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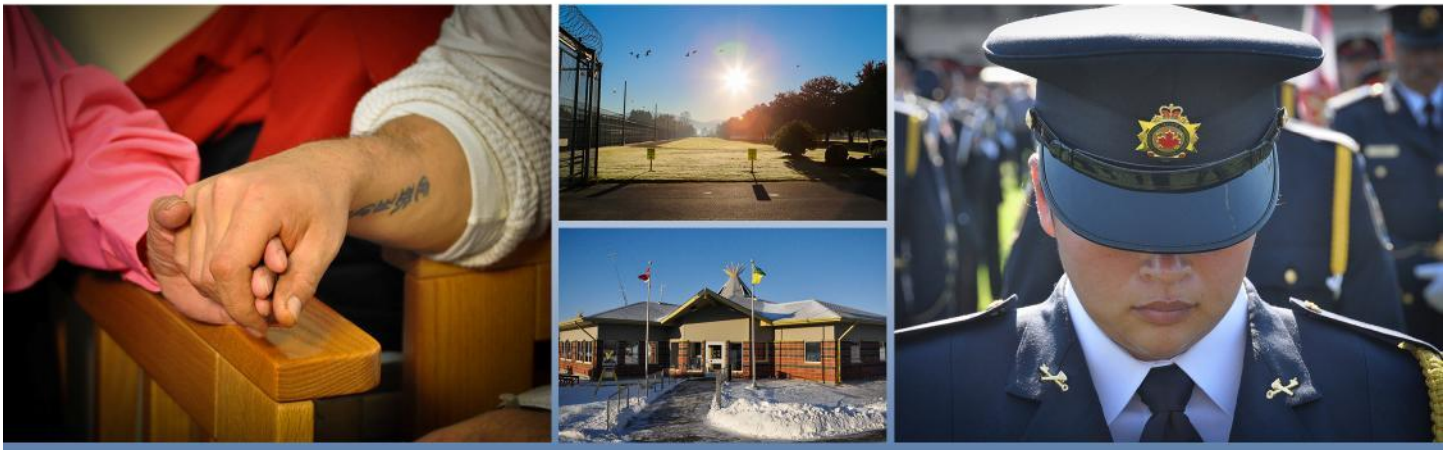

RESEARCH REPORT

An Examination of the Mental Health Continuum of Care

2018 Nº R-410

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An Examination of the Mental Health Continuum of Care for a Sample of Federal Offenders with Serious Impairment Related to Mental Disorders

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Executive Summary

Key words: *Mental health, continuum of care, discharge planning, community mental health services, serious mental disorder impairment, offenders*

Federal offenders assessed as having significant impairment related to mental health problems were selected to be included in a file review to determine the extent to which they received the continuum of care to address their mental health needs. All offenders included in the study had been released for at least two months and had a diagnosis of one of the following: major depressive disorder, bi-polar disorders, or any psychotic disorder. All had a Global Assessment of Functioning (GAF) score of 50 or less signalling serious or severe impairment.

From this sample, the continuum of care was assessed for 40 offenders. Offenders were selected to ensure that women and Indigenous offenders were represented and men's files were selected to ensure cases were equally distributed across regions and were among the most recent releases. Offenders included in the electronic file review were predominantly non-Indigenous (70%), men (75%), half were rated high static risk and 65% were rated high dynamic need.

The review of files for the selected offenders revealed that the majority received health services while incarcerated. Further, the majority (86%) of those who still had mental health needs at the time of release had evidence of some form of planning to address mental health care while in the community, and all offenders with significant needs on release received community mental health services. All told, over two-thirds of offenders received the complete continuum of care.

A second goal of the study was to assess how well offender mental health care or clinical discharge planning services were recorded in electronic records. We found that during the period of the study it was difficult to easily access information relevant to assessing the continuum of care. Correctional Service of Canada Health Services is in the process of fully implementing an electronic health record and planned amendments may improve data access and extraction.

We recommend that the Mental Health Branch examine methods to improve electronic record keeping that will allow for more efficient monitoring of the degree of support and services offenders with mental health problems receive throughout their sentence. In addition, an OMS flag alerting staff when to start development of the clinical discharge plan could allow sufficient time to implement effective release planning for complex cases.

In summary, based on the purposive sampling examining a group of offenders with significant mental health needs, we determined that most had file evidence of having received the complete continuum of care. Nevertheless, this was only determined though examination of multiple documents. Clear, consistent and accessible record keeping is necessary to allow ongoing monitoring of the full range of care throughout the full period offenders are under warrant.

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Introduction

There is a consensus in the international literature that there is an elevated prevalence of serious mental disorders among criminal justice populations relative to rates in the community (e.g., Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016). This is a consistent observation even when personality disorders and substance use disorders are not considered (Beaudette, Power, & Stewart, 2015). Recent surveys estimating the prevalence of mental health disorders among incoming federally sentenced men (Beaudette, Power, & Stewart, 2015) and women in custody (Derkzen, Barker, McMillan, & Stewart, 2017) established that 73% of men and 79% of women met criteria for at least one current disorder, of these, at least 40% were assessed as having a serious level of impairment.

The literature is also consistent with regard to the recommended best practice principles for the provision of health care to correctional clients. A comprehensive system of care would include: early assessment of the type and severity of the mental disorder and determination of the associated level of intensity of treatment required during incarceration; the provision of appropriate levels of care based on this assessment, discharge planning to pave the way for the continuity of care in the community, and finally, the provision of mental health services in the community or the brokerage of community services by a parole or case management officer (Baron, Erlenbusch, Moran, O'Connor, Rice, Rodriguez, & Salazar, 2008; FPT Working Group, 2012; Lurigio, Rollins, & Fallon, 2004; Wang, Hong, Samuels, Shavit, Sanders, & Kushel, 2010). Although methodologies for fully assessing the impact of these comprehensive processes are complex, the outcome studies have generally confirmed that participants benefit from the services and there is an attendant reduction in recidivism among participants compared to non-participants (Kesten, Leavitt-Smith, Rau, Shelton, Zhang, Wagner, & Trestman, 2007; Mayfield, 2009; Wang et al., 2010).

In CSC, a key component of the Mental Health Strategy includes the provision of community mental health services (CMHS) which represent the "transitional care" piece leading up to and following release to the community. Elements of CMHS can include: clinical discharge planning provided by clinical social workers and/or nurses at men's and women's institutions (CSC, 2012); community mental health specialists (clinical social workers and nurses) services to support offenders with mental disorders residing in the community;

community psychology services for offenders to ensure continuity of service and response to the special needs of offenders with mental disorders in the community, and mental health awareness and other training to institutional and community correctional staff, halfway house staff, parole offices, community partners, etc. The Mental Health Strategy outlines a commitment to promoting continuity of services and better preparing "offenders with mental disorders for release to the community" (CSC, 2012). Effective information sharing and collaboration to ensure a seamless transition from correctional to community health care services are identified as critical to support the reintegration of offenders with mental disorders (CSC, 2012).

Since 2005, CSC has implemented the CMHS designed to include clinical discharge planning and follow-up mental health services in the community provided by CSC mental health staff. An outcome study completed in 2014 examining the impact of participation in this process on recidivism rates found that while the provision of both discharge planning and community mental health sessions reduced recidivism, participation in discharge planning alone did not appear to have an impact although the authors noted that the discharge planning group may have differed from those receiving both the discharge planning and the community follow-up in ways that contributed to this finding (Farrell MacDonald, Stewart, & Feeley, 2014).

Various components of the continuum of care have been highlighted as key elements of the process but are recognized as often being difficult to implement. For example, it has been noted that clinical discharge planning can be of variable quality; insuring that offenders are released with an insufficient amount of psychiatric medication (typically two-weeks, which still leaves the individual very little time to make arrangements to get a prescription filled after release. The Evaluation report of Health Services that found evidence that several offenders had left custody without the required two weeks of medication (n=4) and another study of women in the community in which the women offenders cited long wait times for treatment and interruption in prescription renewals as a cause of disruption during transition (Thompson et al., 2015). Another consideration is that financial coverage for medications is often not secured prior to release, nearly guaranteeing discontinuity in pharmaceutical treatments. Interestingly, in another study of women on community release it was highlighted that many women leave prison with mental health needs, but no formal diagnosis which has an impact on obtaining mental health services in the community as federal assistance is not attainable without an Axis 1 diagnosis (Thompson et al., 2015). Promotion of timely case preparation including initiating

contact with community resources well in advance of release and beginning discharge planning as early as possible is considered a best practice procedure.

The recent evaluation report on CSC's Health Services (CSC, 2017) noted that CSC's mental health intake assessments were completed efficiently and almost all offenders were assessed and identified through the Computerized Mental Health Assessment Screening System (CoMHISS)**.** What is more**,** almost all (95%) of offenders flagged by CoMHISS received a service within the designated timeframe of 50 days from admission. However, some challenges to the continuum of care were noted. Interviewed staff stated that it was difficult to ensure continuity of health care when offenders were transferred between institutions, and cited medication-management and a lack of communication as the predominate causes. It was noted that a large source of discontinuity in mental health care was related to offenders leaving without health cards. The report highlighted that OMS information in this regard was 'patchy' making it difficult to calculate the percentage of offenders who leave with health cards. In some provinces and territories, offenders must wait until after release to apply for a health card, and this may first require the acquisition of citizenship documentation. Community Parole Officers or Community Mental Health staff can assist with health-card acquisition post-release but many staff explained that they ran into challenges securing a health card due to a lack of citizenship documentation, a lack of money to pay the fees, and challenges associated with applying for a health card in a different province/territory. While there is an inter-provincial agreement for discharged offenders to receive basic health-care coverage for up to a three-month period while waiting for a health card, only half of the staff interviewed indicated they were aware of such an agreement.

Staff interviewed in the Evaluation report also expressed their dissatisfaction with the short-notice they often receive to conduct discharge planning which they attributed to parole hearings or movement between institutions. However, many staff felt this could be prevented since some of these offenders had been incarcerated for years. In interviews, staff observed that delays in launching discharge planning meant less time for making community ties, attempting to secure health documentation for offenders nearing release, and entering offenders on appropriate waitlists. This is particularly true of complex cases. Thompson and colleagues confirmed this as a problem in their research in which less than half of parole officers reported felt they were given adequate time to plan for the release of women with complex needs (Thompson et al., 2015). Despite these barriers, most (75%) of offenders examined in the Evaluation report who had

conditional discharge plans were followed up in the community.

Current Study

The current study responds to the Evaluation Report's Management Action Plan Recommendation 10 on clinical discharge planning and community mental health services calling for CSC to: 1) conduct a review of 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; and, 2) ensure that clinical discharge planning activities are tracked in electronic information systems. Recommendation 6 of the report specifically calls for CSC to 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.

The study, therefore, was designed to determine whether a cohort of offenders considered to have significant mental health impairment was provided a continuum of mental health care while under CSC supervision. The complete continuum of care was defined as provision of three components: 1) treatment and/or services provided while incarcerated, 2) appropriate discharge planning prior to the release, 3) and, early provision of services in the community following release.

The following research questions were explored:

1) What proportion of offenders received mental health services and/or treatment while incarcerated?
    a. What types of mental health services and/or treatment did the offenders receive?
2) What proportion of offenders had file evidence that some form of planning to address their mental health needs had been conducted to assist in community reintegration?
    a. What types of planning occurred prior to release?
    b. How many offenders in the sample were judged not have a mental health need that would require reintegration planning at release?
3) What proportion of offenders received some form of mental health service while under community supervision?
    a. What type of service(s) did they receive?
    b. Were there differences between pre-release planning and actual services accessed in the community?

    c. What barriers to mental health support were present in the community?

4) Finally, what proportion of offenders received the complete continuum of care in addressing their mental health needs?

Inconsistencies in the recording of mental health or clinical discharge planning in electronic form will be assessed by exploring the following questions:

5) How many of the offenders' files had a specific clinical discharge plan?
6) When offenders did not have a clinical discharge plan, what sources of information contained mental health support planning information regarding community reintegration?
    a. How accessible was this information?

Method

Participants

Offenders who had been assessed on the SCID in two previous studies[1] to determine the prevalence of mental health disorders in CSC (Beaudette, Power, & Stewart, 2015; Brown et al.[2]., in press) were selected to be included in the electronic file review of the assessment of the mental health continuum of care. Among the offenders interviewed for these two studies, 66 offenders were identified as meeting the following criteria:

1) had results of a diagnostic interview after admission to a federal institution and had been released on community supervision for at least two months without experiencing a suspension, revocation, death, or deportation/extradition; and,
2) had a significant mental health impairment (e.g., a diagnosis of any one of the following: major depressive disorder, bi-polar I disorder, bi-polar II disorder, or any psychotic disorder, as well as a Global Assessment of Functioning (GAF) score of 50 or less, i.e., a level associated with serious or severe level of impairment.

We considered that offenders with these mental health conditions and degree of impairment would meet the criteria for the study as individuals with "significant mental health impairment."

Of these 66 offenders, the continuum of care was assessed for 40 offenders (61%). The 40 offenders were not randomly selected; rather, offenders were selected to ensure that women

[1] The study determined the prevalence rates of major mental disorders among 1,110 men offenders using the Structured Clinical Interview for DSM Axis I and Axis II disorders (SCID-I and SCID-II). Current and lifetime rates were obtained for the following disorders: 1) mood; 2) psychotic; 3) substance use; 4) anxiety; 5) eating; 6) pathological gambling; 7) antisocial personality disorder (APD); and 8) borderline personality disorder. Data were collected over a six-month period at reception centres in each region between March 2012 and September 2014. With the exception of offenders presenting with security concerns, all offenders admitted on new warrants of committal were approached to participate. The national consent rate was 78%.

[2] The study determined the prevalence rates of major mental disorders among women currently in custody in CSC facilities. Using the Structured Clinical Interview for DSM Axis I and Axis II Disorders (SCID-I and SCID-II) the following disorders were assessed: 1) mood; 2) psychotic; 3) substance use; 4) anxiety; 5) eating; 6) pathological gambling; 7) Antisocial Personality Disorder (APD); and 8) Borderline Personality Disorder (BPD). Rates were obtained for both lifetime and current prevalence (i.e., the past month). Women in custody were approached to participate in the diagnostic interview from February 2016 to October 2016. In total, 154 women from across the five regions provided consent and were included in the study as part of the in custody sample. An additional 6 women in the Regional Psychiatric Centre were approached to participate in the diagnostic interview in December 2017. Another 86 women were approached to participate in the diagnostic interview from October 2016 to October 2017. In total, 246 women from across the five regions provided consent and were included in the study as part of the intake sample.

and Indigenous offenders were represented. Men's files were selected to ensure cases were equally distributed across regions and were among the most recent releases so that the file reviews could focus on offenders that would more accurately represent current mental health practice.

Offenders included in the electronic file review were predominantly non-Indigenous (28/40 = 70%; see Appendix A, Table A1) men (75%) with high static risk (48%) and high dynamic need (75%) ratings. Most offenders were rated as having either low (45%) or medium (48%) reintegration potential. Half were serving sentences of less than 4 years and most were convicted for violent crimes (80%). All five regions were represented (ranging from 15% in Quebec and 30% in Prairie region). Nearly three-quarters (70%) of those included in file review received a non-discretionary release. Given the purposive sampling strategy, differences between offenders included and excluded in the file review were examined. The two groups were similar with a few notable exceptions. Those excluded were more likely to be serving shorter sentences for non-violent offences (see Appendix A, Table A1).

All included offenders were diagnosed at the time of their interview as having a major mental disorder and suffering at least a serious (or severe) level of impairment based on the GAF (i.e., a score $\leq$ 50). Almost half of those included in the file review were diagnosed with a major depressive disorder (See Appendix A, Table A2). The majority of offenders also met criteria for substance misuse, anxiety, or borderline personality disorders. All of the included offenders had co-morbid diagnoses.

Procedure/Analytic Approach

Three sources of information were used to capture data for statistical analyses: 1) Offender Management System (OMS) databases, 2) Mental Health Tracking System (MHTS)[3] and 3) Open Source Clinical Application Resource (OSCAR)[4]. These databases were queried to examine any institutional mental health services that offenders received between their admission and the early period of their release. Unless otherwise stated, summary information will be

[3] The Mental Health Tracking System (MHTS) was developed to standardize data collection and enable standardized reporting on the continuum of mental health services offered by the Correctional Service of Canada (CSC). CSC is required to collect information on mental health services to support internal and external reporting commitments (Mental Health Branch- CSC, 2012). This system calculated data from 2012 to 2016.
[4] OSCAR is used and an electronic medical record at CSC. The program was implemented in 2017 and currently being adapted by CSC.

presented that resulted from triangulation of information contained in all data sources.

Multiple data sources were used to gather relevant information on release planning and support provided to offenders. These include: memo to file documents, *Health Status at Discharge: Gist Report, CSC/SCC 1371*; OSCAR summary notes, casework records, and, when necessary, correctional plan documents.

Electronic case files were reviewed up to approximately six months prior to release in an effort to gather information relevant to mental health need planning pertaining to the first release that occurred after diagnosis. Information was collected on:

- the referrals or applications that were completed (e.g., referrals to general practitioners, specialist mental health services outside of CSC, CSC community mental health services, etc.),
- any implementation steps recorded (e.g., whether the referrals were accepted, whether there was hand off to community staff members, whether the offender was responsible for implementation, etc.), and
- details about medication that were prescribed for post-release as part of institutional discharge planning.

Offenders were followed between two and six months in the community to gather information relevant to the community-based services provided. This included information about any new referrals and the implementation of services. Offenders were followed until they either experienced a suspension/revocation, or they were in the community for six months. As well, any barriers that inhibited the offender from being referred to, or participating in, services were noted. See Appendix B for a copy of the coding manual.

Analyses

Descriptive statistics, such as percentages and frequencies were calculated to assess the participation of offenders in institutional mental health services, the parole officers' completion of discharge planning, and offenders' participation in services in the community or the brokering of services for offenders by parole officers. The results section highlights information of practical importance. The disaggregation of information by gender, region or Indigenous ancestry was not possible due to small numbers.

Results

The results are presented in five sections. The first four sections provide the outcome of the extent to which mental health services were delivered in the institutions, pre-release planning to address mental health needs was completed, community mental health services were brokered on release, and offenders were provided with the complete continuum of care. The final section provides an overview of the availability and accessibility of mental health information on offenders' electronic case records.

Institutional Mental Health Services

File information combining coding from OMS, OSCAR and the previous Mental Health Tracking System (MHTS) indicated that the majority of the offenders received some form of mental health service or treatment while incarcerated (80%, n = 32). Examples of treatment or services included Dialectical Behavioural Treatment (DBT), psychiatric services, counselling with a mental health nurse, and admissions to regional treatment centres. In total, 20% of offenders in the sample were admitted to a regional treatment centre at some point in their custodial sentence[5].

OSCAR has recently been implemented and is currently being revised; given this, it is not surprising that only 58% of offenders in the sample had OSCAR files that could be reviewed for the purpose of this study. Through OSCAR it was possible to examine how many of these offenders had a Mental Health Needs Scale (MHNS) completed. The MHNS is the tool used to assess the level of need for mental health services. Ten offenders had a MHNS completed (43%) and of these, 70% were rated as having elevated or considerable need.

Pre-Release Mental Health Needs Planning

Given the dynamic nature of mental health needs, electronic files were assessed to ensure that offenders who met our criteria for serious mental health impairment at intake were still considered to have significant needs in this area prior to release. Overall, 28% of offenders were considered to *not* have an active mental health need at the time of release as documented in their

[5] As based on data captured only in OSCAR, no offenders were admitted to a regional treatment centres for intermediate care during the period of the study, possibly because this treatment option was relatively recently added to the menu of psychiatric care services in CSC.

files. For the purpose of the current review, the remainder of offenders were considered to still have some mental health needs. Of these offenders, 86% had some form of mental health needs planning completed prior to release. This documentation was recorded electronically in a varieties of ways, including a Community Mental Health Discharge planning report, Health Status at Discharge: Gist Report, and other information found within OMS, MHTS, and OSCAR databases. The information regarding pre-release planning was not consistently retrievable within documentation sources and was not recorded in a systematic manner. Overall, pre-release planning was generally adapted to address the unique needs of each offender and most plans involved referrals to either CSC community mental health services, general practitioners, and/or medication prescriptions.

Community Mental Health Services

Of those considered to still have a mental health need at the time of release, all received some form of mental health treatment/support in the community. In the community, the majority of offenders participated in the treatment/services that had been planned for them prior to release. When there was evidence of additional referrals being made on release these were most often to CSC community mental health services and, to a lesser extent, to general practitioners, non-CSC mental health services, and residential or medical treatment for substance misuse.

Although all offenders in the sample received some form of mental health support during their release, over half of the case files mentioned barriers to finding services and support to meet mental health needs in the community. Generally, three themes were noted: offender-related challenges, administrative-related challenges, and challenges relating to accessing non-CSC subsidized health services in the community. Offender-related challenges often included: not liking certain types of supports such as AA or a particular psychologist, medication refusal, low trust in CSC psychiatrists, refusal to participate in medical pre-testing required for mental health-related prescriptions, offender not following treatment plan, treatment refusal/no shows, and lack of engagement. Administrative-related challenges included: issues with pre-release planning being completed without involvement of a psychologist who later changed the recommendations, medical insurance not being activated, waitlists for non-CSC services, short periods under community supervision due to the offender's sentence ending or a return to custody, and shortage of medication. A theme noted in several case files related to non-CSC health services in the community. Examples of these challenges included issues such as the

general practitioner declining to refer the offender to a psychologist or in order to prescribe certain medications to circumvent possible drug-seeking behaviour.

Continuum of Mental Health Care

As presented in Table 1, of those offenders we considered to still have a mental health need at release, 69% were assessed as having received the complete continuum of care to address their mental health needs. To meet this requirement, offenders had to have received treatment or services while in the institutions, to have file documentation of mental health-related release planning, and to have received some level of care in the community while under supervision.

Given challenges associated with missing information, a post-hoc review to assess why individuals may not have received the complete mental health continuum of care was undertaken. Although missing information limited conclusions related to this review, it appeared that those who did not receive a continuum of care had fewer mental health needs and were more likely to refuse services. As well, those who were flagged as not receiving institutional mental health services had received some level of care while in custody but it was not captured in the MHTS (e.g., substance misuse treatment, involvement of a mental health nurse).

Availability and Accessibility of Mental Health Needs on Electronic Records

A second goal of the study was to examine issues in the recording of mental health services in the institution or community and clinical discharge planning.

File review revealed that of those offenders whom we considered to have mental health needs at the time of release, only 31% had a formal clinical discharge plan document on file (but see below for evidence in other files that community release planning involving mental health care was often completed). This percentage was determined by examination of GIST reports[6] from the OSCAR system or Community Mental Health Discharge planning reports. It is difficult to assess why this occurred. It is possible that two-thirds of offenders did not require a formal discharge plan. The low percentage could also be attributed to electronic record keeping practices. For example, during the study period the MHTS was being replaced by OSCAR. This transition may have had an impact on record-keeping practices. When available, we found that

[6] It is important to note that the OSCAR program was implemented in 2017 and currently being adapted by CSC, therefore, only offenders discharged following OSCAR implementation could have a GIST report available on file.

the Community Mental Health Discharge planning report was the singular document that captured all pre-release information relevant to mental health need, medications, and community support referrals. It was easily accessible in OMS records and written in a manner that would be accessible to any member of the case management team.

Table 1

Continuum of Care Participation for Offenders with Significant Impairment (n = 40)

	% (*n*)
Received mental health services and/or treatment while incarcerated	80 (32)
Had mental health needs at release	73 (29)
Had some form of mental health needs planning to assist in community reintegration	86 (25)
Received mental health support while under community supervision	100 (29)
Complete continuum of care met	69 (20)

The current state of electronic records in OMS, MHTS and OSCAR made it difficult to assess whether there was a continued need for treatment and what level of need and support were required upon release. When cases did not have a GIST report or Community Mental Health Discharge planning report available, additional information was garnered from casework records for the vast majority of offenders (e.g., as seen in Table 2, casework record documents were accessed for 98% of offenders). For a minority of offenders (28%), the pre-release correctional plan had to be accessed to determine whether they had a current mental health concern because this information could not be found in any other documentation. Although casework records often contained information pertaining to mental health needs, release planning, and community support, in very few cases was all information provided sufficient to assess whether the continuum of care was being met. The lack of a central data source on mental health service delivery and unsystematic reporting of the information made it difficult to accurately assess the

continuum of care being provided to offenders – especially with regard to release planning and community follow-up components. Given these issues, it is possible that mental health needs may have been overlooked and an opportunity to provide a continuum of care missed.

Table 2

Information Sources Used to Assess the Pre-Release Mental Health Needs Planning and Community Services (n = 40)

	Documents accessed	Documents with relevant information
	% (*n*)	% (*n*)
Memos to file	95 (38)	24 (9)
Gist report	23 (9)	44 (4)
Other OSCAR information	53 (21)	71 (15)
Casework records	98 (39)	95 (37)
Correctional plan	28 (11)	45 (5)

Note. The recent implementation of the OSCAR system in 2017 limited the number of offenders who had available information.

Discussion

This review of files of federal offenders who had significant impairment related to their mental health found that the majority received health services while in the institution. Further, the majority of those who were considered to have mental health needs at the time of release had some form of mental health needs planning for their release and, notably, all offenders with mental health issues received community services as required, whether through CSC provided services or through provincially funded health care services in the community. All told, over two-thirds of offenders were considered to have received the complete continuum of care. With respect to access to mental health care in the community a significant number of the offenders in our sample were able to access provincially funded services. This would be considered a preferred option given that it will allow continuity of service after warrant expiry. Further engagement with provinces and territories to increase offenders' early access to community health resources on release is recommended.

With respect to the recording of mental health care or clinical discharge planning, current record keeping practices made it difficult to easily access information. In particular, the OSCAR records cannot be fully maintained in the community given that mental health care may frequently be provided by non CSC staff who would not have direct access to the database and for privacy reasons, OSCAR is not accessible to parole officers or other case management team members in the community. It is important to recognize that CSC health services is in the process of fully implementing this new electronic health record system and planned amendments will improve the access and data extraction from the database for CSC health care staff. We recommend two areas where electronic record keeping could be improved to more efficiently monitor the degree of support and services offenders with mental health problems receive while in the institutions and the community:

- First, the creation of a systematic requirement to report mental health needs at various points in the sentence and for this information to be entered into a single document and in a consistent manner. This will allow ease of access to all members of the case management team. To allay privacy concerns, these records could be focused on the type of support required rather than the particulars of mental health diagnoses. This recommendation is consistent with guidelines that are in place for discharge planning; however, the systematic

implementation has not occurred with all offenders with mental health needs.

- Second, we recommend the use of a flag alerting case management to the need to begin implementing discharge planning well in advance of release. This could provide staff with sufficient time to implement effective release planning for complex cases.

Implications

Based on the purposive sampling strategy examining a group of offenders who had significant mental health needs, it was determined that most had file evidence of having received the complete continuum of care. Nevertheless, this was only determined though examination of multiple documents. Clear, consistent, and accessible record keeping is necessary for ongoing monitoring of the full range of care throughout the period of the warrant.

Limitations

The selected sample is small and purposive and may not reflect the overall continuum of care for offenders at all levels of need. There is a possibility selecting such a high need group may have masked issues with continuity of care and inconsistent record keeping for those with lower levels of need.

Mental health needs are dynamic and changes in these needs may be difficult to reflect in documentation without the implementation of specific documentation accessible to case management teams where these changes can be consistently recorded.

It is possible that during the timeframe of the study which spanned the use of three types of systems of recording mental health needs in electronic formats (OMS, MHTS, and OSCAR), that data gaps were more likely especially given the recent implementation of OSCAR and decommissioning of MHTS.

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Appendix A: Supplementary Analysis

Table A1

Profile of Offenders by Group

	Excluded in file review (*N* = 28)	Included in file review (*N* = 40)
	% (n) or M (SD)	% (n) or M (SD)
Demographic		
Age in years	37 (12)	36 (12)
Male	46 (26)	54 (30)
Female	0 (0)	100 (10)
Indigenous	†	79 (11)
Non-Indigenous	46 (24)	54 (28)
Admitting Region		
Atlantic	59 (10)	41 (7)
Quebec	54 (7)	46 (6)
Ontario	0 (0)	100 (8)
Prairie	40 (8)	60 (12)
Pacific	†	88 (7)
Risk/Need Profile		
Static Risk		
Low	†	71 (5)
Medium	43 (12)	57 (16)
High	39 (12)	61 (19)
Dynamic Need		
Low	0 (0)	0 (0)
Medium	44 (8)	56 (10)
High	38 (18)	63 (30)
Reintegration Level		
Low	33 (9)	67 (18)
Medium	44 (15)	56 (19)
High	†	†
Sentence		
Less than 4 years	51 (21)	49 (20)
More than 4 years	20 (5)	80 (20)
Indeterminate	0 (0)	0 (0)
Most serious offence on sentence		
Violent	29 (13)	71 (32)
Non-violent	62 (13)	38 (8)
Release type		
Discretionary	52 (13)	48 (12)
Non-discretionary	32 (13)	68 (28)

Table A1 *Continued*

	Excluded in file review (*N* = 28)	Included in file review (*N* = 40)
	% (n) or M (SD)	% (n) or M (SD)
Fiscal year of release		
FY12/13	†	0 (0)
FY13/14	62 (8)	38 (5)
FY14/15	60 (9)	40 (6)
FY15/16	50 (6)	50 (6)
FY16/17	0 (0)	100 (19)
FY17/18	†	†

† numbers suppressed due to frequency less than 5.

Table A2

Current Mental Diagnoses by Group

Disorder	Excluded from File Review (*N* = 27)	Included in File Review (*N* = 40)
	% (n)	% (n)
Major Mental Disorder	100 (27)	100 (40)
Bipolar I disorder	19 (5)	15 (6)
Bipolar II disorder	†	†
Major depressive disorder	46 (12)	53 (21)
Psychotic disorder	31 (8)	38 (15)
Alcohol/substance use disorders [a]	88 (23)	88 (35)
Anxiety disorders	62 (16)	68 (27)
Eating disorders	0 (0)	†
Pathological gambling	†	†
Borderline personality disorder	62 (16)	63 (25)
Antisocial personality disorder	65 (16)	75 (30)

† Numbers supressed due to frequency less than 5.

[a] Diagnosis of substance misuse disorders relies on lifetime estimates

Appendix B: Continuum of Care Coding Manual

Offender FPS_____

FOR OFFENDERS WHO HAVE BEEN RELEASED

For file review – first limit your review to the first discharge summaries created before and after release (i.e., those closest to release). If all information has not been identified expand your review to the remainder of the discharges summaries and casework records. When accessing casework records you will have to search the document for the following terms: mental health, psych, cmh, med, anti, etc. If information is still missing below, please check all data sources examined in the last question.

1. Is there a discharge plan on file before release?

    1. Yes (date of first completed if available) _____
    2. No

    Data source _____

2. Is there a documentation regarding mental health support in the community on file after release?

    1. Yes (date of first completed if available) _____
    2. No

    Data source _____

3. Is there documentation that there are no mental health needs present?

    1. Yes (date of first completed if available) _____
    2. No

    Data source _____

4. Does the researcher feel the continuum of care has been satisfied?

    1. Yes
    2. No

5. What type of documents address mental health needs and support provided:

_____

_____

6. For the period before release is there documentation that includes the following:

*a. Are there referrals/applications for access to community mental health services, specifically [**check all that apply**]*

	Yes	No	Unknown		Data Source of first mention	Date
Application for Health Card				Has card already		
Referral to GP for follow-up						
Referral for specialist Mental Health Services outside of CSC						
Referral to the CMHS						
Referral to substance use services						
Residential services						
Opioid substitution						
Other (please specify: _____						
Not applicable - Please provide reason below (e.g., records indicate improvement in mental health) _____						

*b. What implementation steps are mentioned in the report? [**check all that apply**]*

	Yes	No	Unknown	Data Source of first mention	Date
Referrals are accepted/completed					
Some referrals are accepted/completed					
Hand off to parole officer					
Hand off to CSC community mental health staff					
Offender to assume responsibility for implementation					
Discharge planner to follow-up with offender after release (unknown if this will happen, but we'll look to see if it's ever noted – we will code this as planned vs documented that the follow-up happened)					
Not applicable - Please provide reason below (e.g., records indicate improvement in mental health) _____					

c. If the offender has been on medications during incarceration are medications prescribed for post-release as part of the discharge planning?

1. Yes
2. No
3. Not applicable [no meds]
4. Unknown

If yes, for how long will the prescription last in weeks? _____

Data Source _____ Date _____

If yes, is there a plan for refilling meds?

1. Yes
2. No
3. Unknown

Data Source _____ Date _____

7. For the period after release is there documentation that includes the following:

*a. Are there referrals/applications for access to community mental health services, specifically [**check all that apply**]*

	Yes	No	Unknown		Data Source of first mention	Date
Application for Health Card				Has card already		
Referral to GP for follow-up						
Referral for specialist Mental Health Services outside of CSC						
Referral to the CMHS						
Referral to substance use services						
Residential services						
Opioid substitution						
Other (please specify: _____						
Not applicable - Please provide reason below (e.g., records indicate improvement in mental health) _____						

*b. What implementation steps are mentioned in the report? [**check all that apply**]*

	Yes	No	Unknown	Data Source of first mention	Date
Referrals are accepted/completed					
Some referrals are accepted/completed					
Hand off to parole officer					
Hand off to CSC community mental health staff					
Offender to assume responsibility for implementation					
Discharge planner to follow-up with offender after release (unknown if this will happen, but we'll look to see if it's ever noted – we will code this as planned vs documented that the follow-up happened)					
Offender participating in services planned pre-release					
Not applicable - Please provide reason below (e.g., records indicate improvement in mental health) _____					

c. Was the offender able to acquire their medications within two weeks of release

5. Yes
6. No
7. Not applicable [no meds required]
8. Unknown

7. Are there barriers noted in **ANY** discharge plan, including [***check all that apply***]

	Yes	No	Unknown	Data Source
Change in release location				
Referrals declined by MH professional/service outside of CSC				
Referrals declined by MH professional/service at CSC				
Offender refusal for service				
Offender no shows				
Other Barriers **list in rows below**				

8. If, there is not documentation showing mental health care services were provided at any point, please check which of the following types of documentation were examined:

- Discharge summary
- Casework record log
- _____