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Audit of Regional Treatment Centres and the Regional Psychiatric Centre

Internal Audit

378-1-252

January 5, 2011

Canada

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Table of Contents

EXECUTIVE SUMMARY

BACKGROUND

The audit of the Correctional Service Canada's (CSC's) Regional Treatment Centres was conducted as part of CSC's 2009-12 Audit Plan. All of CSC's key corporate documents such as the Corporate Risk Profile, the Report on Plans and Priorities and the transformation agenda identify "Mental Health Care Capability for Inmates" as a risk to the Service and a key priority.

CSC is obligated, under the Correctional and Conditional Release Act (*CCRA)* to provide inmates with essential health care and reasonable access to non-essential health and mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community. Health care includes "medical care, dental care and mental health care, provided by registered health care professionals."[1] "Mental health care" is defined as "the care of a disorder of thought, mood, perception, orientation or memory that significantly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life."

To fulfill this legislative obligation, CSC has five Regional Treatment Centres which offer acute and chronic mental health care to inmates suffering from the most serious mental health conditions and require in-patient treatment. Treatment centres are "hybrid" facilities, in that they are considered to be a "penitentary" subject to the provisions of the federal *CCRA*, and a "hospital" subject to the provisions of the relevant provincial legislation[2]. All treatment centres with the exception of the Prairies Regional Psychiatric Centre are co-located within the confines of another CSC institution and all are considered multi-security level institutions.

The objective of the audit was to provide reasonable assurance that the treatment centres have adequate and effective controls in place to support the delivery of mental health services to inmates. The audit assessed the adequacy and effectiveness of the treatment centres' management control framework for mental health services and determined the extent to which CSC is complying with existing mental health care legislation and directives for mental health services.

To achieve these objectives, the audit team visited all five Regional Treatment Centres and carried out detailed reviews of inmates' files, conducted observations, interviews and examined and reviewed various forms of documentation.

[1] Corrections and Conditional Release Act (CCRA) s. 86 (1)
[2] Centre Régional de Santé Mentale in the Québec region is not designated a psychiatric facility under Provincial Legislation

CONCLUSION

Management Control Framework

Some elements of a management control framework are in place for mental health services delivered to inmates at the treatment centres. Commissioner's Directives are addressing the majority of the legislative requirements of the CCRA and the standing orders developed at the institutions comply with policies. Individual roles and responsibilities for mental health services are defined. All treatment centres have continuous quality improvement programs in place and are working towards achieving and/or renewing their accredited status.

However, there are still a number of areas requiring improvements to ensure that a comprehensive and integrated management control framework is in place. Those areas for improvement include:

- Commissioner's Directives applicable to the treatment centres that would fully address all legislative requirements;
- Better defined interrelationships between various positions including clinical and security positions, RTC Executive Directors, Regional Psychologists and Regional Directors of Health Services;
- A detailed plan for the Health Services Sector to provide greater integration between physical and mental health services and to ensure standardized mental health practices at the treatment centres;
- A resource model that would formalize and standardize the financial and staffing needs of the treatment centres;
- Better follow-up for training to ensure staff at the treatment centres are currently in compliance with NTS standards; and
- Better monitoring and reporting to assist in determining whether the treatment centres are meeting their strategic goals or mandate.

Compliance with Legislative Requirements

Sections 85 to 89 of the CCRA prescribe CSC's responsibilities in relation to mental health and mental health services for federal offenders. CSC develops policies and directions describing how CSC will ensure these legislative requirements will be met. In some instances, CSC has not yet defined how these legislative requirements will be met, while in other cases a standardized process for ensuring these requirements are being met has not been established. In yet other cases, documentation was not always on file to demonstrate compliance. Specifically, CSC needs to:

- Define essential and non-essential mental heath care;
- Develop a standardized process for ensuring all health care professionals are in good standings with their respective professional licensing bodies;
- Ensure that better documentation is on file to demonstrate compliance with the requirements to:

- Consider the inmate's mental health and mental health needs in making decisions to transfer, administratively segregate and discipline; and
- Obtain the informed voluntary consent of inmates prior to issuing treatment; and
- Comply with provincial legislation when the treatment centres treat inmates who do not have the capacity to understand informed consent.

Compliance with Commissioner's Directives and Policy Requirements

As mentioned above, CSC establishes policies in the form of Commissioner's Directives, many of which are used to ensure legislative requirements are being met and detail how services are to be delivered. CSC is in compliance with policy requirements applicable to the Regional Treatment Centres in areas such as:

- Conformity to admission and discharge criteria;
- Provision of medical information as required for investigative purposes;
- Opportunities are provided to inmates to communicate with treatment centre management through inmate committees or range representatives; and
- Treatment Centres and Regional Headquarters are conducting reviews of all use of force incidents.

However, there are still a number of opportunities for improvement in the following areas:

- Improve tracking of programming offered and rates of completion of programs;
- Ensure the Commissioner's Directives on Use of Force and Use of Restraint Equipment for Health Purposes are better followed;
- Ensure compliance with policy when medication is being administered to inmates; and
- Better and consistent processes to demonstrate compliance with requirements to communicate information about high risk suicidal and self-injurious inmates and standardizing mechanisms to signal level of risk associated with inmates.

Recommendations have been made in the report to address these areas for improvement. Management has reviewed and agrees with the findings contained in this report and a Management Action Plan has been developed to address the recommendations (see ***Annex C***).

STATEMENT OF ASSURANCE

This audit engagement was conducted with an audit level of assurance.

In my professional judgment as Chief Audit Executive, sufficient and appropriate audit procedures have been conducted and evidence gathered to support the accuracy of the opinion provided and contained in this report. The findings and conclusions are based on a comparison of the conditions, as they existed at the time, against pre-established audit criteria that were shared with management. The findings are applicable only to the issues examined.

_____ Date: _____

Sylvie Soucy, CIA

A/Chief Audit Executive

1.0 INTRODUCTION

The audit of the Correctional Service Canada's (CSC's) Regional Treatment Centres was conducted as part of CSC's 2009-12 Audit Plan. All CSC's key corporate documents such as the Corporate Risk Profile, the Report on Plans and Priorities and the transformation agenda identify "Mental Health Care Capability for Inmates" as a risk to the Service and one of CSC's key priorities.

On an average day during the 2009-2010 fiscal year, CSC was responsible for over 13,000 federally incarcerated offenders housed within CSC's 57 institutions. About four out of five offenders admitted to a federal penitentiary have a serious substance abuse problem. Over the last few years, CSC has witnessed an increase in the proportion of offenders identified with mental health problems at intake.

CSC has undertaken a number of initiatives in the area of mental heath care as part of the transformation agendas priorities. These initiatives include: the implementation of a mental health screening system at CSC's intake sites; Improving the capacity to provide mental health services to offenders in the community; Providing mental health awareness training to community and institutional staff; and enhancing the psychological and psychiatric services provided at CSC's institutions and Regional Treatment Centres (RTCs).

Correctional Service Canada is obligated, under the Correctional and Conditional Release Act (*CCRA*), to provide inmates with essential health care which conforms to professionally accepted standards. Health care includes "medical care, dental care and mental health care, provided by registered health care professionals."[3] "Mental health care" is defined as "the care of a disorder of thought, mood, perception, orientation or memory that significantly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life."[4]

To fulfill its responsibilities in 2009-10, CSC allocated over $690 thousand for NHQ institutional mental health service delivery and over $25 million to five regional treatment centers for delivery of mental health care in their facilities.

[3] Corrections and Conditional Release Act (CCRA) s. 86 (1)
[4] Corrections and Conditional Release Act (CCRA) s. 85

Table 1.1: CSC's Initial Budget Allocation for the Five Regional Treatment Centres

Region	2009-2010			
	Total FTE	Funds allocated for Mental Health Services[5]	Funds Allocated For all Health Related Services (including Mental Health Services[6])	Total Funds Allocated to the Regional Treatment Centres (including Health Related Services[7])
Atlantic	60.0	2,679,798	4,748,041	5,543,824
Québec	119.5	4,479,622	5,553,881	15,116,800
Ontario	168.7	5,216,678	5,491,706	14,129,557
Prairies	298.5	6,734,318	8,806,859	26,147,124
Pacific	134.7	6,212,451	8,228,780	13,441,931
Total	**781.4**	**$25,322,867**	**$32,829,267**	**$74,379,236**

Source: Financial resource information provided by Corporate Services

CSC has five Regional Treatment Centres spread across Canada. Each treatment centre offers acute and chronic mental health care to inmates suffering from the most serious mental health conditions and requiring in-patient treatment. The Prairies, Ontario, and Atlantic Regional Treatment Centres' are all designated "psychiatric facilities" meaning that the mental health laws of the province in which they are located apply. The Pacific region has two units under the direction of the Executive Director, the "Psychiatric Unit" in the Pacific regional treatment centre is designated as a psychiatric facility, while the "Rehabilitation Unit" is not a designated psychiatric facility and provides assistance to inmates who are characterized as having lower intellectual abilities, lower functioning, lower education and chronic mental and/or physical disabilities. The Centre Régional de Santé Mentale (CRSM) at the Archambault Institution in the Québec region has not been designated as a "hospital" under provincial legislation.

The following table shows the total number of beds at each of the Regional Treatment Centres.

[5] Activity 840-Mental Health Services
[6] Activity 800-Health Services Administration, 820-Clinical Health Services, 840-Mental Health Services, 860-Public Health Services
[7] All Activities including: 800, 820, 840 and 860

Table 1.2 Treatment Centre Occupancy Rates and Beds as at the Site Visits

Region	Beds Occupied	Beds Unoccupied	Total Number of Beds[8]
Atlantic	31	12	43
Québec	77	26[9]	103
Ontario	111	15[10]	126
Prairies	177	30	207
Pacific	177	19	196
Total	**573**	**102**	**675**

Source: Auditor count at Regional Treatment Centres

Treatment centres are ”hybrid” facilities, in that they are considered to be a “penitentiary” subject to the provisions of the federal *CCRA*, and a “hospital” subject to the provisions of the relevant provincial legislation[11]. All treatment centres with the exception of the Prairies Regional Psychiatric Centre are co-located within the confines of another CSC Institution and all are considered multi-level security institutions.

In February 2007, CSC’s Executive Committee (EXCOM) approved a key organizational change in the management of health services, the intent of which was to improve the quality and consistency of health care delivery across Canada. Effective September 2007, Health Services became a separate sector headed by the Assistant Commissioner, Health Services. The new Health Services governance structure was implemented to increase the focus on health services (See Section 4.1.3 for the organizational chart).

The Regional Treatment Centre’s Executive Director responsibilities can include managing both clinical responsibilities, such as medical and health care provision and operational responsibilities, such as security or case management, depending on the treatment centre and whether the centre has its own correctional staff. The Ontario and the Prairies Regional Treatment Centres Executive Directors are responsible for both the clinical and operational functions, whereas the Executive Directors of the Atlantic, Québec and Pacific Regional Treatment Centres have responsibility over the clinical function only. In the Atlantic, Québec and Pacific regions, operations are provided by the CSC Institution where the treatment centre is co-located.

Although the governance model was implemented in 2007, it was only recently that changes were made in the governance structure at some of the treatment centres. As a result of these changes all the treatment centres are now managed by an Executive Director who reports directly to the Assistant Deputy Commissioner Institutional Operations (ADCIO) in the region. At the regional level, the Regional Deputy

[8] Excluding those beds temporarily closed and under construction
[9] The Québec regional treatment centre had an additional 18 units that were temporarily closed at the time of the audit.
[10] The Ontario regional treatment centre had an additional 24 units under construction at the time of the audit.
[11] Centre Régional de Santé Mentale in the Québec region is not designated a psychiatric facility under Provincial Legislation

Commissioner is accountable and responsible financially and operationally for the management of treatment centre resources. The Health Services Sector provides functional guidance in the clinical operations of the Regional Treatment Centres. It is also responsible for the funding to the treatment centres related to physical health care.

There have been several reports and reviews completed on the Regional Treatment Centres in recent years which raised the need for CSC to enhance the mental health services provided to inmates.

2.0 AUDIT OBJECTIVES AND SCOPE

2.1 Audit Objectives

The overall audit objective was to provide reasonable assurance that CSC has adequate and effective controls in place to support the delivery of mental health services to inmates in the regional treatment centres. The three sub-objectives were:

- To assess the adequacy and effectiveness of CSC's management control framework for mental health services delivered to inmates at the treatment centres.
- To determine the extent to which CSC is complying with sections 85 to 89 of the CCRA legislation concerning mental health services delivered to inmates at the treatment centres.
- To determine the extent to which CSC is complying with directives when administering mental health services to inmates at the treatment centres.

Specific criteria related to each of the objectives are included in ***Annex A***.

2.2 Audit Scope

The audit of the treatment centres was national in scope and included visits and/or communications with all five Regional Treatment Centres, their respective Regional Headquarters, and CSC's National Headquarters. The audit review period spanned September 2007, when the new governance model for health was implemented, to September 2009. However, it went as far back as April 2006 to review meeting minutes of treatment centre Executive Directors.

We conducted interviews, file review, and observations at each site to assess the adequacy and effectiveness of CSC's management framework for mental health services. This included governance, roles and responsibilities, staffing and resourcing, training, monitoring and reporting, and its compliance with legislation and Commissioner's Directives.

Please note that at no time during our audit process did we draw conclusions on the ability or the decisions made by treatment centre staff to clinically assess, diagnose, or treat any of the inmates at any of the treatment centres. We relied on the evidence on file to conclude on the treatment centres' compliance with applicable Commissioner's Directives.

The audit excluded:

- Mental health intake assessment at the reception centre, as this will be covered in a future engagement, and
- CSC's service contract with the Institut Philippe-Pinel de Montréal

3.0 AUDIT APPROACH AND METHODOLOGY

Audit evidence was gathered through a number of techniques:

Interviews: We conducted a total of 124 interviews as part of the planning and examination phases of the audit. Interviews were conducted of CSC staff at NHQ, RHQ and the treatment centres.

Review of Documentation: We reviewed and analysed provincial and federal legislation, Commissioner's Directives, policies, procedures, training material, monitoring and reporting documents, professional bodies standards, reports, and meeting minutes.

File Testing: We tested compliance with legislation and Commissioner's Directives by randomly selecting 93 inmates' files representing 148 admissions. For each admission, we reviewed the corresponding files:

- Treatment Centre;
- Health Care;
- Case Management;
- Admission and Discharge;
- Psychology;
- Discipline and Dissociation; and
- Offender Management System (OMS) and Reports of Automated Data Application to Reintegration (RADAR).

We randomly selected 267 different treatment centre staff to determine whether they were in compliance with four mandatory courses. In addition, 74 uses of force incidents and 169 program offerings were randomly selected as part of file testing.

Observations: We observed a total of 17 processes at the different centres visited including administration of medication; Admission, Discharge and Transfer team meetings; nursing debriefings; Serious Court, which is the administrative tribunal that presides over charges laid against inmates by treatment centre staff; and morning operations debriefings.

Analytical Review: Analytical reviews were conducted throughout the audit in order to identify trends, issues and best practices.

4.0 AUDIT FINDINGS AND RECOMMENDATIONS

4.1 Management Framework for Mental Health Services

We assessed the adequacy and effectiveness of CSC's management control framework for mental health services delivered to inmates at the treatment centres by examining the following areas:

- Legislation, Commissioner's Directives, and mental health standing orders developed at the treatment centres;
- Roles and responsibilities;
- Staffing and resources;
- Training; and
- Monitoring, reporting, and continuous improvement activities.

4.1.1 Legislation and Commissioner's Directives

We expected to find that the Commissioner's Directives applicable to the treatment centres were current and complied with legislation. [12]

We found that the Commissioner's Directives applicable to the treatment centres are current, consistent and comply with legislation. Although they address most legislative requirements, some requirements under sections 86 and 88 were not covered in the CDs.

We reviewed Sections 85 to 89 of the *CCRA* which defines and outlines CSC's mental health service requirements (See ***Annex D*** for *CCRA* requirements) and compared these requirements against the applicable Commissioner's Directives to ensure the Commissioner's Directives addressed all legislative requirements. For the following sections we found the Commissioner's Directive addressed the *CCRA* requirements:

- Section 85 – Defines health and mental health care
- Section 86(2) - Conformance with professionally accepted standards;
- Section 87 - Consideration of the state of mental health and mental health needs of offenders in decisions to transfer, segregate, or discipline;
- Section 88 (with the exception of those sections noted below) - Informed consent prior to giving treatment;
- Section 89 - Force feeding of inmates.

We further analyzed Commissioner's Directive 803 *Consent to Health Services Assessment, Treatment and Release of Information* against the *CCRA* and each province's *Mental Health Act*, *Hospital* Act, and federal privacy legislation. We focused

[12] We reviewed and analyzed the following CDs: 710-2 – Transfer of Inmates, 726 – Correctional Programs, 800 – Health Services, 803 – Consent to Health Services Assessment, Treatment and Release of Information, 825 – Hunger Strikes, 840 – Psychological Services, and 850 – Mental Health Services against the *CCRA,* the *CCRR*, and provincial legislation.

our review on sections of each treatment centre's provincial legislation pertaining to admission and discharge criteria, involuntary treatment, and the release of information. We found that:

- Admission and discharge criteria at all the treatment centres were consistent with *Mental Health* provincial legislation;
- CD 803 Consent to Health Services Assessment, Treatment and Release of Information was consistent with provincial legislation[13] with respect to involuntary treatment; and
- CD 803 Consent to Health Services Assessment, Treatment and Release of Information was consistent with federal legislation with respect to the release of information.

However, we found the Commissioner's Directives did not address all legislative requirements for the following sections of the *CCRA*.

Section 86

Section 86 (1a and b) of the *CCRA* requires that CSC provide inmates with essential health care which includes mental health and reasonable access to non-essential health and mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community. In 2009, the Health Services Sector developed a National Essential Health Services Framework. Under this framework, essential and non-essential physical health care services have been defined. The Commissioner's Directive on "Health Services" and Section 85 of the *CCRA* define mental health care, however, further work on defining mental health care services for mental health care has not yet been undertaken. Section 4.2.1 of this report provides additional information related to essential and non-essential health and mental health care work which has been completed by CSC.

Section 88

Section 88 (2 a to e) of the *CCRA* lists the conditions that must be met for consent to be considered informed. The Commissioner's Directives reviewed addressed Sections 88 2(a, b, d and e), but not Section 88 2(c) which requires the inmate to be advised of and have the ability to understand any reasonable alternatives to the treatment. Alternatives to treatment are understood in this section as meaning that all treatment options deemed to be reasonable are to be disclosed to the inmate. Commissioner's Directive 803 – Consent to Health Services Assessment, Treatment and Release of Information indicates inmates will be given alternatives only after they have refused to consent to the initial treatment offered. Section 4.2.4 of this report provides additional information and the results of audit work related to CSC obtaining inmates consent prior to issuing treatment.

There is no legal obligation for legislative requirements to be individually addressed in the Commissioners Directives. However, if not all areas are addressed, there is a

[13] *Mental Health Act* and *Hospital Act*

greater risk of inconsistent application of the legislation and for those requirements which have not been addressed to be overlooked.

4.1.2 Commissioner's Directives and Mental Health Standing Orders

We expected to find that mental health standing orders at the treatment centres complied with Commissioner's Directives.

We found that the standing orders that we reviewed at the treatment centres are in agreement with the relevant Commissioner's Directives.

Standing Orders are developed at each institution and provide detailed information on how staff members are to implement directives and legislative requirements. The authority to develop standing orders is delegated to the Institutional Head.[14] We found that there was no requirement for the treatment centres to have specific mental health standing orders. Of those standing orders reviewed, all agreed with their respective Commissioner's Directives.

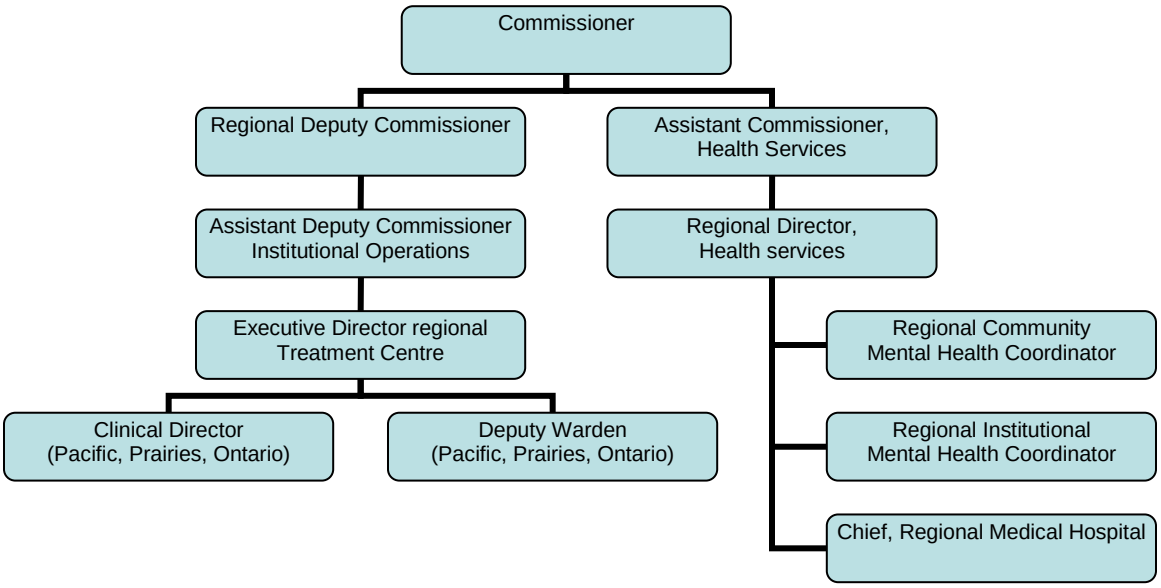
4.1.3 Governance, Roles and Responsibilities

4.1.3.1 Governance

CSC approved a model for the governance of mental health in February 2007. This model specifically addressed the five regional treatment centres and was implemented in September 2007. The following diagram illustrates the governance structure for mental health as modified in May 2008.

[14] *HOW TO DEVELOP POLICY IN CSC: Roles, responsibilities and governance of CSC's policy framework*

Table 4.1.3.1: Mental Health Governance Structure[15]



This chart illustrates the reporting structure for the treatment centres.

In 2008, a National Mental Health Advisory Council was tasked to "focus on…the full implementation and monitoring of the Mental Health Governance" model. The Council was mandated to provide advice and recommendations to:

- Guide development of a robust mental health services system, consistent with the transformation agenda;
- Determine and prioritize national and regional mental health needs; including the allocation of current and new mental health resources;
- Ensure that mental health activities at all levels contribute positively to the CSC transformation agenda and to the safe reintegration of inmates;
- Identify changing regional and national challenges and opportunities and ensure that CSC's mental health strategy is responsive to these; and
- Identify and promote national, regional and local partnerships, both within CSC and beyond, to further the goals of CSC's Mental Health strategy.

We expected that organizational roles and responsibilities for mental health services are defined and are being adhered to by NHQ, RHQ, and by the treatment centres.

We found that not all roles and responsibilities for mental health services within the mental health governance model are defined.

Under the new governance model, the Health Services Sector is to exercise a functional oversight role in the following areas of treatment centre operations: professional practices and treatments, admission and discharge criteria, hospital status, human

[15] The most recent governance structure was presented as part of an update on the new governance structure related to mental health in May 2008

resources management, monitoring and accountability, and budgets. As discussed further in Section 4.1.6, the Health Services Sector oversees the amount of physical health care funding provided to the treatment centres based on predefined formulas, while NHQ Finance controls the amount of mental health care funding initially allocated to the RTC's since it is currently based on previous years spending. The treatment centres are accountable for their operations; however, they have little control over the funding received as this is determined by NHQ and RHQ.

Sub-services agreements between Health Services, Institutions, and Regional Headquarters have been developed to assist the treatment centres in the delivery of mental health services. These agreements contain specific arrangements with respect to the distribution of tasks and responsibilities related to the administrative functions of the treatment centres and areas where Health Services will assist the treatment centres administratively.

Within the governance model, the Regional Director of Health Services, the Regional Psychologist, and the Executive Director of the Regional Treatment Centres all share a role in the delivery of mental health services, but have different roles and responsibilities under different lines of authorities. These three positions have a significant influence on the operational and clinical direction of the treatment centres. We found that the roles and responsibilities for the service delivery aspects of these positions have not been formally defined to date.

The Regional Psychologist and the Regional Treatment Centre Executive Director both have a line reporting relationship to the RDC via the ADCIO. The Regional Director of Health Services reports directly to the Assistant Commissioner, Health Services at NHQ. At a Regional Treatment Centre Executive Directors meeting in 2007, it was recognized that the Commissioner's Directive on "Mental Health Services" should be revised to reflect the regional responsibilities for mental health, given the new governance model. The Health Services Sector was identified by the Executive Directors' as the body that would be responsible for updating the directive. We found that this directive has not been revised in spite of the need expressed by the Executive Directors. In our view, this may assist CSC in clarifying the roles and responsibilities, in particular the funding and reporting models required to support the consistent delivery of mental health services across the regions.

Progress on the work of the National and Regional councils has been slow.

According to the National Mental Health Council's terms of reference, the Director General of Mental Health is to report bi-annually to the EXCOM Sub-Committee on Health on the council's progress; however, up to now, progress on the Council's mandate has been limited, particularly in relation to the development of a resource allocation model which would reflect the funding needs of the treatment centres. In addition, the Health Services Sector has also been identified as being responsible for finalizing a treatment centre funding formula. A resource allocation review is currently being conducted, but has yet to result in any changes to the mental health resource allocation process. Through discussions with RTC financial staff, we were informed the treatment centres have not yet been consulted during this review.

In our review of minutes from meetings of the treatment centres' Executive Directors, we found that it was recognized that a regional coordinating strategy was essential and recommended that a Regional Mental Health Council that included the Assistant Deputy Commissioner of Institutional Operations, the Regional Director of Health Services, the treatment centre Executive Director, the Regional Chief Psychologist, and the coordinators of the community and institutional mental health initiatives be established. The implementation of such councils was to ensure full coordination and operational support for the mental health initiatives.

These Regional Mental Health Councils were established and have a mandate which includes the intake assessment process, needs identification, implications for placement, gaps in services, crisis intervention, mental health treatment needs, programs and services, discharge planning, staff training and development, resourcing, and HR recruitment and staff retention. All regions have created a Regional Mental Health Council but progress on the Regional Council's mandate has varied by region.

We found that the Health Services Sector currently has no plan in place to provide greater integration between physical and mental health care, no plan in place to ensure standardized mental health practices at the treatment centres and no formal process to respond to requests made by the treatment centres for functional guidance.

The new governance model approved by EXCOM, established the Mental Health Branch to ensure that standardized practices existed and to provide greater integration of physical and mental health services. Although integration between physical and mental health services is included in many documents released related to the new governance structure, no document identifies the type of integration expected. The current reporting structure has resulted in physical and mental health operating independently, although the ACHS has functional guidance over both areas of health. We also found that the Health Services Sector has no plan in place to integrate physical and mental health given the current structure. As discussed further in section 4.2.1 the Health Services Sector, in its 2009 National Essential Health Services Framework, has identified the need for a mental health framework that would assist in fulfilling this mandate; however, the development of this framework has not occurred to date.

The governance model stresses that Health Services Sector plays a stronger functional role in treatment centre operations although we found NHQ does not have a plan or process in place which specifies the timeframes for responding to guidance requests. During interviews, we found that the response time for requests made for functional guidance from NHQ and RHQ was inconsistent. Accreditation is one area where functional guidance was slow to arrive. The approval of tools or processes that would address accreditation requirements was of particular concern to the treatment centres as it affected, and often hindered, their accreditation process. Health Services recently completed a system-wide accreditation primer for physical health services under the "Q-mentum" process, and is currently developing similar tools required to address improvement areas that are common to the treatment centres.

4.1.3.2 Roles and Responsibilities

We expected that individual roles and responsibilities for mental health services are defined and are being adhered to by the treatment centres.

We found that individual roles and responsibilities for mental health services are defined and are being adhered to by clinical and correctional staff at the treatment centres.

Most clinical staff have job descriptions, even though most of them had not been updated for many years. We also found that for correctional staff, generic post orders[16] existed at the Atlantic, Ontario and Québec treatment centres, and that the Pacific and Prairies treatment centres had post orders for correctional staff that were assigned to the treatment centre.

The Ontario and the Prairies Regional Psychiatric Centres were the only treatment centres to have their own roster of correctional staff. Management at all of the treatment centres told us that continuity of correctional staff and their ability to work within the treatment centre environment were important factors in how well staff were able to perform in the treatment centre environment, but found that the deployment practices at the treatment centres are predominantly based on the seniority of correctional staff and was sometimes problematic.

The interrelationship between the roles and responsibilities of the clinical and correctional staff is not clear.

Mental Health teams consist of a psychologist, nurse, case management officer, a psychiatrist when necessary, and ad hoc members as appropriate.[17] We were advised that clinical staff is typically responsible for managing the mental health issues of inmates, while correctional staff is responsible for managing behavioural issues of inmates at the treatment centres by ensuring that treatment can take place within a safe and secure setting for all parties.

The treatment centres conveyed the importance of a multi-disciplinary approach; however, many treatment centre staff reported that regular multi-disciplinary meeting were not held. We found that multi-disciplinary teams existed in all of the treatment centres but not on a formal basis where the roles and responsibilities of each team member were clearly defined in relation to each other.

In our review of minutes from meetings of the treatment centres' Executive Directors from June 2007 and other CSC documentation, we found that CSC supported the provision of specialized multi-disciplinary training to all treatment centre staff to support collective responsibility for problem solving and diffusing of situations. In February 2010, to support this approach, the Deployment Standards and Scheduling Branch, in

[16] Post orders are the site-specific rules at institutional posts that dictate how staff must accomplish their duties. They are signed by either the institutional head or Deputy Warden
[17] CD 850 Mental Health Services– Page 3 Paragraph 2

consultation with the Mental Health Branch issued a draft document outlining deployment standard for correctional staff at the treatment centres, this document is currently undergoing a consultation process.

We found examples where roles and responsibilities between clinical and correctional staff were unclear when interventions with inmates were required. We noted that clarity of roles and responsibilities could help resolve conflicts between the necessities for security versus the provision of health services. For example, we observed that at times this lack of clarity resulted in staff being hindered in the performance of their duties because of the predominance of security concerns over treatment.

4.1.4 Staffing and Resourcing

We expected to find that staffing levels and resources for mental health services are identified, allocated, and distributed according to their approved organizational plan.

We found no approved organizational plans for the treatment centres which identify staffing and resource needs.

We found that all of the treatment centres except the Atlantic regional treatment centre have human resource plans; however these plans do not identify all the resources needed to provide mental health services at the treatment centres. The Prairies, Ontario, and Québec regions have human resource plans that identify vacant and anticipated vacancies but do not indicate the number of actual positions required for each category of staff to meet the needs of the inmates. As a result of these gaps, it is not clear how their staffing needs are identified. The Pacific region's human resource plan identified the number of staff required, but we found that some areas of the plan had not been completed and therefore it is difficult to know if the numbers are justified.

Resource allocation model is complex, not well documented and explained and not well understood by key internal stakeholders.

The typical funding allocation model for an institution as well as for the treatment centres includes regular operational activities, such as administration, operations, security, meals, etc (called Entity 1 envelope) and institutional allocations managed out of NHQ (called Entity 4 envelope). Examples of these Entity 4 items may include: IM/IT, training, physical health care and mental health care in institutions other than RTCs. Entity 1 activities tend to be funded based on resource indicators such as the number of inmates, the number of FTE's, the size of the institution, etc.; some expenses are funded based on historical costs. Entity 4 Physical Health also has established resource indicators, although there are no similar indicators for mental health in the treatment centres as this is also funded based on the actual amount spent in prior year.

Traditionally Entity 4 allocations are controlled by NHQ, more specifically the functional Sector responsible for the activities. This is not the case for Entity 4 mental health care funding for the RTC's. Unlike Entity 4 physical health care, responsibility for the RTC's mental health care expenditures falls under the Regional Deputy Commissioner.

Following the initial allocations by NHQ, RHQ may then re-allocate both Entity 1 and 4 funds, either increasing or decreasing the amount of funds the treatment centres receive. These re-allocations are to address regional needs, compensate the treatment centres for additional services they provide to RHQ and to compensate other institutions for the additional services they provide to the treatment centres. Each region has a different process for allocating and distributing funding to their respective treatment centre. There is no mechanism in place that links the current resource needs of the treatment centres to the yearly allocations by NHQ.

We noted that many of the individuals interviewed in the regions did not fully understand the resource allocation or reporting system. Currently there is a consultation process underway to allow for the creation of specific health resource indicators for the RTC's.

We found that all of the treatment centres have funding gaps and that the funding allocation for each of the treatment centres is inconsistent.

Throughout the year, the budget allocations to the treatment centres are adjusted based on additional funding provided to the RTC's and new initiatives introduced by NHQ and RHQ. When funding pressures have been identified by the treatment centres, they are first reported to the region. Depending on whether the funding shortfall is Entity 1, Entity 4 Physical Health or Entity 4 Mental Health the process for requesting additional funds varies. Typically, if the region either does not have a sufficient amount in their budget to cover the shortfall or if the shortfall falls outside of the regions' responsibility, the request for additional funds will be elevated to NHQ.

The treatment centres are assuming costs for which they are not completely and continually resourced. Examples of costs being absorbed include: costs related to aging inmates, self-harmers, population management, damaged Crown assets, building maintenance for the regional hospital in the Prairies region, and costs incurred in the process of transferring offenders to the community. We also found that the Atlantic, Ontario, and Pacific treatment centres leave some funded positions vacant in order to absorb costs for which they are not resourced on an ongoing basis. By delaying treatment centre staffing, the treatment centres offset costs where current funding does not cover their actual costs.

The following table illustrates the variation of full-time equivalents and NHQ allocations for each treatment centre.

Table 4.1.4.1: Funding Allocations by NHQ to the Treatment Centres

	FTE	Number of Beds	FTE per Number of Beds	2009 – 2010 NHQ Budget Allocation	NHQ Budget Allocation per Bed
Atlantic	60.0	43	1.4	$ 5,543,824	$ 128,926
Québec	119.5	121	1.0	$ 15,116,800	$ 124,932
Ontario	168.7	150	1.1	$ 14,129,557	$ 94,197
Prairies	298.5	207	1.4	$ 26,147,124	$ 126,315
Pacific	134.7	196	0.7	$ 13,441,931	$ 68,581
Total	**781.4**	**717**[18]	**1.1**	**$ 74,379,236**	**$ 103,737**

Source: Auditor observation and Financial resource information provided by Corporate Services

We found that none of the treatment centres had stable funding for the provision of program to inmates.

The Commissioner's Directive on "Correctional Programs" states "Offenders shall be assigned to a correctional program based on their Correctional Plan and on established correctional program selection criteria."[19] We found that although treatment centres are required to provide programming, none of them have received stable program funding. The following table illustrates the inconsistencies in program funding to each of the treatment centres.

Table 4.1.4.2: Program Funding Allocated by NHQ to the Treatment Centres

Region	2009-2010		2008-2009	
	FTE	Funding Allocated for Programming	FTE	Funding Allocated for Programming
Atlantic	0.0	$167	0.0	$152
Québec	2.0	$164,640	1.0	$78,566
Ontario	1.0	$88,872	0.0	$599
Prairies	2.0	$168,621	1.0	$81,437
Pacific	4.0	$331,036	2.0	$161,374
Total	**9.0**	**$753,336**	**4.0**	**$322,128**

Source: Financial resource information provided by Corporate Services

4.1.5 Training

We expected to find that training is offered and delivered to treatment centre staff.

Based on file review, we found that the treatment centres compliance with the National Training Standards varied greatly between courses and regions.

Since September 2007, the Health Services Sector is responsible for determining training requirements (both substance and timing) for all areas of professional health

[18] Includes those beds temporarily closed and under construction
[19] CD 726 Correctional Programs-Page 3, paragraph 11

practice for health care staff. The Health Services Sector recognized that all staff at the treatment centres requires continuous learning, training, and development to help them intervene more effectively with inmates at the treatment centres. Furthermore, many mental health professionals require on-going professional development as part of their licensing requirements to maintain their clinical positions. The following four National Training Standards courses were reviewed for compliance with National Training Standards requirements.

Mental Health Awareness Training

The Mental Health Awareness Training (FSWCO) course is identified as a National Training Standard in effect since April 1st, 2009 and must be completed once by all correctional staff. Individuals completing the course "will be able to successfully demonstrate knowledge and understanding of various mental health issues as they pertain to the mandate of CSC and to their individual role in interacting with and assisting inmates with mental disorders."[20]

At the time of the audit, treatment centre staff informed us that all the regional treatment centres except for the Prairies were currently "training the trainers" for the Mental Health Awareness course. Therefore, training had yet to be provided to staff except for the Prairies region where the Mental Health Awareness Training was completed prior to it becoming a National Training Standard requirement. Subsequent inquiry at each of the treatment centres and the Health Services Sector indicated that approximately 65% of staff at the treatment centres have completed the Mental Health Awareness Training since our fieldwork was completed.

For the following three training programs, the details on compliance can be found in table 4.1.5.1 below.

Pinel Restraint System Training

The Pinel Restraint System[21] Training (PINEL1) course has been in effect since April 1st, 2009 and must be completed by correctional staff at the treatment centre once within 6 months of their appointment. Individuals completing the course "will successfully demonstrate proficiency in the practical application and the theoretical knowledge of law and policy that are required to be qualified in the physical application of the Pinel soft restraint system."[22]

[20] NTS, September 1, 2009 version, page 39
[21] The Pinel system restraint is a one-point and up to seven-point soft restraint system that restrains a portion of an individual's body (i.e. head, shoulders, etc.).
[22] NTS, September 1, 2009 version, page 32

Suicide and Self-injury Prevention Refresher

The Suicide Prevention Refresher Training (SUICD5) online course is identified as a National Training Standard in effect since April 1st, 2005 and must be completed by treatment centre staff every 2 years from the anniversary date of completion. The prerequisite course is Suicide Prevention and is part of the New Employee Orientation Program. Individuals completing the course "will be able to successfully demonstrate knowledge and skill proficiency to detect and respond to behaviours that may be indicative of suicidal or self-injurious intent."[23]

Professional Development for Psychologists

Professional Development for Psychologists (PSYD1) is identified as a National Training Standard in effect since April 1st, 2006 and must be completed annually. Individuals completing the course "will be able to demonstrate knowledge and skill required of the psychologists working in the federal correctional system. This includes the knowledge and skills related to risk assessment, mental health assessment, and suicide prevention for psychologists, mental health law/ethics and clinical supervision."[24]

The following table summarizes the file review results based on data contained within CSC's Human Resource database for the three standards for which data existed:

Table 4.1.5.1: File Review Results for National Training Standards Reviewed

Region	Pinel Restraint System Training Compliance within Timelines	Suicide and Self-Injury Prevention Refresher Training Compliance within Timelines	Professional Development for Psychologists Compliance within Timelines
Effective date of training requirement	April 1, 2009	April 1, 2005	April 1, 2006
Review Period	September 1, 2007 to September 30, 2009	September 1, 2007 to September 30, 2009	April 1, 2008 to March 31, 2009
Atlantic	40% (10/25)	92% (23/25)	100% (5/5)
Québec	96% (24/25)	80% (20/25)	100 % (5/5)
Ontario	95% (18/19)	96% (24/25)	100% (5/5)
Prairies	88% (22/25)	92% (22/24)	100% (5/5)
Pacific	38% (9/24)	78% (18/23)	60% (3/5)
Total	**70% (83/118)**	**88% (107/122)**	**92% (23/25)**

Source: Financial resource information provided by Corporate Services

[23] NTS, September 1, 2009 version, page 33
[24] NTS, September 1, 2009 version, page 52

4.1.6 Monitoring, Reporting and Continuous Quality Improvement

4.1.6.1 Monitoring and reporting

We expected to find that monitoring and reporting mechanisms, including continuous quality improvement programs are in place and reporting requirements are being met by NHQ, RHQ, and the treatment centres.

We found no performance indicators at RHQ, or at NHQ which would assist treatment centres in demonstrating that they are meeting their strategic goals or mandate.

Since September 2007, the Health Services Sector is responsible for defining performance indicators for treatment centres that would measure treatment outcomes. We found that no performance indicators or performance management framework specific to the treatment centres have been developed to date.

We found no consistent reporting framework for the treatment centres.

As mentioned previously, funding to the treatment centres is typically allocated through Entity 1 for their non-clinical operations. The Health Services Sector oversees funding for physical health operations under Entity 4, but has no direct authority over the treatment centres' spending of Entity 4 funding as the treatment centres have no direct reporting relationship to the Health Services Sector. The reporting relationship for the treatment centres is the same as other institutions, although not all of the funding for the treatment centres follows this reporting structure, which makes accountability for spending unclear and difficult.

We found that financial monitoring and reporting requirements are limited. However, for those requirements which are in place, they are being met at NHQ, RHQ and at the treatment centres.

We found that the reporting that exists is mostly financial in nature. The financial reporting requirements imposed by NHQ and RHQ cover the production of monthly financial cash forecasts at the regional and treatment centre levels. The analysis which accompanies the monthly financial forecasts to support the financial position of each treatment centre varies by region in terms of detail and consistency. Health Services Sector informed us they are monitoring the health envelope to ensure that funding was being used for providing health services.

Good Practice

The Prairies Regional Psychiatric Centre has monitoring and reporting mechanisms in place for performance reporting that is linked to their strategic goals.

The Prairies region has identified strategic goals specific to their operation and have developed indicators to measure whether they are meeting their goals in the form of a colour-coded "dashboard". The dashboard is published on their Infonet as part of their corporate reporting function.

4.1.6.2 Continuous quality improvement

We expected to find continuous quality improvement programs in place.

We found that all of the treatment centres have continuous quality improvement programs in place.

The Health Services Sector is responsible for coordinating a Continuous Quality Improvement Program for all of the treatment centres that would ensure that the delivery of mental health services is consistent with principles of patient care.

CSC requires that all treatment centres operate as accredited forensic hospitals respecting applicable provincial legislation. Accreditation allows organizations "to embed practical and effective quality improvement and patient safety initiatives into their daily operations." [25] At this time, Accreditation Canada is the organization providing the RTC's with their accreditation status. System-wide areas assessed during accreditation include "governance, leadership and management, infection prevention and control, and medication management, while population-specific and service excellence standards address specific sectors, services, conditions, and populations."[26]

All of the treatment centres except the one in the Atlantic region have been accredited for many years. In 2008, Accreditation Canada changed from the "AIM" accreditation process to a newly established "Q-mentum" accreditation process. Effective January 2010, all accredited treatment centres are required to become accredited under this process.

The Pacific Regional Treatment Centre was the first treatment centre to obtain conditional accreditation status under the "Q-mentum" process, with accredited status expected in mid 2010. In January 2010, CRSM in Québec also received conditional accreditation status under the "Q-mentum" process.

The Health Services Sector has not yet been involved in the development, implementation, monitoring, or coordination of the RTC's continuous quality improvement programs. In the meantime, each RTC has developed its own continuous

[25] http://www.accreditation.ca/Shop-for-Standards/
[26] http://www.accreditation.ca/Shop-for-Standards/

quality improvement programs and processes. We noted that none of the treatment centres received ongoing funding to support their continuous quality programs, including accreditation.

Good Practice

The Prairies region has established local continuous improvement requirements in addition to the ones identified during their accreditation process.

The Prairies Regional Psychiatric Centre has had a Quality Improvement Council since March 2009 to better coordinate and prioritize quality improvement. The Council's mandate is to facilitate and support mental and physical health, and operational excellence with an evidence-based, comprehensive quality improvement process. In addition to its accreditation requirements, the Council has identified other improvements to additional areas, including patient orientation for new admissions, program planning and referrals, and treatment care plans.

CONCLUSION:

Some elements of a management framework are in place for mental health services delivered to inmates at the treatment centres. Commissioner's Directives are addressing the majority of the legislative requirements of the CCRA and the standing orders developed at the institutions comply with policies. Individual roles and responsibilities for mental health services are defined. All treatment centres have continuous quality improvement programs in place and are working towards achieving and/or renewing their accredited status.

However, there are still a number of areas requiring improvements to ensure that a comprehensive and integrated management control framework is in place. Those areas for improvement include:

- Commissioner's Directives applicable to the treatment centres that would fully address all legislative requirements;
- Better defined interrelationships between various positions including clinical and security positions, RTC Executive Directors, Regional Psychologists and Regional Directors of Health Services;
- A detailed plan for the Health Services Sector to provide greater integration between physical and mental health services and to ensure standardized mental health practices at the treatment centres;
- A resource model that would formalize and standardize the financial and staffing needs of the treatment centres;
- Better follow-up for training to ensure staff at the treatment centres are currently in compliance with NTS standards; and
- Better monitoring and reporting to assist in determining whether the treatment centres are meeting their strategic goals or mandate.

Recommendation 1[27]	
The Assistant Commissioner Health Services should revise the Mental Health Management Framework for the Regional Treatment Centres to ensure that: a) The governance model is clear, understood and being adhered to; b) With the assistance of the Assistant Commissioner Corporate Services, governance is supported by a robust resource allocation model which is consistent with the other CSC activities and reflect the operating environment of the treatment centres; c) With the assistance of the Assistant Commissioner Correctional Operations and Programs, interrelationships between clinical and operational staff involved in mental health care activities requiring interventions are well defined and understood; and d) Performance monitoring and reporting requirements are established and communicated in order to better meet clinical objectives.	

Recommendation 2[28]	
The Assistant Commissioner Health Services should develop processes to standardize mental health practices at the treatment centres and provide guidance to the Regional Treatment Centres when required.	

4.2 Compliance with CCRA

This sub-objective aimed to determine the extent to which CSC is complying with sections 85 to 89 of the *CCRA* legislation concerning mental health services delivered to inmates at the treatment centres. To do so, we examined how the treatment centres:

- Provide "essential mental health care" and "reasonable access to non-essential mental health care" (Section 86 (1));
- "Conform to professionally accepted standards" (Section 86(2));
- Consider the state of mental health and mental health needs of the inmate in decisions to transfer, segregate, or discipline (Section 87);
- Obtain voluntary informed consent prior to issuing treatment (Section 88 (1));
- Comply with applicable provincial legislation when inmates do not have the capacity to understand the conditions required to give informed consent (Section 88 (5)); and

[27] Recommendations have been coded to identify the urgency required for addressing the recommendation. Recommendations in red represent those recommendations which we believe need to be addressed immediately, yellow represents those recommendations which we believe need to be addressed in the near future, and green represents those items which we believe need to be addressed after yellow recommendations have been addressed.

[28] For an explanation of the recommendation colour coding system, see the footnote for Recommendation 1

- Ensure that inmates are not force fed as a result of direction provided by CSC (Section 89).

4.2.1 "Essential" and "Non-Essential" Mental Health Services

Per Section 86 (1) of the *CCRA*, we expected to find that CSC provides inmates at the treatment centres with "essential mental health care" and "reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful integration into the community."

We were unable to assess compliance with a national standard on whether CSC provides inmates at the treatment centres with "essential mental health care" and "reasonable access to non-essential mental health care"

As stated in section 4.1.1, neither essential nor non-essential mental health care, including interventions that would fall under each, have been developed.

In March 2009, the Health Services Sector established a "National Essential Health Services Framework" in response to the internal audit of physical health care conducted in April 2008. As part of this framework, essential and non-essential health care was defined, listing specific interventions for each. In its second phase, the National Advisory Committee on Essential Health Services was to be established and consist of members from Health Services, Corporate Services and other sectors. The Committee is a key component of establishing, monitoring and updating the Framework on an ongoing basis. In addition, this committee was to address other components of essential health services including mental health. To date, no similar framework for what constitutes "essential" or "non-essential" mental health services has been developed, although we were advised that the development of the framework would appear in a future work plan.

According to Commissioner's Directive 850 – Mental Health Services, treatment centres are "…responsible for the planning and implementation of essential mental health services in their respective regions in collaboration with regional and national management"[29]. In the absence of a National definition, clinical staff at each of the treatment centres has defined what constitutes essential and non-essential mental health care on a case-by-case basis.

4.2.2 Professionally Accepted Standards

Per Section 86 (2) of the CCRA, we expected to find that the provision of mental health services for inmates at the treatment centres "conform to professionally accepted standards."

The Commissioner's Directive on "Health Services" states "Health services shall only be provided by health care professionals who are registered or licensed in Canada,

[29] Commissioner's Directive 850 – Mental Health Services, paragraph 7.

preferably in the province of practice."..[30] As a result, we expected to see evidence that CSC ensures health care providers at the treatment centres are in good standing with their respective licensing body, as the professional association would take action against those members found not to be conforming to their prescribed standards.

Based on CSC's definition of professionally accepted standards contained within the Commissioner's Directive on "Health Services", we did not see anything which would lead us to believe professional staff members at the treatment centres are not members in good standing with their respective professional licensing bodies.

We tested a total of 122 professionally licensed staff including nurses, psychologists and psychiatrists to determine whether they are currently members in good standing with their respective licensing bodies. For the staff members for whom we received support, members were in good standing. We did not see anything throughout the audit that would lead us to believe that staff members at the treatment centres are not members in good standing with their respective licensing bodies.

We found that there is no standardized practice for confirming that health care providers at the regional treatment centres are members in good standing with their respective licensing body.

Each treatment centre has a different process in place to determine whether a staff member is in good standing with his/her respective licensing bodies. These practices range from active monitoring using internally developed spreadsheets which include retaining a copy of information supporting the membership status and recording whether support was received, to an informal system where no documentation is retained. Typically, professional staff will provide support on a yearly basis when they seek reimbursement for the annual fees they must pay to maintain membership with their respective colleges. This same oversight mechanism is not available to CSC for professional staff hired on a contract basis.

4.2.3 Consideration of Inmate's State of Mental Health and Mental Health Needs in Decisions

Per Section 87 of the CCRA, we expected to find that CSC considers the inmate's state of mental health and mental health needs in decisions to transfer, administratively segregate, or discipline inmates at the treatment centres.

Based on file review, we found that CSC did not consistently have documentation on file to demonstrate it had considered the inmate's state of mental health and mental health needs in decisions to transfer or administratively segregate inmates at the treatment centres. We also found that CSC did not have documentation on file to demonstrate it had considered the inmate's state of mental health and mental health needs in decisions to discipline inmates at the treatment centres.

[30] Commissioner's Directive 800-Health Services, Paragraph 9

We found the Commissioner's Directives on transfer, administrative segregation, and discipline did not contain direction for staff on how to demonstrate they considered the inmate's state of mental health and mental health needs in decision-making.

Section 87 of the *CCRA* requires the Service to take into consideration an inmate's state of health and health care needs in all decisions affecting the inmate, including decisions to transfer, administratively segregate and discipline. Per section 85 of the *CCRA,* health care needs include mental health care. We noted that the Commissioner's Directive on Transfers refers to this *CCRA* requirement and states the inmate's mental health needs must be considered in cases where inmates are at risk of self-harming or are suicidal. When inmates are not identified as being at risk the Commissioner's Directive does not explicitly require that the inmate's mental health state or needs be taken into consideration when deciding to transfer.

We also did not find a specific area on the transfer decision documentation where the individual was required to indicate whether they have considered the inmate's mental health state or mental health needs. As a result, we could only assess compliance when the consideration of the inmate's needs was documented in the file. We reviewed all transfer decision documents included within the inmate's files to assess whether the documentation within the file demonstrated the inmate's state of mental health and mental health needs were considered prior to being transferred from the treatment centre. We found that in 58% (70 out of 121) of transfer decisions there was evidence to show the mental health needs and mental health state were considered.

The Commissioner's Directive on administrative segregation states that a psychologist must provide an opinion on the inmate's mental health status at the time of the assessment and within the first 25 days of the administrative segregation. Furthermore, the Commissioner's Directive requires Health Service professionals to advise the institutional head in writing if they recommend the termination of administrative segregation or the alteration of the administrative segregation conditions on the grounds of the physical or mental health of the inmate. When assessing whether the inmate's state of mental health and mental health needs were considered prior to and during the inmate being segregated, we reviewed all documentation within the inmate's files. We found that in 72% (13 out of 18) of cases where the inmate was segregated, there was evidence within the file to demonstrate the inmate's mental health needs and mental health state were considered.

Our review of discipline cases included those cases where formal charges were laid at the RTC. The Commissioner's Directive on Discipline states as a principle that the inmate's mental health be considered, although the directive does not specify where this consideration should be recorded. We reviewed the charges documents and accompanying information in the inmate's files to determine whether there was documented evidence the inmate's state of mental health and health care needs were determined and considered and found that 1% (1 out of 69) of the cases had evidence the inmates state of mental health and mental health needs were considered .

Table 4.2.3.1: Documented consideration of mental health needs in Decisions to Transfer, Administratively Segregate and Discipline.

Type of decision	Sample Size	Cases Where the Consideration of Mental Health Needs was Documented
Transfer OUT	121	58% (70/121)
Segregation	18	72% (13/18)
Discipline	69	1% (1/69)

Source: File review conducted on site and Offender Management System review

To complement our file review, we attended numerous morning debriefs and multi-disciplinary meetings and through observation, found that treatment centre staff informally considered the mental health state and mental health needs of the inmates during their meeting discussions; however, these discussions are not documented in the inmate's files, therefore there is a risk to CSC as they were not able to demonstrate compliance with the *CCRA*.

4.2.4 Voluntary Consent

Per Section 88 (1) of the CCRA, we expected to find that CSC obtains informed voluntary consent by the inmate at the treatment centre prior to issuing treatment.

Based on file review, we found that CSC could not always demonstrate that it had obtain informed voluntary consent prior to issuing treatment to inmates at the treatment centres.

Provincial laws require that a patient be placed in a hospital voluntarily (the inmate has accepted treatment) or involuntarily, if a physician deems the inmate not to be competent to give informed consent at which point the inmate would be considered certifiable. If an inmate withdraws consent and is deemed able to do so, the inmate should be moved back to his/her parent institution within a reasonable period of time. Informed voluntary consent for psychiatric treatment is obtained through a standard CSC form. Section 88 (1) of the *CCRA* requires consent for treatment to be informed and voluntary. The following table summarizes the results of file review when determining whether CSC obtained the informed and voluntary consent for treatment of an inmate.

Table 4.2.4.1: Rates of Compliance on Voluntary Consent

Region	Number of Voluntary Admissions	Number of files where the inmate refused to consent	Number of files where signed consent for mental health treatment was documented
Atlantic	33	2	61% (19/31)
Québec	21	0	86% (18/21)
Ontario	19	1	89% (16/18)
Prairies	33	0	67% (22/33)
Pacific	24	1	91% (21/23)
Total	**130**	**4**	**76% (96/126)**

Source: File review conducted on site

We found evidence of a signed standard CSC treatment form on file in 76% (96 out of 126) of inmate admissions to the treatment centres. For the other 30 files, there was no evidence that voluntary consent was obtained for treatment.

4.2.5 Involuntary Admissions

Per Section 88 (5) of the CCRA, we expected to find that CSC complies with provincial legislation when administering mental health services when inmates at the treatment centres do not have the capacity to understand informed consent.

Based on file review, we found that CSC did not consistently comply with provincial legislation when inmates at the treatment centres did not have the capacity to understand the requirements for consent to be informed.

Section 88(5) of the *CCRA* defers to provincial legislation where an inmate does not have the capacity to understand the conditions which need to be met for informed consent to be provided. In four out of five provinces where CSC has treatment centres, the certification process begins when an inmate is deemed by a physician a risk to him or herself or others and does not have the capacity to understand informed consent. When this occurs an "initial certificate" is issued. If, after the initial certification, which generally lasts 72 hours, the involuntary admission remains in effect, then the certificate must be renewed within the time period established by the provincial legislation that applies to the treatment centre. If the certificate is not renewed, then the treatment centre does not have the legal authority to treat the inmate without first obtaining his/her voluntary informed consent.

The Québec legislation concerning involuntary admissions requires that a "tutor or curator" act in the sole interest of the individual being certified when an individual is deemed to be a risk to him or herself or others and does not have the capacity to understand informed consent[31]. CRSM in Québec is not designated as a psychiatric

[31] Under the Civil Code of Québec, no person may be made to undergo treatment without providing consent. In cases where the individual is incapable of giving or refusing consent to treatment a tutor or curator, who acts as a substitute decision maker acts on the individual's behalf and provides consent

facility under its provincial legislation; nonetheless, we expected to find evidence on file that CRSM in Québec had the legal authority to keep and treat the inmates on an involuntary basis. As part of our sample there were two individuals in the Québec region who were deemed to be involuntary admissions. We did not assess whether treatment was provided for these two individuals, although there was no evidence on file that CSC had the authority to treat them on an involuntary basis.

Out of the 148 admissions we reviewed, 18 or 12% were involuntary. We found documentation on file to support that CSC had the initial authority to treat the inmate involuntarily at the treatment centre in 12 out of 16 or 75% of the involuntary admissions within our sample.

Table 4.2.5.1: Number of Files where Documents Demonstrated Compliance for Involuntary Admissions

Region	Total # of Involuntary Admissions	Documents on file demonstrating compliance with requirement for CSC to have initial authority to treat the inmate on an involuntary basis
Atlantic	2	50% (1/2)
Québec	2	N/A[32]
Ontario	7	71% (5/7)
Prairies	5	80%(4/5)
Pacific	2	100% (2/2)
Total	**18**	**75% (12/16)**

Source: File review conducted on site

From our original sample of 18 involuntary admissions, there were four files, excluding the two files referred to in Table 4.2.5.1 from Québec, where the initial certificate or equivalent in Québec was not on file. Within these files, one inmate was released within 72 hours, two became in compliance after the 72 hour period, and one had insufficient information in the file to determine whether the inmate was considered as a voluntary or involuntary admission during the time he remained at the treatment centre.

The following table summarizes the results of the 12 inmates where the initial certificate was on file and where the inmate stayed more than a 72 hour period.

while ensuring they act in the interests of the individual. A court order can also be issued to force an individual to receive treatment when they are incapable of giving consent and categorically refuses to receive care.

[32] We were unable to assess whether the two involuntary admissions received treatment prior to receiving consent as required by legislation.

Table 4.2.5.2: Rates of Compliance for Involuntary Admissions where Initial Certification was on File and Inmate Remained after 72 hours

Region	Total # of Involuntary Admissions with Initial Certificate (or Québec Equivalent) on File	# of Inmates Who Remained After 72 Hours	Involuntary Admissions in Compliance	Involuntary Admissions Where Unable to Assess Compliance
Atlantic	1	0	N/A	N/A
Québec	0	0	N/A	N/A
Ontario	5	3	67% (2/3)	33% (1/3)
Prairies	4	4	75% (3/4)	25% (1/4)
Pacific	2	1	100% (1/1)	0% (0/1)
Total	**12**	**8**	**75% (6/8)**	**25% (2/8)**

Source: File review conducted on site

We were unable to asses 2 of the 8 files as the documentation in the file did not clearly indicate whether the inmate was considered to be a voluntary or involuntary admission throughout their admission.

For the eight inmates who remained after the initial 72 hour period has expired, we expected to find either a renewal of the certificates, a voluntary consent form, a discharge date, or any documentation in the files that would indicate a change in the inmate's involuntary status. This was the case 75% of the time for those inmates who remained over 72 hours.

4.2.6 Force Feeding

Per Section 89 of the CCRA, we expected to find that CSC does not force feed any inmates at the treatment centres.

We found no evidence in our sample that CSC force fed inmates who were on hunger strikes at any of the treatment centres.

The Commissioner's Directive on Hunger Strikes states that "a hunger strike consists of a situation where an individual refuses all solid food and all fluids except water and it has been verified that he or she has done so for a period of at least 7 days unless an underlying medical condition necessitates earlier intervention…The Service shall not direct the force feeding of an inmate who had the capacity to understand the consequences of fasting at the time he or she made the decision to fast."[33] We found two cases where a hunger strike was declared during the audit review period; one in the Atlantic region and the other in the Prairies region, but there was nothing in the file to indicate force feeding took place.

[33] CD 825 – paragraph 4

CONCLUSION:

Sections 85 to 89 of the CCRA prescribe CSC's responsibilities in relation to mental health and mental health services for federal offenders. CSC develops policies and directions describing how CSC will ensure these legislative requirements will be met. In some instances, CSC has not yet defined how these legislative requirements will be met, while in other cases a standardized process for ensuring these requirements are being met has not been established. In yet other cases, documentation was not always on file to demonstrate compliance. Specifically, CSC needs to:

- Define essential and non-essential mental health care;
- Develop a standardized process for ensuring all health care professionals are in good standing with their respective professional licensing bodies;
- Ensure that better documentation is on file to demonstrate compliance with the requirements to:
    - Consider the inmate's mental health and mental health needs in making decisions to transfer, administratively segregate and discipline; and
    - Obtain the informed voluntary consent of inmates prior to issuing treatment; and
    - Comply with provincial legislation when the treatment centres treat inmates who do not have the capacity to understand informed consent.

Recommendation 3[34]	
The Assistant Commissioner Health Services should define essential and non-essential mental health services.	

Recommendation 4[35]	
The Assistant Commissioner Health Services should develop a standardized process to assist the Regional Deputy Commissioners in monitoring that professional staff and contractors are always in good standing with their licensing body. The Assistant Commissioner Health Services should also ensure that this verification is performed yearly.	

[34] For an explanation of the recommendation colour coding system, see the footnote for Recommendation 1

[35] For an explanation of the recommendation colour coding system, see the footnote for Recommendation1

Recommendation 5[36]
The Regional Deputy Commissioners should put in place processes with the assistance of: a) The Assistant Commissioner Correctional Operations and Programs to ensure that consideration of the inmates mental health and mental health needs is documented when making decisions to transfer, administratively segregate and discipline inmates; b) The Assistant Commissioner Health Services to ensure compliance with the requirements to obtain the informed voluntary consent of inmates prior to issuing treatment and to ensure the requirements of provincial legislations when treating inmates who do not have the capacity to understand informed consent are being followed.

4.3 Compliance with Commissioner's Directives

This third sub-objective aimed to determine the extent to which CSC is complying with directives when administering mental health services to inmates at the treatment centres. As such, we examined how RTCs ensure that:

- Inmates meet admission and discharge criteria;
- Inmates with identified mental health issues are being offered and are completing the programs referred to them by treatment centre staff;
- They comply with policy requirements when disclosing confidential medical information for investigative purposes;
- They comply with the requirement to establish inmate committees at the treatment centres;
- They comply with use of force policy requirements;
- They comply with use of restraint equipment policy requirements;
- They comply with policy requirements when medication is administered; and
- They comply with policy requirements when responding to medical emergencies, self-harmers, and suicidal inmates.

4.3.1 Admission and Discharge Criteria

We expected to find that inmates in the treatment centres meet admission and discharge criteria.

Based of file review, we found that overall, inmates in the treatment centres met the admission (95%) and discharge (88%) criteria as per RTC requirements most of the time.

[36] For an explanation of the recommendation colour coding system, see the footnote for Recommendation 1

Admission and discharge criteria for each of the treatment centres are based on the provincial legislation but each treatment centre have further specified and defined the conditions for admission and discharge.

Generally, inmates admitted to the treatment centres have identified serious mental health illnesses. Some inmates within our sample were admitted and discharged more than once. When an inmate has been admitted or discharged, it can be for more than one reason.

All of the treatment centres that are designated as psychiatric facilities have their own admission and discharge criteria which conform to their respective mental health related to provincial legislation. The "Rehabilitation Unit" located within the Pacific regional treatment centre and CRSM in Québec also have there own admission and discharge criteria. For files where the admission criteria was not met, the inmate either did not meet the admission requirement (for example did not have an identified mental health issue) or the reason for admission was not stated in the file.

Table 4.3.1.1: Number of Files Where Admission Criteria was Met

Region	# of Inmates Admitted	Total # of Admission	Compliance with Admission Criteria
Atlantic	19	35	100% (35/35)
Québec	19	23	100% (23/23)
Ontario	15	26	96% (25/26)
Prairies	22	38	95% (36/38)
Pacific	18	26	81% (21/26)
Total	**93**	**148**	**95% (140/148)**

Source: File review conducted on site

Through interviews, we were informed that there were inmates residing at the treatment centres that did not have identifiable mental health issues, but our sample did not capture these individuals. These persons do not suffer from mental health conditions but are often aging, physically impaired, and/or vulnerable in their parent institution. We noted that CSC currently does not have a strategy for housing aging inmates who require continual supervision and care. As such, the treatment centres are currently assuming this responsibility. The Health Services Sector is currently looking to institute national admission and discharge criteria which would include aging offenders as a reason for admission.

Inmates are discharged from a treatment centre for many reasons such as, being assessed as stabilized, they no longer consent to treatment, or they have reached their release date. For files where the discharge criteria was assessed as not being met, the inmate was either discharged for a reason other then those stated in the discharge criteria or the reason for discharge was not noted in the file.

Table 4.3.1.2: Number of Files Where Discharge Criteria was Met

Region	Total # of Discharges	Compliance with Discharge Criteria
Atlantic	33	97% (32/33)
Québec	8	100% (8/8)
Ontario	26	65% (17/26)
Prairies	38	84% (32/38)
Pacific	26	100% (26/26)
Total	**131**	**88% (115/131)**

Source: File review conducted on site

The table below provides information on the average length of stay of an inmate within our sample.

Table 4.3.1.3: Median and Average Length of Stay at Treatment Centre of Inmates in File Review Sample

Region	Number of Discharges	Total Number of Days Inmates at Treatment Centre	Median Length of Stay	Average Length of Stay
Atlantic	33	2,014	35	61
Québec	8	1,297	120	162
Ontario	26	1,208	28	46
Prairies	38	3,336	51	88
Pacific	26	3,275	77	126
Total	**131**	**11,130**	**51**	**85**

Source: File review conducted on site

Good Practice

We found some treatment centres have instituted a requirement that discharge summaries be prepared when an inmate is discharged from the treatment centre. These summaries include information related to the inmates stay, including the reason the inmate was originally admitted, the progress the inmate has made while at the treatment centre and the reason why the inmate has been discharged.

4.3.2 Treatment Centre Programs

We expected to find that inmates with identified mental health issues are being offered and are completing the programs they are referred to by staff at the treatment centre.

We found program offerings at all of the treatment centres vary.

The treatment centres offer 3 types of programs: core, modified core, and non-core. A core program is a correctional program that is "a structured intervention that addresses

the factors directly linked to inmates' criminal behaviour."[37] The Pacific, Prairies, and Ontario regional treatment centres offer core programs such as Sex Offender, Violence Prevention, Family Violence Prevention, and Substance Abuse. At the time of the audit, CRSM in Québec did not offer core programs and the Atlantic regional treatment centre did not offer any programs.

Modified core programs are core programs in substance but their modes of delivery have been altered to be more responsive to the inmates at the treatment centres. Modifications can include shorter session durations, longer program offerings, fewer participants, or more individual assistance. Currently, modified core programming is offered in the Pacific and Prairies regions.

Non-core programs are programs which are developed and delivered at the treatment centres. These non-core programs are intended to help offenders improve their skills in various areas. All of the treatment centres, except in the Atlantic region, offer non-core programs or programs that are developed and delivered locally at the treatment centres.

Examples of the non-core programs include, Skills Management, Community Reintegration, Mental Health Management, Social Skills, and Stress Management.

The following table summarizes the results of file testing to determine the number of programs offered within our sample.

Table 4.3.2.1: Number of Programs Offered at the Treatment Centres

Region	Number of Programs Offered			Total Number of Programs Offered	Total Number of Inmates Offered Programs
	Core	Modified Core	Non – Core		
Atlantic	N/A	N/A	N/A	N/A	N/A
Québec	N/A	N/A	10	10	7
Ontario	3	N/A	36	39	31
Prairies	17	4	67	88	28
Pacific	16	4	12	32	28
Total	**36**	**8**	**125**	**169**	**94**

Source: File review conducted on site

We expected to find a formalized process in place to track and record programs offered to inmates at the treatment centres.

The Pacific Regional Treatment Centre and the Prairies Regional Psychiatric Centre have a formalized referral process for program offerings; however, none of the five treatment centres have a systematic mechanism in place to track program offerings.

A correctional program referral is the means of identifying an inmate to participate in a correctional program. We reviewed referral documentation from treatment centre staff and OMS program reports. At the Pacific and Prairies treatment centres, inmates are

[37] Correctional Programs CD 726, Paragraph 5

offered programs on a systematic basis, based on identified programming needs, while the Ontario and Québec treatment centres refer inmates to programs on an informal ad hoc basis.

We found for those inmates who were offered programming that 41% of the programs were completed

The table below provides an overview of the results by region.

Table 4.3.2.2: Treatment Centre Program Offerings and Completions

Region	Number of Programs Completed			Program Completion Rates
	Core	Modified Core	Non – Core	
Atlantic	N/A	N/A	N/A	N/A
Québec	N/A	N/A	80% (8/10)	80% (8/10)
Ontario	0% (0/3)	N/A	64% (23/36)	59% (23/39)
Prairies	29% (5/17)	0% (0/4)	15% (10/67)	17% (15/88)
Pacific	94% (15/16)	100% (4/4)	33% (4/12)	72% (23/32)
Total	**56% (20/36)**	**50% (4/8)**	**36% (45/125)**	**41% (69/169)**

Source: File review conducted on site and Offender Management System review

Treatment centre staff informed us that non-core programming offered and delivered at the treatment centres is not credited towards the inmates' correctional plan.

4.3.3 Treatment Centre Investigations

We expected to find that the treatment centres comply with policy requirements when disclosing confidential medical information for investigative purposes.

For the 30 investigations completed at the treatment centres during our review period, we saw nothing that would lead us to believe that policy requirements related to disclosing confidential medical information for investigative purposes was not met.

The Commissioner's Directive on "Investigations" states that "when the investigation is convened…health professionals either on the board of investigation or consulted by the board of investigation will determine the relevance of medical information, in each case, and will share that information with the other members of the board. Disclosures…are guided by the Privacy Act and the rules of conduct of the respective professional governing bodies."[38]

We reviewed Executive Summaries and Situational Reports for incidents that occurred at the treatment centres and found no issues related to difficulties obtaining the medical information which was required. Our file review did not identify any areas of non-compliance with the requirement that confidential medical information be provided for

[38] CD 041 – paragraphs 37 and 38

investigative purposes. In addition, the Investigations Branch told us that they have not had any issues with obtaining the medical information they needed for investigative purposes during the period under review.

4.3.4 Treatment Centre Inmate Committees

We expected to find that CSC has established inmate committees at the treatment centres.

We found that CSC has mechanisms in place to ensure that communications and consultations are maintained with the treatment centres' inmate population.

The Commissioner's Directive on "Inmate Committees" states that "all institutions, including regional treatment centres, should normally have an inmate committee". The Commissioner's Directive further states that "…in situations where this is not practical or feasible, measures must be implemented to ensure that open communications and consultations are maintained with the inmate population through alternative mechanisms."[39] We found that the Prairies Regional Psychiatric Centre has an inmate committee and the Pacific, Ontario and the Atlantic regional treatment centres utilize their respective co-located institutional inmate committees. CRSM in Québec utilizes "range representatives", to address issues within the range directly with the unit's Correctional Manager or other delegate.

4.3.5 Use of Force

We expected to find that CSC complies with policy requirements when use of force is applied to inmates at the treatment centres.

Based on file review, we found that the treatment centres and Regional Headquarters comply with policy requirements to conduct a review of all uses of force.

Since April 1st, 2009, the Commissioner's Directive on "Use of Force" requires that all uses of force undergo numerous reviews including a preliminary, institutional, regional, and national review.

The purpose of the Institutional Head and regional reviews is "to ensure compliance with laws and policy…"[40] We reviewed uses of force documentation for the treatment centres, in the regions, and at NHQ and found that all cases reviewed complied with policy requirements to complete treatment centre and regional reviews.

[39] CD 083 – Paragraph 8
[40] CD 567-1 Paragraph 15

Table 4.3.5.1: Rates of Compliance According to Levels of Review of Uses of Force

Region	# of Use of Force Incidents	Treatment Centre Review	RHQ Review
		Compliance with Institutional Review Requirement	Compliance with Regional Review Requirement
Atlantic	15	100%	100%
Québec	15	100%	100%
Ontario	14	100%	100%
Prairies	14	100%	100%
Pacific	14	100%	100%
Total	**72**	**100%**	**100%**

Source: File review

Based on file review, we found that the treatment centres have generally not complied with policy requirements to conduct a preliminary review for all uses of force within two working days as required by the Commissioner's Directive on "Use of Force".

As a result of the April 1st, 2009 revisions to the Commissioner's Directive on "Use of Force" preliminary reviews by the institution are required and are to be completed within 2 working days of the event to identify any serious deficiencies. [41] Prior to April 1st, 2009 there was no requirement for a preliminary review to be conducted. Out of our sample of 72 uses of force, 13 took place after April 1st, 2009 of which only 2 files had evidence that a preliminary review was conducted within the prescribed 2 working days.

We found that National Headquarters did not comply with the requirement to review uses of force within the 30 working day period.

The Director General of Security "must ensure that each incident involving use of force is reported accurately and subsequently reviewed at the institutional, regional and national levels."[42] In addition, the revised Commissioner's Directive requires all uses of force be reviewed at the national level.[43] This review must be completed within 30 working days from the date the use of force package is received from the region.[44] Prior to the April 1st, 2009 revisions to the Commissioner's Directive the Director General, Security determined which incidents were reviewed at the national level.[45]

We reviewed NHQ's database of uses of force from April 1st, 2009 to March 18th, 2010 and found a total of 122 uses of force which occurred at the RTC's were received from RHQ. We found that none of them had been reviewed within the 30 working day period. As of March 18th, we found that only 17 out of the 110 files were reviewed and closed.

[41] CD 567-1 Paragraph 46
[42] CD 567-1, Paragraph 17c
[43] CD 567-1, Paragraph 61
[44] CD 567-1, Paragraph 61
[45] CD 567-1 Paragraph 35 (2008-01-24)

Video-recordings for Uses of Force whether planned or spontaneous were not always done as prescribed by the policy requirements.

The Commissioner's Directive on "Use of Force" states "A video-recording must be made from the beginning…of any planned use of force, and as soon as possible once a spontaneous use of force is underway."[46] For the period under review, out of 28 planned uses of force, we found 2 that were not video-taped. In one of these incidents the video had been destroyed by mistake prior to our review. In the second incident no explanation was provided detailing why the use of force was not video-recorded. We also found that in 11% (5 out of 44) of the spontaneous uses of force we reviewed, video-recording was initiated as soon as possible.

The Commissioner's Directive further requires that "when a planned use of force is not video-recorded from the onset, or a spontaneous use of force was not video-recorded as soon as it was possible, the Institutional Head includes as part of the institutional review, a written explanation for the inability to video-record."[47] We found that 85% (33 out of 39) spontaneous uses of force were not video-taped as soon as possible but did include a recording of the medical assessment. For those spontaneous uses of force which were not video-recorded at the onset of the use of force, we expected to find within the institutional head's review an explanation regarding why the use of force was not video-recorded. We found explanations were not consistently provided when video-recordings have not occurred.

Table 4.3.5.2: Rates of Compliance with Recording of Uses of Force

		Planned Uses of Force	Spontaneous Uses of Force	
Region	Total Sample Size	# and % Evidence of Video Recording	# and % Evidence of Video Recording beginning as Soon as Possible	# and % of File Where Explanation for Not Recording Was Provided
Atlantic	15	100% (4/4)	0% (0/11)	9% (1/11)
Québec	15	67% (2/3)[48]	8% (1/12)	9% (1/11)
Ontario	14	100% (9/9)	20% (1/5)	50% (2/4)
Prairies	14	86% (6/7)	14% (1/7)	17% (1/6)
Pacific	14	100% (5/5)	22% (2/9)	72% (5/7)
Total Compliance	**72(43%)**	**93% (26/28)**	**11% (5/44)**	**26% (10/39)**

Source: File review

[46] CD 567-1, Paragraph 24
[47] CD 567-1, Paragraph 19p
[48] Video recording was destroyed prior to our review taking place, therefore we were unable to assess compliance

We found an inconsistent understanding of when a use of force begins and ends.

We found an inconsistent understanding at the treatment centres on whether the use of Pinel restraints[49] is a use of force or a clinical intervention. Most treatment centre staff understands the use of Pinel restraint equipment to be a clinical intervention; however, we found staff in one treatment centre who understood it to be a use of force and considered the duration that an inmate was in the Pinel restraint system as being a "status of use of force". Prior to a May 19th, 2010 policy bulletin, the securing of an inmate in Pinel was considered by NHQ to be a reportable use of force. This new policy bulletin states "…for offenders who are engaged in self-injury and comply with a request, or request themselves, to be placed in the Pinel Restraint System, this incident will be classified as a non-reportable use of force."

A policy bulletin was released April 1st, 2009 indicating that a revised "Use of Restraint Equipment for Health Purposes" Commissioner's Directive was also being released on that date. The revisions to the Commissioner's Directive would have clarified CSC's position that a Use of Force is considered over once a health status assessment have been completed. We noted this revision has yet to be released. Generally, when treatment centre staff considers the application of Pinel to be a "Use of Force", they consider it to be complete once the nursing staff conducts the health status assessment, at which point a clinical intervention begins.

4.3.6 Use of Restraint Equipment for Health Purposes

We expected to find that CSC complies with policy requirements when restraint equipment is used on inmates at the treatment centres.

Based on file review, we found that CSC did not consistently comply with policy requirements when restraint equipment was used for health purposes on inmates at the treatment centres.

Commissioner's Directive 844 states that "Restraints are necessary in any situation where there is risk of serious bodily injury to the inmate" and after "…all less restrictive measures, including verbal interventions and negotiation, have been tried but have not been effective in resolving the situation.[50]

At a minimum, when an inmate is in Pinel restraints, treatment centre staff must assess a number of the inmate's vital signs[51]. These observations are to be recorded on the "Seclusion and Restraint Observation Report" every 15 minutes. Within 72 hours after restraints have been removed, the multi-disciplinary team shall "evaluate the

[49] The Pinel system restraint is a one-point and up to seven-point soft restraint system that restrains a portion of an individuals body (i.e. head, shoulders, etc.)
[50] CD 844, Paragraph 3a and b
[51] CD 844, Paragraph 33

appropriateness of having used the restraints." [52] The following table summarizes results from our sample.

Table 4.3.6.1: Rates of Compliance with Commissioner's Directive on Use of Restraint Equipment

Region	# of Pinel Cases	Compliance with requirement for Nurse to Assess Heart Rate	Compliance with requirement Entries be Recorded Every 15 Minutes	Compliance with requirement for an Evaluation of Use of Restraint
Atlantic	No cases of Pinel available to be sampled			
Québec	3	100% (3/3)	100% (3/3)	33% (1/3)
Ontario	3	33% (1/3)	100% (3/3)	33% (1/3)
Prairies	2	50% (1/2)	100% (2/2)	100% (2/2)
Pacific	3	67% (2/3)	100% (3/3)	67% (2/3)
Total	**11**	**64% (7/11)**	**100% (11/11)**	**55% (6/11)**

Source: File review

We found that the Commissioner's Directive on the Use of Restraint Equipment for Health Purposes lacks direction on oversight and monitoring beyond the institutional level when restraint equipment is used for health purposes.

The Commissioner's Directive states that licensed physicians, psychiatrists, psychologists and nurses may authorize the use of soft restraints, while physician or psychiatrist are the only clinical staff who can authorize the application of Pinel.

When a health care professional is not present in the institution, and where time and circumstances do not permit, the Institutional Head or delegate may authorize the use of soft restraints, including Pinel, without prior consultation with a health care professional, but must immediately notify the on-call physician or psychiatrist of the application of restraints.[53] We found the Commissioner's Directive on the "Use of Restraint Equipment for Health Purposes" does not require a review beyond the institutional level to be completed following the application of Pinel restraints for health purposes. The Commissioner's Directive requires a written report containing the institutional evaluation be sent to the RDC and Regional Director of Health Services, but does not indicate the process that is to be undertaken by these individuals once the report is received. We found that NHQ Security reviews who has authorized the application of Pinel, to determine whether policy was followed; however, there is no regional or national monitoring required in the policy related to the frequency and appropriateness of Pinel use.

4.3.7 Administration of Medication

We expected to find that CSC complies with policy requirements when medication is administered to inmates at the treatment centres.

[52] CD 844, Paragraphs 33, 35 and 39
[53] CD 844, Paragraphs 11 – 13

We found that CSC did not consistently comply with all policy requirements when medication is administered to inmates at the treatment centres.

The Commissioner's Directive on the "Administration of Medication" defines the administration of medication as "the process of giving medication to an inmate as prescribed by a clinician" and states that "the management, control, storage and dispensing of drugs and medical supplies shall be in accordance with generally accepted management and pharmacy practices."[54] CSC nursing staff utilizes a Medication Administration Record (MAR) to document the medication being administered to inmates at all of the treatment centres. The MAR provides a record of medication prescribed by the institutional physician and all medications administered to the inmate.

In April 2008, the Health Services Sector published the "Documentation and Health Care Record Maintenance Guidelines", which provides direction to nursing staff on the administration of medication. The guidelines indicate that "all entries are to be made as soon as possible after the care is provided" and that when completing the MAR, the nurse must initial in the box corresponding to the day of the month when each medication is administered.

We found that 2 of the regional treatment centres complied with policy requirements when medication was administered to inmates at the treatment centres. We observed non-compliance at the remaining three treatment centers, with respect to when the MAR was signed during the administration of medication process, as it was signed when the medication was prepared for administration instead of when administered as required by policy.

We also found that at one treatment centre medication was prepared for administration hours before its administration. We also observed issues with how controlled drugs had been secured in the medication room. As well, we observed issues with how controlled drugs were being transported to the medication room from another area.

4.3.8 Managing Medical Emergencies and Managing and Responding to Suicidal and Self-Harming Inmates

We expected to find that CSC complies with policy requirements when managing and responding to medical emergencies at the treatment centres.

We were unable to assess whether CSC complied with policy requirements when managing medical emergencies as we were unable to determine a sample due to limitations with the system used for recording medical emergencies.

A medical emergency as defined within the Commissioner's Directive on the "Prevention, Management and Response to Suicide and Self-Injuries" is an injury or

[54] CD 805 – Paragraph 26

condition that poses an immediate threat to a person's health or life which requires medical intervention."[55]

We also expected to find that CSC complies with policy requirements when managing and responding to suicidal and self-harming inmates at the treatment centres.

We found that CSC is in compliance with several elements of Commissioner's Directive on Prevention, Management and Response to Suicide and Self-Injuries requirements. However, compliance rates vary among regions on the provision of direction on communicating the conditions of the suicide watch and when the watch can be terminated.

The Commissioner's Directive on "Prevention, Management and Response to Suicide and Self-Injuries" outlines the process for suicidal and self-injurious inmates and requires staff take the necessary actions when suicidal and self-injurious inmates are referred on an emergency basis to them.[56] At this time the "Psychologist or designated members of the interdisciplinary mental health team shall determine the degree of risk for suicide or self-injury and the appropriate level of intervention."[57] If this risk is high and cannot be reduced to an acceptable level, the inmate is to be placed on suicide watch. When the suicide watch is in place, the mental health team managing the case is to provide staff with directions on the specific conditions of the watch. The Psychologist or designated member of the interdisciplinary mental health team will recommend to the manager in charge when the suicide watch can be terminated."[58]

Table 4.3.8.1: Rates of Compliance with the Commissioner's Directive on Prevention, Management and Response to Suicide and Self-Injuries.

Region	# of High Risk Cases	Compliance with requirement to Closely Manage Case	Compliance to Requirement to Determine the Degree of Risk	Compliance with Requirement to give Specific Direction on Conditions	Compliance with Requirement to be in a Suicide Watch Cell under Continuous Monitoring	Compliance with Requirement to Communicate Termination of Suicide Watch
Atlantic	4	75% (3/4)	100% (4/4)	0% (0/4)	100% (4/4)	0% (0/4)
Québec	4	100% (4/4)	100% (4/4)	75% (3/4)	100% (4/4)	50% (2/4)
Ontario	11	100% (11/11)	100% (11/11)	73% (8/11)	91% (10/11)	45% (5/11)
Prairies	7	100% (7/7)	100% (7/7)	0% (0/7)	86% (6/7)	71% (5/7)
Pacific	2	100% (2/2)	100% (2/2)	0% (0/2)	100% (2/2)	0% (0/2)
Total	**28**	**96% (27/28)**	**100% (28/28)**	**39% (11/28)**	**93% (26/28)**	**43% (12/28)**

Source: File review conducted on site

Based on our sample, we found no evidence at any of the treatment centres that self injurious/suicidal inmates were disciplined for self-injurious behaviour. We also found

[55] CD 843 - Paragraph 4
[56] CD 843, Paragraph 16
[57] CD 843, Paragraph 17
[58] CD 843, Paragraphs 18, 20, and 21

that each treatment centre had different mechanisms in place to signal the level of suicide risk associated with the inmate on suicide watch. In one region, we found observation sheets within the treatment centre file to indicate the level of monitoring required for high suicide/self-injury risk inmates. We did not find formalized mechanisms in three other treatment centres that clearly communicated risk levels of high suicide inmates. Although no standard process is currently in place we have been informed CSC is currently working on a policy which would standardize this process.

Good Practice

The Ontario regional treatment centre has a formalized suicide and self-injury risk identification system in place.

This system consists of coloured sheets each associated with a different risk level. These sheets identify the risk level of the inmate as well as any restrictions imposed to ensure the inmate's safety.

CONCLUSION:

As mentioned above, CSC establishes policies in the form of Commissioner's Directives, many of which are used to ensure legislative requirements are being met and detail how services are to be delivered. CSC is in compliance with policy requirements applicable to the Regional Treatment Centres in areas such as:

- Conformity to admission and discharge criteria;
- Provision of medical information as required for investigative purposes;
- Opportunities are provided to inmates to communicate with treatment centre management through inmate committees or range representatives; and
- Treatment Centres and Regional Headquarters are conducting reviews of all use of force incidents.

However, there are still a number of opportunities for improvement in the following areas:

- Improve tracking of programming offered and rates of completion of programs;
- Ensure the Commissioner's Directives on Use of Force and Use of Restraint Equipment for Health Purposes are better followed;
- Ensure compliance with policy when medication is being administered to inmates; and
- Better and consistent processes to demonstrate compliance with requirements to communicate information about high risk suicidal and self-injurious inmates and standardizing mechanisms to signal level of risk associated with inmates

Recommendation 6[59]

The Regional Deputy Commissioners should:

a) Ensure compliance with Commissioner's Directive on Use of force, more specifically with respect to requirements:
   - o Concerning the timelines applicable to preliminary reviews and national reviews along with the Assistant Commissioner Correctional Operations and Programs; and
   - o Video recording of use of force incidents;

b) Ensure that when restraints are used for health purposes, the required medical checks and post-restraint use evaluations are completed and recorded; and

c) Ensure the policies on administration of medication are followed when medication is administered to inmates.

Recommendation 7[60]

The Regional Deputy Commissioners with the assistance of Assistant Commissioner Health Services should ensure the directions on the specific conditions of inmates who have been identified at high risk for suicide and self-injury are clearly communicated and documented in a standardized format.

[59] For an explanation of the recommendation colour coding system, see the footnote for Recommendation 1

[60] For an explanation of the recommendation colour coding system, see the footnote for Recommendation 1

5.0 OVERALL CONCLUSION

In relation to the Management framework, some elements are in place for mental health services delivered to inmates at the treatment centres. Commissioner's Directives are addressing the majority of the legislative requirements of the *CCRA* and the standing orders developed at the institutions comply with policies. Individual roles and responsibilities for mental health services are defined and all treatment centres have continuous quality improvement programs and are working towards achieving and/or renewing their accredited status..

However, there are still a number of areas requiring improvements to ensure that a comprehensive and integrated management control framework is in place. Those areas for improvement include:

- Commissioner's Directives applicable to the treatment centres that would fully address all legislative requirements;
- Better defined interrelationships between various positions including clinical and security positions, RTC Executive Directors, Regional Psychologists and Regional Directors of Health Services;
- A detailed plan for the Health Services Sector to provide greater integration between physical and mental health services and to ensure standardized mental health practices at the treatment centres;
- A resource model that would formalize and standardize the financial and staffing needs of the treatment centres;
- Better follow-up for training to ensure staff at the treatment centres are currently in compliance with NTS standards; and
- Better monitoring and reporting to assist in determining whether the treatment centres are meeting their strategic goals or mandate.

Compliance with Legislative Requirements

Sections 85 to 89 of the CCRA prescribe CSC's responsibilities in relation to mental health and mental health services for federal offenders. CSC develops policies and directions describing how CSC will ensure these legislative requirements will be met. In some instances, CSC has not yet defined how these legislative requirements will be met, while in other cases a standardized process for ensuring these requirements are being met has not been established. In yet other cases, documentation was not always on file to demonstrate compliance. Specifically, CSC needs to:

- Define essential and non-essential mental health care;
- Develop a standardized process for ensuring all health care professionals are in good standing with their respective professional licensing bodies;
- Ensure that better documentation is on file to demonstrate compliance with the requirements to:
    - Consider the inmate's mental health and mental health needs in making decisions to transfer, administratively segregate and discipline; and

- Obtain the informed voluntary consent of inmates prior to issuing treatment; and
- Comply with provincial legislation when the treatment centres treat inmates who do not have the capacity to understand informed consent.

Compliance with Commissioner's Directives and Policy Requirements

As mentioned above, CSC establishes policies in the form of Commissioner's Directives, many of which are used to ensure legislative requirements are being met and detail how services are to be delivered. CSC is in compliance with policy requirements applicable to the Regional Treatment Centres in areas such as:

- Conformity to admission and discharge criteria;
- Provision of medical information as required for investigative purposes;
- Opportunities are provided to inmates to communicate with treatment centre management through inmate committees or range representatives; and
- Treatment Centres and Regional Headquarters are conducting reviews of all use of force incidents.

However, there are still a number of opportunities for improvement in the following areas:

- Improve tracking of programming offered and rates of completion of programs;
- Ensure the Commissioner's Directives on Use of Force and Use of Restraint Equipment for Health Purposes are better followed;
- Ensure compliance with policy when medication is being administered to inmates; and
- Better and consistent processes to demonstrate compliance with requirements to communicate information about high risk suicidal and self-injurious inmates and standardizing mechanisms to signal level of risk associated with inmates.

Recommendations have been provided to assist in addressing these opportunities for improvement.

AUDIT OBJECTIVES AND CRITERIA

OBJECTIVES	CRITERIA
1. To assess the adequacy and effectiveness of CSC's management control framework for mental health services delivered to inmates at the treatment centres.	1.1. Commissioner's Directives applicable to the treatment centres are current and comply with legislation.
	1.2 Mental health standing orders at the treatment centres comply with Commissioner's Directives.
	1. 3 Roles and responsibilities for mental health services are defined and are being adhered to by NHQ, RHQ, and by the treatment centres.
	1.4 Staffing levels and resources allocations for mental health services are identified, allocated, and distributed according to their approved organizational plan.
	1. 5 Training is offered and delivered to treatment centre staff.
	1.6 Monitoring and reporting mechanisms, including continuous quality improvement programs are in place and reporting requirements are being met by NHQ, RHQ, and the treatment centres.
2. To determine the extent to which CSC is complying with sections 85 to 88 of the *CCRA* legislation concerning mental health services delivered to inmates at the treatment centres.	2.1 CSC provides inmates at the treatment centres with "essential mental health care" and "reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful integration into the community."
	2.2 The provision of mental health services for inmates at the treatment centres conforms to professionally accepted standards."
	2.3 CSC considers the inmate's state of mental health and mental health needs in decisions to transfer, administratively segregate, or discipline inmates at the treatment centres.
	2.4 CSC obtains informed voluntary consent by the inmate at the treatment centre prior to issuing treatment.

OBJECTIVES	CRITERIA
	2.5 CSC complies with provincial legislation when administering mental health services when inmates at the treatment centres do not have the capacity to understand informed consent.
	2.6 CSC does not force feed any inmates at the treatment centres.
3. To determine the extent to which CSC is complying with directives when administering mental health services to inmates at the treatment centres.	3.1 Inmates in the treatment centres meet admission and discharge criteria.
	3.2 Inmates with identified mental health issues are being offered and are completing the programs they are referred to by staff at the treatment centre.
	3.3 The treatment centres comply with policy requirements when disclosing confidential medical information for investigative purposes.
	3.4 CSC has established inmate committees at the treatment centres.
	3.5 CSC complies with policy requirements when use of force is applied to inmates at the treatment centres.
	3.6 CSC complies with policy requirements when restraint equipment is used on inmates at the treatment centres.
	3.7 CSC complies with policy requirements when medication is administered to inmates at the treatment centres.
	3.8 CSC complies with policy requirements when managing medical emergencies and when managing and responding to suicidal and self-harming inmates at the treatment centres.

LOCATION OF SITE EXAMINATIONS

Region	Sites
National Headquarter	• Finance • Grievances • Health Services Sector • Investigations Branch
Atlantic	• Shepody Healing Centre • Dorchester Institution • Regional Headquarters
Québec	• CRSM • Archambault Institution • Regional Headquarters
Ontario	• RTC Ontario • Kingston Penitentiary • Regional Headquarters
Prairies	• Regional Psychiatric Centre • Regional Headquarters
Pacific	• RTC Pacific • Pacific Institution • Regional Headquarters

MANAGEMENT PREAMBLE TO TC AUDIT MAP

CSC has undertaken a number of initiatives in the area of mental health care as part of the transformation agenda priorities. One initiative has been the implementation of a mental health screening system at CSC's 16 intake sites. The Computerized Mental Health Intake Screening System (CoMHISS) provides standardized processes to identify offenders that require a more in-depth mental health assessment and/or intervention. Approximately 5,000 offenders have been screened using either this computerized system or the paper and pencil version of the tests as of March 1st, 2010. A spectrum of primary mental health services is offered, including group and individual interventions in the areas of mental health promotion, prevention and early intervention, assessment and individualized treatment planning, and evidence-based treatment and support services in a manner respectful of diversity (i.e. Aboriginal and women offenders). Primary mental health services are integrated within the wider correctional planning and institutional supervision frameworks, mindful of the multiple needs with which offenders with mental disorders present (e.g. health, employment, substance abuse, education, programming, etc.). Service Delivery Guidelines for both the mental health screening system and the Primary Mental Health Care component of the Institutional Mental Health Initiative have been developed to inform and assist mental health teams on the provision of services to offenders with mental health concerns. A total of approximately 98FTE positions have been filled as of March 2010, to support the delivery of primary mental health care and the mental health screening system.

Capacity has been improved to provide mental health services to offenders in the community through discharge planning, hiring of mental health professionals in the community, contracting with community service providers, and provision of mental health awareness training to CSC staff and partners. Approximately 49 new positions were created to support the Community Mental Health Initiative and 43 contracts are now in place to provide specialized services at 52 sites for offenders with mental health disorders through the Community Mental Health Initiative.

In support of its mental health strategy, CSC has offered mental health awareness training to front line community staff beginning in 2007, and institutional staff beginning in December 2008. To the end of March 2010, over 700 community and 1500 institutional CSC employees have received the two day awareness training. An additional 450 non-CSC staff and community partners (e.g CRF staff and contractors) have received this training. Mental health training for all correctional officers remains a priority for CSC, with staff at maximum security institutions as the target group for FY2010-11.

The Service also continues to focus on the enhancement of psychological and psychiatric services at institutions and Regional Treatment Centres (RTCs). In October 2009 CSC's Executive Committee approved the establishment of a Complex Needs Program pilot at the Regional Treatment Centre in the Pacific Region. This Program is to provide a new resource for the most serious self-injurious offenders.

CSC has also recently implemented Regional Suicide / Self-Injury Prevention Management Committees (RSPMC) in all regions. RSPMC is a mechanism to assist and support institutions in providing an effective continuum of care to offenders encountering severe mental health and/or behaviour difficulties during their period of incarceration. Finally, CSC is developing a Correctional Mental Health Strategy with its federal, provincial, and territorial partners.

AUDIT OF REGIONAL TREATMENT CENTRES AND THE REGIONAL PSYCHIATRIC CENTRE MANAGEMENT ACTION PLAN (MAP)

Recommendation:	**Recommendation No. 1** The Assistant Commissioner Health Services should revise the Mental Health Management Framework for the Regional Treatment Centres to ensure that: a) The governance model is clear, understood and being adhered to; b) With the assistance of the Assistant Commissioner Corporate Services governance is supported by a robust resource allocation model which is consistent with the other CSC activities and reflects the operating environment of the treatment centres. c) With the assistance of the Assistant Commissioner Correctional Operations and Programs interrelationships between clinical and operational staff involved in mental health care activities requiring interventions are well defined and understood; and d) Performance monitoring and reporting requirements are established and communicated in order to better meet clinical objectives.
Management Response / Position:	☑ **Accepted** ☐ **Accepted in part** ☐ **Rejected**

Action(s)	Deliverable(s)	Approach	Accountability	Timeline for Implementation
What action(s) has / will be taken to address this recommendation?	*Expected deliverable(s) / indicator(s) to demonstrate the completion of the action(s)*	*How does this approach address the recommendation?*	*Who is responsible for implementing this action(s)?*	*When will action(s) be completed to fully address the recommendation?*
Health Services will: Develop a Memorandum of Understanding (MOU) between the Assistant Commissioner Health Services and Regional Deputy Commissioners which clearly identifies functional and line authorities for treatment centre governance,	Regional MOUs signed by ACHS and RDCs.	Clear governance model of Regional Treatment Centres which is defined by MOUs and Commissioners Directive 850.	ACHS/RDCs	March, 2011
a) CD 850 *Mental Health Services* will be updated to articulate regional responsibilities for mental health with emphasis on the roles of the RDHS, Regional Psychologist and Executive Director of Treatment Centres.	Promulgation of CD 850		ACP	March, 2011

Action(s)	Deliverable(s)	Approach	Accountability	Timeline for Implementation
b) Corporate Services, in collaboration with Health Services, will finalize Resource Indicator (RI) model for treatment centres which addresses mental health, operations/case management and other resource requirements.	Regional Treatment Centre RI model is finalized by March, 2011.	Treatment centre budget allocations are based on a consistent resource formula.	ACCS/ACHS	March, 2011
c) COP will undertake a study for EXCOM decision with recommendations on how best to provide stability in the CX staffing model at treatment centres (i.e., deployment standards, scheduling and selection of CX).	Study and recommendations presented to EXCOM for decision.	Stronger and more efficient working relationships between the staffing groups through a more stable CX staffing model at Regional Treatment Centres.	ACCOP/SDC	April, 2011
Human Resources Management will develop interdisciplinary training to be offered at all Treatment Centres. Below are key milestones:	Training material is developed and training plans are in place for all treatment centres	Interdisciplinary training will assist in defining working relationships between clinical and operations staff while emphasizing collective responsibility for mental health services.		
a) Training analysis report for ACHS and ACHRM review and approval.			ACHRM	December, 2010
b) Training recommendations presentation by ACHRM/ACHS to Learning and Development Board.			ACHRM/ACHS	January, 2011
c) Interdisciplinary training is developed.			ACHRM/ACHS	TBD
d) Implementation plan is developed and training is rolled out to all treatment centres.			ACHRM/ACHS	TBD
d) In collaboration with Executive Directors Treatment Centres (EDTCs), Health Services will develop a performance measurement framework. Below are key milestones;	National Treatment Centre PMF is in place.	Through the on-going process of collecting and analyzing performance information, treatment centres can assess and report on how well they are doing in relation to priority indicators.	ACHS	
a) EDTC consultation to determine priority performance indicators.			ACHS	December, 2010
b) Begin data collection.			RDCs	March, 2011
c) Regional roll up of data for 2011-2012			RDCs	Biannual roll-ups beginning Fiscal year 2011-12

Recommendation:	**Recommendation No. 2** The Assistant Commissioner Health Services should develop processes to standardize mental health practices at the treatment centres and provide guidance to the Regional Treatment Centres when required
Management Response / Position:	☑ **Accepted** ☐ **Accepted in part** ☐ **Rejected**

Action(s)	Deliverable(s)	Approach	Accountability	Timeline for Implementation
What action(s) has / will be taken to address this recommendation?	*Expected deliverable(s) / indicator(s) to demonstrate the completion of the action(s)*	*How does this approach address the recommendation?*	*Who is responsible for implementing this action(s)?*	*When will action(s) be completed to fully address the recommendation?*
Develop and implement standardized mental health service guidelines at all Regional Treatment Centres. Key milestones include:	Standardized Service Guidelines are completed and implemented at all RTCs.	Standardized practices will promote consistency of mental health services at all Regional Treatment Centres.	ACHS/RDCs	April, 2012
a) Review of the use of RTC discharge summaries to identify opportunities for improvement and to establish standardized processes.	Findings of review are completed.		ACHS	December, 2010
	Work plan for discharge summaries is developed to ensure consistency across RTCs.			January, 2011
b) Identify best practices in the areas of assessment, treatment planning, mental health interventions, progress monitoring and discharge planning.	Summary of Best Practices.		ACHS	

Recommendation:	**Recommendation No. 3** The Assistant Commissioner Health Services should define essential and non-essential mental health services.
Management Response / Position:	☑ **Accepted** ☐ **Accepted in part** ☐ **Rejected**

Action(s)	Deliverable(s)	Approach	Accountability	Timeline for Implementation
What action(s) has / will be taken to address this recommendation?	*Expected deliverable(s) / indicator(s) to demonstrate the completion of the action(s)*	*How does this approach address the recommendation?*	*Who is responsible for implementing this action(s)?*	*When will action(s) be completed to fully address the recommendation?*
a) Finalize admission and discharge criteria for treatment centres.	Admission and discharge criteria are promulgated.	Standardized criteria is applied nationally. Also supports the work to standardize mental health practices identified in recommendation No. 2	ACHS	December, 2010
b) Define essential and non-essential mental health services (National Advisory Committee on Essential Health Services).	A framework for essential and non essential mental health care is established.	This framework will provide a mechanism for promoting consistency of mental health service across the country.	ACHS	October, 2011

Recommendation:	**Recommendation No. 4** The Assistant Commissioner Health Services should develop a standardized process to assist the Regional Deputy Commissioners in monitoring that professional staff and contractors are always in good standing with their licensing body. The Assistant Commissioner Health Services should also ensure that this verification is performed yearly.
Management Response / Position:	☑ **Accepted** ☐ **Accepted in part** ☐ **Rejected**

Action(s)	Deliverable(s)	Approach	Accountability	Timeline for Implementation
What action(s) has / will be taken to address this recommendation?	*Expected deliverable(s) / indicator(s) to demonstrate the completion of the action(s)*	*How does this approach address the recommendation?*	*Who is responsible for implementing this action(s)?*	*When will action(s) be completed to fully address the recommendation?*
Health Services will develop a process to monitor that professional staff and contract health providers are in good standing with their licensing body on an annual basis. Regions to implement.	ACHS memorandum to RDCs outlining monitoring process.	Standardized approach is established by Health Services and is applied to Regional Treatment Centres by the RDCs	ACHS/RDCs	June, 2011

Recommendation:	**Recommendation No. 5** The Regional Deputy Commissioners should put in place processes with the assistance of: a) The Assistant Commissioner Correctional Operations and Program to ensure that consideration of the inmates mental health and mental health needs is documented when making decisions to transfer, administratively segregate and discipline inmates; b) The Assistant Commissioner Health Services to ensure compliance with the requirements to obtain the informed voluntary consent of inmates prior to issuing treatment and to ensure the requirements of provincial legislations when treating inmates who do not have the capacity to understand informed consent are being followed.
Management Response / Position:	☑ **Accepted** ☐ **Accepted in part** ☐ **Rejected**

Action(s)	Deliverable(s)	Approach	Accountability	Timeline for Implementation
What action(s) has / will be taken to address this recommendation?	*Expected deliverable(s) / indicator(s) to demonstrate the completion of the action(s)*	*How does this approach address the recommendation?*	*Who is responsible for implementing this action(s)?*	*When will action(s) be completed to fully address the recommendation?*
a) COP will review and where required amend relevant CDs concerning inmate administrative segregation, transfer and discipline to reflect the requirement that decision makers take into consideration any physical and mental health concerns as identified by Health Care/Psychology and to document that this has occurred in all segregation, transfer and discipline related decisions.	Revised CDs and Policy Bulletins where required.	Ensures clear policy direction and institutional practices.	ACCOP	December, 2010
Development of a process to ensure that professional assessments are requested and shared with the decision maker prior to making any inmate segregation, transfer and disciplinary decisions.	Development of process and necessary guidelines.	Ensures mental heath information is taken into consideration prior to decision making process regarding administrative segregation, transfer and discipline.	ACCOP	December, 2010
b) Health Services will reinforce the requirement to document voluntary consent of inmates prior to issuing treatment and to ensure compliance with provincial legislation when treating inmates who do not have the capacity to make informed consent.	ACHS memorandum to RDCs outlining the documentation process.	Reinforces treatment centre compliance with CCRA and provincial legislation and establishes a process for monitoring compliance	ACHS	January, 2011

Action(s)	Deliverable(s)	Approach	Accountability	Timeline for Implementation
		and implementing corrective actions where required.		
In the interim EDTCs will conduct file audits on all in-patients and confirm compliance in these areas.			RDCs	December, 2010
CD 803 revised to address all CCRA conditions that must be met for consent to be considered informed.	CD 803 promulgated.	Revised CD 803 addresses all CCRA requirements	ACHS	February 2011

Recommendation:	**Recommendation No. 6** The Regional Deputy Commissioners should: a) Ensure compliance with Commissioner's Directive on Use of force, more specifically with respect to requirements: o Concerning the timelines applicable to preliminary reviews and national reviews along with the assistant Commissioner Correctional operations and programs; and o Video recording of use of force incidents; b) Ensure that when restraints are used for health purposes, the required medical checks and post-restraint use evaluations are completed and recorded; c) Ensure the policies on administration of medication are followed when medication is administered to inmates.
Management Response / Position:	☑ **Accepted** ☐ **Accepted in part** ☐ **Rejected**

Action(s)	Deliverable(s)	Approach	Accountability	Timeline for Implementation
What action(s) has / will be taken to address this recommendation?	*Expected deliverable(s) / indicator(s) to demonstrate the completion of the action(s)*	*How does this approach address the recommendation?*	*Who is responsible for implementing this action(s)?*	*When will action(s) be completed to fully address the recommendation?*
a) A working group will be formed to revise CD 567-1 *Use of Force* with respect to use of force reviews and video recording of these incidents. Below are key milestones:	The working group will submit a report outlining findings and recommendations.	The working group will make recommendations on how best to streamline the process of use of force reviews while ensuring accountability and transparency.	ACCOP	
a) Working group Terms of Reference are completed.	If required, the Security Branch will revise the policy and Management Control Framework.			October, 2010
b) Working group will submit its report to ACCOP with findings and recommendations.				November, 2010
c) Findings and recommendations to be presented to EXCOM for decision				January, 2011
b) Information sessions are planned for CSC staff following promulgation of CD 843 *Management of Inmate Self-*	Information sessions are	Staff is clear on role and responsibilities relative to	ACHS	June, 2011

Action(s)	Deliverable(s)	Approach	Accountability	Timeline for Implementation
Injurious and Suicidal Behavior. In the interim, EDTCs will ensure: a) Nursing Supervisors review the requirements in CD 844 Use of Restraint Equipment for Health Purposes specific to the required assessment of inmate's physical health status and, b) CD 844 is reviewed specific to the requirement that post – restraint use evaluations are completed within 72 hours and that a written report of the evaluation is submitted to the Institutional Head with a Copy to the RDC and Regional Director of Health Services. c) EDTCs will ensure that Treatment Centre Nursing Supervisors review the professional nursing standard of medication administration as outlined by their respective provincial regulatory body.	held. Confirmation from EDTCs on actions taken. Confirmation from EDTCs on actions taken.	CD 843. EDTCs are clear on roles and responsibilities. Medication administration occurs per respective provincial regulatory body standards.	RDCs RDCs	December, 2010 December, 2010

Recommendation:	**Recommendation No. 7** The Regional Deputy Commissioners with the assistance of Assistant Commissioner Health Services should ensure the directions on the specific conditions of inmates who have been identified at high risk for suicide and self-injury are clearly communicated and documented in a standardized format.
Management Response / Position:	☑ **Accepted** ☐ **Accepted in part** ☐ **Rejected**

Action(s)	Deliverable(s)	Approach	Accountability	Timeline for Implementation
What action(s) has / will be taken to address this recommendation?	*Expected deliverable(s) / indicator(s) to demonstrate the completion of the action(s)*	*How does this approach address the recommendation?*	*Who is responsible for implementing this action(s)?*	*When will action(s) be completed to fully address the recommendation?*
The Health Services Sector is revising Commissioner's Directive CD 843 *"Prevention, Management and Response to Suicide and Self-Injuries"*. The revised CD will include standardized watch levels as well as clear standardized communication and documentation standards. Regions to implement once promulgated.	CD 843 revised.	CD 843 and the Annex provide clear direction to staff with respect to the management of this high risk/ high needs offenders. It also ensures that the management is standardized across CSC.	ACHS/RDCs	Fall, 2010

ANNEX D

CORRECTIONAL AND CONDITIONAL RELEASE ACT
SECTIONS 85-89

HEALTH CARE

85. In sections 86 and 87,

"health care" means medical care, dental care and mental health care, provided by registered health care professionals;

"mental health care" means the care of a disorder of thought, mood, perception, orientation or memory that significantly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life;

"treatment" means health care treatment.

86. (1) The Service shall provide every inmate with

(a) essential health care; and
(b) reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community.

(2) The provision of health care under subsection (1) shall conform to professionally accepted standards.

87. The Service shall take into consideration an inmate's state of health and health care needs

(a) in all decisions affecting the inmate, including decisions relating to placement, transfer, administrative segregation and disciplinary matters; and
(b) in the preparation of the inmate for release and the supervision of the inmate.

88. (1) Except as provided by subsection (5),

(a) treatment shall not be given to an inmate, or continued once started, unless the inmate voluntarily gives an informed consent thereto; and
(b) an inmate has the right to refuse treatment or withdraw from treatment at any time.

(2) For the purpose of paragraph (1)(a), an inmate's consent to treatment is informed consent only if the inmate has been advised of, and has the capacity to understand,

(a) the likelihood and degree of improvement, remission, control or cure as a result of the treatment;
(b) any significant risk, and the degree thereof, associated with the treatment;
(c) any reasonable alternatives to the treatment;
(d) the likely effects of refusing the treatment; and
(e) the inmate's right to refuse the treatment or withdraw from the treatment at any time.

(3) For the purpose of paragraph (1)(a), an inmate's consent to treatment shall not be considered involuntary merely because the treatment is a requirement for a temporary absence, work release or parole.

(4) Treatment under a treatment demonstration program shall not be given to an inmate unless a committee that is independent of the Service and constituted as prescribed has

> (a) approved the treatment demonstration program as clinically sound and in conformity with accepted ethical standards; and
> (b) reviewed the inmate's consent to the treatment and determined that it was given in accordance with this section.

(5) Where an inmate does not have the capacity to understand all the matters described in paragraphs (2)(a) to (e), the giving of treatment to an inmate shall be governed by the applicable provincial law.

89. The Service shall not direct the forcefeeding, by any method, of an inmate who had the capacity to understand the consequences of fasting at the time the inmate made the decision to fast.