental health services. Challenges in regards to offender identification and payment for essential health services were also examined. Specific questions were included in regards to meeting the health care needs of women offenders, Indigenous offenders and older offenders during pre-release and community supervision.

2.2 APPROACH

The evaluation of CSC's health services used a mixed-method research design, incorporating both quantitative and qualitative methodologies. Several lines of evidence were used to address the evaluation issues and questions, including:

2.2.1 LITERATURE AND DOCUMENT REVIEW

An extensive examination of peer-reviewed literature and internal and external documents was conducted, including:

- CSC and other governmental documents and reports (e.g., legislation, policies and regulations, evaluation reports, research reports, audit reports, board of investigations, and other corporate and operational documents);
- A review of Canadian public health initiatives;
- A review of community health roles and responsibilities;
- A review of the prevalence of health issues in the Canadian population and in the offender population;

- A review of the methods of diversion for mental health needs from the criminal justice system; and,
- An environmental scan of health services in other correctional jurisdictions.

2.2.2 QUALITATIVE DATA[3]

Interviews with Offenders: Intake and Incarceration

Offender interviews for intake and incarceration were conducted during institutional visits between November 2014 and January 2015. An interview guide was developed using open-ended and closed-ended questions (such as 5-point Likert-scales, dichotomous and categorical multiple choice questions). Criteria to participate in the intake questionnaire included offenders who were admitted to CSC within the previous 3 to 12 months. The criteria for the incarceration questionnaire included offenders who were incarcerated for a minimum of 15 months or more at CSC at the time of the evaluation. In total, 104 offenders participated in the intake interviews and 149 offenders participated in the incarceration interviews.

The data collected through both questionnaires was entered into Snap Survey software and exported into SPSS and Microsoft Excel. The Evaluation team analyzed qualitative data obtained through open-ended questions using the iterative and inductive[4] process to identify relevant themes. Qualitative data obtained through closed-ended questions were analyzed using descriptive analysis techniques. Frequencies and percentages were calculated based on the number of valid responses to the questions.

Interviews with Offenders: Regional Treatment Centre

Offender interviews were conducted at RTCs located in the Quebec and Prairie regions between January 26 and 29, 2015. An interview guide was developed using open- and closed-ended questions (dichotomous questions and one categorical multiple choice question). In total, 32 offenders participated in the interviews. They were incarcerated for a minimum of 2 months to a maximum of 108 months.

[3] The federal government has transitioned from using the term Aboriginal to describe First Nations, Inuit and Métis peoples to the term Indigenous. The transition took place during the evaluation. The data collection instruments used the term Aboriginal; however, the evaluation report has replaced this with Indigenous where applicable.
[4] An iterative and inductive qualitative analysis process identifies emerging themes and meaning from data through a repetitive reflexive process (see Srivastava & Hopwood, 2009 and Patton, 1980).

Electronic Questionnaires with Staff

Four electronic questionnaires were developed using Snap Survey software and administered through CSC's Intranet site (InfoNet). The questionnaires solicited the views and experiences of health services and non-health services staff in regards to the delivery of health services to offenders throughout the continuum of care. Respondents were representative of all security levels, regions, genders, and facilities across Canada. In addition, an electronic consultation was developed using Microsoft Word and was sent through Outlook. Data were analyzed using the same process and procedures as used for the offender interviews.

Intake and Incarceration

- *Intake*: this questionnaire was launched in October 2014 and solicited responses from health services staff and managers involved in the delivery of health services during intake. A total of 116 participants responded,[5] all regions participated in the questionnaire.
- *Incarceration*: this questionnaire was launched in August 2015 and solicited responses of health services staff members involved in the delivery of health services to offenders during the incarceration period. A total of 196 participants responded[6] with representation from all regions across CSC.
- *General Staff – Incarceration and Intake:* this questionnaire was launched in July 2015 and solicited responses pertaining to general staff and management experiences with health care services during incarceration. A total of 167 participants responded,[7] all regions participated in the questionnaire.

[5] The majority of respondents were from the nursing (53.9%, n = 62) and psychology (18.3%, n = 21) groups. The remaining respondents included: social work (7.8%, n =9), clerical (6.1%, n = 7), administrative services (4.3%, n = 5), pharmacy (2.6%, n = 3), welfare programs (2.6%; n = 3), and others.

[6] The largest percentage of respondents were from the nursing (46.4%, n = 89) and psychology (24.0%, n = 46) classifications. In addition, questionnaires were completed by respondents in the administrative services (8.9%, n =17), clerical (7.3%, n = 14), pharmacy (3.6%, n = 7), social work (3.1%, n =6), engineering and scientific support (2.6%, n = 5), executive and welfare programs (1.6%, n = 3) classifications.

[7] The majority of respondents worked in the institutions (94.5%, n = 156) while a small proportion were from Regional Headquarters (RHQ; 5.5%, n = 9). The majority of respondents worked in men's institutions (80.1%; *n* = 125) while a few (19.8%, n = 31) indicated working in women's institutions. The highest proportion of respondents (38.9%, n = 63) were educators followed by correctional officers (21.6%, n = 35) and employees who work in welfare Programs (19.1%, n = 31). A few respondents worked in administrative services (12.3%, n = 20), the executive group (3.7%; n = 6) and other groups (4.3%, n = 7).

Pre-Release and Community Supervision

- *Pre-Release and Community Supervision*: this questionnaire was launched in August 2016 and solicited responses from institutional and community health services staff as well as managers involved in the delivery of health services to offenders at pre-release and during community supervision. A total of 291 participants responded,[8] all regions participated in the questionnaire.
- *Regional Directors, Health Services*: this consultation was launched in August 2016 and solicited responses from Regional Directors respecting the responsibilities and processes related to offender provincial health cards, payment of fees and essential health services coverage. All regions participated in the consultation.

2.2.3 QUANTITATIVE DATA

Automated data

Various sources of automated data were used for the Evaluation, such as:

Offender Data: Data pertaining to mental health referrals, assessments, and services were obtained from the Computerized Health Intake Screening System (CoMHISS) and the Mental Health Tracking System (MHTS) and analyzed using Statistical Analysis System (SAS) software. Additional data related to sub-population profiles, offender characteristics and correctional outcomes (e.g., institutional incidents) were extracted from the Offender Management System (OMS) and analyzed using SAS.

Human Resource Data: Data extracted from the Human Resource Management System (HRMS) database were provided by CSC's Human Resources Management Section. Data on staff classifications, positions and location, as well as data specific to Aboriginal perceptions training were retrieved for FY 2014 to 2016.

[8] There were mainly two distinct categories of respondents. The largest percentage of respondents was from case management team (57%, n = 165). About half were community parole officers (53%, n = 87), and a small number institutional parole officers (22%, n = 36), parole office supervisors (13%, n = 21). The other category was health services staff (39%, n = 112). Some of the health services staff were institutional nurses (34%, n = 38), community mental health nurses (26%, n = 29), and a small number of clinical social workers (14%; n = 16). There was a remaining small number of uncategorized respondents (5%, n = 14).

Financial Data: Financial data for health services expenditures was retrieved from the Integrated Financial & Material Management System (IFMMS) for FY 2012-13 to 2015-16 and were analyzed using Excel.

2.3 MEASURES

Analysis of Qualitative Data

The following scale was used throughout the current report to indicate the weight of emerging qualitative themes[9] and to facilitate the interpretation of evaluation results.

- *A few/a small number of interviewees* = less than 25%;
- *Some interviewees* = 25% to 45%;
- *About half of interviewees* = 46% to 55%;
- *Many interviewees* = 56% to 75%;
- *Most interviewees* = over 75%; and,
- *Almost all interviewees* = 95% or more.

2.4 LIMITATIONS AND MITIGATION STRATEGIES

Evaluations face constraints that may have implications for the validity and reliability of the evaluations findings and recommendations. The following table outlines the limitations encountered along with the impact experienced and the mitigation strategies put in place to ensure decision makers have confidence in evaluation the findings and recommendations.

Limitation	Impact	Mitigation Strategy
Missing or unreliable data (e.g., health referrals, wait times, program participation, level of need, financial expenditures, offender identification, clinical discharge planning activities).	Inability to report on the effectiveness, efficiency and/or economy of the health services evaluation.	Unreliable data was excluded from our analyses and recommendations were made to track and record pertinent information.
Sample size too small to conduct analyses and/or draw conclusions: - Older offenders (e.g., health services intake assessment	Comprehensive information for specific populations of offenders is not complete. Inability to analyze the effectiveness and efficiency of	Older offender health requirements and services were assessed in other components of the evaluation where possible (e.g., health services for specific

[9] This scale has been adapted from Employment and Social Development Canada.

Limitation	Impact	Mitigation Strategy
screening tool) -Women and Indigenous offenders (e.g., impact of mental health treatment on correctional outcomes in mainstream institutions and RTCs)	services for specific populations (e.g., women and Indigenous offenders) independently.	populations). Women and Indigenous offenders were included in the overall analyses.
Correctional outcomes (e.g., institutional incidents) could be the result of time passing (i.e., outcomes more likely to occur later in an offender's sentence) or participation in mental health treatment.	Difficult to determine the construct validity of the analysis.	A random sample of offenders was selected as a comparison group and arbitrary treatment timelines were implemented to compare results.
During mental health treatment, offenders may demonstrate heightened emotional instability, resulting in correctional outcomes (i.e., institutional incidents).	Difficult to determine if treatment has any significant impact on correctional outcomes during treatment.	Results will be presented to identify that outcomes during treatment are to be interpreted with caution.
A small number of RTC interviews were completed.	Experiences reported only represent a small subset of the population.	Other lines of evidence were used to substantiate and provide further information on data received in interviews.

3.0 FINDINGS

The key findings of the Evaluation on Health Services are presented under the following seven FIFEs:

- FIFE #1: Relevance of CSC's Health Services
- FIFE #2: Effectiveness and Efficiency of CSC's Health Services Intake Assessment Process
- FIFE #3: Offender Access to Care and Services
- FIFE #4: Public Health Education and Harm Reduction
- FIFE #5: Institutional Mental Health Services
- FIFE #6: Pre-Release and Community Health Services
- FIFE #7: Management and Coordination of Health Services

FIFE #1: RELEVANCE OF CSC'S HEALTH SERVICES

The first FIFE focuses on the continued relevance of mental, clinical and public health services, including the need for health care services, and alignment of health services with departmental and government priorities and federal roles and responsibilities. This section provides a broad overview of offenders' health care needs. Specific health care needs of offenders (including needs for special populations) in the context of services provided will be reviewed in more detail during subsequent phases of the evaluation as we progress to an examination of the effectiveness and efficiency of health services provided to offenders. The findings, supporting evidence and implications for the relevance of health care services are presented below along with next steps, which are meant to guide decisions in the development of a MAP.

3.1 NEED FOR HEALTH SERVICES

FINDING 1: NEED FOR HEALTH SERVICES

There is a continued need for delivery of clinical, public and mental health services to CSC offenders.

There is a demonstrated need for health services within Canadian federal institutions. Although federal offenders have many of the same mental, clinical, and public health issues as the general Canadian population, the prevalence of certain health issues is significantly higher among federal offenders compared to the general public. Offenders often enter the correctional systems in poor health and have had limited contact with the health system.[xv] Compared to the Canadian population, offenders have more lifestyle risk factors associated with poor health (such as history of injection drug use, employment problems), and have higher rates of substance abuse, communicable diseases and mental illnesses upon arrival to the correctional institution.[xvi] In addition, studies have found that factors related to the prison environment, such as shared accommodations, can exacerbate existing health conditions (especially conditions related to stress) or contribute to new health issues, particularly with respect to infectious disease transmission.[xvii]

The following section provides an overview of some of the most prevalent health care needs of offenders in CSC (see Appendix B for more specific information on specific populations).

Evidence:

There is a significant need for clinical health services for offenders, which is expected to grow with an aging offender population.

- CSC is responsible for providing health service screening, referral and treatment to inmates including emergency and urgent health care.[xviii]
- In addition to ongoing acute physical needs that require more immediate and urgent attention (such as treatment of falls, broken limbs), many offenders have chronic clinical health care needs (e.g., central nervous system illnesses, cardiovascular illnesses, and respiratory illnesses)[10] that require continuous care and/or monitoring.
- Among newly admitted federal offenders, the most prevalent self-reported current or past clinical health conditions for men and women offenders are head injuries (34% and 23%, respectively), back pain (19% and 26%), and asthma (15% and 16%).[11] [xix] For women offenders, menopause is also a prevalent condition (19%).[xx]
- Prevalence of some conditions was higher among CSC offenders than the general population (e.g., asthma).In addition, although the rates of diabetes (8%) and obesity (23%) are high among CSC offenders; the rates are comparable to those of the general Canadian population.[xxi]
- CSC offenders are aging. According to a 2014 research study, the proportion of incarcerated offenders over the age of 50 years has increased since 2006 and is expected to continue to increase over the next five years, with the most prominent increase projected to occur among non-Indigenous men offenders.[xxii] Furthermore, certain chronic illnesses (e.g., high blood pressure, high cholesterol) increase with age, and will consequently increase the need for chronic care among CSC's older offenders.[xxiii]

Communicable diseases (e.g., HCV, HIV) are more prevalent among federally incarcerated offenders than the general Canadian public.

- The most frequent public health issues (i.e., communicable diseases) among the federal offender population are Hepatitis C Virus (HCV), Latent Tuberculosis Infection (LTBI), and the Human Immunodeficiency Virus (HIV).

[10] Some of the chronic physical health needs can also result in acute episodes (e.g., heart attack).
[11] These rates were based on self-report of current or past head injury and may therefore include a broad range of injuries. A review of health files found that 2% of offenders had evidence of current or recent brain injury. See Correctional Service Canada. (2015). *Estimates of chronic disease prevalence among CSC inmates.* Ottawa, ON: Health Services.

- According to CSC Health Services data, the prevalence of HCV, LTBI, and HIV were 17%, 17%, and 1%, respectively.[xxiv] Rates of HCV and HIV are higher among the federal offender population in comparison to the Canadian population (1% and 0.3% respectively).[xxv]
- The self-reported prevalence rates of HCV and HIV are consistently higher among Indigenous offenders than non-Indigenous offenders and among older offenders than young offenders.[xxvi]
- In addition, HIV and Acquired Immunodeficiency Syndrome (AIDS) are key risk factors for Tuberculosis (TB). Within the Canadian population, the prevalence of TB is disproportionately higher among Indigenous peoples (19.9 per 100,000) than non-Indigenous peoples (0.6 per 100,000).[xxvii]

Mental disorders are among the most frequent conditions affecting federal offenders.[xxviii] Among the most commonly identified mental health issues were anxiety disorders and antisocial personality disorder.

- According to the 2012 Canadian Community Mental Health Survey,[xxix] approximately one in ten Canadians meet the criteria for a current (i.e., within past12 months) mental or substance use disorder.
- Comparisons between the offender population and the general Canadian population on rates of mental health disorders are difficult due to the use of different definitions and samples, but evidence indicates that mental health issues are at least as prevalent, and more so for specific disorders, among the offender population.
- Mental disorders are among the most frequent chronic conditions affecting federal offenders. According to the treatment-based definition utilized by CSC Health Services, 28% of incarcerated offenders have mental health needs.[12] This includes 57% of women offenders (26% of men offenders), and 32% of Indigenous offenders (26% of non-Indigenous).[xxx]
- The most prevalent mental health disorders among federal offenders are:[xxxi]
    - Men offenders: anxiety and mood disorders with current prevalence rates of 30% and 17%, respectively.[13]

[12] Mental health need is determined by having at least one mental health treatment-oriented service or stay in a treatment centre in the previous six-months.

[13] This refers to a one-month prevalence rate [the prevalence rate for current disorders (i.e. disorders that were present in the month prior to the study)].

  - Women offenders: anxiety disorders (e.g., prevalence rates of 31% for post-traumatic stress disorder, 18% for specific phobia, and 16% for generalized anxiety disorder) and attention-deficit/hyperactivity disorder (17%).[14]

- Personality disorders, which are characterized by stable and consistent expression of pathological personality traits that cause impairment to the individual or interpersonal functions,[xxxii] are also common among federal offenders.
  - The lifetime prevalence of antisocial personality disorder for men and women offenders were 44% and 83%, respectively.[15]
- Self-injurious behaviour (SIB)[xxxiii] occurs for both men and women offenders, but for different reasons. A research study examining incidents of SIB within a 30-month period found that women more frequently engaged in SIB whereas men's SIBs were more likely to result in more serious bodily harm. The difference in bodily harm may be related to the different types of SIB committed by men and women offenders. Specifically, the researchers noted that women offenders were more likely than men offenders to engage in head banging behaviour, which is less likely to result in visible physical injuries. In comparison, men offenders were more likely than women offenders to cut themselves, overdose, threaten to harm themselves, and open wounds.

3.2 ALIGNMENT WITH PRIORITIES AND FEDERAL ROLES & RESPONSIBILITIES

FINDING 2: ALIGNMENT WITH PRIORITIES AND FEDERAL ROLES & RESPONSIBILITIES

CSC Health Services are aligned with federal government priorities. CSC is responsible for providing health services to federal offenders, but there is an ongoing need for partnerships to effectively and efficiently deliver services to offenders.

[14] This refers to a one-year prevalence rate [the sample's continued experiences with an active disorder (i.e. in the year prior to the study)].
[15] A lifetime prevalence rate refers to the proportion of a population that has experienced a condition at some point in their life. Such rates are used for personality disorders because they involve enduring patterns of behaviour.

Evidence:

The priorities of CSC's Health Services are aligned with CSC corporate priorities and ultimately to federal government priorities and legislation related to health service.

- Health Services provide services that contribute to four of CSC's six corporate priorities.
  - Health Service contributes to safe management of eligible offenders during their transition from the institution to the community, and while on supervision by providing essential health care and reasonable access to non-essential mental health care.
  - Health Services contributes directly to addressing the mental health needs of offenders through timely assessment, effective management, appropriate intervention, relevant staff training and rigorous oversight.
  - Health Services supports CSC's corporate priority, to provide "[e]ffective, culturally appropriate interventions for First Nations, Métis and Inuit offenders"[xxxiv] through its commitment to "[i]mprove capacity to address the health needs of Indigenous offenders, aging offenders and offenders with mental health disorders".[xxxv]
  - Health Services contributes to CSC's corporate priority of "[p]roductive relationships with diverse partners, stakeholders, victims' groups, and others involved in public safety",[xxxvi] for example, by engaging national and regional or local partners to assist in the transition of offenders with mental health needs to the community.
- In addition, CSC's Health Services contributes more broadly to the Government of Canada's Mental Health Action Plan for Federal Offenders [xxxvii] and aligns with the federal government's priority to support the health and well-being of all Canadians.[xxxviii] The Minister of Public Safety and Emergency Preparedness has also been given the mandate to work with other Ministers to address gaps in services to those with mental illness throughout the criminal justice system.[xxxix]

The delivery of health services for Canadians is a shared responsibility between the federal, provincial, and territorial governments. CSC retains ultimate responsibility for the health care of federal offenders although partnerships play an important role in service delivery and facilitating continuity of services.

- In general, the delivery of health services falls under the jurisdiction of the provincial government.[xl]

- However, the federal government is responsible for the provision of health services for specific groups: First Nations and Inuit peoples (Health Canada); veterans (Veterans Affairs Canada); members of the Canadian Forces (Department of National Defence); members of the Royal Canadian Mounted Police (RCMP); refugee claimants (Citizenship and Immigration Canada); and, inmates in federal correctional facilities (CSC). According to section 86(1) of the *Corrections and Conditional Release Act* (CCRA), CSC is mandated to provide "essential health care; and reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community".[xli]
- A review of potential alternative models for the delivery of health services for federal offenders reaffirmed the role of CSC in the delivery of health services to federal offenders. The review examined legislation concerning health service delivery in Canada, existing health service delivery arrangements for provincial/territorial correctional populations, practices in some international jurisdictions, and feedback from external stakeholders and partners.[xlii] Additionally, it was concluded that improvements to service delivery should be explored through new partnerships.
- Partnerships with other levels of government (e.g., provincial and territorial governments[16]) and non-governmental stakeholders are established to ensure continuity of services from admission to a federal institution, throughout the period of incarceration, release to community supervision, and finally after warrant expiry particularly in light of the different roles and responsibilities of the partners prior to, during, and after the completion of an offender's sentence.[17]

CSC Health Services is involved in mental health diversion for offenders after they enter the federal correctional system by facilitating re-entry into the community and support for offenders supervised in the community.

Mental health diversion within the criminal justice context refers to "an option to divert persons with mental disorders to appropriate treatment, supports and corrections systems in order to address the mental issue contributing to the offending behaviour" and may be offered at various points along the continuum of involvement with the criminal justice system.[xliii]

[16] CSC is part of the Federal, Provincial, Territorial Heads of Corrections Working Group on Health and Mental Health.
[17] CSC partners with governmental and non-organizations across the country that provide supports to offenders with mental health needs, at both the national and provincial levels (e.g., Mental Health Commission of Canada, Canadian Mental Health Association, National Aboriginal Health Organization, etc.).

Diversion can occur before (pre-contact) or after (post-contact) initial contact with the criminal justice system (see Appendix C for more information).

Pre-contact diversion occurs prior to an individual's first contact with the criminal justice system (i.e., prior to encounter with police)

- Pre-contact diversion initiatives focus on crime prevention through interventions that target an individual's mental health risk factors before crime occurs.

Post-contact diversion occurs after an individual's first contact with the criminal justice system (i.e., upon contact with police or later)

- Post-contact diversion is for individuals already engaged with the criminal justice system and has been described using the Sequential Intercept Model.[xliv] The model identifies five points (intercepts) at which individuals with mental health needs could be diverted:
  - **Intercept 1:** First interactions with law enforcement and emergency services (e.g., police-based);
  - **Intercept 2:** Post-arrest (pre-trial): initial detention/hearing or pretrial services;
  - **Intercept 3:** Court-based diversion (e.g., mental health courts);
  - **Intercept 4:** Re-entry planning from jails, prisons, and forensic hospitalization; and
  - **Intercept 5:** Community corrections and community support.
- CSC is primarily involved in post-contact mental health diversion at intercepts 4 and 5:[xlv]
  - Intercept 4: (Re-Entry Planning): CSC clinical social workers develop discharge plans for offenders to facilitate the transition from the institution to the community.[18]
  - Intercept 5: (Community Corrections & Community Support): CSC community mental health specialists provide support to offenders supervised in the community to ensure continuity of services.[19]

[18] This involves collaboration with case management staff members (e.g., institutional/community POs) to assess the psychosocial needs of offenders with mental disorders, identify and develop linkage to community resources, and formulate comprehensive discharge plans to facilitate continuity of mental health services into the community.
[19] Services include comprehensive assessment & intervention planning, direct service provision such as individual counselling, consulting with case management staff to assist in managing offenders in the community, and advocacy for offenders with mental health needs.

Effective earlier mental health diversion strategies could result in: cost savings and improved public safety outcomes.

Cost Savings:

- Research shows that mental illness often begins during childhood or adolescence.[xlvi] Investment in pre-contact diversion initiatives targeting the mental health of children and youth could lead to long-term economic impacts. For instance:
  - A study in the UK estimated that £230,000 ($365,000) per person could be saved in the areas of criminal justice, health and increases to individual earnings through early prevention of conduct disorders.[20] [xlvii]
  - A systematic review by the Washington State Institute for Public Policy of evidence-based options to reduce costs to the criminal justice and correctional systems found that Multisystemic Therapy (MST)[21] demonstrated a net savings of $18,213 in victim and criminal justice costs per participant[xlviii] or approximately a savings of $5.27 for every dollar spent on MST.
  - There is some evidence that crime prevention programs are cost-effective. For example, an evaluation of the cost effectiveness of the crime prevention program Stop Now and Plan (SNAP) implemented in Edmonton found that for every dollar spent there was a savings of four dollars (in costs for police, courts, incarceration, probation, etc). [xlix] Although the implementation of SNAP in Edmonton was not specific to youth with mental health issues, there is a model of the program that specifically targets youth with mental health needs. A more recent study examining another SNAP program found savings of $2.05 to $3.75 for every $1 spent on the program based on data on convictions.[l]

Improved Public Safety Outcomes:

- Diversion initiatives may contribute to reductions in recidivism. For example, mental health courts have been associated with fewer arrests and jail days (e.g., an average of 3 days instead of 23 days), a significant to moderate effect on reducing recidivism.[li]

[20] Conduct disorders in children and youth have been identified as a precursor of antisocial personality disorder in adults, which is a particularly prevalent disorder in the offender population. (Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23000 prisoners: A systematic review of 62 surveys. *The Lancet, 359*(9306), 545-550).

[21] MST is a program model that targets youth with serious behavioural issues by addressing the systems or settings related to the problematic behaviour. (MST Services, Inc. (2015). *Multisystemic therapy*. Retrieved from http://mstservices.com/what-is-mst/what-is-mst.).

- Diversion initiatives may also contribute to cost-savings to criminal justice (e.g., costs associated with serving time in jail, encounters with police, and court) [lii] and correctional systems.
- Although costs saved to the correctional system by post-contact diversion initiatives may be displaced to the health system, the costs may nevertheless be offset by savings associated with emergency responses such as ambulance services and hospitalization and criminal justice costs such as arrest and ultimately incarceration.[liii] [22]
- In addition, several community-based prevention programs for at-risk youth have been shown to improve short-term outcomes such as knowledge and attitudes towards substance abuse and violent/aggressive behaviour, as well as reduction in problematic behaviours (e.g., substance abuse, limited attachment to school, associations with delinquent peers, violent/aggressive tendencies, early contact with the justice system, etc.), and contacts with the police.[liv]

Next Steps for CSC:

CSC could strengthen its involvement in mental health diversion activities through engagement with governmental and non-governmental partners and stakeholders.

- CSC is engaged in several initiatives with a focus on mental health partnerships, including:
  - An Integrated Community Engagement Strategy, in which one of the areas of focus is mental health; and,
  - A sub-committee comprised of Assistant Deputy Ministers on Mental Health (with one of the areas of focus is outreach to partners, including mental health prevention and diversion).
- It is through strong partnerships that opportunities may arise to collaborate and contribute to referrals to appropriate, timely services for individuals with mental health needs.
- At a broad level, opportunities exist for CSC and federal partners (e.g., Health Canada and Public Safety Canada) to engage other national stakeholders (such as the Canadian Mental Health Commission and others) in prevention and intervention efforts in order to address mental

[22] For instance, among participants in *Streets to Homes* (a program in Toronto that offers help in finding long-term housing for homeless people), just under one half of sampled participants had mental disorders. Furthermore, the number of arrests and jail admittances were reduced by 56% and 68%, respectively (City of Toronto, 2009), as cited in Centre for Addiction and Mental Health, & Canadian Council on Social Development. (2011). *Turning the key: Assessing housing and related supports for persons living with mental health problems and illness.* Calgary, AB: Mental Health Commission of Canada.

illness or provide other supports outside of the criminal justice and correctional systems (e.g., housing for persons with mental disorder).

- In addition, CSC could engage in other partnerships and activities to intervene at earlier intercepts in the Sequential Intercept model, to divert individuals from entering CSC jurisdiction. Activities may include:
  - Liaising with local police services, first responders, crisis response sites and subsequent mental health service providers (intercept one).
  - Case management staff participation in post-arrest (pre-trial) diversion in order to divert parolees from incurring additional sentences for relatively minor infractions (intercept two).
  - Providing subject matter expertise on effective case management to therapeutic courts to contribute to both public safety and therapeutic results (e.g., integrating correctional case management practices to address both criminogenic needs and mental health needs - intercept three).
- Emerging research on mental health diversion also suggests benefits with respect to public safety results and cost-savings. Persons with significant mental health needs will require mental health treatment, either within the correctional environment or in the community. From a humanitarian perspective, it may be more appropriate to treat some offenders in the community, particularly those who are low risk, but who have high needs, and whose criminal behaviour is likely the result of having a mental illness.[lv]

RECOMMENDATION 1: MENTAL HEALTH DIVERSION

That CSC maintains productive relationships with partners who support individuals with mental health disorders.

FIFE #2: EFFECTIVENESS AND EFFICIENCY OF CSC'S HEALTH SERVICES INTAKE ASSESSMENT PROCESS

The following section focuses on assessment of offenders' health service needs and referral to appropriate health care services during the intake period. The effectiveness and efficiency of the offender intake assessment tools and process are examined. The findings, supporting evidence and implications for the relevance of health care services are presented below along with next steps, which are meant to guide decisions with regards to the development of a management action plan.

Overview: Health Services Main Intake Assessment Tools

During the intake period, offenders are offered voluntary assessments, including physical and mental health screening and assessments.[23] CSC Health Services administers four main tools to assess offender health at intake: the 24-Hour Health Intake Assessment, the 14-day Health Intake Assessment, Infectious Disease Screening, and the Computerized Mental Health Intake Screening System (CoMHISS).

The *24-Hour Health Status Intake Assessment* is a tool administered by a nurse within 24 hours of an offender's admission to an institution. This assessment includes questions about offenders' immediate mental (e.g., suicidal or self-harming behaviour) and physical health needs (e.g., current physical health issues, allergies, and medications).[24]

The *14-Day Health Status Intake Assessment* is an assessment tool completed by a nurse within the first two weeks of the offender's admission to the institution. At the time of the evaluation, this tool involved a series of questions about the offender's mental (e.g., stress management, etc.) and physical (e.g., diabetes, etc.) health. It is similar to the 24-Hour Health Status Intake Assessment, but is more detailed and addresses both the offender's immediate health needs and medical history. This assessment also involves measurement of height, weight, and vital signs (e.g., blood pressure).[25]

[23] Although this document refers to "assessments," note that assessment processes and tools also comprise a screening component.
[24] Falls risk screening is also completed as part of the 24-hour intake assessment. If the screening criteria are met, offenders are referred for the Morse Falls Scale to determine whether fall prevention interventions should be implemented.
[25] The Health Status Admission Assessment is also completed as part of the 14-day intake assessment for those who are 50 or older or those with self care needs, to identify any special health care needs for these populations. Note, as of August, 2015, the Health Status at Admission Assessment is completed for those who are 65 years or older or anyone with self-care needs.

The 14-day Infectious Disease Screening is performed by a nurse within 14 days of an offender's admission to the institution. This assessment includes questions concerning the offender's immunization/vaccination history and any tests for infectious diseases (e.g., sexually transmitted diseases, tuberculosis, and hepatitis). During this assessment, the nurse also discusses risk factors for infectious diseases with the offender, such as tattoos, drug use, and body piercing.

Computerized Mental Health Intake Screening System (CoMHISS) is an offender self-administered assessment tool that specifically assesses mental health needs. It is completed within 3 to 14 days of admission and is used to identify offenders who are experiencing any mental health symptoms that may require further assessment and intervention. The assessment includes questions related to past or present mental health symptoms, diagnoses, medications or treatments, suicidal ideations, attention deficit hyperactivity disorder (ADHD), as well as cognitive deficiencies and intellectual abilities.

3.3 EFFECTIVENESS OF HEALTH SERVICES INTAKE ASSESSMENT

FINDING 3: EFFECTIVENESS OF HEALTH SERVICES INTAKE ASSESSMENT

The overall health services intake assessment tools and processes are effective in identifying offender health needs.

Evidence: Effectiveness of Intake Assessment

Health intake assessment tools and processes are effective in identifying offender health needs.

No significant challenges with the intake assessment tools and process in identifying offender health care need were observed based on a comprehensive review of health-related documents, reviews, and investigations.

- All offenders admitted to CSC must be offered the opportunity to participate in the health service intake assessment, including the 24-hour assessment, 14-day assessment, infectious disease screening, and CoMHISS.[26]
    - According to Health Services performance measurement data, most offenders complete these assessments and many are completed on time in accordance with health services guidelines. Rates of timely completion of intake assessments for fiscal year 2013/2014: 24-

[26] The types of offender admission pertaining to each assessment are described on p.31 of this report.

Hour Assessment (96%), 14-day Assessment (67%), 14-day infectious disease screening (65%),[lvi] and CoMHISS (80%).[lvii]

- Similarly, almost all of the offenders interviewed for the evaluation during the intake period indicated that they completed the health status intake assessments.[27]

- CSC's health services intake assessment process was explicitly identified as a strength in the 2014 CSC Health Services Accreditation report.[lviii] Specifically,
  - The Pacific Region was acknowledged for strengths in "intake assessment and medication reconciliation process on admission, transfer and release" (p. 42) and exemplary "falls prevention program and alert identification of inmates at risk" (p. 43).
  - In the Ontario Region, the accreditation team noted that extensive assessments were "consistently applied across all the institutions visited during the on-site survey" (p. 43) and "all requests for health care are triaged by a nurse, with response and further action communicated to the inmate" (p. 44).
- Examination of Mortality Reviews and health-related Boards of Investigation[28] available at the commencement of the current evaluation[29] did not find any evidence that the intake assessment tools and process was a contributing factor to the incident. Although a few intake assessments were completed after the timeframes outlined in guidelines, there was no evidence that the timing of the assessments had an impact on the incidents.[30]

[27] Percentage of offenders interviewed during intake period who reported that they had completed each of the following intake health assessment tools: 24 hour and 14 day 95% (n=95), infectious disease screening 95% (n=93), and CoMHISS 89% (n=57).

[28] CSC conducts Boards of Investigations (BOIs) when significant incidents occur as well as Mortality Reviews in the cases on deaths by natural causes. Only health-related BOIs were reviewed for this investigation including: assault of a staff member, assault of an inmate, suicide of an inmate, attempted suicide of an inmate, attempted suicide and subsequent death, self -inflicted injury of an inmate, overdoes interrupted, hostage-taking on an inmate, injury of inmate, death by unknown cause of an inmate.

[29] The evaluation examined reports available at the time the evaluation commenced, which included reports that were convened and completed in fiscal year 2012-2013.

[30] In most cases where a health intake assessment was completed late, it was the 14-day assessment, all of which were ultimately completed, and there was no evidence within the reports to suggest that the timing of the assessments had an impact on the incident. In one investigation, the Health Status Admission Assessment for offenders who are 50 or older was not completed; however, there was no evidence to suggest that its non-completion had an impact on the incident.

- Finally, few health services staff members reported challenges related to the accuracy of the tools or challenges related to the referral process in identifying offender health needs based on results of the 24-hour, 14-day, or infectious disease assessment tools.[31]

The majority of offenders were satisfied with the health intake assessment and most staff and offenders agreed that intake assessments were completed at an appropriate time to identify offender health needs.

- The majority of offenders interviewed were extremely or very satisfied that the health intake and screening assessment processes identified existing mental (78%, n=74), physical (63%, n=62), and public health care needs (i.e., infectious disease needs; 84%, n=76) upon their arrival at CSC.[32]
    - Among those who reported lower levels of satisfaction, a few offenders reported they had unidentified physical health needs (n=7), or that their mental health assessment had not been through enough (n=7);
    - Offenders suggested that health intake and screening process could be improved by: reviewing previous medical records from the community or from the provincial correctional system (n=6), or by modifying the intake process (e.g., to take more time to complete the assessments or include more one-on-one assessment for CoMHISS; n=12).
- Most offenders also reported that they received follow-up on referrals. Specifically, the majority of offenders, 74% (n=64) indicated that they were advised by a nurse that a referral for a follow-up appointment would be made to address their health needs, of which 89% (n=57) reported receiving the follow-up appointment with a health care professional.
- Few staff or offenders reported that they disagreed with the timing of the health intake assessments to identify offender health needs.[33]

[31] Less than one-quarter of health services respondents familiar with the tools identified any challenges to accuracy of the 24-hour (23%, n=13), 14-day (22%, n=11), or infectious disease assessment (14%, n=6). Few health services staff reported experiencing challenges referring offenders to health services based on the results of the 24-hour (24%, n=13), the 14-day (20%, n=10), or the infectious disease screening (10%, n=4). Note that number of respondents for each assessment tool varied, due to the fact that only staff members familiar with each of the assessment tools were asked to respond to these questions.

[32] Based on interviews with a sample of offenders recently admitted to CSC (within 3 to 7 months of admission).

[33] The following percentages of offenders interviewed at intake disagreed with the timing of intake assessments (14%, n=15). For staff questionnaire respondents, percentage disagreement was: 24-hour (13%, n=8), 14-day (20%, n=11), Infectious Disease Screening (20%, n=9), CoMHISS (32%, n= 7).

CoMHISS[34] is generally effective in identifying offender mental health needs, but may somewhat over-identify offenders requiring mental health treatment.

According to data analyzed as part of the current evaluation (i.e., selected from all offenders admitted to CSC in FY 2013-2014 and FY 2014-2015), among the sample of offenders who completed CoMHISS assessment:[35]

- 26% (n=2034) were flagged for mental health follow-up;
- 20% (n=1524) were assessed as unclassified;[36] and,
- 54% (n=4188) were screened out.[37]

To examine the effectiveness and sensitivity of CoMHISS, the percentage of offenders who received mental health treatment among offenders who were flagged and screened out by CoMHISS was examined. Offenders were considered to have received mental health treatment if they received a mental health treatment-oriented service resulting from a referral generated within 4 months of admission[38] or if they were admitted to a Regional Treatment Centre.[39]

CoMHISS effectively *screens out* most offenders who do not require mental health treatment:

- Most offenders (79%; n=3309 of 4188) screened out by CoMHISS did not receive mental health treatment.
- Few offenders (21%; n=879) screened out by CoMHISS received mental health treatment.

[34] Note that the effectiveness and over-identification of needs could not be examined for all intake mental health assessment tools since information on referral from other intake tools is not tracked electronically.
[35]CoMHISS identifies three groups of offenders: (1) Flagged: offenders require mental health follow-up; (2) Unclassified: offenders have a moderate need for mental health services and mental health staff are required to conduct at least a file review to determine whether or not an offender required follow-up mental health assessment or services; and, (3) Screened out: offenders do not require follow-up mental health services.
[36] Among offenders who were unclassified, 39.5% (n=602, including 44 offenders admitted to a regional treatment centre) received mental health treatment and 60.5% (n=922) did not receive mental health treatment.
[37] These percentages are comparable to those reported by Martin et al (2013) who examined the scoring model utilized in the current version of CoMHISS for all offenders admitted to the Pacific Region over a 15-month period from October 2006 to December 2007. See Martin, S., Wamboldt, A., O'Connor, S., Fortier, J., & Simpson, A. (2013). A comparison of scoring models for computerised mental health screening for federal prison inmates. *Criminal Behaviour and Mental Health, 23*(1), 6-17.
[38] In order to examine the intake period, treatment-oriented services were only included if they were linked to a referral that was made within 4-months of the offender's admission. Treatment-oriented services included: group or individual counselling; group or individual mental health counselling; psychiatric clinic; skills training, self-care or activities of daily living; suicide or self-injury intervention; and, treatment planning.
[39] Date of admission to a regional treatment centre was between the offender admission date in fiscal year 2013-14 or 2014-15 to the data extraction date in September, 2015.

- Among those offenders screened out who did receive treatment, mental health need may have been identified through other intake assessments[40] particularly since research indicated that each of the three mental health intake assessment tools uniquely identify offenders requiring mental health follow-up.[lix]Alternately, the referrals and treatment may have been required as a result of an urgent or emerging need within the intake period.

CoMHISS may be over-sensitive in that some offenders *flagged* for further mental health assessment did not receive mental health treatment:

- Many offenders (60%; n=1222 of 2034) who were flagged by CoMHISS received mental health treatment.
- A few offenders (2.5%; n=50) flagged by CoMHISS refused services.[41]
- Some offenders (37.5%; n=762) flagged by CoMHISS did not receive any mental health treatment for a referral made during admission, suggesting that the tool may be over-sensitive.
- This finding is consistent with results from staff questionnaires:
  - Many (75%, n=14) health services staff familiar with the administration of CoMHISS reported challenges with respect to the accuracy of CoMHISS in identifying offender health needs. The most commonly noted issue was that there were a number of "false positives" or that the tools screened in offenders for further assessment who did not have a mental health need.
  - About half (53%, n=10) of health services staff respondents also reported challenges making referrals based on results of CoMHISS, most commonly noting that that offenders were unnecessarily screened-in for further assessment.
- The current version of CoMHISS includes assessment of ADHD as well as cognitive deficits.[42] Although offenders with these conditions may be flagged by CoMHISS, they may not necessarily be referred for treatment but rather results would be taken into consideration in assessing programming needs.

[40] This information was not available, since the sources of other referrals for mental health treatment (other than CoMHISS) are not tracked electronically.
[41] 1 offender refused the referral and 49 offenders refused at least one mental health service. The service may have been a treatment-oriented service or another service (such as an assessment that may have led to a future treatment-oriented service). Therefore all were included as refusals in this analysis.
[42] Other issues may have impacted on these results, including the possibility that CoMHISS referrals or treatment were delayed beyond the initial intake period, or that data entry errors occurred in MHTS.

Health services intake assessment tools are generally responsive to the needs of specific offender populations. However a minority of staff members indicated that there may be communication or cultural challenges to the administration of health services intake assessment tools for Indigenous and visible minority offenders.

- Information for the intake assessment period was reviewed (where available) for the following groups of offenders: Indigenous offenders, visible minority offenders, older offenders, and women offenders.
- Based on the available information from staff questionnaires, offender interviews, and health services performance measurement data, the assessment tools were reported to be generally responsive to the needs of these specific offender populations (see Appendix D for more detailed information for specific populations).
- However, a few challenges to the intake assessment process were reported for Indigenous and visible minority offenders.
    - Although most health service staff respondents did not report any challenges for specific populations, a few reported that there were communication or cultural challenges[43] in completing intake assessments for Indigenous (n=10) or visible minority offenders (n=15).
- Most health services staff (61%, n=34)[44] and Indigenous offender respondents[45] (78%, n=18) reported that Elders were rarely involved in completion of intake assessment tools, but many Indigenous offenders interested in following a traditional healing path reported that having an Elder present would have been helpful (n=11).[46]

[43] Communication and cultural challenges include language barriers and barriers with the assessment not identifying offenders' mental health issues due to cultural differences surrounding beliefs about mental health.
[44] Percentages for staff ranged from 61% for 14-day intake assessment to 73% for COMHISS or infectious disease screening (see Appendix D for more information).
[45] This represented the percentage of Indigenous offenders interested in following a traditional healing path who reported that they did not have an Elder present during health intake assessments.
[46] The presence of Elders during health intake assessments is not specified in health services guidelines with the exception of CoMHISS where, according to the *National Guidelines: Version 2.2* (June 2014), offenders may request the presence of an Indigenous advisor during the CoMHISS assessment.

3.4 EFFICIENCY OF HEALTH SERVICES INTAKE ASSESSMENT PROCESS

FINDING 4: EFFICIENCY OF HEALTH SERVICES INTAKE ASSESSMENT PROCESS

Duplication of offender health information collected through CSC health services intake processes and tools results in inefficiencies in assessing offenders' health care needs.

Evidence: Assessment Process

Health services intake assessment policies and guidelines result in repeated administration of health service intake assessments, particularly for the 24-hour intake assessment.

- According to CSC health services guidelines, at admission, all offenders arriving at a CSC institution must be offered a health assessment, including: *24-hour Intake Health Status Assessment; 14-day Intake Health Status Assessment, 14-Day Infectious Disease Screening; and Computerized Mental Health Intake Screening System*.
- Furthermore, there exist additional guidelines for the administration of these four health intake assessments at various points along an offender's sentence:
  - 24-hour assessment: must be conducted following a court return, an inter- or intra-regional transfer and/or a warrant of suspension.[lx]
  - 14-day assessment: must be offered to offenders who are re-admitted to CSC following a period of release to the community for more than twelve months and those who resided in the community for less than twelve months but have had significant changes in their health status within that period.
  - Infectious disease screening: must be offered to offenders who are re-admitted to CSC following a period of release to the community for more than twelve months and those who resided in the community for less than twelve months but have had significant changes in their health status within that period.
  - COMHISS assessment: may be offered to offenders re-admitted to the institution on suspension, revocation or transfer at the institution's discretion.[lxi]
- When asked about the appropriateness of the criteria for the intake assessment tools, health services staff members reported that there was repetition within the assessment process:

- 24-hour assessment: About half (53%, n=31) of health services staff members reported that they disagreed with the requirement to conduct the assessment after a brief absence from the institution. Respondents agreed that this criterion was unnecessary as some offenders only go out for a few hours, for example to go to court (n=22), and that an alternative form/assessment should be developed for this population (n=13).
- 14-day assessment: Some (30%, n=17) health services staff reported that they disagreed with the criteria for the 14-day assessment. They suggested that conducting the assessment is unnecessary for all offenders returning from the community (n=15).
- Infectious Disease screening: Few (13%, n=6) health services staff reported that they disagreed with the criteria.
- COMHISS assessment. Few health services staff (18%, n=4) reported that they disagreed with the criteria.

Evidence: Assessment Tools

There is repetition of information collected across health related intake assessment tools, particularly concerning mental health information.

Duplication of information between health services intake assessment tools:

- Mental health information is collected by three of the four health services assessment tools: the 24-hour assessment, 14-day assessment, and CoMHISS.[47] Duplicate information on suicide/self-injurious behaviour, medication for mental health disorder, depression/sadness, and mental health diagnosis, assessment, or treatment is collected through at least two of these tools.
- Physical health information, at the time of the evaluation, is collected by three of the four intake assessment tools: the 24-hour assessment, 14-day assessment, and infectious disease assessment. Duplicate information on current physical health needs, infectious diseases, and use of tobacco is collected by at least two of these tools.
- Many health services staff members agreed that there was unnecessary duplication of health information across the health services intake assessment tools (69%, n=40).

[47] These assessment tools are administered through different sources, formats and timeframes. For example the 24-hour assessment is administered early, it assesses offenders' immediate needs, and it is administered by a nurse. CoMHISS is administered after the 24-hour assessment, collects a broader scope of mental health information (including ADHD and cognitive deficiencies), and it is self-administered by the offender on a computer.

- Most commonly, health services staff members reported that the 24-hour assessment and the 14-day assessment were repetitive of one other (n=14) and CoMHISS was identified as being repetitive with other intake assessment tools (n=4).
- Health services staff identified mental health and suicide/self-injury risk information as being repeated across various assessment/screening tools (n=19).

Duplication of information between health services intake assessment tools and other CSC health-related assessment tools:

- In addition to the four health specific intake assessment tools identified above, (which are administered by health services personnel), several other CSC health-related assessment tools may also be administered at intake by other personnel (e.g., correctional officers, parole officers, correctional program officers). Several of these tools also collect health-related information:
  - Offender Intake Assessment: in addition to information related to criminal history and risk, the Offender Intake Assessment collects information related to substance use and coping;
  - Immediate Needs Checklist – Suicide Risk: used by non-clinical staff to identify offenders who may be at risk for suicide; and,
  - Computerized Assessment for Substance Abuse, Specialized Sex Offender Assessment, Spousal Assault Risk Assessment: these assessments collect mental health information related specifically to the topic of the assessment tools (e.g., substance use, sexual deviance, risk for family violence, etc.).
- Most health services staff members (82%, n=37) and some other staff members[48] (31%, n=11) reported that there was unnecessary duplication of health information between health services intake assessment tools and other assessment tools completed at intake.
  - The most commonly noted issue was duplication of mental health information (including suicide risk) across multiple assessment tools (health services staff, n=23; other staff, n=8).
  - Some health services staff members mentioned sources of duplication, reporting that the Immediate Needs Checklist – Suicide Risk and the 24-hour assessment were the most repetitive (n=5) followed by the Immediate Needs Checklist – Suicide Risk and CoMHISS (n=3).

[48] Note that many non-health services staff members reported that they did not know whether there was duplication or not. Percentages here are reported out of those staff members who were knowledgeable about the issue.

Efficiency of health services intake assessment tools:

- In addition to the repetition of information collected through intake assessment tools, these tools were also reported to be too lengthy.
  - Health services staff members reported that they experienced challenges in the efficient administration of: the 24-hour assessment (30%, n=16), the 14-day assessment (43%, n=23) and COMHISS assessment (62%, n=13).[49]
  - The most commonly noted issue was that there was repetition of information collected through the tools (n=21).
  - Some staff also reported that the assessments were too lengthy (n=10).

The duplication of information between assessment tools leads to duplication of health referrals.

Mental Health Referrals:

- Offenders undergo multiple assessments, any or all of which may identify a need for a mental health referral, resulting in multiple referrals for mental health follow-up and inefficiencies in the referral process.[50]
- Most health services staff members reported that at least occasionally, multiple referrals were submitted for an offender for the same mental health care service[51] (85%, n=78).
  - Specifically, multiple referrals occurred between *different health services intake assessment tools:* Health services staff most commonly reported duplicate mental health referrals between the 14-day and 24-hour (54%, n=27), between the 14-day and CoMHISS assessments (46%, n=17); and between the 24-hour and CoMHISS assessments (36%, n=18).
  - Multiple referrals also occurred between *health services intake assessment tools and other CSC health-related assessment tools:*[52] About half of health services staff reported duplicate mental health referrals between other health related assessments conducted at intake and: the 24-hour (52%, n=26), 14-day (51%, n=19), and CoMHISS assessments (53%, n=19).

[49] Few staff members (9%, n=4) identified challenges in the efficient administration of the infectious disease screening.
[50] Referrals may also be submitted as a result of offender self-referral or staff observation.
[51] For duplication of mental health care referrals: occasionally (21%), frequently (60%), always (4%).
[52] Health services staff also reported that duplicate referrals came from health services intake assessment tools and staff referrals or offender self-referrals. Health services staff also noted that duplicate referrals are sometimes received from multiple different staff members (e.g., nurses, correctional officers).

- Analysis of data in Health Services' Mental Health Tracking System (MHTS; which includes information on offender referrals and services) also indicates that multiple referrals for offenders are made for offenders early in their sentence.[53]
- Specifically, 61% of offenders in the sample (n=5643) were referred for a mental health service within the first month of admission to the institution, and 35% (n=3275) had multiple referrals during the first month.[54]
- However, only a few of these offenders (n=68) had a referral that was cancelled because there were duplicate referrals prior to assigning them to a mental health professional.[55]
- Based on the data in the MHTS, it was not possible to determine which assessment tools (if any) were more likely to result in a duplicate referral.[56]
- However, results of a file review conducted by CSC's Research Branch indicated that 21% of offenders had multiple referrals for further mental health assessment that were generated from some combination of the 3 intake assessment tools that collect mental health data (i.e., 24-hour assessment, 14-day assessment, COMHISS).[57] [lxii]
- The same file review also found that each tool uniquely identified some offenders in need of mental health follow-up that the other tools did not (i.e., CoMHISS uniquely identified 13% of offenders; 24-hour assessment: 5%; 14-day assessment: 5%).[lxiii]
- Therefore, it is not possible based on these results, to determine whether any one tool (or set of tools), could effectively identify mental health needs in a more efficient manner.

[53] Once an offender has completed an intake assessment and is determined to require a mental health referral, forms are completed and subsequently reviewed by the Chief Psychologist (or delegate) to determine the appropriate follow-up action. The evaluation team examined mental health services data for a two-year admission cohort (FY 2013-2014 and FY 2014-2015) of all federal offenders admitted with a warrant of committal to a federal institution. It is important to note that offenders admitted to a regional treatment centre are considered to have the highest level of mental health need and their mental health service information are not consistently entered into MHTS. Therefore, referrals within MHTS pertaining to offenders who were admitted to a regional treatment centre were excluded from analysis because the data would not be comprehensive for these offenders.

[54] Of all offenders who had at least one referral (n=5643), 42% (n=2368) had only one referral and 58% (n=3275) had multiple referrals (32% received two referrals and 26% received three or more referrals).

[55] These 68 offenders accounted for 75 of the referrals cancelled as duplicate referrals. Those referrals that are assigned to a mental health professional may subsequently result in further treatment, or the referrals could be cancelled by the mental health professional for reasons that could include cancellations due to duplicate referrals.

[56] MHTS tracks by whom the referrals were made (e.g., mental health staff, health staff, parole officer, offender), but it does not identify the assessment tool from which the referral was made.

[57] 5% were referred based on all 3 tools; an additional 8% had referrals from both CoMHISS and the 24-hour assessment; 5% had referrals from both CoMHISS and the 14-day assessment; and, 3% had referrals from both the 24-hour and the 14-day assessments.

Physical Health Referrals:

- Most health services staff members reported that at least occasionally, multiple referrals were submitted for an offender for the same physical health care service[58] (81%, n=58).[59]
- Health services staff reported duplicate referrals: between the 14-day and 24-hour assessments (57%, n=24), between the 14-day and infectious disease assessments (52%, n=17), and between the 24-hour assessment and infectious disease screening (31%, n=13).[60]

Implications:

- **Workload:** Many health services staff members reported that the duplication of physical (62%, n=28) and mental health referrals (51%, n=26) is problematic, noting that multiple referrals for the same service causes an increase in workload for health services staff (n=34). Staff described increased workload resulting from issues such as:
  - Duplication of administrative tasks (n=10);
  - Duplication of services provided directly to offenders (n=6); and,
  - Confusion among staff concerning the status of a referral (n=8).
- **Correctional Setting:** Most health services respondents (82%, n=64) also reported challenges in completing health intake assessment/screening as a result of working in a correctional environment, including:
  - Operational issues impacting on access (e.g., lockdowns, movement/incompatibility issues, n=45);
  - Adequate and confidential work space (n=26);
  - Staffing resources such as sufficient staff/escorts to facilitate offender access for assessments (n=9); and,
  - Offender competing priorities/commitments (n=7).
- **Timeliness:** Results also indicate that there are challenges to complete some of the intake assessment tools on time, particularly the 14-day intake assessment (67%) and the 14-day

[58] For duplication of physical health care referrals: occasionally (26%), frequently (46%), always (8%).
[59] Information on physical health referrals is not currently tracked electronically. Therefore, it was not possible to assess the degree to which multiple referrals for physical health care may be made for offenders through any source of physical health data.
[60] Note that a small percentage of staff also reported duplication between each of the four main health services assessment tools and *other* health related tools conducted at intake. However, respondents did not specifically identify which of the other health related tools included duplicate physical health information.

infectious disease screening (65%), which were implemented within the timeframes outlined in health services guidelines less than 70% of the time.[lxiv]

Next Steps:

- Health services staff members had several suggestions for improving efficiency and reducing duplication of health services tools or processes, including:
  - Reviewing, streamlining, and combining health-related intake assessment forms (n=30);
  - Identifying the most effective intake assessment tools and eliminating the others (n=8);
  - Implementing a centralized electronic health care record (n=36);
  - Implementing a tracking/monitoring system for referrals (n=11); and,
  - Facilitating access to pre-existing offender health information (e.g., community hospital records, n=21; provincial correctional facility records, n=16).
- **Intake Assessment Process:** CSC Health Services is implementing changes to the guidelines concerning Health Care Requirements on Reception and Transfer, in order to reduce the repetition of health services assessment tools within short time frames.
- **Assessment Tools – Physical Health:** CSC Health Services has made changes to the assessment of offender physical health by eliminating repetitive physical health information in the 24-hour, 14-day, and infectious disease assessments, and combining the information into one assessment of physical health to be completed within the first 24 hours of admission.
- **Assessment Tools – Mental Health:**
  - CSC requires more information on the tools to ensure an effective and efficient screening process.[lxv] There is repetition of mental health information collected through health services assessment tools (i.e., 24-hour, 14-day, CoMHISS), and through other assessment tools collected at intake (e.g., Immediate Needs Checklist – Suicide Risk), and also duplication of mental health referrals. Results of recent research[lxvi] also suggest some degree of overlap as well as uniqueness among three health services intake assessment tools (24-hour, 14-day, CoMHISS) in identifying offenders for further mental health follow-up.
    Additional research will be required to determine which mental health assessment tool (or combination of tools) will effectively identify offender mental health needs in the most efficient manner.

RECOMMENDATION 2: EFFICIENCY OF HEALTH SERVICES INTAKE ASSESSMENT TOOLS AND PROCESSES

That CSC Health Services endeavor to increase the efficiency of health-related intake assessment processes by considering the following:

- Eliminating the requirement for repeated administration of health assessments;
- Optimizing and eliminating unnecessary repetition of health information between assessment tools; and,
- Ensuring health referrals are appropriately recorded and monitored.

FIFE #3: OFFENDER ACCESS TO CARE AND SERVICES

The following section provides an overview of offenders' access to clinical, public, and mental health care during incarceration. We also examined specific activities where challenges and opportunities were identified related to: provision of specialist services, offender transfers, and health information sharing.

3.5 ACCESS TO CLINICAL, PUBLIC, AND MENTAL HEALTH CARE

FINDING 5: ACCESS TO CLINICAL, PUBLIC, AND MENTAL HEALTH CARE

CSC offenders have access to clinical, public, and mental health care to address their needs. The majority of offenders receive initial mental health services according to established time-frames; clinical health services are not tracked electronically. Health Services is in the process of implementing an Electronic Medical Record.

Evidence: Access to Care and Services – Clinical, Public, and Mental Health

- CSC has a responsibility to provide health services as prescribed by the Corrections and Conditional Release Act (CCRA): "The Service shall provide every offender with: essential health care and reasonable access to non-essential mental health care that will contribute to the offender's rehabilitation and successful reintegration into the community".[lxvii]
- Within CSC, the Health Services Sector provides clinical (including medical and dental), mental, and public health services for offenders.
- CSC's National Essential Health Services Framework outlines the procedures required to access essential and non-essential health services, the coverage available, and the guiding principles used by staff to determine eligibility for essential and non-essential clinical, public, and mental health services. Offender requests are reviewed and prioritized according to urgency and services are provided by a health care provider.[lxviii]
- Incarcerated offenders may access health services by:[lxix]
    - Self-referral - submitting an offender request to Health Services, or
    - Institutional staff referral – health services staff or any staff member in the institution, or
    - Health Care Centre drop-in hours (where available).

Clinical and Public Health

Assessment, screening, and treatment for clinical and public health needs occur on an ongoing basis throughout incarceration. Wait times for clinical and public health services are not tracked electronically, although some offenders reported clinical health services were not received in a reasonable timeframe.

Clinical Health: Acute and Chronic Issues

Clinical services refer to "assessment, diagnosis and treatment of acute and chronic physical illnesses." [lxx] Through clinical health services, offenders receive medical and dental care. Essential clinical health services include services such as: diagnostic services and treatment, assistive devices and mobility aids (e.g., wheelchairs, canes, hearing aids), vision care, and dental care (with a focus on pain relief and management of infection, disease management, and education on good or proper oral hygiene). [lxxi, 61]

- Most of the offenders sampled reported (92%, n=136) that over the last year they had made requests to see a health care professional for general clinical health care issues, and most reported (89%, n=120) that the requests resulted in an appointment.[62]
    - Among the few offenders (11%, n=15) who reported that requests did not result in an appointment, 9 indicated that they were waiting to see a medical professional (e.g., dentists, doctors, optometrists).

Public Health: Infectious Diseases

Through public health services, CSC provides treatment, screening and testing for infectious diseases. Initial screening and testing is offered to all offenders upon admission, regardless of their risk profile.[lxxii] Throughout incarceration, testing is also available at the offender's request, upon recommendation by health services staff, or following an incident where exposure to infection may have occurred. Testing for tuberculosis (TB) is offered to all inmates one year post-admission and every two years thereafter. Not all inmates request health-related testing during their incarceration; all testing is voluntary.

[61] Non-essential clinical health services may consist of orthotics, respiratory devices, chiropractic services, and fluoride treatments. Such services are at the offender's expense; Health Services may assist in coordinating the offender's access to these services.

[62] Clinical health related appointments within the last year: 90% (n=122) of offenders reported having had an appointment with a doctor, 61% (n=83) with a nurse and 32% (n=44) with a dentist.

- Rates of screening and testing that occurred among inmates throughout their incarceration (post-admission) in 2014-15 were:
  - Blood borne and sexually transmitted infection assessment: 31%[lxxiii]
  - TB assessment: 82%[lxxiv]
  - Human immunodeficiency virus (HIV) test: 24%[lxxv]
  - Hepatitis C virus (HCV) test: 23%[lxxvi]
- Following infectious disease screening, offenders with an infection are offered treatment. For example, in the calendar year 2014:[lxxvii]
  - The average monthly number of offenders receiving treatment for HIV nationally was 156, representing 91% of the average monthly number of active cases (N=171);[63]
  - The number of offenders treated for HCV nationally was 151.
- Among offenders sampled (34%, n=49) who reported that they had made requests to see a health care professional for infectious disease issues over the last year, most (86%, n=42) reported that the requests they made resulted in an appointment.
  - Among the offenders (14%, n=7) who reported the requests had not yet resulted in an appointment, 4 indicated that they considered the wait time for treatment to be long. Time between referral for infectious disease treatment and treatment is not tracked, so average times between referrals and appointments could not be determined. According to health services guidelines, offender requests are reviewed and prioritized according to urgency.[lxxviii]

Timeliness of Service:

- According to *Commissioner's Directive (CD) 800: Health Services*:[lxxix]
  - The Institutional Head will ensure that a process is in place to allow offenders to submit in confidence a request for health services and to facilitate access to these services;
  - All institutional staff/contractors will relay an offenders' request for health services to a health care professional in a timely manner;

[63] "Offenders in CSC who are known to be infected with HIV are offered treatment for infection. Decisions on starting the treatment and remaining on treatment due to side effects, resistance or response are clinical decisions made by the treating infectious disease expert and the patient." (p.14)

  - The current Commissioner's Directive for Health Services does not include a timeframe for response to a request. However, the previous *Commissioner's Directive 800: Health Services* (2011) stated that offender requests must be dated and a signed response must be provided to offenders within 15 days.
- Most health services staff (78%, n=83) and many general staff (60%, n=71) agreed that offenders have access to clinical health care in a timeframe that is appropriate for their level of need.
- Many offenders reported (58%, n=69) that the appointments they received for their clinical health care issues were within a reasonable timeframe.
  - Among those who disagreed (42%, n=50), they reported long wait times for services such as: dental care, specialists/community practitioners, and optometry services. However, wait times for specialist services also exist in the community, and offender access to community specialists is also dependent on community wait times. Time between referrals and clinical services, including specialist services, is not tracked, so average times between referrals and appointments could not be determined.
- Most offenders reported (78%, n=31) the appointment(s) they received for their public health (infectious disease care) needs occurred within a reasonable timeframe.
- Clinical health services are not recorded electronically. However, CSC is currently in the process of implementing an Electronic Medical Record which will allow greater access to clinical health information.

Mental Health

Assessment and treatment for mental health care needs occurs as required throughout incarceration. The majority of initial institutional mental health services were provided within 7 days of referral. Access to mental health services occurs in a timely fashion according to most offenders interviewed.

Mandated under the CCRA, CSC is responsible to "provide every inmate with essential health care and reasonable access to non essential mental health care".[lxxx] Essential mental health services are needed and provided when an offender has significant mental health needs in the areas of emotion, cognition and/or behaviour indicative of a mental health disorder.[lxxxi] Furthermore throughout

incarceration, an offender can access primary mental health care, intermediate mental health services[64] and specialized services in the form of intensive care at Regional Treatment Centres.[lxxxii]

- Of the total institutional flow-through population[65] in 2014-15 (n=20,657), 45%, (n=9,371) of offenders received at least one mental health service in the institution; and in total, there were 18,872 initial institutional mental health services provided. [lxxxiii, 66]
- Among offenders (36%, n=52) who reported that they had asked to see a mental health professional over the last year, most reported (85%, n=44) that their requests resulted in an appointment.[67]
    - Among the few offenders (15%, n=8) who reported that requests did not result in an appointment, the most common reason was being waitlisted to see mental health professional (e.g., psychologists, psychiatrists) (n=4).

Timeliness of Service:

- A total of 3,983 offenders were screened by the Computerized Mental Health Intake Screening System (CoMHISS) in 2014; of those, 27% (n=1,081) were identified as requiring mental health follow-up care, and, of those, 95% received a service within the designated timeframe of 50 days from admission or 40 days from referral.[lxxxiv, 68]
- In 2014-15, 60% (n=11,405) of initial institutional mental health services were provided within 7 working days and 84% were provided within 28 working days of being requested.[lxxxv]
- Many health services staff (72%, n=88) and about half of general staff (51%, n=56) agreed that offenders have access to mental health care in a timeframe that is appropriate for their level of need.
- Most offenders reported the appointment(s) they received for their mental health needs occurred within a reasonable timeframe (80%, n=35).

[64] Intermediate mental health services were not included in the scope of this evaluation due to the fact that intermediate mental health care was not fully implemented in CSC institutions at the commencement of the evaluation.
[65] Flow-through population refers to the number of offenders that have been in an institution over a given time period.
[66] Mental h**e**alth services may include counselling, crisis intervention, and skills training.
[67] Mental health related appointments within the last year: a few offenders reported having had an appointment with a psychiatrist (24%, n=33), psychologist (21%, n=29), or social worker (3%, n=4).
[68] Percentage of flagged offenders who received a follow-up service by region in 2014: Atlantic 99% (n=207); Quebec 98% (n=212); Ontario 99% (n=270); Prairies 93% (n=286); and, Pacific 73% (n=53). Offenders are to receive a follow-up service within 50 days of admission or 40 days from referral.

Challenges to Health Services Delivery and Areas of Opportunity

A review of CSC documents such as Boards of Investigations (BOIs), Mortality Reviews, Accreditation Reviews, Compliance and Operational Risk Reports (CORR) was conducted to identify any specific challenges or common themes. Staff members and offenders were also asked for their input and suggestions. Finally, a scan of the literature in the area of correctional health delivery was conducted to determine any good practices, and any areas of opportunity for CSC to improve access to quality and timely care.

3.6 ACCESS TO COMMUNITY HEALTH CARE SPECIALISTS

FINDING 6: ACCESS TO COMMUNITY HEALTH CARE SPECIALISTS

The provision of community health care specialist services for offenders for non-urgent care is subject to wait times in the community. CSC uses telemedicine (where provincial telemedicine programs are available) to address procedural issues associated with health care specialist appointments in the community. CSC does not systematically collect data regarding referrals to specialist services (in-person or telemedicine).

Evidence: Community Health Care Specialists

CSC provides specialist services to offenders in the areas of mental, clinical, and public health. Staff reported challenges in facilitating offender access to health care specialists in the community.

- CSC provides general health care services through health care professionals such as nurses and psychologists employed by CSC and doctors contracted to provide general care. Appointments with physicians/specialists and other health care professionals occur according to need and institutional operational requirements. When offenders are referred to community medical/psychiatric services, they are subject to the same waiting periods as the general Canadian population.[lxxxvi]
- Multiple specialist services are provided in the areas of clinical, public, and mental health, but electronic data was unavailable to provide reliable statistics on the number of various specialist services accessed or the time required accessing them. The Mental Health Tracking System (MHTS) could not be used to consistently track the number and timeliness of psychiatric

services offered to offenders. However, the implementation of the Offender Health Information System- Electronic Medical Record (OHIS-EMR) will allow psychiatrists to use the system to record their appointments with offenders, enabling more reliable tracking of these services.

- Procedural challenges (availability of security escorts, security clearance for contractors) were reported by health services staff and general staff related to heath care contractors and specialists coming into CSC to provide services (health services staff 64%, n=58; general staff 46%, n=29) and to offenders going out into the community for specialist services (health services staff 62%, n=55; general staff 29%, n=20).
- Procedural issues related to requirements for Specialist Services may include:
  - Wait Times:
    - Staff reported wait times and limited hours to access specialist care (health services staff: n=17; general staff: n=19).
  - Escorts:
    - Staff reported challenges associated with security escorts (e.g., resources required, availability of escorts, etc.) for appointments in the community (health services staff n=20; general staff n=9).
  - Recruitment:
    - Staff reported challenges in the recruitment and retention of community specialists (e.g., their willingness to work with offenders, or to work in a correctional environment) (health services staff n=13; general staff n=5).
  - Administrative/Logistical:
    - Obtaining security clearances for community specialists (health services staff n=9; general staff n=2).
    - Administrative requirements and scheduling challenges (health services staff n=9; general staff n=3).
    - Correctional environment and limited space for delivery of health services (health services staff n=10; general staff n=4).

Telemedicine has been implemented in some institutions within CSC regions with the goal of increasing offender access to essential health services including community specialists.

Telemedicine is the delivery of health care services and information using telecommunication technologies. Through live interactive video and electronic diagnostic equipment inmates can be seen remotely by specialists for assessment, consultation and ongoing treatment monitoring. The use of telemedicine is in its infancy in many jurisdictions across Canada. CSC's use of telemedicine mirrors the availability of the required infrastructure within individual provinces. For example, the province of Ontario has put in place a comprehensive telemedicine infrastructure network and reports significantly higher rates of service delivery than other provinces.[69, lxxxvii] Supported by the availability of telemedicine in the province of Ontario, CSC's Ontario region is the most advanced in terms of using this technology. CSC uses telemedicine to access a range of specialty services detailed below. Telemedicine is an important mechanism for effectively and efficiently accessing services for inmates (e.g., timely access and avoid costly medical escort).[lxxxviii]

- Results of the Health Services Accreditation Report (2014) noted that there were opportunities to increase the use of telemedicine in CSC, particularly for the Atlantic, Quebec, and Prairie regions.[lxxxix]
- Telemedicine was implemented in CSC in the Ontario region in 2008. CSC's partner in Ontario is the Ontario Telemedicine Network (OTN). OTN provides technical and operational supports for telemedicine delivery; it is an independent, not-for-profit organisation funded by the Ontario Government.[xc] A new partnership agreement between CSC and OTN was re-negotiated and signed in 2015. Currently, all CSC Ontario institutions use Telemedicine.
- Objectives for use of telemedicine in CSC include:[xci]
  - Increased access to essential health services for offenders, including access to specialists
  - Faster patient care/decreased wait times
  - Cost savings related to reduced number of medical ETAs
- In 2015, telemedicine was being used in all 5 regions in different capacities (e.g., after-hours care, specialist services) and to different degrees across institutions. Implementation across CSC's 5 regions differs based on available provincial technology infrastructure and progress in addressing issues related to provincial health professional college guidelines/licensing, physician

[69] Note that there may be some differences in reporting practices across provinces.

reimbursement, etc. It is possible that CSC's telemedicine infrastructure growth will be commensurate with provincial infrastructure expansion. By the fall of 2015, the following was reported regarding usage of telemedicine across CSC:

- Telemedicine for Specialist Services:[xcii]
  - Atlantic: Telemedicine provides access to a variety of specialists in some institutions including; infectious disease, urologist, surgeons (pre-admission and surgical follow-up) and respirology.
  - Quebec: Telemedicine consultations are offered with microbiologists for offenders with HCV and psychiatrists for offenders at Port Cartier institution.
  - Ontario: Telemedicine is used to provide a variety of specialist services in some institutions, some of which include; cardiology, diabetes clinic, dietician, orthopedic/pain clinic, congestive heart failure clinic, urology, psychiatry and infectious disease, general surgery, methadone, rheumatology, dermatology.
  - Prairies: Telemedicine is used in some institutions for the following clinics; infectious disease, dermatology, neurology, dietician, palliative care, oncology, and psychiatry services.
  - Pacific: no specialist services available via telemedicine.
- Telemedicine for After-Hours Care:
  - Most regions (Pacific, Ontario, Prairie, and some Atlantic institutions) support access to CSC Regional Hospitals outside of regular business hours, using telemedicine.

Impact of Telemedicine in CSC:

- Telemedicine in CSC is not currently available in all institutions for reasons described above (provincial infrastructure; provincial health professional guidelines/licensing etc), and the types of services vary across institutions and regions. However, some preliminary evidence regarding the impacts and offender satisfaction with telemedicine were available from the Ontario Region.
- Results of a 2011-2012 Ontario telemedicine satisfaction survey conducted with offenders who had used telemedicine to access health services indicated that:
  - Most offenders (79%, n=122) were satisfied or very satisfied with their telemedicine experience;

  - Most offenders (81%, n=126) felt comfortable talking to the doctor using telemedicine technology; and,
  - Most offenders (80%, n=122) felt they received enough information about the telemedicine appointment and the equipment used and felt comfortable asking questions about their appointment.
  - Although overall level of satisfaction was relatively high, some offenders who responded to the survey suggestion (n=14) reported a preference to see a doctor in person.
- The Ontario Region reported some preliminary evidence of the impact of telemedicine on access to after-hours services:
  - Between January and July 2015, the Ontario Regional Hospital received 61 "after hours" phone calls through telemedicine: 22/61 calls were sent to outside hospital and 33/61 were recommended to follow-up with an institutional nurse the next day.[70]

Telemedicine has also been successfully utilized in some US correctional systems to increase access to community specialists.

- Telemedicine has also been used to facilitate increased access to community specialists in other jurisdictions such as the United States (US).[xciii] Several US correctional systems[71] reported benefits of telemedicine, including:
  - <u>Increased Access and Reduced Escorts to Community:</u> Telemedicine has the potential to improve access to doctors and specialists and reduce escorts to the community, for example:[xciv]
    - Some prisons were able to obtain services through telemedicine that would have otherwise been unavailable. For example, Pennsylvania prisons were able to obtain services from an infectious disease expert to care for HIV positive prisoners through telemedicine.
    - Psychiatrists were accessible more often via telemedicine resulting in more effective medication management and monitoring of offenders with psychiatric illness; this was thought to stabilize patients and avoid crisis.

[70] The statuses of the other 6 calls were: 1 individual was admitted to the Regional Hospital, 2 individuals refused care and 3 were disposition unknown.
[71] Under the U.S. Department of Justice, the U.S. correctional systems included in the review were federal prisons in: Colorado, Pennsylvania, Louisiana, Wyoming, and Texas.

        - The use of telemedicine allowed correctional facilities to avoid 35 trips to outside specialists.
    - Wait times: While using telemedicine, the time between a prisoner's initial referral and the appointment with the specialist decreased. Before telemedicine the average wait time to see a specialist was 99 days, after telemedicine the average wait time was 23 days.[xcv]
    - Recruitment: More health professionals may be willing to work with offenders through telemedicine as specialists no longer have to travel and it provides easier access.[xcvi]

Community health care specialist services are delivered in the context of the Canadian health care system and offenders are subject to similar wait times for specialist health care services as the general Canadian population. Usage of telemedicine varies across Canadian provincial health systems.

Health Care in the Canadian Context:

- When offenders are referred to community medical services, they are subject to waiting periods for specialist health care services, similar to the general Canadian population.[xcvii]
- In 2014 and 2015, the Canadian national median wait time for a referral by a general practitioner to an appointment with a specialist was approximately 8.5 weeks. The national median wait time from an appointment with a specialist to treatment was just under 10 weeks.[xcviii]
    - The longest wait time for a referral from a general practitioner to an appointment with a specialist was in Prince Edward Island (28.3 weeks) while the shortest were in Saskatchewan and Ontario (6.7 weeks and 6.8 weeks).
    - The longest wait time between appointments with a specialist to treatment was in Newfoundland & Labrador (20.5 weeks) while the shortest was in Saskatchewan (6.9 weeks).
- In 2004, the Government of Canada developed the 10-Year Plan to Strengthen Health Care, which involved committing $5.5 billion to reduce wait times to quality health care by training and hiring more health care professionals, addressing backlogs, and expanding treatment and services.[xcix]
- Telemedicine is being used in Canada as an alternative method of health services delivery. It can be used to reach individuals in rural or remote locations and is used to provide home-care, clinical and educational services.

- CSC's access to telemedicine is driven by its use in the provincial health care system relevant to the CSC region and institution. Comparing telemedicine programs within Canada is complicated due to the differences in telemedicine programs and the program data that are available.[c]
- The availability of telemedicine to Canadians varies in terms of where it is offered, how it is offered and what services are offered. For example, there are different types of technology used (e.g., connection through video camera, use of digital stethoscopes, and robots), types of services available (e.g., psychiatry services, paediatrics, infectious disease services) and telemedicine can be community or hospital-based. In 2012, the three most common types of services delivered by telemedicine in Canada were:[ci]
  - *Mental Health (Psychiatry and Psychology)*
  - *Cardiology, Diabetes, Genetics, Oncology*
  - *Chronic Pain, Neurology, Rehabilitation (Occupational Therapy), Rehabilitation (Physiotherapy)*
- The structure of telemedicine programs also differ between provincial/territorial jurisdictions, for example: telemedicine is coordinated by a single provincial program in Ontario, Manitoba and Newfoundland and Labrador; whereas, in British Columbia, New Brunswick and Nova Scotia, telemedicine programs are regional or health authority based; telemedicine programs can also be hospital based.[cii] Ontario has the largest usage of telemedicine in Canada and has experienced growth rates of approximately 30% per year over the last few years yet makes up less than 0.1% of the provincial health budget.[ciii]
- Physician reimbursement, funding for equipment, training for health practitioners, increased bandwidth and improved comfort levels with technology by health practitioners are all areas where there is opportunity for improvement if the use of telemedicine is to spread across Canada.[civ]

RECOMMENDATION 3: ACCESS TO COMMUNITY HEALTH CARE SPECIALISTS

That CSC Health Services collect data on wait times to access selected specialists services for non-urgent care; and implement strategies (for example increased use of telemedicine where appropriate) if wait times exceed available Canadian benchmarks.

3.7 TRANSFERS

FINDING 7: TRANSFERS

Challenges to continuity of care and information sharing or documentation during transfers were identified. Inaccurate information sharing may be a result of incomplete documentation in the Health Services Transfer Summary forms.

Evidence: Transfers

Transfers for federal offenders can occur within the same region (intra-regional) or to a different region (inter-regional) for numerous reasons, such as penitentiary placement, for access to a service or treatment (e.g., cultural program, intensive mental health treatment), to be closer to home or a community, or be security-related. Transfers can also occur on a voluntarily, involuntarily, or emergency basis.[cv]

Health services staff and offenders reported challenges to continuity of care and information sharing related to transfers. Incomplete documentation of health information in the Health Services Transfer Summary form is currently being addressed through regional health services action plans.

- Many health services staff reported experiencing challenges in ensuring the continuity of health care services and treatments when offenders were transferred between institutions in different regions (59%, n=60) and between institutions in the same region (49%, n=50).
    - The most commonly noted challenges related to medication management issues (n=26), delayed, outdated or incomplete health information (n=20), a lack of communication and preparation regarding transfers (n=12) differing service and treatment models (n=19), lack of available staff and resources (n=9), and language barriers from a lack of translation of health information (n=7).
- Twenty-five percent (25%, n=36) of offenders interviewed reported having been transferred between institutions within the past year.
    - A few offenders who had been reporting ongoing health care at the time of transfer[72] suggested that health care services were different across institutions (physical health: n=12;

[72] Of those, n=19 reported receiving ongoing health care for clinical heath, n=10 for mental health, and n=4 for infectious disease at the time of their transfer.

mental health: n=6), but the number of responses were too small to analyze for any common themes.

Documentation:

- According to policy CD 710-2 (Transfer of Inmates), the Health Services Transfer Summary form (0377-01) is completed by the sending institution and translated if necessary into the language of the receiving institution. This ensures that key health information, such as medical and psychological reports and intake assessments, are reviewed and any relevant health care services and treatments are maintained.
- In 2013-14 and 2014-15, a review of Boards of Investigations (BOIs) indicated that 4% of BOI cases included issues related to documentation of the Health Services Transfer Summary.
- A review of compliance related to the Health Services Transfer Summary form in the fall of 2015 (CORR) identified that sections of the transfer form were not fully completed in all regions, for example: sections related to major mental health problems and methadone/Suboxone section.

Next Steps:

- In order to ensure accurate information sharing during transfers, the Health Services Transfer Summary form must be completed accurately prior to transfer. Incomplete transfer summary documentation was identified as an issue through CORR. Action plans to achieve compliance and risk mitigation strategies were developed by Health Services in each region to deal with areas of non-compliance. Compliance has been achieved in 2 out of 4 regions (Prairie and Quebec are not yet compliant).[73] Health Services continues to monitor progress towards compliancy. In April 2016, Health Services began the implementation of an Offender Health Information System that includes an Electronic Medical Record system (OHIS-EMR). As of July 2016 the OHIS-EMR has been fully implemented in 4 regions (Atlantic, Quebec, Ontario, and Pacific). Full implementation in the Prairie region is expected by the end of September 2016. The electronic medical record allows real time access to offender medical records by all regions.

[73] For all five CSC regions included in the CORR monitoring, non-compliance was found in the Atlantic, Quebec, Prairie and Pacific regions.

- CSC's Internal Audit Sector is currently conducting an audit of the transfer process. Issues identified related to transfers and health services will be addressed through Audit recommendations and action plans.

3.8 INFORMATION SHARING

FINDING 8: INFORMATION SHARING

Some CSC personnel reported a lack of understanding of the guidelines for sharing of personal health information, and the sharing of health information could be improved. There are opportunities to implement electronic medical records to enhance information sharing.

Evidence: Information Sharing

According to CSC policy, "the sharing of information should be carried out in a way that upholds an individual's rights to privacy and confidentiality, while still ensuring that relevant parties have access to appropriate information in order to address the risks and needs of the offender".[cvi] Appropriate sharing of personal health information with those who have a "need-to-know", is a key element in the provision of quality and timely care to offenders.[cvii] Information sharing, among health services staff and between registered health care professionals and other institutional staff (i.e., case management and operations), must respect professional obligations of health professionals.[74] Protecting client privacy and confidentiality is part of the standards of practice for licensed health professionals (e.g. nurses, physicians, psychologists, social workers etc), whereby individuals have a professional obligation to understand and follow applicable legislation governing privacy and the collecting and sharing of information.

Within CSC, the *Guidelines for Sharing Personal Health Information* outline information sharing protocols. In addition, CSC offers the Fundamentals of Mental Health Training, which is mandatory training for parole officers and correctional officers, and includes a component on the sharing of

[74] Two groups of health services staff were surveyed for the evaluation: those working with offenders at intake and those working with offenders during incarceration (after penitentiary placement). The information reported in this section was collected from health services staff working with offenders during the incarceration period. However, some general questions related to access to care and information sharing were also asked of health services staff working at intake. Responses of intake staff were scanned for commonality or differences of themes and issues. Overall, the pattern of responses for staff working with offenders at intake was similar to those working with offenders during the incarceration period.

personal health information. It outlines references to relevant legislation, policies and guidelines and defines the "need-to-know" principle "information that is pertinent and necessary to an individual performing his/her current duties."[cviii, 75] Discussions take place in small groups on various scenarios with respect to information sharing.

Most CSC clinical health information is currently documented in paper files, and mental and public health information is managed through a combination of paper and electronic records. CSC Health Services is currently implementing an Electronic Medical Record system.

- The importance of effective documentation is emphasized in the Accreditation Report (2014) which identified the use of manual documentation of health related information as an issue, as it poses a significant risk for missing and inaccurate information. The Accreditation Report identified opportunities to implement electronic health records in CSC to better track health related information and mitigate risks.
- Presently, most offender health care information is maintained in paper files, including institutional health care records, regional psychiatric centre records and psychology mental health files. In addition, specific health related information is tracked electronically for mental health in MHTS and for public health in the Web-Enabled Infectious Disease Surveillance System (WebIDSS), although these systems are currently in transition. The key elements of the latter two electronic systems will be incorporated into the OHIS-EMR.
    - Many health services staff agreed that they had access to the appropriate offender databases/records required for them to perform their duties during the incarceration period (70%, n=103). The most common database/records that health services staff had access to include: OMS, the offender's institutional health care record, and Psychology/Mental Health files.
    - Health services staff and general staff reported the following communication mechanisms to be effective in sharing offender health-related information: in-person information meetings/phone calls (86%, n=125, 85%, n=116 respectively); paper records/reports (84%, n=122; 39%, n=52 respectively); and formal meetings (72%, n=105; 50%, n=68 respectively).

[75] For example, a correctional officer may not "need-to-know" the specific medications an offender is taking; however, they may need to know symptoms related to the medication relating to mobility or behaviours that could affect security or case management.

Good Practice - Implementation of Electronic Medical Records:

A review of research literature was conducted to determine effective and efficient options to support information sharing and management. The use of electronic medical records was commonly discussed as an effective tool for information management in correctional settings and in the community. Electronic medical records (EMRs) are computer-based medical records that contain demographic information, medical and drug history, and diagnostic information such as laboratory results and diagnostic imaging.[cix] Benefits of using EMRs include: [cx]

- Reduced redundant care
- Increased speed of patient treatment
- Improved patient safety
- Increased efficiencies in workflow and laboratory and diagnostic test management
- Communication and quality of care: Centralized patient information gives health care providers better access to information and allows different health care providers to access the same information
- Reduced inaccuracies: EMRs keep information centrally located reducing the risk of losing documents

Health Services staff reported higher levels of understanding of the Guidelines for Sharing Personal Health Information compared to general staff.

CSC has developed *Guidelines for Sharing Personal Health Information*, which provides staff with information on the types of offender health information that may be shared, with whom, and in what context.[cxi] Personal health information should only be shared with those who have a "need-to-know", which includes only information that is pertinent and necessary to an individual performing his or her current duties. The purpose of the guidelines are to ensure that staff members have the information necessary to perform their duties to address offenders' risks and needs, while maintaining offenders' right to privacy and confidentiality.

- Many health services staff and some general staff agreed that the guidelines provided clear direction regarding:
    - *What* type of information can be shared (health services staff: 70%, n=91, general staff 57%, n=50);

- With *whom* information can be shared (health services staff: 73%, n=93, general staff 53%, n=47); and
- *How* information can be shared (health services staff: 70%, n=89, general staff 51%, n=43).

The sharing of personal health information, particularly between health services staff and operational personnel could be improved.

A review of CSC documents indicated that the sharing of personal health information does not always occur as it should. Among BOIs, information sharing issues were identified in 2013-14 (37% out of 86 BOI cases) and 2014-15 (19% out of 96 BOI cases).[76] Information sharing issues identified through these investigations included information sharing between a variety of different groups, including information sharing with offenders, operations, and health services. The following section provides an overview of the specific information sharing issues related to health in 2013-14 to 2014-15 BOIs.

Information Sharing within Health Services:

- A small percentage (3%) of 182 BOI cases from 2013-14 and 2014-15 represented issues of information sharing within health services.
- Many health services staff (67%, n=97) agreed that there is sufficient information sharing with other health services staff.

Information Sharing between Health Services and Other Institutional Staff:

- A review of 182 BOI cases in 2013-14 and 2014-15 identified information sharing issues between health services staff and:
  - Operational staff (7% of BOI cases); and,
  - Case management staff (1% of BOI cases).
- Some health services staff and general staff members reported that they would like access to more information than what is currently shared; however, it is not clear if the information that they would like access to falls under the "need-to-know" criteria established by the guidelines.

[76] Note that these included all BOIs for investigated incidents at the Tier I and II levels in 2013-14 and 2014-15 that had been investigated and completed. Not all 2013-14 and 2014-15 BOI cases had been completed at the time the data was obtained.

- Many health services staff (61%, n=81) agreed that there is sufficient information sharing with other general staff.
- Some general staff agreed (34%, n=41) that health information is shared to enable them to perform their duties. It was suggested that more information be shared concerning:
  - Health conditions that can impact offenders participation in work/school/correctional plan (e.g., receive notification if an offender is sick and unable to attend school, if a medical condition can affect their classroom performance, any health conditions that would interfere with offender completing their correctional plan n=14);
  - Health information to address an emergency/maintain safety (e.g., have a basic health profile, pre-existing conditions available in case of emergency n=6);
  - Public health (e.g., infectious diseases n=12);
  - Mental health (e.g., suicide risk, stress, diagnoses that may affect behaviour in programs n=12); and,
  - Medication (n=10).

Next Steps:

Documentation of Health Information:

- In 2016, CSC began the implementation of the National Offender Health Information System which consists of two components, an Electronic Medical Record (OHIS-EMR) and an electronic Pharmacy system (OHIS-PHARM).[77]
- As of July 2016 the OHIS-EMR has been fully implemented in 4 regions (Atlantic, Quebec, Ontario, and Pacific). Full implementation in the Prairie region is expected by the end of September 2016. The electronic medical record allows real time access to offender medical records by all regions.
- It is anticipated that OHIS-EMR will improve the quality of health care delivery and patient safety by facilitating integration of health information, information sharing among health services staff.

[77] Implementation in all institutions in Ontario and Pacific, and one institution in remaining regions, is scheduled to begin in September 2016, with full implementation to all institutions scheduled for March 2017.

Guidelines for Sharing Personal Health Information:

- In November 2015, CSC updated the *Guidelines for Sharing Personal Health Information*. The guidelines, which now apply to all staff, have been clarified in terms of references to legislation and policy, include additional examples to assist staff in making informed decisions about information sharing and understanding the need-to-know principle, and reference the use of electronic information sources.[cxii]
- Changes to the guidelines seem to have addressed some of health services staff and general staff suggestions. In order to improve the *Guidelines for Sharing Personal Health Information*, staff suggested:
  - Modifying format/content of guidelines (e.g., make the wording less vague; provide examples, better understanding of what information can be shared with outside agencies; health services staff n=6).
  - Providing staff with ongoing training regarding the guidelines (e.g., in relation to the parameters of the need-to-know principle; health services staff n=2; general staff n=4).

Health Information Sharing Practices:

- To enhance the management and sharing of health related information, health services staff and general staff suggested the following:
  - Enhance communication and information sharing practices between staff members through various mechanisms (e.g., brief daily meetings, greater involvement of general staff to attend institutional mental health team (IMHT) meetings, sending emails; health services n=8, general staff n=8).
  - Implement the electronic health care record (health services n=18).
  - Establish consistent protocols to share information (e.g., standardized practices across the organization, develop form for absence from work/school; general staff n=9).

RECOMMENDATION 4: INFORMATION SHARING

That CSC Health Services improve the understanding of information sharing requirements and limitations, as elaborated in their guidelines, in accordance with privacy laws and other relevant legislation. That CSC Health Services improve timely access to relevant and accurate medical records for Health Care staff. These will be accomplished by:

- Finalizing the implementation of electronic medical records to improve accessibility and consistency of health information;
- Enhancing awareness of information sharing procedures and "need-to-know" principle among CSC personnel, including concrete examples of where and how the principle should be applied; and
- Conducting a review of information sharing issues identified in BOI incidents to contribute to existing lessons learned and to inform procedural/policy changes if necessary.

FIFE #4: PUBLIC HEALTH EDUCATION AND HARM REDUCTION

CSC provides numerous public health programs to offenders. To reduce and eliminate the transmission of bloodborne and sexually transmitted infections among inmates while incarcerated, CSC Health Services offers numerous programs and services that range from screening and testing, treatment, vaccinations, health education and awareness, distribution of harm reduction materials, and staff education and training. The following section focuses on health education and awareness programs and harm reduction measures. The degree to which CSC health education and harm reduction programs are targeted to address prevalent health needs of offenders, overall delivery of these services including offender access, and impacts of health education programs and initiatives are examined.

3.9 HEALTH EDUCATION DELIVERY

FINDING 9: HEALTH EDUCATION DELIVERY

CSC's health education programs and initiatives target many of the significant health needs of the offender population, but offender access to and voluntary participation in some programs is limited.

Evidence: Health Education Programs: Offender Needs and Access

CSC offers health education initiatives that are intended to address the most prevalent health needs of our offender population.

Within CSC, the Health Services Sector provides public health services to federal offenders in order to prevent, control disease and promote good health within federal institutions.[cxiii] During intake and throughout incarceration, numerous bilingual health education and information materials are available to offenders, which include: the Reception Awareness Program (RAP), the Inmate Suicide Awareness and Prevention Workshop (ISAPW), the Peer Education Course (PEC) and the Aboriginal Peer Education Course (APEC), as well as other materials, such as monthly fact sheets and PowerPoint presentations on specific health topics (see Appendix E).

Health education programs and initiatives target numerous health needs of the offender population in the areas of clinical, public, and mental health.

Clinical Health: Acute and Chronic Issues

- Health education materials related to acute and chronic health issues are shared with offenders in CSC institutions primarily through the development of fact sheets:
  - National fact sheets are developed on specific health topics and are distributed in paper format or displayed on monitors in CSC institutions. Recent topics include many prevalent chronic health needs of the offender population, such as heart health, back pain, asthma, healthy eating, and diabetes.[cxiv]

Public Health: Infectious Diseases

- To address offender health care needs in the area of infectious diseases, Health Services provides a variety of education and information-based programs and materials throughout an offender's sentence which are intended to increase an offender's knowledge of prevalent infectious diseases, such as human immunodeficiency virus (HIV) and hepatitis C virus (HCV).
  - RAP is offered to all offenders during intake. It provides information on infectious diseases, such as HIV, HCV, and sexually-transmitted infections (STIs). Topics covered include means of transmission, such as methods to clean injecting, tattooing and piercing equipment, using harm reduction materials like condoms and dental dams and substance abuse programs and treatments (e.g., Opiate Substitution Therapy (OST) or methadone).
  - PEC is offered in most CSC institutions. Its purpose is to train offenders to become peer support workers for other offenders and to provide information on a wide variety of topics, including information on infectious diseases [e.g., HIV, HCV, tuberculosis (TB), STIs] and harm reduction.[78]
  - APEC provides information on infectious diseases and harm reduction and trains offenders to use a culturally-sensitive approach in providing information and peer support to Indigenous offenders.[cxv]
  - Fact sheets are developed that provide information on infectious diseases, such as HIV/AIDS, TB, HCV, and Methicillin-resistant Staphylococcus Aureus (MRSA).[cxvi]

[78] For women, PEC and the Peer Support Program for Women have recently been integrated into a new program called the Peer Mentorship program which is anticipated to be implemented in 2016-2017.

Mental Health

- In support of promoting mental health, health promotion is centred on general mental health well-being, awareness of signs and identification of symptoms, as well as where and how to seek support.
    - ISAPW provides information on the identification of signs and symptoms of suicide risk, tips on helping others who are exhibiting suicidal behaviour, and suggestions for who to contact in the institution for support.[cxvii]
    - RAP is primarily focused on delivering information related to infectious diseases and offers some general information on mental health, such as the availability of institutional support services and tips for managing stress.
    - PEC and APEC also offer general information in recognizing symptoms of stress and its management.
    - Fact sheets are also available on topics such as suicide prevention.[cxviii]

CSC offers a range of health education programs to address offender's needs related to physical health, chronic and infectious diseases and mental health. Many of these programs are targeted at addressing the high prevalence of infectious diseases among our population, and the ability of infectious diseases to spread easily within a closed environment. Consistent with CSC's focus on health education for infectious disease, results of a literature review on correctional health promotion found that the majority of offender specific health education initiative studies concentrated on infectious diseases, particularly HIV prevention and risk reduction.[cxix]

Offender Perceptions:

- Some offenders mentioned that health education should include more information on specific topics, such as what services are available, nutrition, hygiene, mental health, Alzheimer's, heart disease, fetal alcohol spectrum disorder (FASD) and cancer (n=25).
- Most offenders reported that the health information and materials that they had received over the course of incarceration (89%, n=124) and also at intake (89%, n=80)[79] met their individual needs related to factors such as areas of culture, gender, language, age.

[79] Health information and materials are presented both during the intake period (most commonly RAP, ISAPW) and throughout incarceration after penitentiary placement (most commonly PEC/APEC, fact sheets). Two sets of interviews

- Among offenders who participated in health education initiatives, most indicated that they would recommend the program/initiative to other offenders (PEC 100%, n=19; RAP 95%, n=36; ISAPW 95%, n=36).

Evidence: Health Education Delivery

Offender participation in health education programs and initiatives is moderate, and health education and awareness programs are not offered consistently.

According to CSC policy *Intake Assessment Process and Correctional Plan Framework,* the Assistant Warden, Interventions, is responsible for the intake assessment process and the correctional planning of the sentence and will ensure the provision of pre-treatment and awareness programs such as suicide awareness and prevention.[cxx]

Reception Awareness Program:

- *The Health Services Performance Measurement Report 2012-2013* states that RAP is offered to all new admissions during the intake period.[cxxi]
- RAP is delivered in a classroom setting in all regions except the Atlantic region where it is delivered one-on-one by a nurse during the initial blood borne and sexually transmitted infections (BBSTI) assessment. This accounts for the greater number of sessions in the Atlantic region.
- In 2013-14, the following number of RAP sessions were delivered across the provinces: Atlantic (n=414), Quebec (n=7), Ontario (n=55), Prairie (n=77), Pacific (n=18).[cxxii]
- About half of health services staff (51%, n=31) reported that RAP was offered at their institutions.
- Offender participation:
    - In 2014-2015, CSC reported that a total of 37% of newly admitted offenders participated in RAP.[cxxiii] The proportion of participants varied by region with Atlantic having the highest rate of participation (85%, n=483) followed by the Prairies (60%, n=916), Pacific (39%, n=135), Ontario (27%, n=337) and Quebec (2%, n=20).[cxxiv]

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were conducted with two different groups of offenders: at intake and during incarceration (after pen placement). Results in these sections are presented from either of these samples when and where applicable.

- Similarly, 40% (n=38) of offenders interviewed for the evaluation reported that they participated in RAP.

Peer Education Course/Aboriginal Peer Education Course:

- The *Public Health Performance Measurement Report 2013-2014* produced a summary of regions and institutions where the program is intended to be delivered.[cxxv]
- In 2013-2014, PEC was expected to be offered in a total of 41 of 55 institutions across Canada.[80] However, only 35 institutions offered PEC.[81,cxxvi]
- In 2013-2014, APEC was expected to be offered in 26 of 55 institutions across Canada.[82] In total, 23 institutions offered APEC.[83,cxxvii]
- Most health services staff reported that PEC (79%, n=62) and APEC (72%, n=46) were offered by trained PEC support workers that were available at their institution.
- Offender participation:
  - Many offenders (64%, n=89) indicated that they knew how to access the services of the PEC/APEC support worker.
  - Of the offenders who were interviewed, a few reported that they used the services offered through a PEC or an APEC support worker (12%, n=18 and 3%, n=5, respectively).[84]

Inmate Suicide Awareness and Prevention Workshop:

- According to *Commissioner's Directive 843: Management of Inmate Self-Injurious and Suicidal Behaviour* Institutional Heads are responsible for ensuring ISAPW is available on a regular basis and that offenders have access.[cxxviii]
- Currently, there is no reliable tracking of ISAPW sessions being offered or offender's attendance rate.

[80] The expected locations of PEC did not include maximum security, RTC/RPCs, receptions centres and the healing lodge.
[81] Not all expected institutions had an active PEC program across the regions, with 4/5 in Atlantic, 7/9 in Quebec, 10/11 in Ontario, 7/9 in Prairie and 7/7 in Pacific.
[82] The expected locations of APEC were more in areas with a high population of Indigenous offenders such as Prairie region and in healing lodges.
[83] Not all expected institutions had an active APEC program across the regions, with 2/2 in Atlantic, 2/4 in Quebec, 4/4 in Ontario, 10/11 in Prairie and 5/5 in Pacific.
[84] Of the offenders who were interviewed, 14% (n=21) participated in PEC and 7% (n=11) participated in APEC to become PEC or APEC support workers, respectively. A few (n=8) offenders reported that they were currently a PEC/APEC support worker/volunteer.

- Many health services staff (66%, n=40) reported that the ISAPW was offered at their institution.
- Some offenders (38%, n=38) reported participating in ISAPW.

Reasons for non-participation:

- Across programs, the most common reasons for non-participation reported by offenders included:
  - Lack of awareness /availability of the program (ISAPW n=24; PEC/APEC n=11; RAP n=29)
  - Perceptions that they did not require the services or need to participate (ISAPW n=10; PEC/APEC n=30).

CSC health education programs and promotional materials are delivered in a variety of formats and at various time periods during an offender's sentence.

Format: CSC delivers health education programs in a variety of formats and at various levels of intensity. RAP can be delivered one-on-one or in a group, most often facilitated by a nurse.[85] ISAPW can be delivered in a group or individually by health services staff and peer support is delivered by PEC/APEC support workers who are trained by health services staff. Offenders also receive promotional materials (i.e., written materials) providing information on various health care issues.

- Many health services staff agreed that health education programs were being delivered in an appropriate format (RAP 69%, n=25; PEC/APEC 64%, n=32; ISAPW 62%, n=13).
- The majority of offenders agreed that health education programs were being delivered in an appropriate format. Of those who participated in health education programs through a group setting, most liked that they were presented this way: RAP (84%, n=26), PEC/APEC (94%, n=17), and ISAPW (94%, n=33).[86]

Timing: CSC provides health education programs during the intake period such as RAP and ISAPW and throughout incarceration like PEC and APEC.

- Some health services staff reported that RAP (55%, n=21) and ISAPW (43%, n=9) were commonly delivered within the first month of admission within their institution.

[85] Additionally, the narrated version of RAP can be run via monitors in the Health Services waiting room.
[86] Most offenders also reported that materials delivered through RAP (97%, n=37), PEC/APEC (95%, n=18), and ISAPW (92%, n=35) were easy to understand.

- Many health services staff agreed that health education programs were being delivered at an appropriate time in the offenders' sentence (RAP 71%, n=25; PEC/APEC 62%, n=24; ISAPW 59%, n=13).
- The majority of offenders agreed that health education programs were being delivered at an appropriate time in their sentence (RAP 92%, n=35; ISAPW 89%, n=33).

Suggestions regarding format and timing:

- RAP could be delivered through other staff or formats (e.g., non-nursing staff, PEC/APEC support workers, video monitor or offender TV channel) (health services staff n=7).
- Health education programs/materials should be delivered in different formats to correspond to offenders literacy levels (e.g., video) (health services staff n=4; offenders n=10).
- Programs should be delivered by Health Services in smaller groups and individually to allow for more interaction (offenders n=4).
- Make health education information readily available in terms of quantity and location (e.g., pamphlets on range, more brochures in maximum) (offenders n=24).
- Programs, particularly RAP and ISAPW, should be delivered earlier within the intake period (e.g., within first week or two of admission) (health services staff n=5).

3.10 IMPACT OF HEALTH EDUCATION & HEALTH REDUCTION INITIATIVES

FINDING 10: IMPACT OF HEALTH EDUCATION & HARM REDUCTION INITIATIVES

Health education programs, particularly those aimed at infectious disease, are associated with increased offender health-related knowledge and related behavioural changes (e.g., reduced risk-taking behaviours). Results of a review indicated that bleach was not always available as required in all CSC institutions, but no recent data were available to confirm the accessibility of other harm reduction products, such as condoms, dental dams, and lubricants.

Evidence: Impact of Health Education Programs

Health education programs and initiatives increase offenders' health-related knowledge.

Results of current surveys with CSC staff and offenders along with previous studies on health education and harm reduction (2010) suggest that CSC health education programs increase offender health related knowledge:

- **Infectious disease prevention:** Most health services staff and offenders perceived that health education programs had a positive impact on offenders' knowledge of infectious diseases.
  - Most health services staff and offenders reported that RAP (81%, n=30; 84%, n=31, respectively) and PEC/APEC (72%, n=34; 89%, n=17, respectively) increased offenders' knowledge of infectious disease prevention. Many general staff (69%, n=33), also agreed that education programs/materials overall increased offenders knowledge about maintaining their health in prison.
  - Most (90%, n=17) offenders agreed that after participating in PEC/APEC training to become a PEC/APEC support worker, their knowledge of infectious diseases increased. In addition, results from a pre-post training survey 2010-2011, indicated that 87% of participants increased their knowledge following the completion of the APEC training program.[cxxix]
  - Results of a previous research study (2010) of CSC offenders on infectious diseases demonstrated that offenders who participated in a health services education programs such as RAP, PEC, and Choosing Health in Prisons (CHIPs) materials, had higher knowledge of HIV[87] and HCV[88] compared to offenders who had not attended health services education programs.[cxxx]
- **Knowledge of suicide signs, symptoms, and where to seek support:** Many health services staff and offenders reported that participation in the ISAPW increased offenders' knowledge about: suicide signs, symptoms, and stressors (91%, n=21; 66%, n=21, respectively), and where to go for support if they needed it (92%, n=23; 94%, n=34, respectively).

[87] HIV: Men and women offenders who attended health education programs were more knowledgeable about HIV (83%; 86%) than men and women offenders who did not attend education programs (78%; 80%).
[88] HCV: Similarly, men and women offenders who attended health education programs were also more knowledgeable about HCV (73%; 78%) compared to men and women offenders who did not attend education programs (68%; 68%).

- **Availability of health services and how to access them:** Most health services staff and offenders indicated RAP had provided information on types of health services available and how to access them (82%, n=31; 97%, n=37, respectively).[89]

Health education programs and initiatives are associated with offender behavioural change.

Results of a previous research study (2010) of CSC offenders on infectious diseases demonstrated that knowledge of HIV and HCV risk factors were associated with less risky behaviour and/or use of harm reduction practices to reduce risk associated with their behaviour.[cxxxi]

- Offenders who were knowledgeable about the risks associated with contracting HIV and HCV were ***less likely*** to engage in risky behaviour.
    - Among men offenders responding to the 2007 Inmate Survey, those who were aware of the risks associated with contracting HIV by injecting drugs with needles that had previously been used by others were less likely to report having injected drugs during the previous 6-months in prison compared to offenders who were unaware of the risks.
- Among offenders who continued to engage in risky behaviour, such as injection drug use, unsafe sex, piercing, those who were knowledgeable about the risks were ***more likely*** to use harm reduction practices.
    - Among men offenders responding to the 2007 Inmate Survey who reported injection drug use within the previous 6-months, those who were aware of the risks associated with needle sharing were more likely to report cleaning their needle with bleach the last time they injected (73%) compared to those who were unaware of the risks (46%).

Implications:

Correctional health promotion programs can impact overall knowledge and behaviours, which can impact the overall health of offenders.

- Results of a recent literature review (2016) suggest that various formats of correctional health promotion were associated with some level of improvement to health related knowledge (e.g., increase in HIV/AIDs knowledge), more proactive attitudes towards behaviours that protect/promote one's health (e.g., more positive attitudes towards condom use) and greater

[89] Many general staff also agreed that education programs/materials in general had a positive impact on offenders' awareness of health services and programs in CSC and how to access them (67%, n=30).

compliance with recommended health behaviours (e.g., getting tested for HIV), for example:[cxxxii]

- The use of educational videotapes and comic book style pamphlets resulted in increased knowledge of communicable disease among offenders. A systematic review on the effectiveness of peer education programs for prisoners found peer education programs have a positive impact on attitudes, knowledge, and behavioural intentions for HIV risk behaviour.
- In a self-directed intervention for HIV, offenders were given a single session with a "talking lap top". The computer used offender responses to assess their perceived interest in behaviour change, as well as potential obstacles for achieving behaviour change. Based on responses, a computer was used to present specific intervention videos to participants that assessed their perception of infectious disease. On follow-up, offenders who had received the intervention were significantly more likely to report they had been tested for HIV than offenders who had not received the intervention.
- Lastly, an eight-session pre-release workshop intervention for HIV positive offenders involving presentations and discussions was associated with significantly greater self-reported use of community resources and less unsafe sexual and drug-related risk behaviour in the months following release.

Infectious diseases can result in significant treatment costs and prevention programs can be cost-effective.

- HIV: A recent study estimated that the combined direct and indirect costs[90] of HIV in Canada are approximately 1.3 million per person and can range from $4.03 to $5.03 billion annually.[cxxxiii]
- HCV: The total annual cost of HCV in Canada amounted to $103 million in 2001.[cxxxiv]
- CSC is one of four federal departments[91] involved in the Federal Initiative to Address HIV/AIDS in Canada. Through this initiative, CSC provides HIV testing, pre- and post-test counselling, education on risk reduction, medical treatment and surveillance for HIV-infected offenders.[cxxxv]

[90] Direct and indirect costs represent medical costs, labor productivity costs, and loss of quality of life.
[91] Other federal government organizations include; the Public Health Agency of Canada, the Canadian Institute of Health Research, and Health Canada.

  - An evaluation of the Federal Initiative to Address HIV/AIDS over the period 2008-09 and 2012-13 found that the cost of HIV infection ($4.03 to 5.03 billion per year) was much higher than the cost to operate the initiative ($72.6 million per year) suggesting it is cost-effective.[cxxxvi]

- Research has shown that the cost-effectiveness of interventions vary depending on the prevalence of infection in the target population and the cost of the proposed intervention.[cxxxvii] For example, studies have shown that school-based programs for students (a population with a very low prevalence of HIV) are the least cost-effective, whereas displaying videos in sexually-transmitted disease (STD) clinics (a population with a higher prevalence of HIV infection) is most cost-effective.[cxxxviii]

Given that the CSC offender population has a higher rate of infectious and blood borne disease (e.g., HIV/AIDS, HCV) relative to the general population[92], delivery of programs within this population provides a significant public health opportunity to reach a high-risk population.

Evidence: Harm reduction measures and initiatives

In addition to health education programs and materials, harm reduction materials and initiatives are offered to offenders throughout incarceration to reduce the risk of transmitting infectious disease and other negative effects of harmful behaviours, including injection drug use and unsafe sex.[cxxxix] To reduce and eliminate the transmission of bloodborne and sexually transmitted infections among inmates while incarcerated, CSC Health Services offers numerous programs and services that range from screening and testing, treatment, vaccinations, health education and awareness, harm reduction materials, and staff education and training[93]. The following section focuses on specific harm reduction measures, including the distribution of harm reduction materials, such as bleach, condoms, dental dams, and lubricants, as well as Opiate Substitution Therapy (OST).

[92] CSC surveillance data indicate the majority of offenders with HIV/HCV infection acquired infection prior to federal incarceration.

[93] A more detailed list of these programs and services includes: staff education and training, screening and testing, HIV testing normalization, addictions screening, health education and awareness, anti HIV-stigma campaigns, peer support programs, risk assessment and counselling, vaccination, diagnosis and treatment of viral hepatitis (A&B), substance abuse counselling, opiate substitution therapy, overdose emergency response and counselling, bleach distribution, mental health referral/counselling, condom/dental dam distribution, post-exposure prophylaxis, HIV and HCV treatment, discharge planning, prevention, diagnosis and treatment of TB.

Harm reduction programs and materials can be effective in reducing offenders' risky behaviours. However, harm reduction materials, such as bleach kits, were not always available to offenders as required.

Opiate Substitution Therapy (OST):

CSC also offers Opiate Substitution Therapy (OST) to address the treatment needs of those with an opiate dependency. The OST program was first introduced to offenders in 2008. It was formerly the Methadone Maintenance Treatment Program (MMTP) and has been revised several times, most recently to add Suboxone and is now called OST.[cxl]

- According to a 2014 research study, offenders who participated in MMTP reported a significantly lower prevalence of heroin injection, injection drug use and syringe sharing. Also noted were reductions in the number of positive tests (26.7% vs. 16.9%) and test refusals (29.0% vs. 21.2%).[94]
- In addition to the harm reduction benefits related to the reduction in drug use and reduction in needle sharing, offenders participating in MMTP incurred fewer serious disciplinary offences (39.7% pre to 32.9% post), spending significantly more time in education programs[95] and having more positive post-release outcomes.[96]
- Many health services staff (55%, n=79) and general staff (58%, n=54) agreed that the administration of opiate drugs addresses the needs of offenders with an opiate dependency, but some suggestions to better address their needs were offered:
    - Improving the delivery (e.g., ensure sufficient number of staff; health services staff n=16; general staff n=3).
    - Improving the format/content of the program (e.g., provide addictions counseling or education health services staff n=9; general staff n=4).
    - Improve monitoring of the program (e.g., continue to monitor offenders for possible diversion of their opiate drugs; health services staff n=7; general staff n=4).

[94] These results are from a pre two year and post two years time period.
[95] In the two years following MMTP initiation, the proportion of successful program completions or attendance more than doubled for substance abuse programs, increasing from approximately 29% in the pre period to 63% in the post period.
[96] The risk of re-incarceration was 36% higher for male non-MMPT offenders compared to MMPT offenders who continued methadone treatments.

Harm reduction materials:

Harm reduction materials provided in institutions include: condoms, bleach, dental dams, and water-based lubricant.[97]

- Many health services staff and general staff surveyed agreed that harm reduction products have a positive impact on offenders' behaviour including reducing the likelihood of risky behaviours such as unsafe tattooing/drug use, and unprotected sex (72%, n=58 and 61%, n=41, respectively).
- Many (60%, n=54) offenders agreed that the health information and harm reduction products that they received enabled them to avoid engaging in risky behaviours. A few offenders (23%, n=21) disagreed:
    - Health information was insufficient to prevent/reduce risky behaviours (n=9)
    - That harm reduction measures were insufficiently supplied (n=5)

Accessibility and supply of harm reduction products such as bleach and condoms:

According to *Commissioner's Directive 800: Health Services*, the Institutional Head is responsible for ensuring that non-lubricated, non-spermicidal latex condoms, water-based lubricants, individually packaged dental dams and bleach are discreetly available to offenders at a minimum of three locations within each institution, as well as in all private family visiting units.[cxli] Furthermore, the *Bleach Distribution's Guidelines* state that upon reception, offenders should be issued bleach kits, informed on the bleach whereabouts, and instructed on the use of bleach as a harm reduction measure.[cxlii]

- Many health services staff (69%, n=51), general staff (78%, n=47), and offenders (69%, n=96) agreed that a sufficient supply of harm reduction products like condoms and bleach kits were available to meet the needs of offenders.
- Most health services staff (87%, n=76), general staff (87%, n=61), and offenders (91%, n=128) agreed that offenders know where to go to access harm reduction products like condoms and bleach kits if needed.

[97] Health services staff and general staff reported that condoms (99%, n=99; 91%, n=73), bleach kits (83%, n=83; 86%, n=69), dental dams (70%, n=70; 56%, n=45), and lubricants (74%, n=74; 63%, n=50) are available in their institutions, respectively.

- Many health services staff (79%, n=62), general staff (78%, n=51) also agreed that harm reduction products (such as bleach kits or condoms) were placed in an easily accessible location for offenders.
- The fall 2015 Compliance and Operational Risk Report found that all CSC sites had a bleach program and designated coordinator in place. However, problems were identified regarding the availability and documentation of bleach kits.[cxliii] 17% of sites were non-compliant in ensuring bleach kits were available and properly labeled. Specifically, it was noted that dispensers were not always available or that they were malfunctioning.[cxliv]

Health services staff, general staff and offenders provided several suggestions related to harm reduction products (e.g., bleach, condoms, dental dams, lubricants):

<u>Increasing the accessibility and range of harm reduction products and ensuring that offender confidentiality is maintained.</u>

- Although many staff and offenders reported that harm reduction products were accessible, some did not (health services staff 20%, n=15; offenders 20%, n=28), suggesting that not all have equal access. They suggested increasing the availability and accessibility of harm reduction products such as ensuring station refills, increasing the frequency of station refills and expanding accessibility (health services staff n=12; offenders n=21).
- Expand the range of harm reduction products offered (general staff n=4; offenders n=15).
- Make harm reduction products available in more locations (e.g., should be available in segregation, in maximums, and on the ranges; offenders n=7).
- Ensure the confidentiality of offenders using harm reduction products (e.g., place stations in more private areas, offenders afraid to ask for stations to be refilled; health services staff n=5).

<u>Providing more education opportunities or information regarding harm reduction products.</u>

- Provide more education on the use of harm reduction products (e.g., increased education on diseases and best practices, how to properly use products, information about effectiveness of bleach in eliminating HIV; offenders n=13).

- Improve the management of harm reduction products (e.g., inform staff on location of products, improve awareness of who is responsible for filling stations; offenders n=6; health services staff n=4).

RECOMMENDATION 5: HEALTH EDUCATION AND HARM REDUCTION

That CSC Health Services ensure that offenders have timely access to health education programs and harm reduction products by:

- Providing clear direction and accountability for delivery and tracking of health education programs; and
- Monitoring the distribution of harm reduction products (bleach, condoms, dental dams, and lubricants) and addressing any identified accessibility issues.

FIFE #5: INSTITUTIONAL MENTAL HEALTH SERVICES

The following section focuses on CSC institutional mental health services, which are provided in mainstream institutions and Regional Treatment Centres. The impacts of institutional mental health treatment on offender behaviour and integration into the institutional environment are examined. In addition, several aspects of treatment for those with high or complex mental health needs are assessed. This included offender admissions to RTCs, offender perceptions of this care, and the role of RCMHCs.

Overview: CSC's Mental Health Care Model

CSC provides a variety of institutional mental health services that are appropriate to offenders' level of need to ensure that offenders are receiving the right interventions at the right time in their sentence. Currently, CSC offers three different levels of institutional mental health care to offenders in mainstream CSC institutions or in a RTC, which include: primary, intermediate[98] and psychiatric hospital care.[cxlv]

Primary mental health care includes mental health promotion, prevention and early intervention, screening, assessment and individualized treatment planning, evidence-based treatment and support services, monitoring of offenders in segregation, and crisis intervention. Primary care also involves coordination of referrals to other levels of care (i.e., intermediate mental health care, psychiatric hospital care, or discharge planning where available). Primary care is provided in mainstream institutions by mental health professionals.

Intermediate mental health care provides mental health care to offenders who do not require admission to hospital, but require a higher level of mental health care than available at the primary care level. Services include: clinical case coordination, assessment, treatment, psychiatric symptom management, therapeutic recreation and leisure activities, provision of care associated with activities of daily living, and discharge planning (where available). There are two types of intermediate mental health care provided to offenders based on their level of need – moderate and high.

- Moderate intensity is intended for those offenders with chronic or sub-acute mental health conditions and with symptoms that are moderate but do not require 24-hour care or access to 24-

[98] Intermediate mental health services were not included in the scope of this evaluation because these services were not fully implemented in CSC institutions at the start of the evaluation.

hour care. These services are offered in mainstream institutions and include availability of clinical staff up to eight hours per day Monday to Friday and evenings and weekends as available.

- High intensity is intended for those offenders with chronic or sub-acute mental health conditions who do not require admission to hospital but whose needs exceed services available in moderate intensity, intermediate mental health care and primary care. These services are offered in close proximity to a hospital or within a RTC. Nursing staff is available up to 12 hours per day Monday to Friday and up to eight hours per day on weekends. Offenders may also have access to 24-hour nursing care if required.

Psychiatric hospital care is provided at RTCs located in each region for offenders with acute mental health concerns requiring a clinical environment that provides 24-hour care. RTCs are "hybrid facilities" in that they are considered to be both a "penitentiary" and a "hospital" subject to the provisions of the federal *Corrections and Conditional Release Act* (CCRA), and relevant provincial legislation respectively. [cxlvi] Services include intensive psychiatric treatment, comprehensive and specialized mental health assessments, intensive psychiatric and nursing services for stabilization, clinical case coordination, psychiatric symptom management, therapeutic recreation and leisure activities and provision of care associated with activities of daily living and discharge planning (where available). Once symptoms are explored and behaviours are stabilised offenders can be returned to mainstream institutions and receive lower levels of mental health care.

3.11 INSTITUTIONAL MENTAL HEALTH CARE OUTCOMES

FINDING 11: INSTITUTIONAL MENTAL HEALTH CARE OUTCOMES

Institutional mental health care provided in CSC mainstream institutions and RTCs was associated with positive impacts on offenders' behavioural stability following treatment, such as reduced likelihood of incidents, serious charges, and involuntary segregation.

Evidence: Institutional Mental Health Care Outcomes

Mental health treatment is essential to alleviate symptoms, improve well-being, facilitate participation in correctional programs and support safe reintegration into institutional and community environments.[cxlvii] Intended mental health care treatment objectives include: symptom reduction,

development of viable coping strategies, improved self-management, prevention of relapse and reduced risk for criminal behaviour.[cxlviii]

The following section focuses on the impact of institutional mental health care services on correctional outcomes among two groups of offenders: (1) those who received mental health care within a mainstream CSC institution only; and, (2) those who received mental health care within a RTC.[99] Correctional outcomes include institutional incidents, institutional charges,[100] admissions to involuntary segregation,[101] national correctional program completions, and education course/credit completions. Overall, institutional incidents were analyzed as well as select sub-categories of incidents recorded in OMS (i.e., assault, behaviour, self-harm)[102] that could be associated with mental health issues.

Correctional outcomes were assessed during two separate time periods: (1) during treatment; and (2) after treatment, and both were compared to before treatment levels. Offenders may receive mental health treatment services at various points in a mainstream institution. For the purposes of this analysis, a "treatment period" was defined as a block of continuous service, where treatment-oriented services[103] were delivered within four months of each other.

[99] Some offenders received treatment at both mainstream institutions and RTCs. These offenders were included in the "RTC group" for analysis. The focus was on the impacts of care received while at a RTC (i.e., "after treatment" outcomes were assessed following RTC treatment, whether or not other treatment may have continued following return to the institution).

[100] Institutional charges may differ from institutional incidents, as correctional staff members may resolve an institutional incident informally (CD 580; CCRA section 41 (1) & (2)). Institutional incidents were included for analysis if the offender was identified as an instigator or an associate in the incident.

[101] Statistical analysis of voluntary segregation could not be conducted due to low rates of the indicator.

[102] In addition to assault, behaviour, and self-harm, other incident sub-categories are recorded in OMS (i.e., possession of contraband, property offences, escapes, and deaths). Although all sub-categories were included in the analysis for "overall incidents," only the three categories with theoretical links to mental health needs were included for sub-incident analysis (i.e., assault, behavior, self-harm).

[103] Treatment-oriented services included: mental health counselling: group/individual; psychiatric clinic; skills training/self-care/activities of daily living (ADL); suicide or self-injury intervention; treatment planning; counselling: group/individual. Many offenders had more than one "treatment period," but the treatment period with the *most* treatment services was selected to be included in the analysis.

- **Legend:** Analysis of outcomes during treatment is shown in tables outlined in "blue" and analysis of outcomes after treatment is shown in tables outlined in "purple".

During Treatment	After Treatment

Outcomes: Treatment in Mainstream CSC Institutions[104]

After treatment, mental health services provided in mainstream institutions were associated with positive outcomes, including: reduced likelihood of incidents, charges, and involuntary segregation, and greater likelihood of completing a correctional program or an education course or credit. During treatment, mental health services provided in mainstream institutions were associated with: reduced likelihood of involuntary segregation, and an increased likelihood of national correctional program completions.

a) During Treatment (vs. Before Treatment):

- *All Offenders:* Offenders receiving mental health treatment in mainstream CSC institutions were less likely to be involuntarily segregated and more likely to complete a national correctional program during treatment, compared to before treatment (see Table 1).
- *Indigenous Offenders:* Indigenous offenders were more likely to complete a national correctional program during treatment in a mainstream institution, compared to before treatment (see Table 1).

[104] Separate statistical analyses were not conducted for women offenders due to the smaller number of women offenders receiving mainstream institutional mental health treatment. However, they are included in the overall sample of "all offenders".

Table 1: Mainstream Institutional Mental Health Treatment – During Treatment vs. Before Treatment

	All Offenders (n = 3,167)	Indigenous Offenders (n = 802)
Incidents - Overall	NS	NS
Assault	____	____
Behaviour	NS	NS
Self-Harm	____	____
Charges		
Minor	NS	NS
Serious	NS	NS
Involuntary Segregation	13% less likely	NS
National Correctional Program Completions	20% more likely	38% more likely
Education Course/ Credit Completions	NS	NS

*More likely and less likely refers to an increase or decrease in the overall likelihood of the outcome event occurring during treatment compared to before treatment.
**NS indicates non-significance.
*** ---- indicates that statistical analysis was not conducted on the outcome due to low rates of the indicator.
****See Appendix F: Table 1 and 2 for more detailed statistical results.

After Treatment (vs. Before Treatment):

- *All Offenders:* After mental health treatment in mainstream CSC institutions, offenders were less likely to be involved in incidents overall, less likely to be charged with a serious offence, and less likely to be involuntarily segregated, compared to before treatment. Offenders were also more likely to complete a national correctional program and education course or credit after receiving mental health treatment in CSC's mainstream institutions (see Table 2).
- *Indigenous Offenders:* Indigenous offenders were less likely to be involuntarily segregated, and more likely to complete a national correctional program and education course or credit after treatment, compared to before treatment (see Table 2).

Table 2: Mainstream Institutional Mental Health Treatment – After Treatment vs. Before Treatment

	All Offenders (n = 3, 167)	**Indigenous Offenders (n = 802)**
Incidents - Overall	9% less likely	NS
Assault	_____	_____
Behaviour	NS	NS
Self-Harm	_____	_____
Charges		
Minor	NS	NS
Serious	30% less likely	NS
Involuntary Segregation	32% less likely	30% less likely
National Correctional Program Completions	23% more likely	30% more likely
Education Course/ Credit Completions	34% more likely	23% more likely

*More likely and less likely refers to an increase or decrease in the overall likelihood of the outcome event occurring after treatment compared to before treatment.
**NS indicates non-significance.
*** ---- indicates that statistical analysis was not conducted on the outcome due to low rates of the indicator.
****See Appendix F: Table 1 and 2 for more detailed statistical results.

Outcomes: Treatment in RTCs[105]

Mental health services provided in RTCs were associated with positive outcomes following treatment, including a reduced likelihood of incidents, serious charges, and involuntary segregation. During treatment, the likelihood of institutional charges and involuntary segregation was reduced; however, the likelihood of incidents was observed to increase.

a) During Treatment vs. Before Treatment:

- *All Offenders:* During treatment, offenders in RTCs were more likely to be involved in incidents overall, including assault and behaviour[106] related incidents, compared to before treatment. However, they were also less likely to be charged with a serious offence, and less likely to be involuntarily segregated during treatment, compared to before treatment (see Table 3).

[105] Separate statistical analyses were not conducted for Indigenous and women offenders due to the smaller number of Indigenous and women offenders receiving treatment at a RTC. However, they are included in the overall sample of "all offenders".
[106] Behaviour related incidents include: minor/major disturbances, disruptive behaviour, substance use, disciplinary problems, threats towards staff/others and cell extraction.

Table 3: RTC Mental Health Treatment: During Treatment vs. Before Treatment

	Overall (n = 617)
Incidents - All	22% more likely
Assault	47% more likely
Behaviour	31% more likely
Self-Harm	NS
Charges	
Minor	NS
Serious	31% less likely
Involuntary Segregation	39% less likely
National Correctional Program Completions* **	NS
Education Course/ Credit Completions* **	NS

*More likely and less likely refers to an increase or decrease in the overall likelihood of the outcome event occurring during treatment compared to before treatment.
**NS indicates non-significance.
***See Appendix F: Table 3 for more detailed statistical results.

b) <u>After Treatment vs. Before Treatment:</u>

- *All Offenders:* After treatment in a RTC, offenders were less likely to be involved in incidents overall, including all incident sub-types examined (assault, behaviour, self-harm), and less likely to be charged with a serious offence, compared to before RTC treatment. Offenders were also less likely to be involuntarily segregated (see Table 4).

Table 4: RTC Mental Health Treatment: After Treatment vs. Before Treatment

	Overall (n = 617)
Incidents - All	19% less likely
Assault	29% less likely
Behaviour	21% less likely
Self-Harm	34% less likely
Charges	
Minor	NS
Serious	31% less likely
Involuntary Segregation	19% less likely
Nat. Correctional Program Completions	NS
Education Course/ Credit Completions	NS

*More likely and less likely refers to an increase or decrease in the overall likelihood of the outcome event occurring after treatment compared to before treatment.
**NS indicates non-significance.
***See Appendix F: Table 3for more detailed statistical results.

Summary:

Overall, mental health treatment had a positive impact on correctional outcomes for offenders. After receiving treatment, offenders were generally less likely to be: involved in institutional incidents, charged with a serious institutional offence, and involuntarily segregated. Further, they were more likely to complete national correctional programs (in mainstream institutions). Although some offenders demonstrated an increased likelihood of incidents during mental health treatment, it is possible that these increases may be associated with heightened emotional instability during this time of crisis or high need.

There was a possibility that some correctional outcomes were being impacted by time alone (i.e., some outcomes may be more or less likely to occur later in an offender's sentence). In order to determine which outcomes were impacted by time, a random sample of offenders was selected from CSC's database and correctional outcomes were measured near the end of an offender's sentence, compared to the beginning of their sentence. Results suggested that, over time, there was a decrease in the likelihood of segregation,[107] an increase in the likelihood of education course or credit completion,[108] and an increase in national correctional program completion.[109] Changes following mental health treatment were also observed for these outcomes (segregation, education, and correctional programs). In some cases, the impact of mental health treatment appeared to have an even greater impact than that observed due to time alone (e.g., 32% decrease in involuntary segregation following treatment for offenders in mainstream institutions, whereas, the overall change from time alone was only 16%). However, it is possible that some of these observed results may have been influenced by time as well.

Overall, institutional mental health treatment demonstrated a number of positive impacts. Given the prevalence of mental health needs in the offender population, management of these needs continue to be a priority to CSC. The next section explores mental health care for offenders with high or complex needs receiving treatment in RTCs or requiring oversight through RCMHCs.

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[107] Offenders in the comparison group were 16.6% (HR = 0.834; 95% CI = 0.770-0.903) less likely to be involuntarily segregated closer to the end of their sentence, compared to the beginning of their sentence.
[108] Offenders in the comparison group were 15% (HR = 1.150; 95% CI = 1.028-1.288) more likely to complete an education course or credit closer to the end of their sentence, compared to the beginning of their sentence.
[109] Offenders in the comparison group were 21.8% (HR = 1.218; 95% CI = 1.148 – 1.293) more likely to complete a national correctional program in the middle of their sentence compared to the beginning of their sentence.

3.12 LEVEL OF CARE BASED ON NEED

FINDING 12: LEVEL OF CARE BASED ON NEED

The Health Services Sector developed a *Mental Health Need Scale* to assess the level of mental health need and determine the appropriate level of care required in accordance with the new refined model of mental health care (primary, intermediate, psychiatric hospital). The validity and reliability of this scale have not been assessed, and electronic data on offender scale results have not been consistently recorded.

Evidence: Implementation of Care for those with High or Complex Needs

More than half of admissions to RTCs occurred within seven days of referral and more than three-quarters within twenty-eight days. The majority of offenders interviewed at RTCs felt that it was the right setting for them to address their mental health needs and that their mental health needs were identified in treatment planning processes.

Services provided to offenders with mental health needs are prioritized based on urgency of the referral, level of need, and the complexity of the case. Offenders' level of need as well as risk and eligibility/release dates are considered as the primary criteria for prioritizing admissions.[cxlix]

- In 2014-15, a total of 633 referrals were made to a RTC, of which 587 offenders were admitted. Of the offenders admitted, 317 were new admissions and 270 were readmissions.[cl,110]
- Of the 587 admissions, 84 had missing referral dates. Of the 503 remaining admissions, 55% (n=277) occurred within seven days of referral and 24% (n=119) within seven to twenty-eight days of referral.[111]
- According to the *Integrated Mental Health Guidelines*, admissions to Psychiatric Hospital Care are intended for offenders with acute mental health concerns requiring a clinical environment that provides 24-hour offender care coverage.[cli]
- About half of health services staff respondents familiar with RTCs and the referral process (46%, n=30) agreed that admissions to RTCs during incarceration are appropriate for the offenders' level of need.

[110] Referrals are reviewed and offenders may not be admitted to a RTC due to their eligibility or lack of consent.
[111] This information was extracted from MHTS for this evaluation.

- Health services staff provided suggestions to improve the referral and admission process to RTCs during incarceration, including:
  - Increasing bed spaces (n=7).
  - Having a designated mental health professional or physician to make referrals (e.g., psychiatric nurse, clinical professional, psychiatrist, physician) (n=7).
  - Streamlining the referral process (n=5).
  - Clarifying and improving communication regarding offender admission criteria (n=4).

Offender perceptions of RTCs:

- Among RTC offenders interviewed for the evaluation:[112]
  - 84% (n=27) reported that the RTC was the right place to take care of their mental health needs.
  - 72% (n=23) perceived that all of their mental health needs were identified in their treatment plan.
  - 41% (n=13) recalled being involved in developing their treatment plan and objectives.[113]
  - 56% (n=18) reported being satisfied overall with the mental health services they were receiving. A few reported being dissatisfied (6%, n=2), and the remaining offenders reported having mixed experiences (e.g., satisfied with mental health services received, but wish it could be a faster process; 38%, n=12).

CSC recently refined its mental health care delivery model to provide more options for mental health services (primary, intermediate, psychiatric hospital care) and to better target the right service and intensity level at the right time for an offender.

- CSC recently refined its mental health care delivery model to provide more options for mental health services (primary, intermediate, psychiatric hospital care) and to be consistent with community and other correctional models of care.

[112] Offenders receiving treatment in RTCs in two regions were interviewed (N=32) about their experiences with receiving care. Due to the varied health conditions of this population and the small number of offenders interviewed, the questions were asked in a more open-ended fashion designed to elicit discussion around specific themes related to admission, treatment and services received.

[113] Some of the remaining RTC offenders did not report awareness or involvement in treatment planning (21%, n=6). Others reported awareness of the planning process (e.g., having meetings), but did not recall being involved in developing their treatment plan and objectives (32%, n=9).

- The goal of the new service delivery model is to better target the right service and intensity level at the right time for the right person. The intensity of mental health services provided to offenders is matched to the identified level of mental health need.
- Prior to 2015, intermediate mental health care services were not implemented in CSC institutions, and health services offered two levels of care: primary and psychiatric hospital care.
- In April 2015, CSC began the phased implementation of intermediate mental health care services in RTCs and select mainstream institutions.[114] Intermediate care was intended to fill the gap between primary care and psychiatric hospital care provided at RTCs.[clii]

The Health Services Sector has developed the Mental Health Need Scale to assist in determining appropriate level of care. Scale information has not been consistently recorded electronically.

- The *Mental Health Need Scale* (MHNS), developed in 2015, was recently revised by the Health Services Sector to better assist in determining the appropriate level of care (primary, intermediate, psychiatric hospital care) based on overall level of mental health need. The MHNS was modelled after various tools that assess mental health status and/or clinical domains.
- The MHNS is a seven-point scale; it is a revision of the previous four-point scale. The previous scale did not indicate eligible levels of care associated with assessed level of mental health need. It replaces the institutional mental health triage form. The current MHNS also provides a more flexible, universal scale capable of showing any changes in an offender's mental health needs over time.
- Under the refined new model of care and according to the new *Integrated Mental Health Guidelines*, referrals for mental health care are triaged using the MHNS to determine the most appropriate required level of care (primary, intermediate, psychiatric hospital care).
- The MHNS provides a series of need indicators ranging from no need, to low, medium or high need. Each level of need corresponds to one or more levels of care: primary care, intermediate moderate intensity care, intermediate high intensity care, and psychiatric hospital care.[cliii,115]
- Given the emphasis on the use of this scale in the new *Integrated Mental Health Guidelines* to determine offender level of need and subsequent assignment to level of care, it is important that

[114] Implementation of intermediate mental health care was completed in April 2016.
[115] If offenders are assessed as no need or low need on the MHNS, self-care may also be an option if necessary, for example psycho-educational sessions on a particular mental health topic or skill development.

this scale be reliably implemented to ensure appropriate placement. However, the reliability and accuracy of this scale have not yet been examined.

- Results of the MHNS are retained electronically on the Electronic Medical Record (EMR) and in hard copy in Mental Health/Psychology, Psychiatric Hospital and/or Health Care files, as appropriate.
- It remains important that accurate results from the scale be recorded electronically to assess implementation and impacts of the new model. Following completion of the MHNS, offender level of need was to be entered into electronic systems (i.e., MHTS and then the EMR once it was fully implemented). However, accurate current and historical data regarding the MHNS was not available electronically to determine level of mental health need of offenders.[116] In addition, historical data regarding the previous MHNS was being overwritten as the system did not allow for the retention of historical information.
- In December 2015, health services staff were instructed to ensure updates to the MHNS were recorded electronically, and in March 2016, a new feature was introduced into the MHTS to allow for historical data to be captured and maintained.

RECOMMENDATION 6: LEVEL OF CARE BASED ON NEED

That CSC Health Services ensure offenders are referred to the appropriate mental health services by:

- Implementing effective management practices to ensure that current information on offender level of need is recorded electronically and that previous records are retained; and,
- Assessing the validity and reliability of the Mental Health Need Scale.

[116] Health Services Sector reported that electronic data on MHNS was not always being entered as required.

3.13 REGIONAL COMPLEX MENTAL HEALTH COMMITTEES

FINDING 13: REGIONAL COMPLEX MENTAL HEALTH COMMITTEES

Regional Complex Mental Health Committees have been established to assist and support institutions in providing an effective continuum of care to offenders with complex mental health needs. The degree to which funds were expended relative to those allocated at the regional level could not be accurately determined because funding was not fully tracked in the financial system.

Regional Complex Mental Health Committees have been established to assist and support institutions in providing an effective continuum of care to offenders with complex mental health needs.

Regional Complex Mental Health Committees

In April 2010, EXCOM approved the establishment of Regional Suicide/Self-Injury Prevention Management Committees to assist institutions in the management of self-injurious and suicidal behaviour. The scope of the committees was later expanded in October 2013, to include offenders with complex mental health needs as well as offenders who persistently and chronically self-injure.[cliv]

The RCMHCs meet monthly to review complex cases, and are mandated to:[clv]

- Identify complex cases for the High Risk/High Needs consultation process;
- Monitor cases of complex mental health needs, as identified by the High Risk/High Need consultation process;
- Monitor incidents of suicidal and self-injurious behaviour, with a focus on repeat self-injurious behaviour;
- Flag items of concern;
- Consult/engage institutions to offer support and advice on management and treatment, as necessary; and,
- Update the National Complex Mental Health Committee (NCMHC) on regional committee activities.

RCMHCs are comprised of senior regional health services and operational staff. Members include: Regional Director of Health Services (Co-Chair), Assistant Deputy Commissioner of Institutional

Operations (Co-Chair), Senior Psychiatrist, Executive Director of the Treatment Centre, Institutional Mental Health Manager, and, as required, Community Mental Health Manager and District Director. Ad hoc members may be included as determined by the meeting chair.

RCMHCs are supported by the NCMHC which provides assistance to regions in providing an effective continuum of care to offenders experiencing significant mental health concerns. The NCMHC:

- Monitors a national list of offenders with complex mental health needs;
- Provides oversight of regional monitoring of suicidal and self-injurious behaviour;
- Supports regional networking and sharing of best practices; and,
- Provides support to RCMHCs to enhance their ability to implement an interdisciplinary team approach.

Through RCMHCs, Health Services released funds to the regions, of which 59% was confirmed in expenditures at the regional level for offenders with complex needs.

During the period of April 1, 2015 to March 31, 2016:[clvi]

- The cases of 229 individual offenders with complex mental health needs were reviewed and discussed at the various RCMHC and NCMHC meetings; this included thirty-eight (38) cases discussed at the NCMHC meetings.
- Specialized funds for additional resources for the treatment and management of twenty (20) offenders with complex mental health needs were provided.
    - Health Services released $764,170 to the regions; 59% of that amount ($447,244) was confirmed in expenditures at the regional level for offenders with complex needs. These funds were provided for:
        - Dedicated staff resources in order to provide additional support to offenders with complex mental health needs;
        - O&M costs associated with complex cases (outside hospitalization, ambulance costs, examinations/tests, physician costs, etc.); and
        - Specialized external assessments and provision of staff training.

- The reason for the discrepancy between funds released and expended is unknown; it is possible that there may have been errors in coding these expenditures in the Integrated Financial and Material Management System (IFMMS).

Health services staff provided some suggestions to enhance RCMHCs such as reviewing roles and functions, creating greater awareness and improving communication and information sharing.

- Some health services staff (42%, n=81) and a few general staff (18%, n=29) reported being familiar with the RCMHCs. Not all staff members would necessarily be expected to be aware of RCMHCs, depending on their role in the institution. Most staff members who reported being aware of the RCMHCs either worked in the health domain or could be included as RCMHC members. These included mental and clinical health professionals (i.e., psychologists, nurses) as well as those in senior operational management positions (i.e., wardens, managers).
- Of the health services staff and general staff [117] who were familiar, some agreed that RCMHCs:
  - Assist institutions in monitoring offender's complex mental health needs (health services staff 61%, n=45; general staff 70%, n=19).
  - Offer support to staff working with offenders with complex mental health needs (health services staff 40%, n=29; general staff 67%, n=16).
  - Provide a forum to share best practices in the provision of care for offenders with complex mental health needs (health services staff 40%, n=27; general staff 77%, n=17).
  - Assisted institutions to improve their capacity to provide effective care/interventions for offenders with complex mental health needs (health services staff 28%, n=19; general staff 58%, n=14).
- Health services staff suggested the following to enhance RCMHCs:
  - Review the role and function of RCMHCs to provide broader support (n=12).
  - Increase resources to better support institutional staff working with complex needs cases (e.g., more nurses, occupational therapists, psychologists, outside specialists; n=12).
  - Improve communication and sharing of information and best practices (n=7).
  - Review composition of RCMHCs (e.g., add front line staff or clinical personnel; n=5).
  - Increase the awareness of RCMHCs and their role (n=4).

[117] Use caution when interpreting the results from general staff members due to the small number of respondents.

Next Steps:

In August 2016, the Terms of Reference (TOR) of the RCMHC were revised and approved. Although the majority of RCMHC roles and activities remained the same, the mandate was expanded to include additional activities, such as psychiatric consultations, non-emergency transfers, and requests for specialized resources. In addition, the membership was expanded to include wardens of Treatment Centres.[clvii]

RECOMMENDATION 7: REGIONAL COMPLEX MENTAL HEALTH COMMITTEES

That CSC Health Services:

- Track nationally and report on activities and expenditures of funds released to regions through RCMHCs; and
- Provide information to institutional staff regarding the role of RCMHCs and identified best practices.

FIFE #6: PRE-RELEASE AND COMMUNITY HEALTH SERVICES

CSC provides a variety of mental health care services to the offender population throughout the continuum of care. The following section focuses on transitions to the community (i.e., discharge planning) and community mental health services. Transition of offenders to community health services is examined, including routine discharge planning, assisting offenders to obtain provincial health cards, and payment for community health services during the transition. The implementation and impacts of community mental health services and clinical discharge planning for those with significant mental health needs are also assessed.

Routine Discharge Planning

Discharge planning is a client-centred process that prepares offenders for transitions in care (e.g., release to the community). Routine discharge planning, offered to all offenders who have ongoing health care needs, consists of comprehensive planning (e.g., needs assessments, intervention planning, coordination of services) to ensure that offenders receive continuity of care when they are released to the community.[clviii] This is important as more offenders are being released with continuous and/or complex health needs and the goal is to prevent "increased physical and psychiatric symptoms, relapse, hospitalization, suicide, homelessness, family and social discord as well as continued involvement with the criminal justice system after release to the community."[clix]

Discharge planning requires coordination among several institutional staff members, including institutional nurses and parole officers.[clx]

The institutional nurse:

- Reviews and updates the offender's health care file;
- Finds out whether the offender is receiving health care that will likely continue after release, identifies any appointments required with community health care specialists, and any accommodation needs related to functional and/or cognitive impairment and arranges for follow-up medical, dental, and/or mental health appointments with health service providers as soon as possible after release;
- Completes required discharge forms (e.g., Health Status at Discharge: Gist Report, Health Services Discharge Summary Report, and Medication Reconciliation);

- Determines whether the offender has a health card or has started the process to obtain one with their institutional parole officer; and,
- Arranges with the regional or local pharmacy for the provision of two weeks supply of medication; additional medication and/or prescription supply may also be provided. Discharge medication is provided to the offender on the release date.

The institutional parole officer (IPO):

- Develops a comprehensive release plan that includes the offenders' health information if relevant to discharge;
- Assists the offender to obtain a provincial health card in the province of the offenders' releasing institution;[clxi] and,
- Informs health services of upcoming case preparation in advance of 6 months before hearing/release, and informs health services of upcoming release 3 weeks in advance (or as soon as possible for last minute releases).[clxii]

3.14 ROUTINE DISCHARGE PLANNING AND OFFENDER INDENTIFICATION

FINDING 14: ROUTINE DISCHARGE PLANNING AND OFFENDER IDENTIFICATION

Processes to assist offenders in obtaining provincial health cards vary across regions and are dependent on provincial/territorial health authority requirements. Procedural challenges associated with assisting offenders to obtain provincial/territorial health cards exist (e.g., prerequisite for a birth certificate, fee requirements, releases to different provinces).

Evidence: Routine Discharge Planning and Offender Identification

The most commonly reported challenges identified by CSC staff related to discharge planning were assisting offenders to obtain provincial/territorial health cards and other ID. It was difficult to determine exactly how many offenders have health cards at release, since information regarding the number of offenders with health cards was inconsistently documented in OMS.

CSC staff reported some challenges related to routine discharge planning:

- More than 50% of CSC staff respondents reported *always* or *frequently* experiencing challenges assisting offenders to obtain provincial health cards (51%, n=90) and other ID (56%, n=93).
- Between 41% and 45% of staff respondents reported *always* or *frequently* experiencing challenges with timely notification of requests for discharge planning (45%, n=81), coordinating medical services in the community (44%, n=77), housing/accommodations for those with special needs (43%, n=73), and coordinating access to medication in the community (41%, n=74).
- Other issues related to discharge planning reported by staff respondents included:
  - Issues related to communication and information sharing within CSC pertaining to discharge planning (n=54). Such as:
    - Insufficient notice of the offender's release (e.g., offender's notice of release is not always provided to health services, quick releases from parole hearings or last minute changes to residency conditions).
    - Need to clarify discharge planning roles and responsibilities (e.g., duplication of work may occur as a result of unclear understanding of responsibilities regarding follow-up).
  - Challenges with ensuring continuity of care (n=50). Such as:
    - Issues coordinating medication (e.g., coordination of methadone treatment in the community or when offenders are released without a two-week supply of medications).[118]
    - Offenders are being released without ID, primarily without their health cards.
  - Challenges with the discharge planning process (n=27). Such as:
    - Not enough planning for complex needs cases (e.g., offenders with high needs).
    - Issues with discharge planning could be improved in terms of consistency, timeliness and resource allocations for discharge planning.

Number of offenders in the community with a health card:

- OMS*:* Records showed that 28% (n=2,289) of CSC offenders in the community[119] had a health card. However, data was missing in OMS for an additional 62% (n=5,133) of CSC offenders in the community, suggesting that OMS is not a reliable source of information.

[118] The Audit of Release Process (2012) also found offenders were not always released with their medications.

- Audit of Offender Release Process*:* 42% (n=117) of offenders had three pieces of identification (ID) upon release (i.e., birth certificate, social insurance number, and health card) according to a file review conducted during an internal audit of the release process (2012).[120] However, information on ID was missing from 39% (n=109) of files reviewed.[clxiii]
- Staff Questionnaires*:* 52% (n=130) of CSC staff reported that more than half of the offenders they worked with had a health card at release.

The process to assist offenders in obtaining provincial/territorial health cards varies across regions and is dependent on provincial/territorial health authority requirements. In some provinces and territories, offenders must wait until after release to apply for a health card.

- According to *CD 712-4 Release Process*: The Institutional Head/District Director must ensure that procedures exist to assist the offender "in obtaining relevant documentation, including health care coverage, social insurance number, birth certificate and citizenship card/permanent resident card."[clxiv]
- According to *CD 566-12 Personal Property of Offenders*: "Important documents (not exceeding $1,000) will be recorded on the Inmate Personal Property Record and will be securely stored in a fireproof cabinet or safe. Items stored in this manner will be photographed and the inmate will sign the Inmate Personal Property Record to confirm its authenticity. These items will also be photographed and the photograph and Inmate Personal Property Record will be stored electronically in OMSR-OPP and will remain in the Admission and Discharge File."[clxv] The CD does not define "important documents" so it is unclear whether offender ID would be considered an important document.

Prior to release

- Regional personnel reported that the process to obtain a health card generally involves the IPO completing and submitting the health application to the provincial/territorial health service. However, the staff member responsible may vary by site, and others may also be involved (e.g., Admissions and Discharge Department, clinical discharge planners).[121] A birth certificate or

[119] Extracted from the data warehouse on 2016-02-28 for all offenders active on that date. Offenders were coded as having a health card if their *most recent record* from OMS indicated they had a health card in their possession, in their personal effects, of with a community support person.
[120] The Audit sampled release files from the period of April 2010 through March 2011.
[121] Based on consultation with Regional Directors of Health Services (RDHSs) in August, 2016.

proof of residency is required to apply for provincial/territorial coverage; if the offender does not have a birth certificate or proof of citizenship, it must be obtained first. The timeframe to complete applications for health cards varies by province and territory. In some provinces and territories the application can be submitted before offenders are released to the community and in others, the application cannot be submitted until after they are released.

- Many (72%, n=131) CSC staff respondents reported that that there are procedures in place at their institution for assisting offenders to obtain provincial/territorial health cards.
  - 55% (n=66) of CSC staff agreed that procedures at their institutions were *effective*;
  - 43% (n=50) of CSC staff agreed that procedures at their institutions were *efficient*.

Following release

- If an offender does not have his or her health card once released, the staff member responsible to assist them varies from region to region (e.g., community parole officers and community mental health staff). Community Residential Facility staff may also assist offenders to obtain their health cards.[122]

New province

- An *Inter-provincial Agreement on Eligibility and Portability* ensures offenders have health coverage for the first 3 months after release. Section 2 of the Agreement reads as follows: "In the case of members of CAF, RCMP, and penitentiary prisoners on discharge or release, the province where incarcerated or stationed at time of release or discharge or, in the case of those on leave prior to discharge, the province where residence has been established, as may be appropriate, will provide initial coverage for the customary waiting period of up to three months."[clxvi]
- The province that the offender was incarcerated in, and subsequently released from, is responsible to provide the coverage if the offender does not have a health card. However, CSC health staff reported that offenders in some provinces did not appear to receive coverage through this Agreement.
  - About half (52%, n=149) of CSC staff members indicated that they were aware of the Agreement.

[122] Based on consultation with RDHSs in August, 2016.

- Of those aware of the Agreement, 33% (n=48) reported that they had *frequently* or *always* initiated the process for offenders who did not have their health card at release; and, another 31% (n=45) reported that they had *occasionally* initiated this process.

According to CSC policy and guidelines, offenders are responsible to ensure the funds are available to obtain personal ID and institutional parole officers are responsible to assist offenders in obtaining a provincial/territorial health card. Other staff, such as community POs, community mental health staff, and institutional nurses, also report assisting offenders to obtain provincial/territorial health cards.

The *Discharge Planning and Transfer Guidelines* outline the roles and responsibilities of offenders and CSC staff to support the continuity of health care for offenders and to support post-release access to health care and community resources. This includes ensuring that offenders have the necessary identification documents (e.g., provincial/territorial health cards) at release.[clxvii]

According to policy and guidelines, offenders, IPOs, and nurses all have a role in relation to obtaining offender identification, including health cards.

- Offender: The offender is responsible for budgeting to ensure that they have the funds available for personal identification (e.g., birth certificate).[clxviii]
- Institutional Parole Officer: The IPO assists the offender in obtaining a provincial/territorial health card prior to release or assists the offender to make a plan to obtain a card as soon as possible after release.[clxix]
- Institutional Nurse:
  - "Within 6 months of being notified of an offender's projected or definite release date," the institutional nurse finds out whether the offender has a health card or has started the process to obtain one with their IPO. [clxx] This information is included in the Health Status at Discharge: Gist Report,[123] which is then sent to the IPO.
  - Within three weeks of discharge, the institutional nurse checks to ensure that the offender has a health card and updates the Health Status at Discharge: Gist Report accordingly.[clxxi]

[123] The Health Status at Discharge: Gist Report includes other health related information related to release, such as any appointments required with community health care specialists and any accommodation needs related to functional and/or cognitive impairment, etc.

- Are the Roles Clear?
  - The percentage of CSC staff who reported that the *Discharge Planning and Transfer Guidelines* clearly outline the roles related to offender health cards is reported below:
    - 54% (n=102) of CSC staff agreed that roles for *IPOs* were clear,
    - 46% (n=75) of CSC staff agreed that roles for *Institutional Nurses* were clear.
- Is it Part of Your Role?
  - The percentage of staff who reported that it was part of their role to assist offenders in obtaining provincial/territorial health cards:
    - IPOs (78%, n=28)
    - Institutional Nurses (24%, n=9)
    - Community POs (25%, n=21)
    - Selected Community Mental Health Personnel[124] (31%, n=15)
- Do you Assist Offenders to Obtain Health Card?
  - Whether they perceived it to be part of their role or not, various CSC staff respondents reported that they had *directly* assisted at least one offender to obtain their health card over the last year:[125]
    - IPOs (70%, n=23)
    - Institutional Nurses (24%, n=8)
    - Community POs (72%, n=59)
    - Selected Community Mental Health Personnel[126] (82%, n=41)
  - Additionally, many staff respondents (72%, n=182) indicated that they had *indirectly* assisted at least one offender to obtain their health card over the last year (e.g., providing notification that an offender did not have a health card).

Procedural challenges related to assisting offenders to obtain provincial/territorial health cards emerged (e.g., need for a birth certificate, fee requirements, releases to different provinces). Suggestions to address these challenges included: modifying existing practices, engaging with provincial/territorial partners, and providing additional support to offenders.

[124] Included: Clinical Discharge Planners, Community Mental Health Nurses, Clinical Social Workers
[125] Note that not all staff responded to this question. Percentages are reported out of the total number of staff responses to this question.
[126] Included: Clinical Discharge Planners, Community Mental Health Nurses, Clinical Social Workers

Challenges in Obtaining Provincial Health Cards

- CSC staff respondents agreed that the following circumstances create challenges to obtaining provincial/territorial health cards:
  - Offender does not have a birth certificate (86%, n=209).
  - Fee requirements to pay for ID (82%, n=182).
  - The province of incarceration was different from the province of release (80%, n=191).
  - Completion of forms (62%, n=146).
- Other challenges were raised by staff through various communications, including the staff questionnaire and other questions directed to Regional Directors of Health Services and Wardens:
  - Require additional supports/procedures to assist the offender in obtaining ID (e.g., through ETAs to get ID or staff follow-up on the process).
  - Issues around offenders' motivation to obtain a provincial/territorial health card.
  - In some provinces/territories offenders are unable to apply for provincial/territorial health coverage until after they have been released (application regulations differ among provincial/territorial health authorities).
  - ID is lost (offenders may leave ID with their family, friends, or at remand centres, where ID is eventually lost or destroyed).
  - In some provinces/territories, CSC provides health coverage until provincial/territorial health insurance is in effect. CSC must then obtain reimbursement within three months, which is time-consuming for community staff.

Good Practices

The following good practices were identified by staff in one or more regions:

- <u>Providing additional support to staff who assist offenders with ID</u>
  - Identifying one person at each institution to be a designated point of contact between the site and the provincial/territorial health authority (e.g., to send applications and receive identification cards).
  - Providing resource sheets for staff members outlining procedures and providing relevant contact information for obtaining health cards in each province/territory.

- Strengthen partnerships with provincial/territorial health authorities
    - Having an administrative agreement with provincial/territorial health authorities outlining the process for an offender to obtain a health card while incarcerated.
    - Identifying a dedicated contact/liaison from the health authority to answer questions.
- Provide additional support or assistance to offenders to obtain provincial/territorial health cards:
    - Providing offenders with a letter from a parole officer to confirm their identity and or address in order to get a health card.

Suggestions

Modifying Existing Processes:

- *Timing: Begin the process to obtain ID earlier:*
    - Complete the application procedures to obtain the provincial/territorial health card (including obtaining birth certificate/proof of citizenship) earlier in the offender's sentence.
    - Begin the process to obtain a birth certificate at intake.
- *Maintain and track existing ID:*
    - Electronically scanning existing ID and putting it in the offender's files so that both case management and health care staff can access as required.
    - Establishing a protocol to store ID.

Engaging Partners:

- *Strengthen partnerships with provincial/territorial health authorities:*
    - Work with provincial/territorial authorities to review the process to obtain identification.
    - Invite representatives from the health authority to the institution to assist inmates with the application process (e.g., through ID clinics).[127]

[127] Community-based ID clinics are offered in multiple regions, for example, through community housing resource centres, community health centres, legal clinics, and other community service organisations.

- *Engage community partners and/or volunteers:*
    - Liaise with community partner agencies that provide ID clinics in the community for at-risk populations.
    - Have community partners or volunteers come to the institution regularly to assist offenders to apply for ID (e.g., host regularly scheduled ID clinics).

Providing Additional Support to Offenders

- *Provide assistance with forms or alternate forms of ID:*
    - Provide assistance in completing applications forms (e.g., give examples of completed forms, offer assistance from staff members or community partners/volunteers).
    - Provide offenders with alternative form of ID from CSC that confirms offenders' identity and citizenship and can be used to help obtain health cards.
- *Facilitate offender payment for ID:*
    - Allocate funds from offender pay to obtain their birth certificates (prerequisite to obtain a provincial/territorial health card).
    - Explore other means of paying for ID (e.g., CSC assumes cost, support from ID clinics offered through community-based services).

RECOMMENDATION 8: RELEASE PLANNING & OFFENDER IDENTIFICATION

That CSC adopt measures to address challenges related to offenders accessing health care in the community by retaining or obtaining offender ID (including health cards); and to clarify the policy, guidelines and procedures pertaining to coordinating access to medication while transitioning to the community.

- Develop guidelines to support the retention of offenders' ID including health cards;
- Establish mechanisms to obtain key ID at intake; and,
- Clarify existing release policy related to the requirements for medication at release and provide consistent communications to staff.

3.15 PAYMENT FOR COMMUNITY HEALTH SERVICES

FINDING 15: PAYMENT FOR COMMUNITY HEALTH SERVICES

According to CSC policy, CSC may cover the cost of some medical expenses in the community if offenders are not covered by provincial/territorial health insurance or other provincial/territorial plans (e.g., disability benefits, drug plans) and have no personal means to pay. Medical expenses covered by CSC in the community vary across regions, which may be related in part to variations in provincial health coverage.

Evidence: Payment for Community Health Services

- According to the *National Essential Health Services Framework*, essential health services are funded by CSC for offenders residing in Community Correctional Centres (CCCs) in circumstances where provincial coverage is not available. CCCs are CSC facilities, therefore offenders residing in CCCs are under CSC's jurisdiction for health services; community residential facilities (CRFs) are not CSC facilities and therefore offenders residing in CRFs are under provincial jurisdiction for health services. Exceptions to the criteria specified in the *National Essential Health Services Framework* must be pre-authorized and approved in writing by the Regional Director Health Services or delegate.[clxxii]
- In some provinces/territories, offenders may apply for provincial/territorial health coverage during incarceration, while in other provinces/territories they may only apply for coverage after release.
- Provincial/territorial health services consist of:
    - General health care (e.g., physician services, hospital or emergency care, mental health services, emergency dental services).
    - Disability benefits (e.g., non-emergency dental care, prescription drugs, prosthetics, mobility aids). Disability benefits are not usually available to the general population, but rather for special needs populations who meet the criteria. Up to date income tax returns and supporting medical assessments may be criterion of applying for disability benefits.

- Prescription drug plans (e.g., for residents that do not have insurance coverage through an employment/group plan or other federal or provincial/territorial plan). Up to date income tax returns may be required to apply for this coverage.

Covering the Cost of Medical Expenses (General)

- In 2015-16, CSC spent $1,765,267 on "pharmacy administration" health related expenditures in the community.[128] The majority of these expenditures were for medications, representing approximately 81% of this total cost, with the remainder being spent on items such as medical devices, optometry, emergency health care, etc.[129]
- CSC provides coverage for essential physical health services. In some regions if the offender has not yet obtained coverage, CSC may pay for appointments, dental care, eyewear, or equipment/medical devices until covered by other provincial benefits. Coverage for medication varies by region, and may also depend on provincial/territorial health care disability benefits or drug plans. In some regions, between two weeks to three months, coverage may be offered pending issuance of provincial/territorial coverage. Some CSC regions support mental health services in the community beyond what is offered through CSC's community mental health services. This can include follow-up psychiatric services offered through contract psychiatrists (e.g., where access to community resources is limited), or visits to a family physician or other specialists. Emergency situations requiring hospitalization may also be covered by CSC.
- Most staff members (86%, n=122) reported that if an offender does not have provincial/territorial health coverage but requires essential health services in the community, there are circumstances in which CSC covers the cost. Services that could be covered included:

  Medication/pharmacy items (94%, n=113)

  - Some staff members reported that CSC provides medical/pharmacy services when:
    - Offenders reside in a CCC/CRF or if they are on conditional release (e.g., day parole, full parole, statutory release with residency condition; n=23);

[128] This is in addition to community health expenditures in other areas such as mental health and other general administrative, nursing or methadone costs.
[129] Source: Integrated Financial and Material Management System (IFMMS), extracted September, 2016.

- Offenders are not covered by health insurance (e.g., provincial health insurance, disability or other social assistance programs, employer's health insurance; n=21);
- Offenders are released without the required two weeks of medication (n=4).[clxxiii, 130]

- Staff respondents reported that CSC could cover the cost for medical services and certain specialized medication, such as:
  - Methadone (n=16)
  - Physical health medication (e.g., lupron, insulin, HIV medication; n=8)
  - Mental health medication (e.g., psychiatric; n=10).

Mental health services (other than those already supported through regular CSC mental health services; 38%, n=46)

- Some staff members reported that CSC covers mental health services in some circumstances:
  - Psychiatric/psychological services and programs (e.g., contract services for remote locations, crisis support, counselling; n=16).

Physical health services (52%, n=62)

- Staff members reported that CSC could cover the costs for services such as:
  - General physical health equipment, such as mobility devices (e.g., walkers, canes, wheelchairs; n=11);
  - Dental care (n=11);
  - Doctor/specialist/emergency care (n=11);
  - Optometry (n=9); and
  - Physiotherapy (n=6).

[130] The type of medication dictates the duration of the supply provided at discharge. According to the *CSC National Formulary*, non-narcotic and non-controlled mediations are generally provided for 14 days; whereas, narcotic and controlled medications (e.g., ADHD medications) are provided for 3-days and at the discretion of the physician. This distinction is not clarified in the Discharge *Planning and Transfer Guidelines* or CD *712-4 Release Process*.

RECOMMENDATION 9: ACCESS TO AND PAYMENT FOR COMMUNITY HEALTH SERVICES

That CSC improve access to community health services to ensure a continuum of health care for offenders during the transition to provincial/territorial health coverage, by:

- Improving partnerships with provincial and territorial health authorities to determine how offenders can better access health care services and disability benefits; and,
- Clarifying and communicating policies and procedures related to CSC's coverage (i.e., payment) for health services in the community and requirements for medication at release.

Overview: CSC's Community Mental Health Services Model

CSC's community mental health services model promotes the continuity of mental health services for offenders transitioning from institutions to the community. This model consists of clinical discharge planning, which is provided in institutions; and community mental health services, which are offered to offenders in select locations in the community. [clxxiv] Community mental health and clinical discharge planning services are provided to offenders on a priority basis, based on urgency of referral, level of need, risk, responsivity and policy requirements.[clxxv] Services are provided by clinical social workers, mental health nurses and psychologists.

- Community mental health services include mental health services for offenders being released from a CSC institution to the community and those under parole supervision in the community. Services include: mobile services, advocacy, clinical accompaniment support, community capacity building, client/family education and monitoring and addressing behaviour related to risk reoffending.[clxxvi]
- Clinical discharge planning services include transitional services to support offenders being released from an institution to the community. Services include: assisting in the development of comprehensive plans to address offender needs at discharge through coordination of services offered institutionally, ensuring consultation and coordination as applicable, and responding to referrals for consultation in complex cases.[clxxvii]
- Eligibility criteria, offenders with major mental disorders and/or moderate to severe impairment are eligible for community mental health and clinical discharge planning services. This includes

those with medium (considerable) or high level of mental health need on the Mental Health Needs Scale.[clxxviii]

3.16 COMMUNITY MENTAL HEALTH SERVICES & CLINICAL DISCHARGE PLANNING

FINDING 16: COMMUNITY MENTAL HEALTH SERVICES & CLINICAL DISCHARGE PLANNING

Community mental health specialists services provided to offenders were associated with lower rates of recidivism; whereas, clinical discharge planning services alone did not appear to have an impact. The number of offenders receiving clinical discharge planning services could not be determined due to inconsistencies in data recording; providing continuity of care is challenging when offenders who receive discharge planning services are released to locations with limited CSC community mental health staff.

Evidence: Community Mental Health Services & Clinical Discharge Planning

Community mental health specialist services were associated with lower rates of recidivism for men and women offenders; whereas, clinical discharge planning services alone did not appear to have an impact on recidivism rates.

- As part of CSC's National Mental Health Strategy, a Community Mental Health (CMH) services model was implemented to better prepare offenders with serious mental disorders for release into the community by strengthening the continuum of specialized mental health support, providing continuity of support and reducing the probability of offenders' criminal recidivism.[clxxix]
- In 2008, an evaluation found preliminary evidence for CMH's effectiveness in reducing recidivism; however, the follow-up period was brief.[clxxx] A more recent study was conducted in 2014 to examine results for this early group of CMH service recipients over a more extended period of time (i.e., 24 months post-release and 48 months post-release) following three treatment groups receiving community mental health services: those who received clinical discharge planning (CDP), those who received Community Mental Health Specialist (CMHS) services, and those who participated in both CDP and CMHS services. Results from the study indicated: [clxxxi]

- Fewer men in the CMHS services group recidivated within 24 months post-release or 48 months post-release compared to men who did not receive the CMHS services or those who received both CDP and CMHS or CDP alone (see Appendix G).
- Fewer women in the CMHS services group or in the combined CDP/CMHS services group, recidivated within 24 months post-release or 48 months post-release compared to women offenders who did not receive CMHS services (see Appendix G).[131]

Community Mental Health Services are provided to approximately 23% of the community offender population. The number of offenders receiving clinical discharge planning services could not be determined due to inconsistencies in data recording.

Offender Access to Community Mental Health Services and Clinical Discharge Planning

- In 2014-15, the community offender population flow-through (i.e., total offenders supervised in the community) totalled 14,178. Of these offenders, 23% (n=3,312) received a community mental health service.[132] The percentage of offenders in the community receiving community mental health services has remained relatively stable over time, ranging from 22% to 23% from 2010-2011 to 2014-2015.[clxxxii]
- In 2014-15, offenders most commonly received their first community mental health service within 14 days of referral (59%, n=1,643). The remaining offenders received their first community service within 15 to 28 days (21%, n=583) or 29 days or later (20%, n=583).[clxxxiii]
- The number of offenders receiving clinical discharge planning activities could not be assessed based on available electronic data due to inconsistencies in recording information in the Mental Health Tracking System (MHTS).
- Most staff members (76%, n=105) agreed that offenders who receive clinical discharge planning services meet eligibility criteria.
- Some staff members (43%, n=62) agreed that offenders receive clinical discharge planning in a timely manner.[133,134]

[131] This should be interpreted with caution because the risk profiles were not equivalent between groups and the group size for women offenders was too small to allow for survival analysis and only a fixed follow-up analysis was undertaken.
[132] Community mental health services provided to offenders may include mental health counselling (individual or group), accompaniment support, suicide or self-injury intervention, assessments, etc.
[133] CDP Timeframe: "The timing of referrals for CDP is guided by the offender's anticipated release date, the case management process and the anticipated level of need."

Offenders with a mental health need receiving mental health services in the community

- Community Mental Health Services were examined further to determine how many offenders with a mental health need received a community mental health service:
  - A sample of offenders released in 2014-15 who were supervised in the community for at least one month (N=5,912),[135] was examined to determine receipt of mental health services *based on mental health need*. Of this sample, 40% (n=2,369) had a mental health need 6 months prior to release.[136] Of those with a mental health need, 40% (n=941) received a mental health service in the community within 6 months following their institutional release.
  - Of those who did not have a mental health need within 6 months prior to release (n=3,543),[137] some (16%, n=552) also received mental health services in the community within 6 months following their release.

Clinical discharge planners' roles and responsibilities are broad. Staff reported that clinical discharge planners spend a significant proportion of their time providing support in areas that may not relate directly to their core responsibilities (e.g., brief interventions, assisting offenders to obtain provincial health cards, indirect support to offenders not on their caseload).

Clinical Discharge Planning Roles and Responsibilities:

- The Discharge Planning Matrix Tool,[138] the *Discharge Planning and Transfer Guidelines*, and the *Integrated Mental Health Guidelines* outline the roles and responsibilities for CSC staff in relation to CDP (see Appendix H for a complete description).[clxxxiv]
- There is an average of two clinical discharge planners per region. Discharge planners are located in CSC institutions or RHQ and provide services to offenders in their region according to need/priority.[clxxxv]

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[134] Remaining staff members either reported "neither agree nor disagree" (21%, n=30) or "disagree/strongly disagree" (36%, n=52).
[135] Our sample included offenders on their first conditional release of FY2014-15, but only if they remained in the community for 30 days or more (this was done to allow time to receive mental health services).
[136] Mental health need is defined as any offender who received a treatment-oriented mental health service 6 months prior to their release. Note that this provides an approximation of need. Reliable information from other data (such as the Mental Health Need Scale) was not available. Therefore, the receipt of a treatment-oriented mental health service in the institution 6 months prior to release was used as a proxy indicator of offender mental health need.
[137] Absence of mental health need was identified as offenders who did not receive a treatment oriented service 6 months prior to release.
[138] The Discharge Planning Matrix Tool was developed in April 2013 as a reference accompanying the *Discharge Planning and Transfer Guidelines.*

Staff Perceptions of Clarity of Clinical Discharge Planning Roles and Responsibilities:

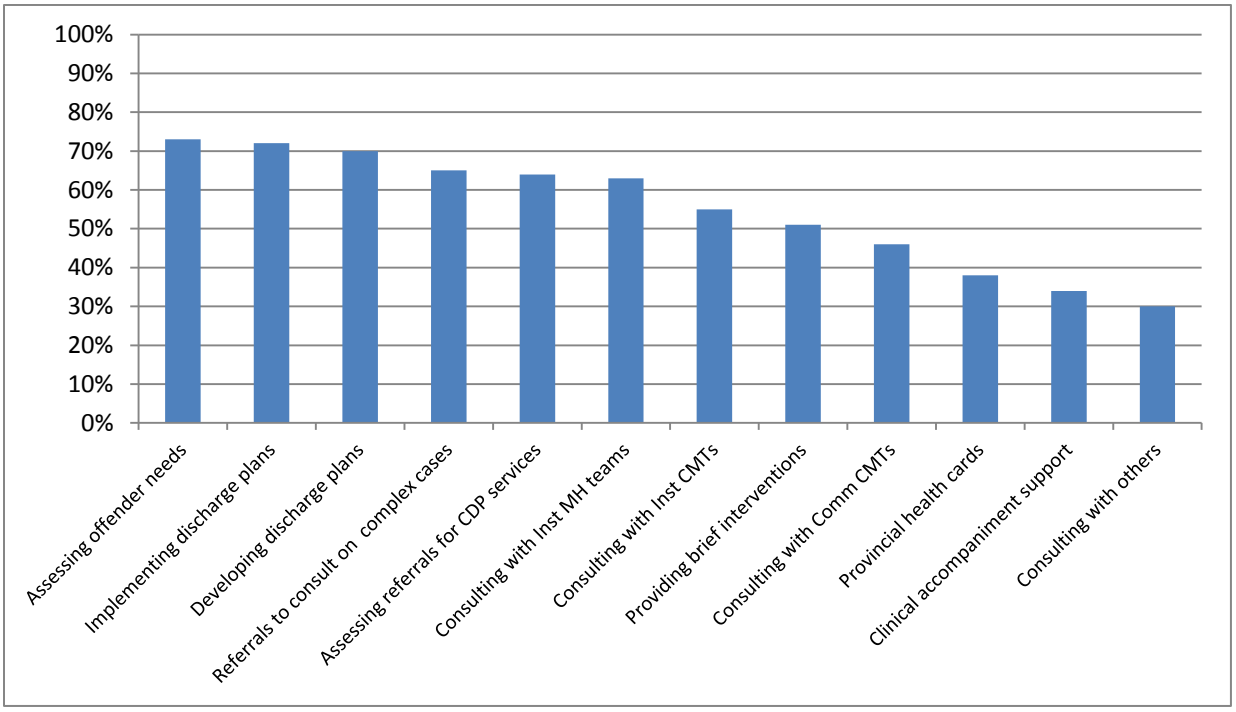
- Staff members agreed that the *Discharge Planning and Transfer Guidelines* and the *Community Mental Health Service Delivery Guidelines* clearly outline the roles and responsibilities related to clinical discharge planning for the following CSC staff:
  - Clinical discharge planners (73%, n=81)
  - Community mental health specialists (69%, n=77)
  - Institutional nurses (62%, n=71)
  - Community parole officers (57%, n=69)
  - Institutional parole officers (52%, n=58)

Clinical Discharge Planning Activities:

- CSC staff respondents reported that clinical discharge planners spent *quite a bit* or a *great deal* of time on the following activities: (see Figure 1).
  - Between 70% and 73% of staff respondents reported: assessing offender needs, implementing discharge plans, and developing discharge plans.
  - Between 55% and 65% of respondents reported: responding to referrals for consultation in complex cases, assessing referrals for clinical discharge planning services, and consulting and coordinating with institutional CMTs and mental health teams.
  - Many respondents (51%) reported that clinical discharge planners spend a great deal or quite a bit of time providing brief interventions, including:
    - Referrals, access and coordination of community services, such as providing information on availability of community resources, supporting application processes, scheduling social assistance appointments, conducting medication reviews (n=17);
    - Therapeutic services for offenders like counselling, crisis intervention, and education (n=9), and,
    - Assisting offenders with administrative tasks like completing forms (n=6).
  - Between 30% and 46% of respondents reported: consulting and coordinating with community CMTs or other staff, helping offenders obtain provincial health cards, and providing clinical accompaniment support.

- Indirect support to offenders not on their caseload:
  - About half of staff respondents (54%, n=28) reported that clinical discharge planners spend more than 20% of their time providing support to offenders not on their case load. Types of support included:
    - Providing assistance and information on an ad hoc basis, such as answering offenders questions and helping them find community services, making referrals for services, assisting parole officers, and attending CMT meetings (n=10).

Figure 1: % of Health Services staff who reported that Clinical Discharge Planners spend quite a bit or a great deal of time on the following activities:



There are no specific guidelines for follow-up on clinical discharge planning once an offender is in the community. Staff report that follow-ups may be done by community mental health staff, community POs, or community psychologists, but that providing continuity of care is challenging when offenders who receive discharge planning services are released to locations with limited CSC community mental health professionals.

Outcomes of Clinical Discharge Planning

- Referrals: Most staff respondents (76%, n=107) agreed that as a result of developing a clinical discharge plan, offenders are being referred to community-based services for mental health interventions.
- Attendance: Many staff respondents (64%, n=81) agreed that as a result of developing a clinical discharge plan, offenders are attending the community-based mental health services/interventions to which they were referred.
    - Of those that disagreed, the most common response was related to challenges accessing community-based mental health interventions/services for offenders (n=9).

Clinical Discharge Planning Follow-up

- Almost all staff respondents (93%, n=110) reported that there is a need to follow-up, at least occasionally, on the clinical discharge plan once an offender is released to the community:
    - 57% (n=67) reported there is *frequently* or *always* a need, and
    - 36% (n=43) reported there is *occasionally* a need to follow-up.
- When asked if follow-up on the clinical discharge plan is done, some respondents (40%, n=43) reported that it was *always* or *frequently* followed-up on and another 35% (n=37) said that it was *occasionally* followed-up on once offenders were released to the community.
- There are no specific guidelines outlining responsibility for follow-up for clinical discharge planning. However, respondents indicated follow-ups were most frequently[139] done by:
    - Community mental health specialists (67%, n=75);
    - Community parole officers (65%, n=73); and,
    - Community psychologists (59%, n=56).

[139] Numbers/percentages reflect the number of staff who reported that each of the following categories of staff "frequently" or "always" followed-up on clinical discharge plans.

Clinical Discharge Planning: Offenders Released to Areas with Limited CSC Community Mental Health Professionals

- According to CSC's *National Essential Health Services Framework*, limited Community Mental Health services (clinical social workers, mental health nurses and psychologists) are available in select locations for offenders with significant mental health needs.[clxxxvi]
- Many[140] staff respondents reported that 20% or more offenders who received clinical discharge planning services were released to an area with limited presence of CSC community mental health professionals.
    - Many staff respondents (96%, n=119) reported that there are challenges when this occurs. Ensuring continuity of care for offenders was the most common challenge identified (n=83), including:
        - Insufficient access to community resources (n=40);
        - Insufficient access to CSC resources (n=29);
        - Difficulty following-up with offenders (n=19); and,
        - Transportation-related issues for offenders and staff (n=16).
- Staff members provided the following suggestions to support offenders released to an area with limited CSC community mental health professional presence:
    - Improving access to community mental health services available to offenders (n=50) by:
        - Hiring more CSC community mental health staff or contractors (n=31);
        - Improving partnerships with community organisations and provincial health systems (e.g., increased number of agreements)(n=17); and,
        - By using alternative methods of service delivery such as increased use of telemedicine (e.g., videoconferencing), liaising with non-traditional community mental health partners (e.g., police services) (n=11).
    - Improving discharge planning processes through better communication with community agencies, timely referrals for services and establishing a connection between the service provider before release or early needs identification (n=26).

[140] 65% (n=50) of staff who responded to this question indicated that at least 20% of offenders were released to area with limited community mental health specialists.

- Providing transportation funds for CSC community mental health staff to travel to better support offenders in the community (n=8).

Staff Perceptions Relating to Challenges and Suggestions for Improving CSC's Community Mental Health Services Model

Challenges:

- Insufficient resources in CSC for community mental health services and clinical discharge planning (e.g., not enough staff to provide services, high workloads, limited services for offenders in remote locations or small centres, and many offenders are complex cases or have high needs; n=59).
- Accessibility of non-CSC community based programs and services (e.g., shortage of service providers that work with offenders, difficulties with timely access to provincial health services and other community-based service providers, particularly in relation to psychiatry services and accommodations for offenders with mental health needs; n=37).
- Other specific challenges including:
  - Information sharing and collaboration (e.g., communications between health services and other sectors or between the institution and the community; n=20).
  - Continuity of medication in the community (e.g., offender released without enough medication, clinics unwilling to fill prescriptions for narcotics; n=16).
  - Challenges related to timeliness of discharge planning (e.g., planning needs to happen earlier, not enough notice given before offenders release date to make referrals, residency location determined at the last minute; n=15).
  - Offenders are being released without provincial health insurance or ID (n=6).

Suggestions:

- Improving communication and collaboration between sites and community (e.g., using a team approach, meeting regularly to discuss referrals, complex cases and suspension, earlier information sharing between health staff and community PO; n=39).
- Increasing resources and/or modifying staff complement to enhance discharge planning services (e.g., increase the number of discharge planners and social workers; n=17).

- Clarifying roles and responsibilities related to the discharge planning process (e.g., establish guidelines to clearly outline caseworkers' roles, clarify Health Services and parole officers roles in the process; n=13).
- Providing offenders with support to ensure continuity of care (e.g., accompanying to appointments, providing supply of medications at discharge, following up on discharge plans in the community, establishing intervention plans that are health-focused; n=16).
- Offering specialized services at CCC/CRF, particularly for mental health (n=8).
- Enhancing community mental health staff ability to respond to offenders' specific needs, for example cultural competency, training or professional upgrading, attention to gender-specific needs (n=7).
- Active engagement between community mental health specialists and external resources (e.g., need to establish links with community resources, develop more partnerships; n=5).

Staff also identified the following good practices currently used in one or more regions:

- Using interdisciplinary teams comprised of health and case management staff.
- Having a mental health nurse working out of the CCC provides direct support to offenders and in-person communication with case management staff.
- Offering community mental health services and discharge planning services in group format.
- Offering individual and group services in the community that include elder services.
- Community mental health staff and clinical discharge planners meet quarterly through videoconferencing to discuss complex cases and resource sharing, etc.
- On-site psychiatric clinic at parole office.

RECOMMENDATION 10: CLINICAL DISCHARGE PLANNING AND COMMUNITY MENTAL HEALTH SERVICES

That CSC:

- Review the model of community mental health service delivery to ensure that community mental health services are being provided to offenders with the greatest mental health needs.
- Ensure that clinical discharge planning activities are tracked in electronic information systems.

FIFE #7: MANAGEMENT & COORDINATION OF HEALTH SERVICES

The following section focuses on overall management and coordination of health services. Health care expenditures and impacts are assessed, and changes to the governance of health services to promote standardization and integration of health services delivery are reviewed. Specific health care needs and initiatives for sub-populations of offenders, including women, Indigenous, and older offenders are examined to identify any potential gaps.

3.17 COORDINATION OF CSC'S HEALTH SERVICES

FINDING 17: COORDINATION OF CSC's HEALTH SERVICES

Following changes to the health services governance structure, there has been greater standardization and integration of health services.

Evidence: Management of CSC's Health Services

CSC has implemented gradual changes to the health services governance structure to promote streamlined and integrated service delivery across mental, clinical, and public health domains.

In 2007, CSC began implementing a new governance structure for Health Services, including the following major changes:

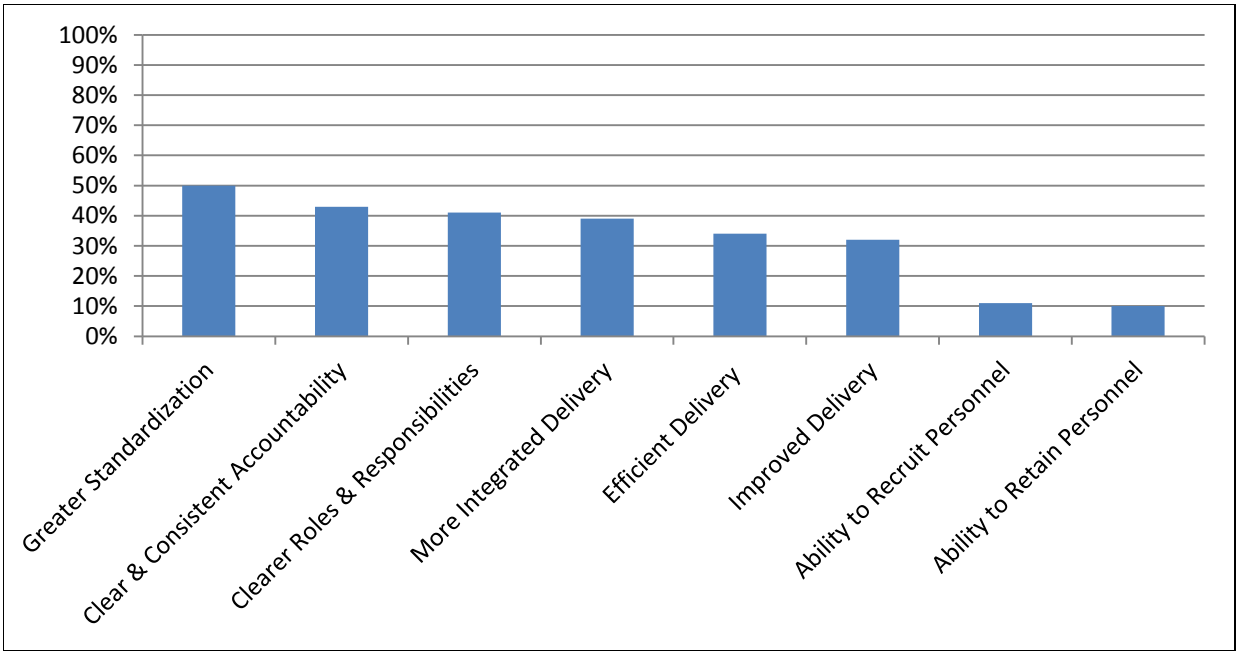
- Creation of the position of Assistant Commissioner Health Services, Director General positions at NHQ, as well as the Regional Director positions in each of CSC's regions (2007).
- Changes in reporting for mental health staff occurred more recently with:
  - Mental health staff in mainstream institutions and the community beginning to report to the Health Services Sector (2013).
  - Health functions in the Regional Treatment Centres beginning to report to the Health Services Sector and the operational function to report through the Warden (2014).

The governance changes were meant to promote clear and consistent accountability, standardization of health service practices, greater collaboration and integration, greater capacity to recruit and retain health services personnel, and efficient delivery of health services.[clxxxvii] Based on their experiences,

institutional health services staff members were asked about perceived impacts of the changes to the Health Services governance structure (see Figure 2).[141]

- Health staff respondents were most likely to agree that changes to the health services governance structure were working well to improve standardization of health care practices. There was also moderate agreement that the governance structure promoted clear and consistent lines of accountability, increased clarity of roles and responsibility, and integrated delivery of physical and mental health services.
- Health services staff were less likely to report that changes to the governance structure had an impact on increasing efficiency of health services delivery, improving delivery of health services, and increasing ability to recruit and retain health services professionals.

Figure 2: Percentage of Institutional Health Services Staff who agreed that the new health services governance structure has resulted in improvements in the following areas



[141] Figure 2 shows percentage of staff who agreed that the governance structure impacted specific issues. Remaining staff either disagreed that there had been an impact of the governance structure, or provided a neutral response "neither agree nor disagree".

- Some institutional and community staff[142] reported experiencing challenges under the new governance structure, including:
  - Not enough resources to support recruitment and retention of health services staff (n=42).
  - A need for greater clarification of roles and responsibilities between different groups (e.g., physical and mental health, community and institutional health services, health services and operations; n=41).
  - Impacts on institutional level decision making (e.g., need for greater involvement/consultation at the regional level and with front line staff; n=29).

CSC has integrated its management and staff reporting structures for mental, clinical and public health services.

- Over the past decade, Health Services has initiated gradual changes to integrate all health services staff in one sector. This includes the integration of mental health staff reporting into the Health Services Sector, (i.e., mental health staff in the institutions and community in 2013, and health services personnel in Regional Treatment Centres in 2014).
- Health Services has also merged clinical health and public health in the NHQ management structure as well as through the Program Alignment Architecture in 2015-2016.
- Health Services has developed guidelines and frameworks to promote standardization and integration of services, such as the *National Essential Health Services Framework* (2015)*;* the *CSC National Formulary* (2016)*;* and, the newly promulgated *Integrated Mental Health Guidelines* (2016).
- Accreditation Canada has identified efforts by Health Services to integrate and standardize services:[clxxxviii]
  - The leadership and staff in all Regions and all levels of the organization, from the national to the regional and institutional, showed efforts to integrate, streamline, standardize, and coordinate practices and processes.
  - Most policies and procedures are developed at a national level, which supports a coordinated and consistent approach to the delivery of quality health services.

[142] This included both health services and general staff in the institution and the community.

- Services for offenders with multiple health care needs:
  - About half of Health Services staff respondents (53%, n=68) agreed that the health services for offenders with multiple health care needs are delivered in an integrated manner in order to best address their needs.[143] They reported some remaining challenges to integration related to:
    - Collaboration, communication and information sharing practices between staff within health services, such as mental and physical health, and between sectors (e.g., Health and Operations) within CSC (n=22).
    - Shortages of specialized health care professionals (e.g., behavioural technicians, occupational therapists and mental health nurses; n=16).
  - Most offenders interviewed (77%, n=97) reported that the health care staff worked well together to provide them with the care they needed.

The Health Services Sector provides mental health and public health performance information and health services prevalence data through research and other special reports. Several recommendations for additional health-related data collection and reporting have been included in relevant sections of this evaluation report to address gaps identified during the evaluation.

- Within CSC, Health Services provides performance information through various reports, including:
  - Annual Mental Health Performance Measurement Reports[144] and Public Health Quarterly Reports.
- Accreditation Canada found the following in regards to collecting information for planning:[clxxxix]
  - Most regions collected and analyzed client flow information. However, several regions did not sufficiently use this information to develop a strategy for meeting demand and improving service.
- CSC research reports and health services prevalence studies (e.g., *Estimates of chronic disease prevalence among CSC inmates, 2015)* inform health services on various clinical, mental and public health related topics. Several recent research reports also identify prevalent clinical,

[143] Some (31%, n=40) health services staff disagreed or strongly disagreed that the health services for offenders with multiple health care needs are delivered in an integrated manner to best address their needs. A few (16%, n=20) neither agreed nor disagreed that the health services for offenders with multiple health care needs are delivered in an integrated manner.

[144] The Mental Health Branch also reports its information disaggregated by sex and Indigenous or non-Indigenous status.

public, and mental health disorders within CSC. These reports provide information about offender health needs, which can be used to inform Health Services planning.

Staff Suggestions:

- CSC's health services staff varied in their perceptions of the sufficiency of analysis of health information for health services planning and activities, with approximately one-third agreeing, one-third disagreeing and one-third being neutral.[145]
- Suggestions to improve health services planning across health domains by Health Services staff included:
  - Dedicating staffing and resources to collect information and conduct planning (n=22).
  - Reviewing health information to ensure relevancy of information collected (e.g., revising performance indicators, resource indicators; n=11).
  - Greater consultation and information sharing between institutions and NHQ regarding data collection and planning (n=14).

Recommendations regarding data collection and reporting:

- To ensure that reliable data will be available to direct future health services planning and analysis, several recommendations have been made throughout this evaluation to collect additional information or to strengthen data recording processes where gaps were identified, specifically:
  - FIFE 2, Recommendation 2: Ensuring health referrals are appropriately recorded and monitored;
  - FIFE 3, Recommendation 3: Collecting data on wait times to access selected specialists services for non-urgent care;
  - FIFE 4, Recommendation 5: Providing clear direction and accountability for delivery and tracking of health education programs;
  - FIFE 5, Recommendation 6: Implementing effective management practices to ensure that current and historical information on offender level of need data is recorded electronically;

[145] Public health planning: 26% (n=23) agreed; 38% (n=33) neither agreed nor disagreed; and 36% (n=31) disagreed. Clinical health planning: 33% (n=32) agreed; 34% (n=33) neither agreed nor disagreed; and 32% (n=31) disagreed. Mental health planning: 34% (n=37) agreed; 36% (n=39) neither agreed nor disagreed; and 31% (n=34) disagreed.

- FIFE 5, Recommendation 7: Tracking expenditures of funds released to regions through RCMHCs;
- FIFE 6, Recommendation 8: Recording identification in OMS; and,
- FIFE 6, Recommendation 10: Ensuring that clinical discharge planning activities are tracked in electronic information systems.

Health Services Expenditures

Health Services account for approximately 11% of CSC's total direct program spending. From 2012-2013 to 2015-2016, CSC total Health Services expenditures (institution and community) decreased by 11%.

- In 2014-2015, total CSC Health Services expenditures ($247.2 million) accounted for 11% of total CSC direct program spending.[146]
- Consistent with CSC's mandate for health services delivery, the majority of spending occurred during the incarceration period. In 2015-2016, institutional health care services accounted for approximately 94%, and community health services account for the remaining 6% of total health services expenditures (see Table 5).
- Total CSC Health Services expenditures decreased by 11% from 2012-2013 to 2015-2016.
- The largest decrease in Health Services expenditures was 7% from 2012-2013 to 2013-2014. This is consistent with an overall reduction in CSC spending that year, as part of the federal government's *Economic Action Plan, 2012,* through which CSC committed to reducing its operating budget by $295.4 million by April 1, 2014.[cxc] During this period, CSC made reductions in the following areas related to health services: dental care, methadone treatment, accreditation, training and NHQ/RHQ.

[146] Direct program spending includes strategic outcome spending (custody, correctional interventions and community supervision), but excludes spending on internal services.

Table 5: CSC Health Services Expenditures, 2012-2013 to 2015-2016

	2012-2013	2013-2014	2014-2015	2015-2016
Clinical and Public Health Services	160,474,397	154,656,758	149,137,433	150,609,703
Mental Health Services[1]	99,224,071	87,259,906	87,617,326	75,474,645
Total Institutional Health Services	**259,698,469**	**241,916,664**	**236,754,759**	**226,084,348**
Community Mental Health Services	8,575,448	8,361,468	8,083,791	11,788,085
Other Community Health Services	2,769,240	2,614,395	2,388,310	2,372,580
Total Community Health Services	**11,344,688**	**10,975,862**	**10,472,101**	**14,160,665**
Total Health Expenditures	**271,043,157**	**252,892,526**	**247,226,860**	**240,245,013**

[1]In 2012-2013, psychology and RTCs and in 2013-2014 RTCs were reported under other Sectors and were not generally reported under Health Services in the Program Alignment Architecture (PAA). However, expenditures related to psychology and RTCs are included in the HS totals reported in this table, since they were included in the Health Services examined as part of this evaluation.
Source: Integrated Financial and Material Management System (IFMMS), extracted September 22, 2016

3.18 INFECTIOUS DISEASE TREATMENT: HEPATITIS C VIRUS

FINDING 18: INFECTIOUS DISEASE TREATMENT: HEPATITIS C VIRUS

CSC expenditures for Hepatitis C Virus (HCV) medication more than tripled from 2013-2014 to 2015-2016 due to a new Canadian approved standard of care. New treatment is more costly, but has resulted in an increased cure rate for individuals with the disease, also reducing the risk of spread of HCV to others.

Evidence: Cost-Effectiveness of Infectious Disease Treatment: Hepatitis C Virus

Health Canada has recently approved several new drugs for HCV treatment, which have improved treatment outcomes.

HCV Treatment:

- Results of a research report in 2014 estimated that the number of cases of HCV within the Canadian population would diminish from 260,000 in 2003 to 188,190 by 2035. However using *first-generation treatments,* the total direct cost of HCV was projected to increase from $168.4 million in 2013 to $258.4 million by 2032. Increases in costs were attributed to complications, such as advanced liver diseases and liver transplantations, which can be further exacerbated as the infected population ages.[cxci]

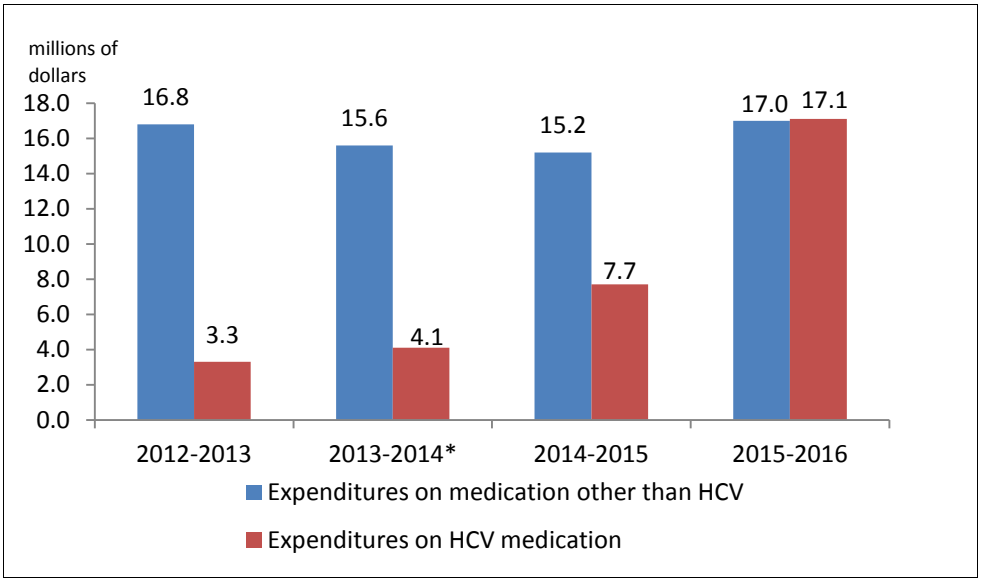
- In 2013 and 2014 Health Canada approved several new drugs for HCV treatment. Treatment outcomes in Canada for HCV have improved as a result of the introduction of highly effective medications including Sovaldi, Harvoni and Holkira Pak.[cxcii] These *new treatments* are now the approved standard of care in Canada and other countries.
- In comparison to the previously approved treatment standards (referred to as "first-generation treatments"), these new treatments:
  - Reduce treatment duration, from approximately 24-28 weeks to 12-24 weeks.[cxciii]
  - Increase drug tolerability by decreasing the number of side effects.[cxciv]
  - Increase the cure rate.
- A person is considered cured when, after completing treatment, the HCV viral load in the blood is undetectable for 12 consecutive weeks. This is called a sustained virological response (SVR).[cxcv] Once cured, the virus can no longer be transmitted to others.[cxcvi]

CSC medication expenditures have increased, related primarily to costs of new HCV treatments which have become the approved standard of care.

CSC Medication Expenditures:

- Increases in CSC medication expenditures in recent years are related primarily to costs of new HCV treatments. CSC is mandated under the CCRA section 86(1) to provide essential health care that conforms to the professionally accepted standards of practice.
- Overall, CSC expenditures for medication increased by 73% from 2013-2014 ($19.7 million) to 2015-2016 ($34.1 million).
- The increase during this time period (2013-2014 to 2015-2016) was mainly due to expenditures for HCV medication, which more than tripled in cost, from $4.1 million in 2013-2014 to $17.1 million in 2015-2016. The largest year-over-year increase occurred from 2014-2015 to 2015-2016 (see Figure 3).
- As a percentage of *total* medication expenditures, costs for HCV medication rose from 16% to 50% of *all* medication expenditures from 2012-2013 to 2015-2016.

Figure 3: Health Services Medication Expenditures, 2012-2013 to 2015-2016



Note. In 2013-2014 the new HCV treatment came into effect which is represented by (*).
Source: IFMMS, extracted September 19, 2016.

Implications:

Health of HCV-Infected Individuals

- The prevalence of HCV in the offender population was 17%[cxcvii] in 2013-2014, which is about 20 times higher than the Canadian population (1%).[cxcviii]
- The Health Services Sector conducted an analysis of treatment outcomes for chronic HCV infections[cxcix] and found that among 312 offenders in CSC treated between February 2015 and April 2016 with the new treatment drugs, HCV was cured in 90-95% of cases. This compares to previous treatments, in which research has demonstrated cure rates of between 40% and 80% in the Canadian population.[cc]
- Increased cure rates of new HCV treatments are associated with reduced cases of liver-related diseases and deaths.[cci]
- While new treatment regimes are more expensive, the introduction of these new treatments suggest cost-effectiveness can be achieved by:
    - Decreased treatment durations;

- Decreased side effects, thereby increasing likelihood of treatment continuity and completion; and,
- Decreased complications that arise from the disease (e.g., cirrhosis of the liver, liver cancer), resulting in reduced medical costs to treat these complications. [ccii]

HCV Prevention

- The Public Health Agency of Canada reported that in 2012 the majority of HCV infections in Canada occurred through the sharing of drug preparation and injection materials.[cciii]
- Once a HCV cure has been achieved through the administration of HCV drugs, HCV can no longer be transmitted to others.[147] This has positive impacts for public health both while offenders are incarcerated and following their release into the community.
- As such public health risks and costs can be reduced by:
  - Reducing ongoing HCV transmission,
  - Reducing public health expenditures for incidences of advanced liver diseases and liver-related deaths.[cciv]

3.19 HEALTH SERVICES FOR SPECIFIC POPULATIONS

FINDING 19: HEALTH SERVICES FOR SPECIFIC POPULATIONS

CSC has implemented policies, guidelines and strategies to address the special health care needs of women and Indigenous offenders. Additional support related to the chronic disease needs of older offenders is required.

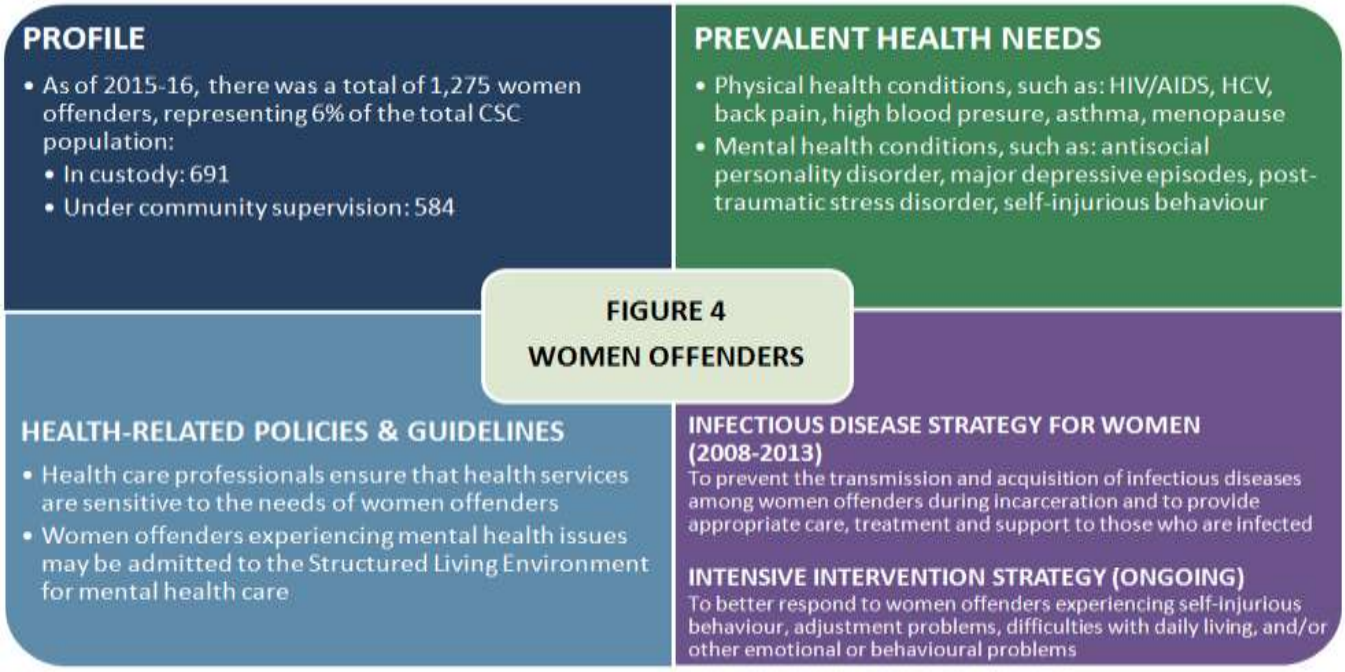
Evidence: Health Services for Specific Offender Populations

CSC is committed to delivering health services in a way that is respectful of gender, culture, religion, and linguistic differences. According to *Commissioner's Directive (CD) 800: Health Services*, Health care professionals must also ensure that health services "are sensitive to the needs of Indigenous and women offenders, and offenders with special needs."[ccv] The evaluation examined the specific health needs, initiatives and strategies for specific populations of offenders, including women, Indigenous and other visible minority groups, as well as older offenders (50 years or older).

[147] Research has shown the rate of late relapse occurs in less than 1% of patients.

Figures 4 to 6 provide a summary of prevalent health conditions and CSC's policies, programs and initiatives designed to address the health needs of women offenders, Indigenous offenders and older offenders (Appendix I provides more detailed information).

Figure 4: Women Offenders



CSC has developed several women-centered programs, initiatives, and strategies to meet the needs of women offenders. Staff reported some challenges accessing resources for women offenders in the community.

Intensive Intervention Strategy

- Under the Strategy, women offenders with mental health problems and/or cognitive limitations are provided with intensive intervention, treatment and programming opportunities and housed in one of two living units, depending on their security level: Structured Living Environments (SLEs) for women offenders classified as minimum and medium security; and, Secure Units for women classified as maximum security.
- Previous findings have indicated that both staff and women offenders agree that the SLE is meeting its intended objectives. Participants of the SLE program stated that the program was meeting their needs and helping to improve their behaviour and reduce institutional incidents.

Infectious Disease Strategy for Women

- Overall, 17% (n=33) of health services staff respondents reported being knowledgeable about the Strategy and about half (52%, n=17) agreed that it had a positive impact on CSC's capacity to address the health needs of women offenders.

Women-Specific Initiatives

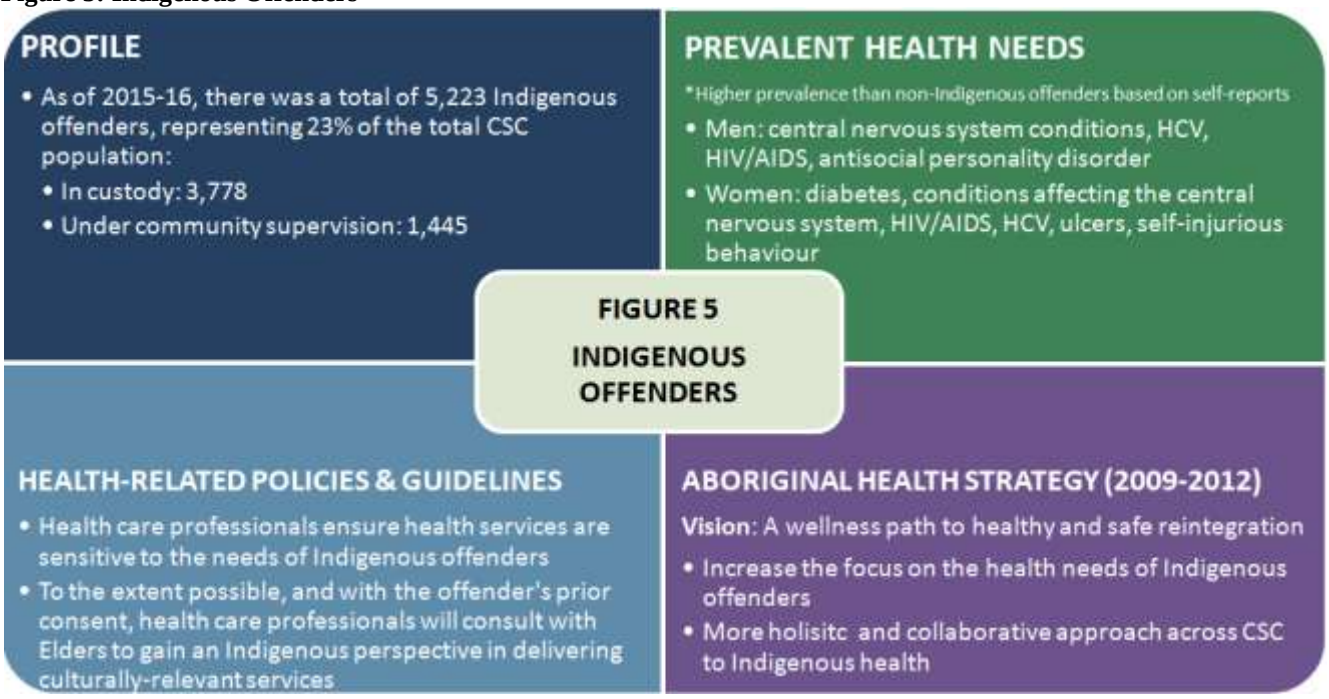
- Specific products have been developed and tailored to meet the health needs of women, including: the Reception Awareness Program for Women, national fact-sheets (e.g., diabetes and women, HIV and women), and the integration of the Peer Education Course and the Peer Support Program into a new program called the Peer Mentorship program.
- According to the *Integrated Mental Health Guidelines*, the Deputy Commissioner of the Women Offender Sector participates in the National Complex Mental Health Committee, and Wardens of women's institutions participate in the Regional Complex Mental Health Committee to provide input into appropriate care for women offenders with complex mental health needs.

Overall Perceptions of Health Services for Women Offenders

- Overall, the majority of staff respondents reported that CSC was meeting the health service needs of women offenders.
- Some staff respondents indicated there were insufficient resources for mental health in the community.

Note: The results presented are not comprehensive, but provide a brief overview of some main initiatives/results within the scope of the evaluation.

Figure 5: Indigenous Offenders



CSC has implemented several initiatives and guidelines to meet the needs of Indigenous offenders. Staff reported some challenges accessing resources for Indigenous offenders in the community.

Aboriginal Health Strategy

- Overall, 22% (n=42) of health services staff respondents reported being knowledgeable about the Aboriginal Health Strategy and some (36%, n=14) agreed that it had a positive impact on CSC's capacity to address the health needs of Indigenous offenders during incarceration.
- During the timeframe of the Aboriginal Health Strategy, 54 Health Services personnel took Aboriginal Perceptions Training from 2009-2010 to 2012-2013.

Indigenous-Specific Initiatives

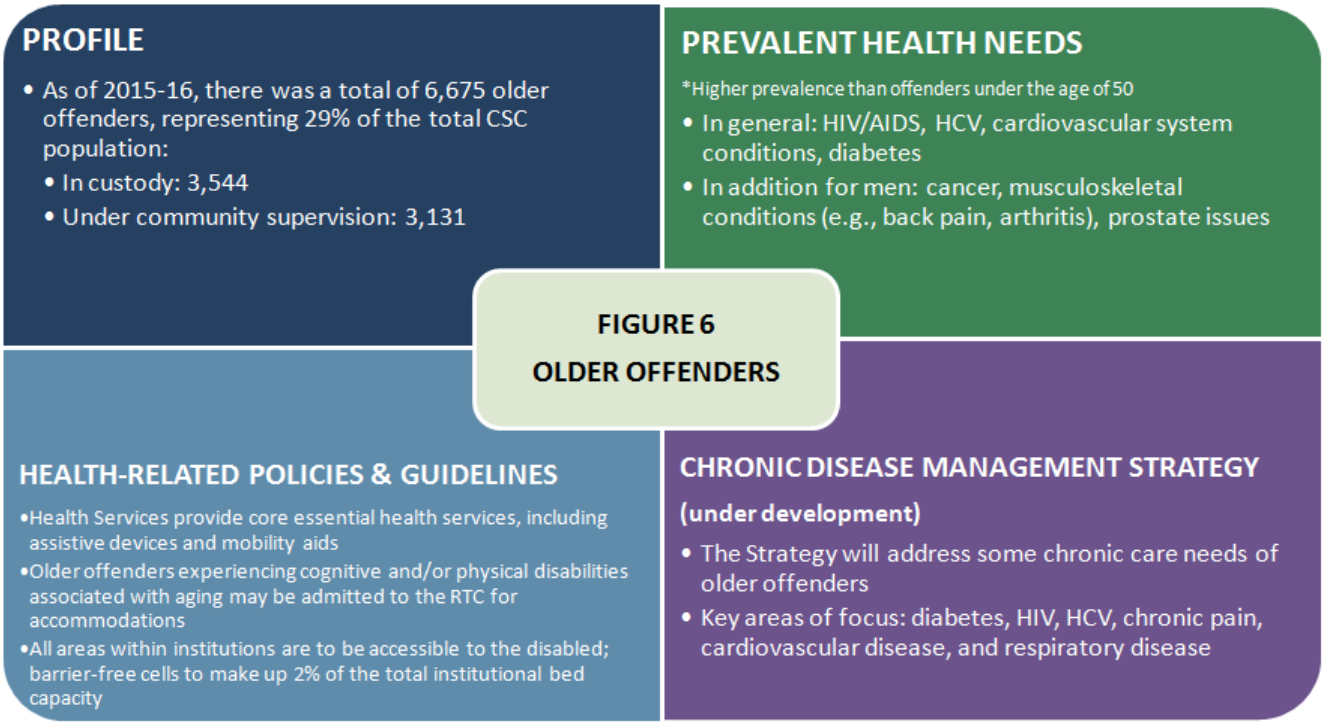
- An Indigenous culture component has been included within the Fundamentals of Mental Health training for staff, and the Aboriginal Peer Education Counsellor program trains Indigenous offenders as peer educators to provide support and education on infectious diseases.
- The Guidelines for Sharing Personal Health Information were updated to include culturally relevant information (e.g., regarding the sharing of health information with Elders).
- The Director General, Aboriginal Initiatives participates in the National Complex Mental Health Committee to provide input into appropriate care for Indigenous offenders with complex needs.
- Indigenous offenders have access to Elders, Spiritual Advisors, Aboriginal Liaison Officers, and other culturally-competent staff who are available to support offenders during intake/assessment (e.g., COMHISS, 24-hour nursing assessments) and throughout their sentence.
- The Elder is invited to be a member of the interdisciplinary health team for managing offender health needs.

Overall Perceptions of Health Services for Indigenous Offenders

- Some staff reported consulting with an Elder for incarcerated Indigenous offenders who want to follow a traditional healing path in regards to mental health needs (51%, n=66), clinical health needs (28%, n=35), and public health needs (9%, n=11).
- Overall, the majority of staff respondents reported CSC was meeting the health service needs of Indigenous Offenders
- The biggest challenge identified by staff was insufficient resources for community mental health services, especially in remote locations or on reserves (n=37).
- Of the Indigenous offenders interviewed (n=51), some (n=17) said that it would have been beneficial to have an Elder present while receiving health care services (e.g., help navigate the health system, provide information on traditional health alternatives).

Note: The results presented are not comprehensive, but provide a brief overview of some main initiatives/results within the scope of the evaluation

Figure 6: Older Offenders



CSC has developed some initiatives to meet the needs of older offenders. Staff suggested that there were opportunities to better meet the needs of older offenders related to services for chronic care and accommodating older offenders within existing infrastructure.

Older Offender-Specific Initiatives

- CSC Health Services conducts screening for "fall risk" as part of their intake assessment. Risk factors are managed through regular consultations with physicians as appropriate and interventions may occur to mitigate the identified risks.
- CSC has introduced an Aging Offenders Resource Kit via Infonet to inform staff on common mental and physical health issues associated with aging and best practices for working with older offenders with health needs.
- The Pacific Region created Echo - a psycho-geriatric unit at the RTC with a Peer Assisted Living (PAL) Caregiver program.
- CSC has a total of 428 barrier-free cells in its mainstream institutions and RTCs.

Overall Staff Perceptions of Health Services for Older Offenders

- Some staff agreed that health services were meeting the health-related needs of older offenders in the institution and in the community. Among those who disagreed, they reported challenges related to:
  - Insufficient resources in the institution (e.g., geriatric care, and services for high needs and/or multiple needs offenders; n=36) and the community (e.g., palliative care, mental health professionals; n=27).
  - Providing accommodations for older offenders within the existing institutional infrastructure (e.g., provide specialized unit or range for offenders with mobility or age related issues; n=34).
  - Finding accommodations in the community (e.g., community care facilities willing to accept them, CCCs/CRFs not equipped for their needs; n=20).

Offender Perceptions of Health Services for Older Offenders

- Of the 42 older offender respondents, more than half (57%, n=24) reported having age-related health care needs.
- Older offenders also reported challenges in the physical layout of the institution, accessing specialized health care equipment, and performing daily activities. Respondents made the following suggestions for improvement:
  - Offer specialized services (e.g., hearing specialist, pain clinics; n=12) and products (e.g., eyeglasses, cane; n=11)
  - Accommodate older offenders through infrastructure changes (e.g., improve wheelchair accessibility; n=10)

Note: The results presented are not comprehensive, but provide a brief overview of some main initiatives/results within the scope of the evaluation.

Summary:

Specific guidelines, programs, and strategies have been initiated for several offender populations, particularly for women and Indigenous offenders. Many of these initiatives have a component related to mental health (e.g., participation in complex mental health committees to represent the needs of women and Indigenous offenders, involvement of Elders on interdisciplinary mental health teams), or public health (e.g., Reception Awareness Program for Women). Positive impacts of mental health initiatives for women and Indigenous offenders have been demonstrated. For example, positive impacts of mental health treatment were reported for Indigenous offenders in the current evaluation (FIFE 5), and positive impacts related to Structured Living Environments,[ccvi] mental health services offered at Pinel,[ccvii] and the Community Mental Health Initiative (CMHI) [ccviii] have been reported in other evaluations or research studies.

The health-related needs of older offenders have become more of a focus for CSC, in part due to the increase in the older offender population in recent years. Chronic and infectious diseases are particularly important for the older offender population, as these are among the most prevalent health-related needs of older offenders. In addition, although few staff identified challenges in the provision of health care for women and older offenders, some staff and offender respondents suggested that there are opportunities to improve the capacity to accommodate individuals with mobility needs within CSC's institutions, and to address specific age-related health care needs for this population.

Next Steps:

- CSC Health Services is currently developing a comprehensive *Chronic Disease Management Strategy*.
    - The Strategy includes seven key health priorities, including diabetes, HIV, HCV, chronic pain, cardiovascular disease, respiratory disease, and the use of antibiotics.
    - Although the *Chronic Disease Management Strategy* is not specifically designated for older offenders, many of the health issues prioritized in the strategy include health issues prevalent among older offender populations.

RECOMMENDATION 11: SPECIFIC POPULATIONS OF OFFENDERS

That CSC Health Services continue to implement the Chronic Disease Management Strategy, with reference to any special needs/requirements for older, women, and Indigenous offenders, and methods for tracking impacts.

4.0 CONCLUSION

The concept of universality respecting health care is outlined in the Canada Health Act,[ccix] this means that all Canadians are entitled to access health care in accordance with the health insurance plan of their respective province; in the case of federally incarcerated persons, CSC provides access to health care.

The evaluation found that CSC Health Services are relevant and meet the needs of federal offenders. Positive impacts were found regarding institutional mental health care where offenders had a reduced likelihood of incidents, serious charges and involuntary segregation following treatment. Several key areas were identified for service improvements, such as:

- Access to institutional health services, for example limited access to some health education programs, bleach kits and community health care specialists;
- Effectiveness and efficiency of the health services intake assessment process, for example duplication of offender health information through intake processes and tools;
- Gaps in policy and procedures to support offenders in obtaining necessary ID required to transition from CSC health services to provincial and territorial health services upon release; and
- Missing or unreliable data among referrals to specialist services (in person or telemedicine), clinical health services information and the mental health needs scale.

This evaluation will assist CSC in improving the delivery of health services for all offenders across the continuum of care.

APPENDIX A: POLICY AND LEGISLATION

A list of Commissioner's Directives that involve a health related component includes:

- CD 705: Intake Assessment Process and Correctional Plan Framework
- CD 705-3: Immediate Needs Identification and Admission Interviews
- CD 702: Aboriginal Offenders
- CD 566-12: Personal Property of Offenders
- CD 860: Offender's Money

APPENDIX B: NEED FOR HEALTH SERVICES

Clinical Health Needs

Men Offenders[ccx]

- 34% of male offenders self-reported head injuries, whereas 19% suffer from back pain, and 15% have asthma. With respect to head-injuries, the prevalence pertains to any current or history of head injuries, and may therefore include a broad range of injuries. A review of health files found that 2% of offenders had evidence of recent brain injury.[ccxi]
- The rates of many chronic conditions (e.g. high blood pressure, high cholesterol, angina, arthritis, etc.) are significantly higher for men offenders over the age of 50 years compared to men offenders under 50 years of age.
- A significantly higher proportion of men offenders have asthma (15%) compared to men in the Canadian population (7%).
- Indigenous peoples in the Canadian population have an increased risk of developing cardiovascular disease,[ccxii] and they comprise a disproportionately high percentage of the incarcerated population (compared to the general population).
- Indigenous men offenders have significantly higher rates of head injuries (43%) than non-Indigenous men offenders (32%).

Women Offenders[ccxiii]

- According to self-reports, 26% of women offenders suffer from back pain followed by head injuries (23%), menopause (19%) and asthma (16%).
- A higher proportion of older women offenders have conditions affecting their cardiovascular system (47%) and they also have a higher prevalence of diabetes (17%) compared to younger women offenders (15%; 4%).
- Compared to the Canadian women population (10%), a higher proportion of women offenders (16%) have asthma.
- A higher proportion of Indigenous women offenders compared to non-Indigenous women offenders have health conditions affecting their central nervous systems (29%; 25%), diabetes (11%; 3%) and ulcers (11%; 6%).

Public Health Needs[148]

The most prevalent public health issues self-reported by men and women offenders are identified below.

Men Offenders[ccxiv]

According to self-reports:

- HCV (9%) and HIV (1%) are the most prevalent communicable diseases among an admission cohort of federal men offenders.
- Indigenous men offenders have a significantly higher prevalence of HCV (16%) and HIV (2%) than non-Indigenous men offenders (HCV 8%, HIV 1%).
- Men offenders over 50 years of age have a higher prevalence of HCV (13%) and HIV (2%) in comparison to men offenders under 50 years of age (HCV 9%; HIV 1%).

Women Offenders[ccxv]

According to self-reports:

- Among an admission cohort of women offenders, the most prevalent self-reported public health issues were HCV and HIV/AIDS (20%). [149]
- In addition, the prevalence of HCV and HIV/AIDS was higher among Indigenous women offenders (27%) than non-Indigenous women offender counterparts (17%).
- Older women offenders have a slightly higher prevalence of HCV and HIV/AIDS (22%) relative to younger women offenders (20%).

[148] The prevalence rates reported in this section were based on offender self-report upon admission and do not take into account test results completed as part of the intake period. Self-reported rates of infectious diseases may be lower than actual prevalence rates. Some information on prevalence rates for specific groups of offenders in CSC from 2000-2006 is available at http://www.csc-scc.gc.ca/publications/infdscfp-2005-06/tb-eng.shtml.

[149] Due to self-reported frequencies of less than five, the prevalence rates for HCV and HIV were reported together in the source research report.

Mental Health Needs

Men Offenders

- Common mental disorders among men offenders were: antisocial personality disorder (44%), anxiety disorders (30%), mood disorders (17%), and major mental illness (12%), which includes major depressive disorder, bi-polar I and II disorders, or any psychotic disorder.[150] [ccxvi]
- Indigenous men offenders had higher rates of personality disorders compared to non-Indigenous men offenders with the most pronounced differences being antisocial personality disorder (60% and 40% respectively) and borderline personality disorder (22% and 14% respectively).[151] [ccxvii]
- Men offenders did not engage in self-injurious behaviour (SIB) as frequently as women offenders; however, their SIB are more likely to result in minor and serious injury compared to women offenders whose incidents of SIB are more likely to result in no significant injury.[ccxviii]

Women Offenders

- The vast majority of women offenders had a psychiatric disorder at some point in their lives. Among the most common were: lifetime prevalence of antisocial personality disorder (83%); experience of a major depressive episode, a type of mood disorder, at some point in their lives (69%), and post-traumatic stress disorder, a type of anxiety disorder, in the past year (31%).[152] Borderline personality disorder was more common in women offenders than in men offenders.[ccxix]
- Twenty-two percent of women offenders had attempted suicide prior to being admitted to CSC.[ccxx]
- Indigenous women offenders experienced higher occurrences of conduct disorder than their non-Indigenous women counterparts (64% and 42% respectively).[ccxxi]
- Although women offenders accounted for 5% of CSC's incarcerated population, they comprised 12% of the offenders who had a SIB incident and accounted for 32% of all SIB

[150] These figures are for one-month current prevalence rates.
[151] Use caution when interpreting these results given the small number of offenders in the Indigenous group in some categories.
[152] Where possible current rates are provided; however, in some cases, only lifetime rates were available.

incidents. Furthermore, Indigenous women offenders engaged in twice as many incidents of SIB compared to non-Indigenous women.[ccxxii]

APPENDIX C: MENTAL HEALTH DIVERSION

Pre-contact with the criminal justice system – crime prevention:

Focus on preventing individuals with mental health needs from coming into contact with the criminal justice system through intervention on risk factors before crime happens.

Post-contact with the criminal justice system – Sequential Intercept Model[ccxxiii]

1 **First interactions with law enforcement and emergency services:** the goal at this stage of diversion is to divert individuals with mental health needs from arrest by providing alternative treatment options and to decrease risk of harm resulting from these interactions.

There are four models of police-based diversion in Canada:

- Crisis Intervention Teams (CIT) – interdisciplinary community liaison teams;
- Psychiatric Emergency Response Teams (PERT) – police officers are paired with licensed mental health professionals;
- Crisis Mobile Teams (CMT) – behavioural mental health specialists assist police officers in situations involving persons with mental disorders; and
- Informal police diversion – police may refer an individual to community mental health services in lieu of charges (generally for less serious acts or on first-arrest).

2 **Post-arrest (pre-trial):** this type of diversion interrupts the standard prosecution process, it occurs between the individual's arrest and their appearance in court. Offenders are diverted from the criminal justice system and referred for treatment or other specialized diversion programs.

There are four elements of the process:

- Appointment of counsel;
- Assessment of the offender;
- Consultation with the victim; and,
- Prosecutorial review of charges and possible diversion. This type of diversion can be requested on behalf of the individual with the mental health need by the defence counsel, crown counsel, police, mental health services, diversion programs, citizens, etc.

3 **Court-based diversion:** designed to divert individuals with mental health needs through mental health courts, mental health dockets, or traditional courts with alternative sentencing planning strategies to a judicially monitored diversion program. The focus is on community-based treatment and restorative remedial measures versus prosecution, and may involve a multidisciplinary team (e.g., judge, crown attorneys, mental health workers).

4 **Re-entry planning from jails, prisons, and forensic hospitalization:** does not specifically focus on diversion per se; rather, it focuses on continuity of care and successful reintegration (or re-entry) into the community. Preparation for reintegration should begin prior to release. Post release, interventions should support offenders' transition from the prison to the community and help maintain gains made in treatment while incarcerated.

5 **Community corrections and community support:** the goal is to divert individuals with mental health needs under community supervision from re-entering the criminal justice system.

Best practices include:

- Mental health screening;
- Managing treatment conditions and technical violations through the use of non-traditional methods that emphasize non-custodial alternatives;
- Use of intensive and specialized case management; and,
- Use of a specialized caseload model (e.g., Have a set of dedicated officers for offenders with mental disorders, reduce officers caseload (typically one third of a traditional caseload); provide officers with sustained training on mental health and other related issues; have officers intervene with offenders directly and coordinate community services)

Sequential Intercept Model Notes

Intercept 1: First interactions with law enforcement and emergency services

Evidence suggests that diversion at this intercept can increase referrals to mental health resources, increase the number of days spent in the community, and reduce the use of force in police interactions with mentally ill offenders.[ccxxiv] More generally, however, the research in this area is limited and further evaluation is needed before firm conclusion can be drawn about the effectiveness of mental health diversion at this intercept.

Intercept 2: Post-arrest (pre-trial)

Generally, diverted offenders at this intercept have more time in the community, greater treatment participation, fewer hospital days in the community, fewer arrests (1 year follow-up), less homelessness (1-year follow-up), and more emergency room contacts.[ccxxv] It is noted that this research needs to be interpreted with caution due to a small number of studies, differing methodology, and variability in what was considered to be a 'diversion' program.[ccxxvi]

Intercept 3: Court Based Diversion

The purpose of mental health courts is to target the root causes of crime committed by individuals with mental health needs (e.g., untreated mental illness) and to help prevent mentally disordered individuals from reoffending. Mental health courts have been associated with fewer arrests and jail days (e.g., an average of 3 days instead of 23 days), reduced recidivism, and lower costs over time (relative to traditional courts.[ccxxvii] Further, mental health courts better linked individuals to mental health services and those individuals were more like to stay in a higher level of treatment than individuals not participating in a mental health court program.[ccxxviii]

Mental health dockets refer to dedicating a period of time during traditional court (e.g., one afternoon per week) to individuals with mental health needs.

Intercept 4: Re-entry planning from jails, prisons, and forensic hospitalization

Preparation for reintegration (or re-entry) into the community should begin prior to release. Good practice suggests that post-release interventions should support offenders' transition from the prison to the community and help maintain gains made in treatment while incarcerated.[ccxxix] This recommendation is in line with CSC's Mental Health Strategy which suggests "dedicated services are required to support a seamless continuity of care from the community to the correctional system and upon return to the community" for offenders with mental health needs.[ccxxx]

Intercept 5: Community corrections and community support

Offenders with mental health issues can have trouble complying with their conditions, placing them at higher risk for technical violations, new offences, and new sentences. Revocation prevention strategies include: incentives for compliance with conditions (e.g., reduce frequency of reporting); graduated scheme of responses before employing the most serious response (i.e., revocation of probation/parole); consult with treatment providers before taking action on a violation related to treatment/mental health evaluation and consider treatment alternatives (e.g., refer to more intensive

treatment); respond to minor technical violations early to prevent more serious technical violations, establishing agreements and guidelines with service providers regarding the support that they will provide and the actions that will be taken for failure to participate in treatment; and, have mental health professionals help offenders better understand the consequences of their behaviour in terms of sanctions.[ccxxxi]

CSC Community Mental Health Specialist services follow an assertive community treatment model in that multidisciplinary teams of professionals provide mentally ill offenders with services tailored to their needs in the community and share responsibility for the offender.[ccxxxii] Generally assertive community treatment based programs (relative to 'treatment as usual') were found to be associated with "better criminal justice outcomes (e.g., any conviction, mean jail time), better improvement of substance abuse problems, and improvement in global functioning and economic self-sufficiency".[ccxxxiii]

APPENDIX D: EFFECTIVENESS OF INTAKE ASSESSMENT FOR SPECIFIC POPULATIONS

Indigenous Offenders

- Most health services staff members and Indigenous offenders did not report any barriers specific to this sub-population of offenders in completing health status intake assessments.[153]
  - Those health services staff members who did identify challenges reported that there were communication or cultural barriers in completing intake assessments for Indigenous offenders (n=10).
- Many health services staff members reported that Indigenous offenders interested in following a traditional healing path, "never" or "rarely" had an Elder involved in completing intake assessment tools.[154]
- Most (78%, n=18) Indigenous offenders interested in following a traditional health path reported that they did not have an Elder present during health intake assessments, but many (n = 11) reported it would have been helpful.[155]
- Indigenous offenders are equally as likely to receive intake assessments (i.e., 24-hour and 14-day) within the appropriate timeframe compared to the whole offender population (Indigenous and non-Indigenous offenders).[156] [ccxxxiv]

Visible Minority Offenders

- Most[157] health services staff members reported that they did not face any challenges completing intake assessments for visible minority offenders.

[153] Percentage of Health Services Staff Questionnaire participants reporting no barriers/challenges for Indigenous offenders: 24-hour (82%, n=44), 14-day (80%, n=41), infectious disease screening (86%, n=36) and CoMHISS (72%, n=13). No Indigenous offenders interviewed at intake reported any specific barriers to intake assessments (0%, n = 31).
[154] Percentage of Health Services Staff Questionnaire participants reporting that Elders were never or rarely involved in completing intake assessment tools: 24-hour Assessment (64%, n=38), 14-day Health Intake Assessment (61%, n=34), Infectious Disease Screening (73%, n=33); or CoMHISS (73%, n=16).
[155] Of those offenders who participated in the current evaluation, 33% (n=34) identified themselves as being Indigenous of First Nations (84%; n=27) or Métis (16%; n=5) descent, and of those 68% (n=23) expressed an interest in following a traditional healing path.
[156] 24-hour assessment - 97% (n=4192) of the whole offender population (Indigenous and non-Indigenous) were screened within the appropriate timeframe compared to 94% (904) of Indigenous offenders. 14-day assessment – 70% (n=3010) of the whole offender population (Indigenous and non-Indigenous) were screened within the appropriate timeframes compared to 70% (n=659) of Indigenous offenders.

- Among those who did report challenges, it was noted that there were communication or cultural barriers in completing intake assessments for visible minority offenders (n=15).

Older Offenders

- Most health services staff members and older offenders did not report any challenges specific to this sub-population of offenders in completing health status intake assessments.[158]
- Some (44%, n=7) older offenders reported having additional health care needs including physical health concerns (e.g., knee pain, osteoarthritis) and other health issues (e.g., heart difficulties, hearing problems, diabetes, and cancer).
  - Of those older offenders who indicated that they had additional health care needs, about half reported that the health services intake assessment screening tool did not identify their age-related health needs (n=4).[159]

Women Offenders

- Most health services staff members and women offenders did not report any challenges completing intake assessments for women offenders.[160]
- Women offenders are equally as likely (or more so) to receive the 24-hour assessment, 14-day assessment, and CoMHISS within the appropriate timeframe compared to the whole offender population (women and men offenders).[161] [ccxxxv]

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[157] Percentage of Health Services Staff Questionnaire participants reporting no barriers/challenges for visible minority offenders: 24-hour (83%, n=45), 14-day (77%, n=39), infectious disease screening (85%, n=34) and CoMHISS (67%, n=12).

[158] Percentage of Health Services Staff Questionnaire participants reporting no barriers/challenges for older offenders: 24-hour (80%, n=44), 14-day (86%, n=44), infectious disease screening (88%, n=35) and CoMHISS (75%, n=12). Almost all older offenders who responded to this interview question reported that they did not experience any specific barriers in completing intake assessments (93%, n=13).

[159] It is difficult to draw conclusions from this information, given the small number of offenders who identified as an older offender (i.e., over the age of fifty) who participated in the evaluation interviews during the intake assessment period (n=16). Older offender health requirements and services will be assessed in additional aspects of the evaluation where possible.

[160] Percentage of Health Services Staff Questionnaire participants reporting no barriers/challenges for women offenders: 24-hour (88%, n=28), 14-day (88%, n=30), infectious disease screening (90%, n=26) and CoMHISS (100%, n=11). Almost all women offenders interviewed at intake reported that they did not experience any specific barriers in completing intake assessments (95%, n=19). Of those offenders who participated in the current evaluation, 20% (n=21) were women.

[161] 24-hour assessment - 97% (n=4192) of the whole offender population (women and men) were screened within the appropriate timeframe compared to 98% (232) of women offenders. 14-day assessment – 70% (n=3010) of the whole offender population (women and men) were screened within the appropriate timeframes compared to 87% (n=204) of

APPENDIX E: DESCRIPTION OF HEALTH EDUCATION INITIATIVES

Reception Awareness Program (RAP):

- RAP is offered to all newly admitted offenders at reception; however, attendance is voluntary.[ccxxxvi] Separate versions of the program are developed and delivered for men and women to address their specific health care needs. RAP provides general information on infectious diseases, harm reduction measures, and related health services and programs offered by CSC.[162] [ccxxxvii]

Peer Education Course/Aboriginal Peer Education Course (PEC/APEC):

- CSC offers PEC and APEC, which are one week training programs[ccxxxviii] offered to offender volunteers who want to become PEC/APEC support workers to other offenders.[ccxxxix] PEC includes a series of modules dealing with infectious diseases and the provision of peer support to offenders infected and affected by these diseases.[ccxl] Similarly, APEC is a one week culturally sensitive training course offered to offender volunteers who want to provide peer support to offenders within the context of the Indigenous culture.[ccxli] The goal of APEC is to learn the basic facts of infectious diseases in order to support encourage and empower Indigenous peers to sustain behavioural and lifestyle changes.[ccxlii] After participating in the PEC/APEC training program, offenders can be selected to work as Peer Support workers within their institutions. Offenders in need of health service support can than request the services offered through a PEC/APEC support worker.

Inmate Suicide Awareness and Prevention Workshop (ISAPW):

- The ISAPW is a three-hour workshop that provides offenders information about suicide including: suicide facts and myths, possible stressors to suicide, signs and symptoms of suicide risk and what to do if someone is thinking about suicide.[ccxliii] The program is delivered by personnel from chaplaincy, nursing, programs, and/or volunteers.[ccxliv] *Commissioner's Directive 843: Management of Inmate Self-Injurious and Suicidal Behaviour* highlights the

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women offenders. CoMHISS – 84% (n=3538) of whole offender population (women and men) were screened within the appropriate timeframes compared to 80% (n=189) of women offenders.

[162] Health services staff members reported that RAP included information on the health services available at CSC (87%, n=33), how to access these services (92%, n=35), how to prevent infectious disease in prison (95%, n=36).

importance of having the Inmate Suicide Awareness and Prevention Workshop available on a regular basis and providing offenders access to the workshop.[ccxlv] CSC aims to deliver this workshop at reception centers in an effort to provide the training to all offenders.[ccxlvi]

Health Services factsheets:

- Health Services offers monthly health promotion and infectious disease prevention factsheets and PowerPoint presentations. The factsheets address specific areas of health concerns, including infectious diseases, chronic conditions, mental health, and general healthy living. Topics may inform on HIV/AIDS, diabetes, TB, heart disease, suicide prevention, and substance abuse.

APPENDIX F: INSTITUTIONAL MENTAL HEALTH SERVICES

Mainstream Institutional Mental Health Treatment

Table 1: Proportional Hazards Regression, Mainstream Institutional Mental Health Treatment & After Treatment Periods Onto Correctional Outcome Likelihood (N = 3, 167)

			95% Confidence Interval	
Variables	***B***	**HR**	**Lower**	**Upper**
Incidents: All				
During Treatment (vs. Before Treatment)	-0.04070	0.960	0.863	1.068
After Treatment (vs. Before Treatment)	-0.09101	0.913*	0.836	0.997
Incidents: Behaviour				
During Treatment (vs. Before Treatment)	0.04524	1.046	0.854	1.281
After Treatment (vs. Before Treatment)	-0.07826	0.925	0.794	1.077
Minor Charges				
During Treatment (vs. Before Treatment)	0.02530	1.026	0.897	1.173
After Treatment (vs. Before Treatment)	-0.06023	0.942	0.836	1.060
Serious Charges				
During Treatment (vs. Before Treatment)	-0.12578	0.882	0.727	1.070
After Treatment (vs. Before Treatment)	-0.35008	0.705***	0.602	0.825
Involuntary Segregation				
During Treatment (vs. Before Treatment)	-0.13634	0.873*	0.769	0.990
After Treatment (vs. Before Treatment)	-0.38467	0.681***	0.605	0.765
National Correctional Program Completions				
During Treatment (vs. Before Treatment)	0.17865	1.196***	1.078	1.327
After Treatment (vs. Before Treatment)	0.20870	1.232***	1.122	1.352
Education Course/Credit Completion				
During Treatment (vs. Before Treatment)	0.02233	1.023	0.901	1.160
After Treatment (vs. Before Treatment)	0.29131	1.338***	1.188	1.508

* p.<.05; **p < .01; ***p<.001. The log-likelihood test for all models were significant as a whole (i.e., p< .0001)

Each model controlled for risk, need, motivation, reintegration potential, age, gender, and Indigenous status. Time interactions were also implemented for variables that violated the proportional hazards assumption.

The significance values for the hazard ratios were corrected for dependence using the modified sandwich estimator (Allison, 2010).

Assault-related incidents, self-harm, and voluntary segregation are not included due to low number of offenders who experienced that event.

Mainstream Institutional Mental Health Treatment: Indigenous Offenders

Table 2: Proportional Hazards Regression, Mainstream Institutional Mental Treatment & Post-Treatment Periods Onto Correctional Outcome Likelihood for Indigenous Offenders (N = 802)				
			95% Confidence Interval	
Variables	***B***	**HR**	**Lower**	**Upper**
Incidents: All				
During Treatment (vs. Before Treatment)	-0.02019	0.980	0.795	1.207
After Treatment (vs. Before Treatment)	-0.07465	0.928	0.784	1.098
Incidents: Behaviour				
During Treatment (vs. Before Treatment)	-0.00847	0.992	0.686	1.434
After Treatment (vs. Before Treatment)	-0.24882	0.780	0.580	1.048
Minor Charges				
During Treatment (vs. Before Treatment)	-0.00244	0.998	0.807	1.234
After Treatment (vs. Before Treatment)	-0.07810	0.925	0.751	1.139
Serious Charges				
During Treatment (vs. Before Treatment)	-0.06992	0.932	0.639	1.360
After Treatment (vs. Before Treatment)	-0.20298	0.816	0.639	1.043
Involuntary Segregation				
During Treatment (vs. Before Treatment)	-0.12117	0.886	0.700	1.122
After Treatment (vs. Before Treatment)	-0.35983	0.698**	0.555	0.877
National Correctional Program Completions				
During Treatment (vs. Before Treatment)	0.32006	1.377**	1.137	1.668
After Treatment (vs. Before Treatment)	0.26252	1.300**	1.090	1.551
Education Course/Credit Completion				
During Treatment (vs. Before Treatment)	-0.00478	0.995	0.804	1.233
After Treatment (vs. Before Treatment)	0.20521	1.228*	1.002	1.505

* p.<.05; **p < .01; ***p<.001. The log-likelihood test for all models were significant as a whole (i.e., p< .0001)

Each model controlled for risk, need, motivation, reintegration potential, age, gender, and Indigenous status. Time interactions were also implemented for variables that violated the proportional hazards assumption.

The significance values for the hazard ratios were corrected for dependence using the modified sandwich estimator (Allison, 2010).

Assault-related incidents, self-harm, and voluntary segregation are not included due to low number of offenders who experienced that event.

RTC Mental Health Treatment

Table 3: Proportional Hazards Regression, RTC Mental Health Treatment & Post-Treatment Periods Onto Correctional Outcome Likelihood (N = 617)				
			95% Confidence Interval	
Variables	***B***	**HR**	**Lower**	**Upper**
Incidents: All				
During Treatment (vs. Before Treatment)	0.19464	1.215***	1.087	1.358
After Treatment (vs. Before Treatment)	-0.21539	0.806***	0.714	0.911
Incidents: Assault				
During Treatment (vs. Before Treatment)	0.38367	1.468**	1.141	1.887
After Treatment (vs. Before Treatment)	-0.34242	0.710*	0.541	0.933
Incidents: Behaviour				
During Treatment (vs. Before Treatment)	0.27319	1.314**	1.099	1.571
After Treatment (vs. Before Treatment)	-0.23994	0.787*	0.654	0.947
Incidents: Self-Harm				
During Treatment (vs. Before Treatment)	0.04428	1.045	0.799	1.368
After Treatment (vs. Before Treatment)	-0.41555	0.660*	0.454	0.959
Minor Charges				
During Treatment (vs. Before Treatment)	-0.23779	0.788	0.605	1.027
After Treatment (vs. Before Treatment)	-0.05286	0.949	0.679	1.324
Serious Charges				
During Treatment (vs. Before Treatment)	-0.36885	0.692**	0.524	0.912
After Treatment (vs. Before Treatment)	-0.37151	0.690***	0.554	0.859
Involuntary Segregation				
During Treatment (vs. Before Treatment)	-0.49070	0.612***	0.513	0.731
After Treatment (vs. Before Treatment)	-0.20673	0.813**	0.695	0.951
National Correctional Program Completions				
During Treatment (vs. Before Treatment)	-0.22237	0.801	0.565	1.135
After Treatment (vs. Before Treatment)	0.05852	1.060	0.824	1.364
Education Course/Credit Completion				
During Treatment (vs. Before Treatment)	-0.28018	0.756	0.548	1.041
After Treatment (vs. Before Treatment)	0.05759	1.059	0.776	1.445

* p.<.05; **p < .01; ***p<.001. The log-likelihood test for all models were significant as a whole (i.e., p< .0001)

Each model controlled for risk, need, motivation, reintegration potential, age, gender, and Indigenous status. Time interactions were also implemented for variables that violated the proportional hazards assumption.

The significance values for the hazard ratios were corrected for dependence using the modified sandwich estimator (Allison, 2010).

Voluntary segregation is not included due to low number of offenders who experienced that event.

APPENDIX G: COMMUNITY MENTAL HEALTH SERVICES

Table 1: Recidivism Outcomes for Men and Women CMHI and non-CMHI Participants

Recidivism within 24 months after release				
	Men		**Women**	
	n (%)	N	n (%)	N
CMHS services	74 (30%)	249	9 (27%)	33
CDP services	34 (52%)	65	6 (43%)	14
CDP/CMHS	27 (43%)	63	3 (17%)	18
Non-CMHS	138 (51%)	269	19 (33%)	58
Recidivism within 48 months after release				
	Men		**Women**	
	n (%)	N	n (%)	N
CMHS services	90 (36%)	249	10 (30%)	33
CDP services	38 (59%)	65	7 (50%)	14
CDP/CMHS	32 (51%)	63	5 (28%)	18
Non-CMHS	165 (61%)	269	27 (47%)	58

Source: MacDonald, S. F., Stewart, L. A., & Feely, S. (2014). *The impact of the Community Mental Health Initiative (CMHI) (R-337)*. Ottawa, ON.

APPENDIX H: CLINICAL DISCHARGE PLANNING - ROLES & RESPONSIBILITIES

The clinical discharge planning process involves coordination among several key staff members whose level of involvement varies according to the offender's health needs.

Roles and responsibilities of clinical discharge planning

The Discharge Planning Matrix Tool,[163] the *Discharge Planning and Transfer Guidelines*, and the *Integrated Mental Health Guidelines* outline the roles and responsibilities for CSC staff in relation to CDP.[ccxlvii]

- The clinical discharge planner is responsible for the following in relation to CDP caseload offenders:[ccxlviii]
    - Developing discharge/integration plans (i.e., Mental Health Assessment for Clinical Discharge in accordance with the content guidelines for Mental Health Assessment and Treatment/Intervention Plans) that include referrals and follow-ups in the various areas such as Housing; Identification; Community Support; Spiritual/Religious/Cultural/Ethnic, etc.
    - Providing the IPO/Community Parole Officer with information for reference in the completion of the Correctional Plan Update, Community Strategy and to assist with other release decision making processes – in accordance with case management timelines.
    - Setting up necessary appointments and medication follow up appointments prior to release.
- The clinical discharge planner is also responsible for the following:
    - Providing brief interventions for offenders when referral for services are two months or less prior to release date or WED; or to address specific needs (e.g., referral to a psychiatrist).[ccxlix]
    - Responding to referrals for consultation in complex cases.[ccl]

[163] The Discharge Planning Matrix Tool was developed in April 2013 as a reference accompanying the *Discharge Planning and Transfer Guidelines.*

- The institutional parole officer, as part of offender case preparation is responsible for the following in relation to collaboration and communication with Health Services:
    - Submits referral request to Health Services for a consultation to clinical discharge planners.[ccli]
    - Informs Health Services of upcoming case preparation in advance of 6 months before hearing or release.[cclii]
    - Informs Health Services of upcoming release 3 weeks in advance (or as soon as possible for last minute releases).[ccliii]
    - Prompts pre-release case-conference prior to release if significant change is shared in the GIST report provided by Health Services prior to release.[ccliv]
- The institutional parole officer, is also responsible for the following in relation to managing offender health information:[cclv]
    - Includes the relevant Health Services information in the Correctional Plan.
    - Ensures the Health Status at Discharge: Gist Reports are placed in the offender Case Management file.
    - Assists offenders to obtain a provincial health card in the province of the offender's releasing institution, or when an offender is being released to a different province, assists the offender to apply for temporary provincial health coverage in the province of incarceration.[cclvi]
- The community parole officer, in preparation for an offender's release to the community, is responsible for the following:[cclvii]
    - Develops the community release strategy in collaboration with the IPO and the clinical discharge planner (where relevant).
    - Includes relevant health care needs in the development of the community supervision strategy.
    - Participates in pre-release conferences when the offender is subject to a condition (e.g., condition to take a medication).

- Institutional nurse, in preparation for offender discharge is responsible for the following:
    - Consults with the clinical discharge planner as required to arrange for follow-up appointments for community health care services.

APPENDIX I: REFERENCES AND SUPPLEMENTARY INFORMATION FOR SPECIFIC POPULATIONS OF OFFENDERS

Women Offenders

Profile[cclviii]

- As of 2015-16, there were a total of 1,275 women offenders in CSC, representing 6% of the total number of federal offenders (n=22,969),[164] including:
  - 691 women offenders in custody, representing 5% of the total in custody population (n=14,646).
  - 584 women offenders under community supervision, representing 7% of the total community population (n=8,323).

Prevalent Health Needs[cclix]

- According to several research reports that examined offender health needs,[165] the most prevalent health conditions for women included: some infectious diseases (e.g., HIV/AIDS, HCV), chronic health conditions (e.g., back pain), and various mental health disorders (e.g., antisocial personality disorder, major depressive episode).

Health-Related Policies and Guidelines

- *Commissioner's Directive (CD) 800 Health Services*: "are sensitive to the needs of Aboriginal and women offenders, and offenders with special needs."[cclx]
- *Commissioner's Directive (CD) 578 Intensive Intervention Strategy in Women Offender Institutions/Units.*[cclxi]

[164] The total offender population includes all active offenders, who were incarcerated in a CSC facility, offenders who were on temporary absence from a CSC facility, offenders who were temporarily detained, offenders who were actively supervised, and offenders who were unlawfully at large for less than 90 days.
[165] Results for physical health were based on a file review of offender self-reported health needs at intake, and results for mental health were obtained from clinical tools used with a sample of offenders.

Health-Related Strategies and Initiatives[cclxii]

- CSC developed the *Infectious Disease Strategy for Women Offenders (2008-2013)* as a framework for the prevention, care, and treatment of infectious diseases in order to support women offenders affected by infectious diseases.[cclxiii] The Strategy was intended "to prevent the transmission and acquisition of infectious diseases among women offenders during incarceration and to provide appropriate care, treatment and support to those who are infected."[cclxiv]
- The *Intensive Intervention Strategy for Women Offenders* was initiated in 1999[cclxv] and was developed to better respond to women offenders experiencing self-injurious behaviour, adjustment problems, difficulties with daily living, and/or other emotional or behavioural problems. As part of the Strategy, women offenders are offered Dialectical Behaviour Therapy (DBT), which is a systematic and comprehensive psychotherapeutic intervention approach that involves learning and developing strategies to help regulate problematic emotions and behaviours.[cclxvi]
- The Peer Mentorship program does not provide therapeutic counselling; rather, it is meant to provide confidential support, and connect offenders to resources and services within and outside the institution. The program provides an opportunity for increased problem solving for individuals and contributes to the personal development and employability of offenders who are trained as Peer Mentors. Implementation of Peer Mentorship is scheduled for 2016-17.[cclxvii]

Overall Perceptions of Health Services for Women Offenders[166]

- Many staff member respondents *agreed* that health services were meeting the needs of Women offenders:

  Institutional Health Services:

  - Health services staff: 71%, n=36
  - General staff: 83%, n=40

  Community Mental Health Services:

  - Health services staff: 72%, n=38
  - General staff: 57%, n=52
  - Staff reported challenges:

[166] Remaining staff either reported "neither agree nor disagree" or "disagree/strongly disagree".

- A few CSC staff members (n=17) indicated that there were insufficient resources for community mental health, including access to CSC mental health services or other mental health services in the community.

Indigenous Offenders

Profile[cclxviii]

- As of 2015-16, there were a total of 5,223 Indigenous offenders in CSC, representing 23% of the total number of federal offenders (n=22,969),[167] including:
  - 3,778 Indigenous offenders in custody, representing 26% of the total in custody population (n=14,646)
  - 1,445 Indigenous offenders under community supervision, representing 17% of the total community population (n=8,323)
- As of 2014-15, there were 3,600 Indigenous offenders in custody and 1,356 in the community, representing approximately 22% of CSC's population.[cclxix]

Prevalent Health Needs

- According to several research reports examining offender health needs,[168] Indigenous offenders were more likely than non-Indigenous offenders to have health needs in some areas of mental health (e.g., antisocial personality disorder) and chronic health conditions (e.g., central nervous system conditions, diabetes) and infectious diseases (e.g., HCV, HIV/AIDS).[cclxx]

Health-Related Policies and Guidelines

- According to *Commissioner's Directive (CD*) *702: Aboriginal Offenders*, the Institutional Head is responsible for ensuring that offenders are provided with services from an Elder/Spiritual Advisor.[cclxxi]
- According to the *Integrated Mental Health Guidelines,* mental health care professionals must "document that Aboriginal Social history has been considered in arriving at a conclusion and

[167] The total offender population includes all active offenders, who were incarcerated in a CSC facility, offenders who were on temporary absence from a CSC facility, offenders who were temporarily detained, offenders who were actively supervised, and offenders who were unlawfully at large for less than 90 days.
[168] Results for physical health were based on a file review of offender self-reported health needs at intake, and results for mental health were obtained from structured clinical interviews used with a sample of offenders.

recommendations, and integrate a discussion of relevant aspects of this history into assessment reports." [cclxxii]

Health-Related Strategies and Initiatives[cclxxiii]

- The *Aboriginal Health Strategy (2009-2012)* offered a strategic framework for CSC to improve culturally-appropriate health services for Indigenous offenders, based on the continuum of care (i.e., through intake, incarceration, pre-release, and community corrections) and the Medicine Wheel. The Strategy had three primary goals:[cclxxiv]
    1. *Increase the focus on the health needs of Aboriginal offenders*
    2. *Building capacity for culturally-safe health services*[169]
    3. *Enhancing collaboration within and outside of CSC*[170]
- An Indigenous culture component was recently added to the Fundamentals of Mental Health Training. The training provides modules that educate on traditional values for Indigenous health, Indigenous social history, symptoms of mental disorder, and resources for working with Indigenous offenders. The modules also focus on applying Gladue principles through case studies.
- As of 2016, the Director General, Aboriginal Initiatives sits on the National Complex Mental Health Committee to provide input into appropriate care for Indigenous Offenders with complex mental health needs. [cclxxv]

Overall Perceptions of Health Services for Indigenous Offenders[171]

- Many staff member respondents *agreed* that health services were meeting the needs of Indigenous offenders in the institution, but fewer agreed that we were meeting their needs in the community:

  Institutional Health Services:

    - Health services staff: 65%, n=78
    - General staff: 72%, n=69

[169] Culturally-safe services are provided by professionals that are aware and understand Indigenous culture and are open and supportive an offender's choice regarding traditional Indigenous healing practices.
[170] Collaboration within and outside of CSC refers internally to collaboration between CSC NHQ, RHQs and each institution; between the Health Services Sector and Aboriginal Initiatives Directorate. Externally, collaboration should occur between internal partners and with the Indigenous Community, and at the federal and provincial/territorial level.
[171] Remaining staff either reported "neither agree nor disagree" or "disagree/strongly disagree".

- Staff reported challenges:
  - Need to address Indigenous health needs in culturally responsive ways (n=12)
  - Insufficient resources (n=6)

Community Mental Health Services:

- Health services staff: 49%, n=34
- General staff: 35%, n=44
- Staff reported challenges:
  - Insufficient resources, including difficulties accessing mental health services in remote locations or on reserve, or insufficient Indigenous staff members or Elders (n=37)
  - Communication or cultural barriers (n=9)

Elder Services:

- Some health services staff respondents reported consulting with Elders regarding Indigenous offenders for:
  - Mental health services (51%, n=66)
  - Clinical health services (28%, n=35)
  - Public health services (9%, n=11)
- Health services staff reported that they consulted an Elder to discuss:
  - Mental health treatment plans or interventions (n=22)
  - Understanding of offenders' cultural beliefs and languages (n=22)
  - Use of culturally sensitive approaches in clinical health care (n=15)
- Health services staff suggested that Elders should be more involved in:
  - Treatments, services, or interventions for offenders (n=18)
  - Communication and information sharing with health services (n=12)

Offender Perceptions:

- Among Indigenous offenders interviewed (n=51):
  - A few (n=3), reported having an Elder present while receiving health care services. Some (n=17) said that it would have been beneficial (e.g., to help navigate the health system, to provide information on traditional health alternatives).

Other Visible Minority Offenders

Profile[cclxxvi]

- The following table shows the ethnic groupings of all CSC offenders at the end 2015-16.[172] The most common other visible minorities (i.e., non-Indigenous offenders) were Black, Asian, and Other offenders.

Ethnic Grouping	Total (%)
Indigenous	5,223 (23%)
Asian	1,256 (5%)
Black	1,768 (8%)
Caucasian	13,521 (59%)
Hispanic	237 (1%)
Other	964 (4%)

Overall Perceptions of Health Services for Other Visible Minority Offenders[173]

- Many staff member respondents *agreed* that health services were meeting the needs of other visible minority offenders in the institution, but fewer agreed that we were meeting their needs in the community.

  Institutional Health Services:

  - Health services staff: 66%, n=74
  - General staff: 75%, n=71
  - Staff reported challenges:
    - Communication and cultural barriers (n=7).

  Community Mental Health Services:

  - Health services staff: 52%, n=34
  - General staff: 29%, n=30

[172] The total offender population includes all active offenders, who were incarcerated in a CSC facility, offenders who were on temporary absence from a CSC facility, offenders who were temporarily detained, offenders who were actively supervised, and offenders who were unlawfully at large for less than 90 days.
[173] Remaining staff either reported "neither agree nor disagree" or "disagree/strongly disagree".

- Staff reported challenges, primarily related to community mental health services:
  - Insufficient resources to meet the needs of visible minority populations (e.g., limited services, lack of information resources; n=18).
  - Language and/or cultural barriers (n=9).

Older Offenders

Profile[cclxxvii]

- As people age, the risk of ill health or disability increases, as does the demand for health care.[cclxxviii] Today, aging Canadians face chronic, mental health, and neurological conditions.[cclxxix]
- As of 2015-16, there were a total of 6,675 older offenders in CSC, representing 29% of the total number of federal offenders (n=22,969),[174] including:
  - 3,544 older offenders in custody, representing 24% of the total in custody population (n=14,646)
  - 3,131 older offenders under community supervision, representing 38% of the total community population (n=8,323).

Prevalent Health Needs

- According to several research reports that examined offender health needs,[175] older offenders had a higher prevalence than offenders under the age of 50 in some areas, such as chronic health conditions (e.g., cardiovascular system issues, diabetes) and infectious diseases (e.g., HIV/AIDS, HCV).[cclxxx]

Health-Related Policies and Guidelines[cclxxxi]

- According to the *National Essential Health Services Framework* core essential health services include physical health, mental health, public health, and dental services. Although there are some exceptions, many items relevant to older offenders and/or offenders with physical disabilities (e.g., mobility devices) are provided under special authorization.[cclxxxii]

[174] The total offender population includes all active offenders, who were incarcerated in a CSC facility, offenders who were on temporary absence from a CSC facility, offenders who were temporarily detained, offenders who were actively supervised, and offenders who were unlawfully at large for less than 90 days.
[175] Results for physical health were based on a file review of offender self-reported health needs at intake.

- According to the *Integrated Mental Health Guidelines*, offenders may be referred for admission to RTC if they experience cognitive and/or physical disabilities (e.g., dementia) that are associated with aging and require 24-hour nursing and other clinical care.[cclxxxiii]
- According to the *Federal Correctional Facilities Accommodation Guidelines*, "all areas within institutions must be accessible to the disabled, including staff, visitor and inmate activity areas". Although some spaces are not required to be accessible due to the nature of the activities (e.g., control posts, mechanical spaces), a portion of spaces are required to be accessible (i.e., a maximum of 2% of cells/bedrooms and support space within housing units).[cclxxxiv] Although these guidelines do not directly address challenges for older offenders, they provide options to address issues of accessibility and mobility, which commonly affect older offenders.
- There are a total of 15,364 regular population (rated-capacity) cells within CSC institutions. Of those, CSC provides 428 barrier-free cells, of which 37 are transitional (i.e., health care cells, segregation cells). As such, 391 permanent barrier-free cells represent 2.5% of all accessible spaces across CSC, which is above the 2% requirement in the *Federal Correctional Facilities Accommodation Guidelines* for CSC as a whole. However, some *individual* institutions were above the 2% level of accessible cells, whereas others were below.
- Barrier-free cells are provided in maximum, medium, and minimum security institutions, women's institutions, multi-level institutions, healing lodges[176] as well as in its RTCs. These cells are distributed in each of the five Regions as follows:
  - Atlantic: 43
  - Ontario: 111
  - Quebec: 75
  - Prairies: 115
  - Pacific: 84

Health-Related Strategies and Initiatives[cclxxxv]

- CSC Health Services is currently developing a comprehensive *Chronic Disease Management Strategy*.

[176] CSC operated healing lodges.

  - The Chronic Disease Management Strategy includes seven key health priorities: HIV, HCV, chronic pain, cardiovascular disease, respiratory disease, and the use of antibiotics.
  - Although the *Chronic Disease Management Strategy* is not specifically designated for older offenders, many of the health issues prioritized in the strategy include health issues prevalent among older offender populations.
- Health Services conducts screening for "fall risk" as part of the Intake Health Status Assessment for offenders aged 65 and older[177] and/or those with self-care needs (as of August 2015, the age requirement to conduct an assessment for incarcerated offenders has changed from 50 years or older to 65 years or older).[cclxxxvi] The assessment examines factors related to activities of daily living.[cclxxxvii,178]
- The Pacific Region has created a psycho-geriatric unit at the RTC, called Echo, with a Peer Assisted Living (PAL) Caregiver program.[cclxxxviii]
  - PAL Caregivers are offenders who work in cooperation with staff to assist a peer who has a physical or cognitive disability, in activities of daily living (e.g., help with eating, bathing, dressing, toileting, maintenance of the living environment and mobility).
  - Training is provided and offenders applying to the program should be actively engaged in their correctional plan and demonstrate positive working relationships with their case management team.

Overall Perceptions of Health Services for Older Offenders[179]

- Some staff *agreed* that health services were meeting the health-related needs of older offenders in the institution and in the community.

  Institutional Health Services:

  - Health services staff: 41%, n=52
  - General staff: 59%, n=61
  - Staff reported challenges:
    - Insufficient resources, services and specialized service providers (e.g., personal care, geriatric specialists, high needs/multiple needs offenders; n=36)

[177] As of August 2015, the age requirement to conduct
[178] Screening for "falls risk" is a Required Organizational Practice under Accreditation Canada.
[179] Remaining staff either reported "neither agree nor disagree" or "disagree/strongly disagree".

        - Challenges accommodating the needs of older offenders within the existing infrastructure (e.g., provide specialized unit or range for offenders with mobility or age related issues; n=34)

    Community Mental Health Services:

    - Health services staff: 46%, n=34
    - General staff: 34%, n=41
    - Staff reported challenges:
        - Insufficient resources, such as palliative care or mental health professionals (n=27)
        - Difficulties finding accommodations (e.g., community care facilities willing to accept them, CCCs/CRFs not equipped for their needs; n=20)

- Twenty-nine percent (29%, n=42) of offenders interviewed reported being over the age of fifty; of these, 57% (n=24) reported having age-related health care needs. They reported having age-related needs such as:
    - Joint or muscle problems (n=12),
    - Cardiovascular conditions (n=5), or
    - Other age-related chronic conditions (e.g., diabetes, menopause, etc; n=12).
- Older offenders also reported experiencing challenges with the physical layout of the institution (55%, n=12), accessing specialized health care equipment (47%, n=9), and performing daily activities (33%, n=7).
    - Offenders interviewed made the following suggestions to address age-related challenges: Offer specialized services (e.g., hearing specialist, pain clinics; n=12);
    - Provide access to specialized products and equipment (e.g., eyeglasses, cane; n=11); and,
    - Accommodate older offenders through infrastructure changes (e.g., improve wheelchair accessibility; n=10).

REFERENCES

[i] Corrections and Conditional Release Act, SC 1992, c 20.

[ii] Public Safety Canada. (2015). *Corrections and conditional release statistical overview*. Ottawa, ON: p. 48.

[iii] Infonet. (2016). *Health services*. Retrieved from http://infonet/eng/Sectors/HealthServices/pages/home.aspx.

[iv] Correctional Service Canada. (2016). *Reports on plans and priorities 2016-17*. Ottawa, ON: p. 7-12.

[v] Beaudette, J., Power, J., & Stewart, L. (2015). *National prevalence of mental disorders among incoming federally-sentenced men offenders (R-357)*. Ottawa, ON: Correctional Service Canada.; Correctional Service Canada. (2015). *Estimates of chronic disease prevalence among CSC inmates.* Ottawa, ON: Health Services.; Derkzen, D., Booth, L., McConnell, A., & Taylor, K. (2012). *Mental health needs of federal women offenders (R-267)*. Ottawa, ON: Correctional Service of Canada.; Nolan, A., & Stewart, L. (2014). *Self-reported physical health status of incoming federally-sentenced women offenders (R-332)*. Ottawa, ON: Correctional Service Canada.; Stewart et al. (2014). *Self-reported physical health status of newly admitted federally-sentenced men offenders (R-314).* Ottawa, ON: Correctional Service Canada.

[vi] Massoglia, M. (2008). Incarceration as exposure: The prison, infectious disease, and other stress-related illnesses. *Journal of Health and Social Behaviour 49*(1), 56-71.; Stewart, L., Sapers, J., Nolan, A., & Power, J. (2014). *Self-reported physical health status of newly admitted federally-sentenced men offenders (R-314).* Ottawa, ON: Correctional Service Canada.; Thompson, B., & Finch, R. (2005). Hepatitis C virus infection. *Clinical Microbiology and Infection 11*(2), 87.

[vii] Awofeso, N. (2010). Prisons as social determinants of hepatitis C virus and tuberculosis infections. *Public Health Reports 125*, 25-33.; Massoglia, M. (2008). Incarceration as exposure: The prison, infectious disease, and other stress-related illnesses. *Journal of Health and Social Behaviour 49*(1), 56-71.; Williams, N. (2007). Prison health and the health of the public: Ties that bind. *Journal of Correctional Health Care 13*(2), 80-92.

[viii] Awofeso, N. (2010). Prisons as social determinants of hepatitis C virus and tuberculosis infections. *Public Health Reports 125*, 25-33.; Massoglia, M. (2008). Incarceration as exposure: The prison, infectious disease, and other stress-related illnesses. *Journal of Health and Social Behaviour 49*(1), 56-71.; Williams, N. (2007). Prison health and the health of the public: Ties that bind. *Journal of Correctional Health Care 13*(2), 80-92.

[ix] Public Safety Canada. (2015). *Corrections and conditional release statistical overview*. Ottawa, ON: p. 48.

[x] Nolan, A., & Stewart, L. (2014). *Self-reported physical health status of incoming federally-sentenced women offenders (R-332)*. Ottawa, ON: Correctional Service Canada.; Stewart, L., et al. (2014). *Self-reported physical health status of newly admitted federally-sentenced men offenders (R-314)*. Ottawa, ON: Correctional Service Canada.

[xi] Sifunda, S., et al. (2008). The effectiveness of a peer-led HIV/AIDS and STI health education intervention for prison inmates in South Africa. *Health Education & Behavior 35*(4), 494-508.

[xii] Dumont, D., et al. (2012). Public health and the epidemic of incarceration. *Annual Review of Public Health 33*, 325-329.

[xiii] Corrections and Conditional Release Act, SC 1992, c 20. Retrieved from http://canlii.ca/t/52129.

[xiv] Correctional Service of Canada. (2015, July 23). *National essential health services framework*. Ottawa, ON.

xv Hayton, P. (2007). Protecting and promoting health in prisons: A settings approach. In L. Moller, et al. (Eds.), *Health in prisons: A WHO guide to the essentials of prison health* (pp. 15-20). Copenhagen, DK: WHO Publications.

[xvi] Stewart, L., Sapers, J., Nolan, A., & Power, J. (2014). *Self-reported physical health status of newly admitted federally-sentenced men offenders (R-314).* Ottawa, ON: Correctional Service Canada.

xvii Awofeso, N. (2010). Prisons as social determinants of hepatitis C virus and tuberculosis infections. Public Health Reports, 125, 25-33.; Massoglia, M. (2008). Incarceration as exposure: The prison, infectious disease, and other stress-related illnesses. Journal of Health and Social Behavior, 49(1), 56-71.; Tarbuck, A. (2001). Health of elderly inmates. Age and Ageing, 30(5), 369-370.

[xviii] Correctional Service Canada. (2015). *Commissioner's Directive 800: Health services.* Ottawa, ON.

[xix] Nolan, A., & Stewart, L. (2014). *Self-reported physical health status of incoming federally-sentenced women offenders (R-332)*. Ottawa, ON: Correctional Service Canada.; Stewart et al. (2014). *Self-reported physical health status of newly admitted federally-sentenced men offenders (R-314).* Ottawa, ON: Correctional Service Canada.

[xx] Nolan, A., & Stewart, L. (2014). *Self-reported physical health status of incoming federally-sentenced women offender (R-332)*. Ottawa, ON: Correctional Service Canada.

[xxi] Correctional Service Canada. (2015). *Estimates of chronic disease prevalence among CSC inmates.* Ottawa, ON: Health Services.

[xxii] Beaudette, J., & Stewart, L. (2014). *Research in brief: Older offenders in the custody of the Correctional Service of Canada (RS 14-21)*. Ottawa, ON: Correctional Service Canada.
[xxiii] Stewart, L., Sapers, J., Nolan, A., & Power, J. (2014). *Self-reported physical health status of newly admitted federally-sentenced men offenders (R-314).* Ottawa, ON: Correctional Service Canada.
[xxiv] Correctional Service Canada. (2014). *Public health quarterly report FY 2013-2014.* Ottawa, ON.
[xxv] Correctional Service Canada. (2015). *Estimates of chronic disease prevalence among CSC inmates.* Ottawa, ON: Health Services.
[xxvi] Nolan, A., & Stewart, L. (2014). *Self-reported physical health status of incoming federally-sentenced women offenders (R-332)*. Ottawa, ON: Correctional Service Canada.; Stewart et al. (2014). *Self-reported physical health status of newly admitted federally-sentenced men offenders (R-314).* Ottawa, ON: Correctional Service of Canada.
[xxvii] Public Health Agency of Caanda. (2013). *Tuberculosis in Canada 2013 – Pre-release*. Ottawa, ON.
[xxviii] Correctional Service Canada. (2015). *Estimates of chronic disease prevalence among CSC inmates.* Ottawa, ON: Health Services.
[xxix] Statistics Canada. (2013, September 18). *Health at a glance: Mental and substance use disorders in Canada*. Retrieved from http://www.statcan.gc.ca/pub/82-624-x/2013001/article/11855-eng.htm.
[xxx] Correctional Service Canada. (2014). *Mental Health Branch performance measurement report: Year-end results 2013-14*. Ottawa, ON.
[xxxi] Beaudette, J., Power, J., & Stewart, L. (2015). *National prevalence of mental disorders among incoming federally-sentenced men offenders (R-357)*. Ottawa, ON: Correctional Service Canada.; Derkzen, D., Booth, L., McConnell, A., & Taylor, K. (2012). *Mental health needs of federal women offenders (R-267).* Ottawa, ON: Correctional Service of Canada.
[xxxii] American Psychological Association. (2012). *DSM-IV and DSM-5 criteria for the personality disorders*. Washington, D.C.
[xxxiii] All statistics on self-injurious behaviour were obtained from Power, J., Gordon, A., Sapers, J., & Beaudette, J. (2012). *A replication study of self-injury incidents in CSC institutions over a thirty-month period (R-293)*. Ottawa, ON: Correctional Service Canada.
[xxxiv] Correctional Service Canada. (2015). *2015-16 Report on plans and priorities*. Ottawa, ON.
[xxxv] Correctional Service Canada. (2013). *Health Services sector priorities for 2013-2015*. Retrieved from http://infonet/Sectors/HealthServices?lang=en.
[xxxvi] Correctional Service Canada. (2013). *Health Services sector priorities for 2013-2015*. Retrieved from http://infonet/Sectors/HealthServices?lang=en.
[xxxvii] Government of Canada. (2014). *Mental health action plan for federal offenders*. Ottawa, ON. Retrieved from http://publicsafety.gc.ca/cnt/cntrng-crm/crrctns/mntl-hlth-ctn-pln-eng.aspx.
[xxxviii] Government of Canada. (2015). *Making real change happen: Speech from the Throne to open the first session of the forty-second Parliament of Canada*. Retrieved from http://www.speech.gc.ca/en/content/making-real-change-happen.
[xxxix] Government of Canada. (2015). Minister of Public Safety and Emergency Preparedness mandate letter. Retrieved from http://pm.gc.ca/eng/minister-public-safety-and-emergency-preparedness-mandate-letter.
[xl] Canada Health Act, RSC 1985, c C-6. Retrieved from http://laws-lois.justice.gc.ca/eng/acts/c-6/page-1.html.; The Constitution Act, 1982, Schedule B to the Canada Act 1982 (UK), 1982, c 11. Retrieved from http://laws-lois.justice.gc.ca/eng/Const/page-15.html#h-38. For further information, see Chenier, N. M. (2014). *Federal responsibility for the health care of specific groups (PRB 04-52E)*. Ottawa, ON: Library of Parliament; Tiedemann, M. (2008). *The federal role in health and health care (2008-58-E)*. Ottawa, ON: Parliament of Canada.
[xli] Corrections and Conditional Release Act, SC 1992, c 20. Retrieved from http://laws-lois.justice.gc.ca/eng/acts/C-44.6/page-1.html.
[xlii] Thomas, J. (2010). *Report on assessment framework for alternative service delivery*. Ottawa, ON.; Thomas, J. (2011). *Implementing the CSC report on an assessment framework for alternative service delivery: Report for CSC's Executive Committee meeting on October 5, 2011*. Ottawa, ON.
[xliii] Hall, N., & Weaver, C. (2008). *A framework for diversion of persons with a mental disorder in B*C. Vancouver, BC: Canadian Mental Health Association.
[xliv] Hall, N., & Weaver, C. (2008). *A framework for diversion of persons with a mental disorder in B*C. Vancouver, BC: Canadian Mental Health Association.; Heilbrun et al. (2012). Community-based alternatives for justice-involved individuals with severe mental illness: Review of the relevant research. *Criminal Justice and Behavior, 39*(4), 351-419.;

Livingston, J., Weaver, C., Hall, N., & Verdun-Jones, S. (2008). *Criminal justice diversion for persons with mental disorders: A review of best practices*. Vancouver, BC: Canadian Mental Health Association.; Munetz, M., & Griffin, P. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, *57*(4), 544-549.

[xlv] Correctional Service of Canada. (2013). *Community mental health service delivery guidelines*. Ottawa, ON.

[xlvi] Statistics Canada. (2007). *Canadian community health survey: Mental health and well-being*. Retrieved from http://www.statcan.gc.ca/pub/82-617-x/index-eng.htm .

[xlvii] Friedli, L., & Parsonage, M. (2007). *Mental health promotion: Building an economic case*. Belfast, IE: Northern Ireland Association for Mental Health.; Hill, J. (2003). Early identification of individuals at risk for antisocial personality disorder. *The British Journal of Psychiatry*, *182*(44), s11-s14.

[xlviii] Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based public policy options to reduce future prison construction, criminal justice costs, and crime rates*. Olympia, WA: Washing State Institute for Public Policy.

[xlix] National Crime Prevention Centre. (2013). *The Stop Now and Plan Program – SNAP: Crime prevention in action*. Ottawa, ON: Public Safety Canada.

[l] Farrington, D., & Koegl, C. (2014).The monetary benefits and costs of the Stop Now and Plan Program for boys aged 6-11, based on the prevention of later offending. *Journal of Quantitative Criminology*, *31*(2), 263-287.

[li] Heilbrun et al. (2012). Community-based alternatives for justice-involved individuals with severe mental illness: Review of the relevant research. *Criminal Justice and Behavior*, *39*(4), 351-419.; Sarteschi, C., Vaughn, M., & Kim, K. (2011). Assessing the effectiveness of mental health courts: A quantitative review. *Journal of Criminal Justice*, *39*(1), 12-20.

[lii] Cowell, A., Broner, N., & Dupont, R. (2004). The cost effectiveness of criminal justice diversion programs for people with serious mental illness co-occurring with substance abuse: Four case studies. *Journal of Contemporary Criminal Justice*, *20*(3), 292-315.

[liii] Centre for Addiction and Mental Health, & Canadian Council on Social Development. (2011). *Turning the key: Assessing housing and related supports for persons living with mental health problems and illness.* Calgary, AB: Mental Health Commission of Canada.; Heilbrun et al. (2012). Community-based alternatives for justice-involved individuals with severe mental illness: Review of the relevant research. *Criminal Justice and Behavior*, *39*(4), 351-419.; Lindberg, A. (2009). *Examining the program costs and outcomes of San Francisco's Behavioral Health Court: Predicting success*. San Francisco, CA: Office of Collaborative Justice Programs, Superior Court of California, San Francisco County.; Ridgely et al. (2007). *Justice, treatment and cost: An evaluation of the fiscal impact of Allegheny Country Mental Health Court*. Santa Monica, CA: RAND.

[liv] Laliberté, D., Rosario, G., Léonard, L., Smith-Moncrieffe, D., & Warner, A. (2014). *Results of crime prevention programs for 12 to 17 year olds*. Ottawa, ON: National Crime Prevention Centre, Public Safety Canada.

[lv] Heilbrun et al. (2012). Community-based alternatives for justice-involved individuals with severe mental illness: Review of the relevant research. *Criminal Justice and Behavior*, *39*(4), 351-419.

[lvi] Correctional Service Canada. (2014). *Nursing intake assessment and medication reconciliation analysis 2013-2014*. Ottawa, ON.

[lvii] Correctional Service Canada. (2014). *Mental Health Branch performance measurement report: Year end results 2013-14*. Ottawa, ON.

[lviii] Accreditation Canada. (2014). *Accreditation Report: Correctional Services Canada, Health Services.* Ottawa, ON.

[lix] Wilton, G., Stewart, L., & Power, J. (2014). *Emerging research results – Agreement among three mental health screening measures (B58)*. Ottawa, ON: Correctional Service Canada.

[lx] Correctional Service Canada (2014). *Health care requirements on reception and transfer*. Ottawa, ON.

[lxi] Correctional Service Canada (2014). *Computerized Mental Health Intake Screening System version 2.2 – National guidelines*. Ottawa, ON.; Correctional Service Canada (2014). *Mental health screening*. Ottawa, ON.

[lxii] Wilton et al. (2014). *Emerging research results – Agreement among three mental health screening measures (B58)*. Ottawa, ON: Correctional Service Canada.

[lxiii] Wilton et al. (2014). *Emerging research results – Agreement among three mental health screening measures (B58)*. Ottawa, ON: Correctional Service Canada.

[lxiv] Correctional Service Canada. (2015). *Mental Health Branch performance measurement report: Year end results 2014-15*. Ottawa, ON.

[lxv] Wilton et al. (2014). *Emerging research results – Agreement among three mental health screening measures (B58)*. Ottawa, ON: Correctional Service Canada.

[lxvi] Wilton et al. (2014). *Emerging research results – Agreement among three mental health screening measures (B58)*. Ottawa, ON: Correctional Service Canada.
[lxvii] Corrections and Conditional Release Act, SC 1992, c 20.
[lxviii] Correctional Service Canada. (2015). *National essential health services framework*. Ottawa, ON.
[lxix] Correctional Service Canada. (2015). *National essential health services framework*. Ottawa, ON: p. 7.
[lxx] Correctional Service Canada. (2015). *National essential health services framework*. Ottawa, ON: p. 2.
[lxxi] Correctional Service Canada. (2015). *National essential health services framework*. Ottawa, ON: Annex A.
[lxxii] Correctional Service Canada. (2013). *Health services sector 2012-2013 performance measurement report*. Ottawa, ON.
[lxxiii] Correctional Service Canada. (2016). Unpublished Health Services surveillance data.
[lxxiv] Correctional Service Canada. (2016). Unpublished Health Services surveillance data.
[lxxv] Correctional Service Canada. (2016). Unpublished Health Services surveillance data.
[lxxvi] Correctional Service Canada. (2016). Unpublished Health Services surveillance data.
[lxxvii] Correctional Service Canada. (2013). *Health services sector 2012-2013 performance measurement report*. Ottawa, ON: p. 14.
[lxxviii] Correctional Service Canada. (2015). *National essential health services framework*. Ottawa, ON.
[lxxix] Correctional Service Canada. (2015). *Commissioner's Directive 800: Health services*. Ottawa, ON.
[lxxx]Correctional Service Canada. (2015). *National essential health services framework*. Ottawa, ON: p. 1.
[lxxxi] Correctional Service Canada. (2015). *National essential health services framework*. Ottawa, ON.
[lxxxii] Correctional Service Canada. (2012). *Towards a continuum of care*. Retrieved from http://www.csc-scc.gc.ca/002/006/002006-2000-eng.shtml.
[lxxxiii] Correctional Service Canada. (2015). *Mental health branch performance measurement report: Year end results 2014-15*. Ottawa, ON.
[lxxxiv] Correctional Service Canada. (2015). *Mental health branch performance measurement report: Year end results 2014-15*. Ottawa, ON: p. 13.
[lxxxv] Correctional Service Canada. (2015). *Mental health branch performance measurement report: Year end results 2014-15*. Ottawa, ON: p. 16.
[lxxxvi] Correctional Service Canada. (2015). *National essential health services framework*. Ottawa, ON.
[lxxxvii] COACH. (2015). *2015 Canadian telehealth report*. Toronto, ON.
[lxxxviii] Correctional Service Canada. (2016). *Health Services Ontario Telemedicine Network*. Ottawa, ON.
[lxxxix] Accreditation Canada. (2014). *Accreditation report: Correctional Service Canada, Health Services*. Ottawa, ON.
[xc] Glauser, W., Nolan, M., & Remfry, A. (2015). *Telemedicine on the rise across Canada*. Retrieved from http://healthydebate.ca/2015/06/topic/telemedicine-across-canada.
[xci] Correctional Service Canada. (2016). *Health Services Ontario Telemedicine Network*. Ottawa, ON.
[xcii] Correctional Service Canada. (2015). *Health Services: Expanding the use of telemedicine*. Ottawa, ON.
[xciii] Schaenman, P., et al. (2013). *Opportunities for cost savings in corrections without sacrificing service quality: Inmate health care.* Washington, D.C.: p. 20.
[xciv] PEW Charitable Trusts and MacArthur Foundation. (2014). *State prison health care spending: An examination.* Retrieved from http://www.pewtrusts.org/mwg-internal/de5fs23hu73ds/progress?id=90xXyrs8KPMaqrCmWFgw_Lg5J4mOsLwoxa-1IUpxoP8; Reno, J., et al. (1999). *Telemedicine can reduce correctional health care costs: An evaluation of a prison telemedicine network.* Washington, D.C.
[xcv] Reno, J., et al. (1999). *Telemedicine can reduce correctional health care costs: An evaluation of a prison telemedicine network.* Washington, D.C.
[xcvi] Ollove, M. (2016). *State prisons turn to telemedicine to improve health and save money.* Retrieved from http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/01/21/state-prisons-turn-to-telemedicine-to-improve.
[xcvii] Correctional Service Canada. (2015). *National essential health services framework*. Ottawa, ON.
[xcviii] Barua, B. (2015). *Waiting your turn: Wait times for health care in Canada*. Vancouver, BC: The Fraser Institute.
[xcix] Health Canada. (2012). *First Minister's meeting on the future of health care*. Retrieved from http://healthycanadians.gc.ca/health-system-systeme-sante/services/quality-qualite/wait-attente/meeting-rencontre-eng.php.
[c] COACH. (2013) *2013 Canadian telehealth report*. Toronto, ON.

[ci] COACH. (2013) *2013 Canadian telehealth report*. Toronto, ON.
[cii] COACH. (2013) *2013 Canadian telehealth report*. Toronto, ON.
[ciii] Glauser, W., Nolan, M., & Remfry, A. (2015). *Telemedicine on the rise across Canada*. Retrieved from http://healthydebate.ca/2015/06/topic/telemedicine-across-canada.
[civ] Glauser, W., Nolan, M., & Remfry, A. (2015). *Telemedicine on the rise across Canada*. Retrieved from http://healthydebate.ca/2015/06/topic/telemedicine-across-canada.
[cv] Correctional Service Canada. (2014). *Commissioner's Directive 710-2-3: Inmate transfer process*. Ottawa, ON.
[cvi] Correctional Service Canada. (2015). *Guidelines for sharing personal health information*. Ottawa, ON: p. 3.
[cvii] Correctional Service Canada. (2015). *Guidelines for sharing personal health information*. Ottawa, ON.
[cviii] Correctional Service Canada. (2015). *Guidelines for sharing personal health information*. Ottawa, ON: p. 4.
[cix] Canada Health Infoway. (2013). *The emerging benefits of electronic medical record use in community-based care.* Toronto, ON.
[cx]Canada Health Infoway. (2013). *The emerging benefits of electronic medical record use in community-based care.* Toronto, ON; Knight, D. (2009). Electronic medical records: Moving jails forward. Retrieved from http://www.corrections.com/news/article/22296-electronic-medical-records-moving-jails-forward.
[cxi] Correctional Service Canada. (2015). *Guidelines for sharing personal health information*. Ottawa, ON.
[cxii] Correctional Service Canada. (2015). *Guidelines for sharing personal health information*. Ottawa, ON.
[cxiii] Correctional Service Canada (2012). *Health services sector 2011-2012 performance measurement report*. Ottawa, ON.
[cxiv] Correctional Service Canada. (2016). *Health promotion*. Retrieved from http://infonet/eng/Sectors/HealthServices/PublicHealth/Pages/HealthPromotion.aspx.
[cxv] Correctional Service Canada. (2013). *Health services sector 2012-2013 performance measurement report*. Ottawa, ON.
[cxvi] Correctional Service Canada. (2016). *Health promotion*. Retrieved from http://infonet/eng/Sectors/HealthServices/PublicHealth/Pages/HealthPromotion.aspx.
[cxvii] Correctional Service Canada. (2012). *Inmate suicide awareness and prevention workshop: Participant's manual*. Ottawa, ON.
[cxviii] Correctional Service Canada. (2016). *Health promotion*. Retrieved from http://infonet/eng/Sectors/HealthServices/PublicHealth/Pages/HealthPromotion.aspx.
[cxix] Nolan, A., & Stewart, L. (unpublished document, under review). Correctional health promotion and health education initiatives: A review of the literature. Correctional Service of Canada. Ottawa, ON.
[cxx] Correctional Service Canada (2014). *Commissioner's directive 705: Intake assessment process and correctional plan framework.* Ottawa, ON: p.3.
[cxxi] Correctional Service Canada (2012). *Health services sector 2012-2013 performance measurement report*. Ottawa, ON.
[cxxii] Correctional Service Canada. (2014). *Performance measurement public health branch report 2013-2014*. Ottawa, ON.
[cxxiii] Correctional Service Canada. (2014). *Departmental performance report*. Ottawa, ON.
[cxxiv] Correctional Service Canada. (2015). *Public health quarterly report – FY 2014-2015.* Ottawa, ON.
[cxxv] Correctional Service Canada. (2014). *Performance measurement public health branch report 2013-2014*. Ottawa, ON.
[cxxvi] Correctional Service Canada. (2014). *Performance measurement public health branch report 2013-2014*. Ottawa, ON.
[cxxvii] Correctional Service Canada. (2014). *Performance measurement public health branch report 2013-2014*. Ottawa, ON.
[cxxviii] Correctional Service Canada (2013). *Commissioner's directive 843: Management of inmate self-injurious and suicidal behaviour*. Ottawa, ON.
[cxxix] Correctional Service of Canada (2012). *Health services sector 2010-2011 performance measurement report*. Ottawa, ON.
[cxxx] Zakaria, D., Thompson, J., & Borgatta, F. (2010). *The relationship between knowledge of HIV and HCV, health education, and risk and harm-reducing behaviours among Canadian federal inmates (R-195).* Ottawa, ON: Correctional Service Canada.

[cxxxi] Zakaria, D., Thompson, J., & Borgatta, F. (2010). *The relationship between knowledge of HIV and HCV, health education, and risk and harm-reducing behaviours among Canadian federal inmates (R-195)*. Ottawa, ON: Correctional Service Canada.
[cxxxii] Nolan, A., & Stewart, L. (unpublished document, under review). *Correctional health promotion and health education initiatives: A review of the literature*. Ottawa, ON: Correctional Service Canada.
[cxxxiii] Health Canada and the Public Health Agency of Canada. (2014). *Evaluation of the federal initiative to address HIV/AIDS in Canada 2008-09 to 2012-13.* Ottawa, ON.
[cxxxiv] EI Saadany, S., et al. (2005). Economic burden of hepatitis C in Canada and the potential impact of prevention: Results from a disease model. *The European Journal of Health Economics, 6*(2), 159-165.
[cxxxv] Health Canada and the Public Health Agency of Canada. (2014). *Evaluation of the federal initiative to address HIV/AIDS in Canada 2008-09 to 2012-13.* Ottawa, ON.
[cxxxvi] Health Canada and the Public Health Agency of Canada. (2014). *Evaluation of the federal initiative to address HIV/AIDS in Canada 2008-09 to 2012-13.* Ottawa, ON.
[cxxxvii] Cohen, D., Wu, S., & Farley, T. (2004). Comparing the cost-effectiveness of HIV prevention interventions. *Journal of Acquired Immune Deficiency Syndromes, 37*(3), 1404-1414.
[cxxxviii] Cohen, D., Wu, S., & Farley, T. (2004). Comparing the cost-effectiveness of HIV prevention interventions. *Journal of Acquired Immune Deficiency Syndromes, 37*(3), 1404-1414.
[cxxxix] Correctional Service Canada. (2013). *Sexually transmitted infection guidelines*. Ottawa, ON: p.65; Correctional Service Canada. (2014). *Commissioner's directive 800: Health Services*. Ottawa, ON: p.3.
[cxl] Correctional Service Canada. (2013). *Report on the national review of CSC's opiate substitution therapy program*. Ottawa, ON.
[cxli] Correctional Service Canada. (2014). *Commissioner's directive 800: Health services*. Ottawa, ON.
[cxlii] Correctional Service Canada. (2015). *Guidelines 800-6: Bleach distribution.* Ottawa, ON.
[cxliii] Correctional Service Canada. (2015). *Compliance and operational risk report: Fall 2015 review.* Ottawa, ON.
[cxliv] Correctional Service Canada. (2015). *Compliance and operational risk report: Fall 2015 review.* Ottawa, ON.
[cxlv] Correctional Service Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON.
[cxlvi] Correctional Service Canada. (2015). *Regional treatment centre standardized processes*. Ottawa, ON: p. 1.
[cxlvii] Correctional Service Canada. (2012). *Towards a continuum of care: Correctional Service Canada mental health strategy*. Ottawa, ON.
[cxlviii] Correctional Service Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON: p. 12.
[cxlix] [cxlix] Correctional Service Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON: p. 30.
[cl] Correctional Service Canada. (2015). *Mental health branch performance measurement report: Year end results 2014-15*. Ottawa, ON: p. 19.
[cli] Correctional Service Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON: p. 2.
[clii] Correctional Service Canada. (2012). *Towards a continuum of care: Correctional Service Canada mental health strategy*. Ottawa, ON.
[cliii] Correctional Service Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON: p. 22-23.
[cliv] Infonet. (2016). *Suicide and self-injury prevention*. Retrieved from http://infonet/eng/Sectors/HealthServices/MentalHealth/Pages/SuicideandSIB.aspx.
[clv] Correctional Service Canada. (n.d.). *Regional complex mental health committees: Terms of reference*. Ottawa, ON.
[clvi] Correctional Service Canada. (2016). Unpublished Health Services data.
[clvii] Correctional Service Canada. (2016). *Regional complex mental health committees: Terms of reference*. Ottawa, ON.
[clviii] Correctional Service Canada. (2014). *Discharge planning and transfer guidelines*. Ottawa, ON: p. 4.
[clix] Correctional Service Canada. (2014). *Discharge planning and transfer guidelines.* Ottawa, ON: p. 4.
[clx] Correctional Service Canada (2014). *Discharge planning and transfer guidelines.* Ottawa, ON.
[clxi] Correctional Service Canada. (2014). Discharge planning matrix tool. Ottawa, ON.
[clxii] Correctional Service Canada. (2014). Discharge planning matrix tool. Ottawa, ON.
[clxiii] Correctional Service Canada. (2012). *Audit of release process*. Ottawa, ON.
[clxiv] Correctional Service Canada. (2014). *Commissioner's directive 712-4: Release process*. Ottawa, ON: p. 2.
[clxv] Correctional Service Canada (2015). Commissioner's directive 566-12: Personal property of offenders. Ottawa, ON: p.10.
[clxvi] Inter-provincial Agreement on Eligibility and Portability, as quoted in Correctional Service of Canada. (2011). *Offender Identification Cards: Review and Recommendations*. Ottawa, ON: p11.

[clxvii] Correctional Service Canada (2014). *Discharge Planning and Transfer Guidelines.* Ottawa, ON.
[clxviii] Correctional Service Canada. (2014). *Commissioner's directive 860: Offender's money*. Ottawa, ON: p. 3.
[clxix] Correctional Service Canada. (2014). *Discharge planning and transfer guidelines*. Ottawa, ON: p. 7.
[clxx] Correctional Service Canada. (2014). *Discharge planning and transfer guidelines*. Ottawa, ON: p. 10.
[clxxi] Correctional Service Canada. (2014). *Discharge planning and transfer guidelines*. Ottawa, ON: p. 12-13.
[clxxii] Correctional Service Canada. (2015). *National essential health services framework*. Ottawa, ON.
[clxxiii] Correctional Service Canada (2016). *National Formulary.* Ottawa, ON: p.16. Correctional Service of Canada. (2014). *Discharge Planning and Transfer Guidelines*. Ottawa, ON: p. 13 . Correctional Service Canada. (2014). *Commissioner's directive 712-4: Release process*. Ottawa, ON: p. 2 & 5.
[clxxiv] Correctional Service of Canada. (2015). *National essential health services framework*. Ottawa, ON.
[clxxv] Correctional Service of Canada. (2015). *Integrated mental health guidelines*. Ottawa, ON: p. 36, 39.
[clxxvi] Correctional Service of Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON: p.2 & p.42.
[clxxvii] Correctional Service of Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON: p.2.; Correctional Service of Canada. (2014). *Discharge Planning and Transfer Guidelines*. Ottawa, ON: p.5.
[clxxviii] Correctional Service of Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON: p.36.
[clxxix] MacDonald, S. F., Stewart, L. A., & Feely, S. (2014). *Research Report: The Impact of the Community Mental Health Initiative (CMHI)* (Report No. R-337).
[clxxx] Allegri *et al.* (2008). Evaluation Report: Community Mental Health Initiative. Ottawa: ON.
[clxxxi] MacDonald, S. F., Stewart, L. A., & Feely, S. (2014). *Research Report: The Impact of the Community Mental Health Initiative (CMHI)* (Report No. R-337).
[clxxxii] Correctional Service of Canada. (2015). *Mental Health Branch Performance Measurement Report*. Ottawa, ON: p.61.
[clxxxiii] Correctional Service of Canada. (2015). *Mental health branch performance measurement report: Year end results 2014-15*. Ottawa, ON: p.28.
[clxxxiv] Correctional Service Canada. (2014). Discharge planning matrix tool. Ottawa, ON:p.2.; Correctional Service of Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON:p.3 & 41.
[clxxxv] Correctional Service of Canada. (2014). *Community Mental Health Service Delivery Guidelines*. Ottawa, ON: p.18.
[clxxxvi] Correctional Service of Canada. (2015). *National essential health services framework*. Ottawa, ON.
[clxxxvii] Correctional Service Canada. (2015). *New governance structure*. Retrieved from http://infonet/eng/Sectors/HealthServices/Pages/governance.aspx.
[clxxxviii] Accreditation Canada. (2014). *Correctional Service Canada, Health Services*. Ottawa, ON.
[clxxxix] Accreditation Canada. (2014). *Correctional Service Canada, Health Services*. Ottawa, ON.
[cxc] Correctional Service Canada. (2015). *Departmental performance report 2013-2014.* Ottawa, ON.
[cxci] Myers, R., et al. (2014). Burden of disease and cost of chronic hepatitis C virus infection in Canada. *Canadian Journal of Gastroenterology and Hepatology, 28*(5), 243-250.
[cxcii] Rein, D. et al., (2015). The cost-effectiveness, health benefits, and financial costs of new antiviral treatments for hepatitis C virus. *Clinical Infectious Disease 61*(2), 157-68.
[cxciii] [cxciii] Canadian AIDS Treatment Information Exchange (CATIE). (n.d.). *Prevention and treatment for hepatitis C virus (HCV).* Retrieved from http://www.catie.ca/en/treatmentupdate/treatmentupdate-191/anti-hcv-agents/prevention-and-treatment-hepatitis-c-virus-hcv.
[cxciv] Rein, D. et al., (2015). The cost-effectiveness, health benefits, and financial costs of new antiviral treatments for hepatitis C virus. *Clinical Infectious Disease 61*(2), 157-68.
[cxcv] Canadian AIDS Treatment Information Exchange (CATIE). (n.d.). *About some terms – SVR_{12} vs. SVR_{24}.* Retrieved from http://www.catie.ca/en/treatmentupdate/treatmentupdate-207/hepatitis-c-virus/about-some-terms-svr12-vs-svr24.
[cxcvi] Pearlman, B., & Traub, N. (2011). Sustained virologic response to antiviral therapy for chronic hepatitis C virus infection: A cure and so much more. *Journal of Clinical Infectious Diseases 52*(7), 889-900.
[cxcvii] Correctional Service Canada. (2014). *Public health quarterly report FY 2013-2014.* Ottawa, ON.
[cxcviii] Correctional Service Canada. (2015). *Estimates of chronic disease prevalence among CSC inmates.* Ottawa, ON.
[cxcix] Smith, J., et al. "*Treatment outcomes for chronic hepatitis C infection with direct acting antivirals among inmates in federal corrections*." Presentation at the Canadian Association for Drugs and Technology in Health (CADTH), National Conference, Ottawa, ON, April 10-12, 2016.
[cc] Myers, R., et al. (2015). An update on the management of chronic hepatitis C: 2015 consensus guidelines from the Canadian Association for the Study of the Liver. *Canadian Journal of Gastroenterology and Hepatology, 29*(1), 19-34.

[cci] Singal A.G. et al. (2010). A Sustained Viral Response Is Associated With Reduced Liver-Related Morbidity and Mortality in Patients With Hepatitis C Virus. *Journal of Clinical Gastroenterology and Hepatology*. (8): 280-288. Retrieved on September 21, 2016 from, http://www.cghjournal.org/mwg-internal/de5fs23hu73ds/progress?id=LzDy1jjDi96bBAv9UIcPmTGoZH7EeLartCzJBPL5JMc,&dl
[ccii] Myers RP et al. (2015). An update on the management of chronic hepatitis C: 2015 consensus guidelines from the Canadian Liver Association for the Study of the Liver. *Canadian Journal of Gastroenterology and Hepatology*. Retrieved on August 30, 2016 from, http://www.liver.ca/files/Professional_Education__Partnerships/Information__Resources_for_HCP/CASL_Hep_C_Consensus_Guidelines_Update_-_Jan_2015.pdf
[cciii] Public Health Agency of Canada. (2016). *Report on Hepatitis B and C in Canada: 2012.* Retreived on September 1st, 2016 from, http://healthycanadians.gc.ca/publications/diseases-conditions-maladies-affections/hepatitis-b-c-2012-hepatite-b-c/index-eng.php
[cciv] Tianhua, He. et al. (2015). *Prevention of Hepatitis C by Screening and Treatment in United States Prisons.* Annals of Internal Medicine. 164(2): 84-92.
[ccv] Correctional Service of Canada. (2013). *Commissioner's directive 800: Health services*. Ottawa, ON: p. 4.
[ccvi] Correctional Service of Canada. (2011). *Intensive intervention strategy for women offenders*. Ottawa, ON.
[ccvii] Correctional Service Canada. (2008). *Correctional Service Canada contract with the Institut Philippe-Pinel de Montréal.* Ottawa, ON.
[ccviii] Correctional Service Canada. (2014). *The impact of the community mental health initiative (CMHI), R-337*. Ottawa, ON.; Allegri *et al.* (2008). Evaluation Report: Community Mental Health Initiative. Ottawa: ON.
[ccix] Canada Health Act, RSC 1985, c C-6.Retrieved from http://laws-lois.justice.gc.ca/eng/acts/C-6/page-2.html#docCont.
[ccx] Unless otherwise cited, the self-reported prevalence rates were derived from Stewart, L., et al. (2014). *Self-reported physical health status of newly admitted federally-sentenced men offenders (R-314).* Ottawa, ON: Correctional Service Canada.
[ccxi] Correctional Service Canada. (2015). *Estimates of chronic disease prevalence among CSC inmates.* Ottawa, ON: Health Services.
[ccxii] Government of Canada. (2015). Heart disease – heart health. Retrieved from http://healthycanadians.gc.ca/diseases-conditions-maladies-affections/disease-maladie/heart-disease-eng.php.; Munro, M. (2012, January 26). First Nations need obesity prevention socio-economic issues contribute to hypertension, heart disease and diabetes epidemic, report says. Retrieved from http://www.naho.ca/blog/2012/01/26/first-nations-need-obesity-prevention-socio-economic-issues-contribute-to-hypertension-heart-disease-and-diabetes-epidemic-report-says/.
[ccxiii] Nolan, A., & Stewart, L. (2014). *Self-reported physical health status of incoming federally-sentenced women offenders (R-332).* Ottawa, ON: Correctional Service Canada.
[ccxiv] Stewart et al. (2014). *Self-reported physical health status of newly admitted federally-sentenced men offenders (R-314).* Ottawa, ON: Correctional Service Canada.
[ccxv] Nolan, A., & Stewart, L. (2014). *Self-reported physical health status of incoming federally-sentenced women offenders (R-332).* Ottawa, ON: Correctional Service Canada.
[ccxvi] Beaudette et al. (2015). National prevalence of mental disorders among incoming federally-sentenced men offenders (R-357). Ottawa, ON: Correctional Service Canada.
[ccxvii] Beaudette et al. (2015). National prevalence of mental disorders among incoming federally-sentenced men offenders (R-357). Ottawa, ON: Correctional Service Canada.
[ccxviii] American Psychological Association. (2012). DSM-IV and DSM-5 criteria for the personality disorders. Washington, D.C.
[ccxix] Beaudette et al. (2015). National prevalence of mental disorders among incoming federally-sentenced men offenders (R-357). Ottawa, ON: Correctional Service Canada.; Derkzen et al. (2012). Mental health needs of federal women offenders (R-267). Ottawa, ON: Correctional Service Canada.
[ccxx] Derkzen et al. (2012). Mental health needs of federal women offenders (R-267). Ottawa, ON: Correctional Service Canada.
[ccxxi] Derkzen et al. (2012). Mental health needs of federal women offenders (R-267). Ottawa, ON: Correctional Service Canada.
[ccxxii] American Psychological Association. (2012). DSM-IV and DSM-5 criteria for the personality disorders. Washington, D.C.

[ccxxiii] Munetz, M., & Griffin, P. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. Psychiatric Services, 57(4), 544-549.
[ccxxiv] See for example Compton, M., et al. (2011). Use of force preferences and perceived effectiveness of actions among Crisis Intervention Team (CIT) police officers and non-CIT officers in escalating psychiatric crisis involving a subject with Schizophrenia. Schizophrenia Bulletin 37(4), 737-745.; Steadman, H. J., & Naples, M. (2005). Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occuring substance abuse disorder. Behavioural Sciences and the Law, 23(2), 163-170.
C) Watson, A., et al. (2010). Outcomes of police contacts with persons with mental illness: The impact of CIT. Administration and Policy in Mental Health 37(4), 302-317.
[ccxxv] Thomas, J. (2010). Report on assessment framework for alternative service delivery. Ottawa, ON.
[ccxxvi] Heilbrun et al. (2012). Community-based alternatives for justice-involved individuals with severe mental illness: Review of the relevant research. Criminal Justice and Behavior, 39(4), 351-419.
[ccxxvii] Sarteschi et al. (2011). Assessing the effectiveness of mental health courts: A quantitative review. Journal of Criminal Justice, 39(1), 12-20.; Thomas, J. (2010). Report on assessment framework for alternative service delivery. Ottawa, ON.
[ccxxviii] Farrington, D., & Koegl, C. (2014).The monetary benefits and costs of the Stop Now and Plan Program for boys aged 6-11, based on the prevention of later offending. Journal of Quantitative Criminology 31(2), 263-287.
[ccxxix] Griffiths, C., Dandurand, Y., & Murdoch, D. (2007). The social reintegration of offenders and crime prevention. Ottawa, ON: National Crime Prevention Centre, Public Safety Canada.
[ccxxx] Correctional Service Canada. (2012). Mental health strategy for corrections in Canada: A federal-provincial-territorial partnership. Ottawa, ON.
[ccxxxi] Livingston et al. (2008). Criminal justice diversion for persons with mental disorders: A review of best practices. Vancouver, BC: Canadian Mental Health Association.
[ccxxxii] Hall, N., & Weaver, C. (2008). A framework for diversion of persons with a mental disorder in BC. Vancouver, BC: Canadian Mental Health Association.
[ccxxxiii] Heilbrun et al. (2012). Community-based alternatives for justice-involved individuals with severe mental illness: Review of the relevant research. Criminal Justice and Behavior, 39(4), 351-419.
[ccxxxiv] Correctional Service Canada. (2013). *Health Services Sector 2012-2013 performance measurement report*. Ottawa, ON.
[ccxxxv] Correctional Service Canada. (2013). *Health Services Sector 2012-2013 performance measurement report*. Ottawa, ON.
[ccxxxvi] Correctional Service Canada. (2013). *Health services sector 2012-2013 performance measurement report.* Ottawa, ON.
[ccxxxvii] Correctional Service Canada. (2013). *Health services sector 2012-2013 performance measurement report*. Ottawa, ON.
[ccxxxviii] Correctional Service Canada. (2015). *Health services program: Infectious diseases*. Retrieved from http://infonet/eng/Regions/Prairie/OurRegion/Institutions/WebSites/EIFW/OurInstitution/Divisions/Interventions/HealthServices/Programs/Pages/InfectiousDiseases.aspx.
[ccxxxix] Correctional Service Canada. (2009). *Infectious disease strategy for women inmate 2008-2013.* Ottawa, ON
[ccxl] Correctional Service Canada. (2009). *Infectious disease strategy for women inmate 2008-2013.* Ottawa, ON.
[ccxli] Correctional Service Canada. (2013). *Health services sector 2012-2013 performance measurement report*. Ottawa, ON.
[ccxlii] Correctional Service Canada. (2015). *Health services program: Infectious diseases*. Retrieved from http://infonet/eng/Regions/Prairie/OurRegion/Institutions/WebSites/EIFW/OurInstitution/Divisions/Interventions/HealthServices/Programs/Pages/InfectiousDiseases.aspx.
[ccxliii] Correctional Service Canada. (2012). *Inmate suicide awareness and prevention workshop: Facilitator's manual.* Ottawa, ON.
[ccxliv] Correctional Service Canada. (2012). *Inmate suicide awareness and prevention workshop: Facilitator's manual.* Ottawa, ON.
[ccxlv] Correctional Service Canada. (2013). *Commissioner's directive 843: Management of inmate self-injurious and suicidal behaviour*. Ottawa, ON.
[ccxlvi] Correctional Service Canada. (2012). *Inmate suicide awareness and prevention workshop: Facilitator's manual.* Ottawa, ON.

[ccxlvii] Correctional Service Canada. (2014). Discharge planning matrix tool. Ottawa, ON:p.2.; Correctional Service of Canada. (2014). *Discharge Planning and Transfer Guidelines*. Ottawa, ON: p.5,7, 9 & 10.; Correctional Service of Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON:p.3 & 41.
[ccxlviii] Correctional Service Canada. (2014). Discharge planning matrix tool. Ottawa, ON:p.2.; Correctional Service of Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON:p.37.
[ccxlix] Correctional Service of Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON:p.41.
[ccl] Correctional Service of Canada. (2014). *Discharge Planning and Transfer Guidelines*. Ottawa, ON: p.5.
[ccli] Correctional Service of Canada. (2014). *Discharge Planning and Transfer Guidelines*. Ottawa, ON: p.7.
[cclii] Correctional Service Canada. (2014). Discharge planning matrix tool. Ottawa, ON:p.2.
[ccliii] Correctional Service Canada. (2014). Discharge planning matrix tool. Ottawa, ON:p.2.
[ccliv] Correctional Service Canada. (2014). Discharge planning matrix tool. Ottawa, ON:p.2.
[cclv] Correctional Service Canada. (2014). Discharge planning matrix tool. Ottawa, ON:p.2.
[cclvi] Correctional Service Canada. (2014). Discharge planning matrix tool. Ottawa, ON:p.2.
[cclvii] Correctional Service of Canada. (2014). *Discharge Planning and Transfer Guidelines*. Ottawa, ON: p.9.
[cclviii] Extracted from the data warehouse in October 2016 for all women offenders, data current up to 2016-04-10.
[cclix] Derkzen, et al. (2012). *Mental health needs of federal women offenders (R-267)*. Ottawa, ON: Correctional Service Canada.; Nolan, A., & Stewart, L. (2014). *Self-reported physical health status of incoming federally-sentenced women offenders (R-332)*. Ottawa, ON: Correctional Service Canada.
[cclx] Correctional Service of Canada. (2013). *Commissioner's directive 800: Health services*. Ottawa, ON: p. 4.
[cclxi] Correctional Service of Canada. (2013). *Commissioner's directive 578: Intensive intervention strategy in women's institutions*. Ottawa, ON: p. 5.
[cclxii] Correctional Service of Canada. (2002). *The 2002 mental health strategy for women offenders*. Ottawa, ON.; Correctional Service Canada. (2009). *Infectious disease strategy for women offenders 2008-2013*. Ottawa, ON. Infonet. (2016). *Health promotion*. Retrieved from http://infonet/eng/Sectors/HealthServices/PublicHealth/Pages/HealthPromotion.aspx.; Correctional Service of Canada . (2016). *Integrated mental health guidelines*. Ottawa, ON.
[cclxiii] Correctional Service Canada. (2009). *Infectious disease strategy for women offenders 2008-2013*. Ottawa, ON.
[cclxiv] Correctional Service Canada. (2009). *Infectious disease strategy for women offenders 2008-2013*. Ottawa, ON: p. 8.
[cclxv] Correctional Service of Canada. (2002). *The 2002 mental health strategy for women offenders*. Ottawa, ON: p.5.
[cclxvi] Correctional Service of Canada. (2002). *The 2002 mental health strategy for women offenders*. Ottawa, ON: p.24.
[cclxvii] Hartle, Kelly. (May 16, 2016). *Implementation of New Peer Mentorship at Women Offender Institutions*. Ottawa, ON: Correctional Service Canada.
[cclxviii] Extracted from the data warehouse, October 2016 for all Indigenous offenders, data current up to 2016-04-10.
[cclxix] Correctional Service Canada. (2016). *Report on plans and priorities 2016-17*. Ottawa, ON..; Public Safety Canada. (2015). *Corrections and conditional release statistical overview*. Ottawa, ON: p. 64.
[cclxx] Beaudette et al. (2015). *National prevalence of mental disorders among incoming federally-sentenced men offenders (R-357)*. Ottawa, ON: Correctional Service Canada..; Derkzen et al. (2012). *Mental health needs of federal women offenders (R-267)*. Ottawa, ON: Correctional Service Canada.; Nolan, A., & Stewart, L. (2014). *Self-reported physical health status of incoming federally-sentenced women offenders (R-332)*. Ottawa, ON: Correctional Service Canada.; Stewart et al. (2014). *Self-reported physical health status of newly admitted federally-sentenced men offenders (R-314)*. Ottawa, ON: Correctional Service Canada.
[cclxxi] Correctional Service of Canada. (2013). *Commissioner's directive 702: Aboriginal offenders*. Ottawa, ON: p. 3.
[cclxxii] Correctional Service of Canada . (2016). *Integrated mental health guidelines*. Ottawa, ON: p.5.
[cclxxiii] Correctional Service Canada. (2010). *A wellness path to healthy and safe reintegration: Aboriginal health strategy 2009-2012*. Ottawa, ON.; Correctional Service Canada. (2015). *Guidelines for sharing personal health information*. Ottawa, ON.; Correctional Service of Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON.; Data extracted from Human Resources Management System (HRMS) in September 2016.
[cclxxiv] Correctional Service Canada. (2010). *A wellness path to healthy and safe reintegration: Aboriginal health strategy 2009-2012*. Ottawa, ON: p. 6.
[cclxxv] Correctional Service of Canada . (2016). *Integrated mental health guidelines*. Ottawa, ON: p.11.
[cclxxvi] Extracted from the data warehouse, October 2016 for all ethnic groupings, data current up to 2016-04-10.
[cclxxvii] Extracted from the data warehouse October 2016 for all older offenders (i.e., offenders over the age of 50), data current up to 2016-04-10.

[cclxxviii] Canadian Medical Association. (2013). *Health and health care for an aging population*. Ottawa, ON: p. 2.
[cclxxix] Public Health Agency of Canada. (2014). *Report on the state of public health in Canada*. Ottawa, ON: p. 3.
[cclxxx] Nolan, A., & Stewart, L. (2014). *Self-reported physical health status of incoming federally-sentenced women offenders (R-332)*. Ottawa, ON: Correctional Service Canada.; Stewart et al. (2014). *Self-reported physical health status of newly admitted federally-sentenced men offenders (R-314).* Ottawa, ON: Correctional Service Canada.
[cclxxxi] Correctional Service Canada. (2014). *Federal correctional facilities accommodation guidelines*. Ottawa, ON.; Correctional Service Canada. (2015). *National essential health services framework*. Ottawa, ON.; Correctional Service of Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON.
[cclxxxii] Correctional Service Canada. (2015). *National essential health services framework*. Ottawa, ON: Appendix A.
[cclxxxiii] Correctional Service of Canada. (2016). *Integrated mental health guidelines*. Ottawa, ON: p. 28.
[cclxxxiv] Correctional Service Canada. (2014). *Federal correctional facilities accommodation guidelines*. Ottawa, ON.
[cclxxxv] Correctional Service Canada. (2011). *Falls prevention strategy*. Ottawa, ON.; Correctional Service Canada. (2013). *Adverse events guidelines*. Ottawa, ON.; Infonet. (2015). *Aging offenders resource kit*. Retrieved from http://infonet/eng/SoloSites/ResponsivityPortal/SpecialNeedsResource/Pages/Aging_Offenders.aspx.; Infonet. (2016). *Peer Assisted Living Program* (PAL). Retrieved from http://infonet/eng/Regions/Pacific/832rhc/service_delivery/Pages/mental_health_services.aspx.
[cclxxxvi] Correctional Service Canada. (2011). *Falls prevention strategy*. Ottawa, ON: p. 9.
[cclxxxvii] Correctional Service Canada. (2013). *Adverse events guidelines*. Ottawa, ON.
[cclxxxviii] Infonet. (2016). *Peer Assisted Living Program* (PAL). Retrieved from http://infonet/eng/Regions/Pacific/832rhc/service_delivery/Pages/mental_health_services.aspx