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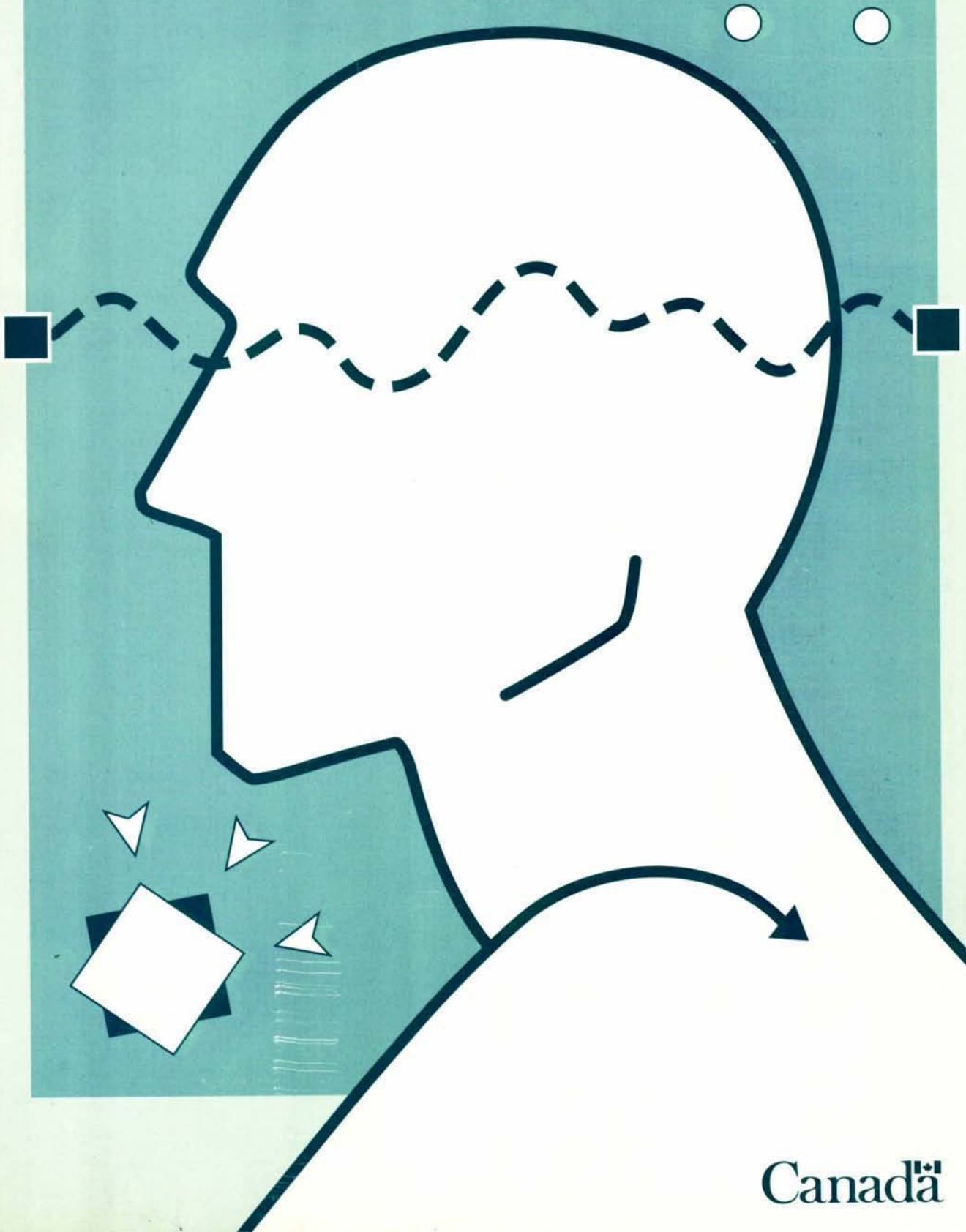
Report of the Task Force on Mental Health



Canada

REPORT OF THE TASK FORCE ON MENTAL HEALTH

CORRECTIONAL SERVICE OF CANADA

September 1991

MISSION STATEMENT

The Correctional Service of Canada, as part of the criminal justice system, contributes to the protection of society by actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure, and humane control.

"We respect the dignity of individuals, the rights of all members of society, and the potential for human growth and development."

Core value 1

"We recognize that the offender has the potential to live as a law-abiding citizen"

Core value 2

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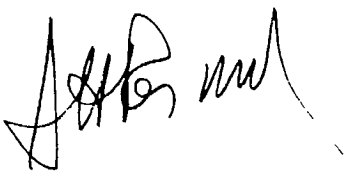
PREFACE

In June of 1989, Mr. Ole Ingstrup, Commissioner of the Correctional Service of Canada, commissioned a Task Force on Mental Health Care to offenders. This Report presents the findings and recommendations of the Task Force. It proposes a strategic framework for mental health care, governing the planning and delivery of a continuum of mental health services and programs to federal offenders, from reception to warrant expiry. It also provides abstracts of a series of discussion papers, and a list of recommendations emerging from these documents. A companion volume details the discussion papers addressing the specific issues the Task Force identified as areas of concern.

The emphasis of the Task Force was placed on fostering and promoting mental well being, through the creation of healthy interactions between the offender, the Correctional Service of Canada, and the community. To achieve this goal, the Task Force proposes a uniform mental health care delivery system consistent with the Mission of the Service and prevailing community and professional standards. The Task Force believes that the implementation of the proposed recommendations will be a necessary step towards the achievement of our Mission: to actively encourage and assist offenders to become law-abiding citizens while exercising reasonable, safe, and humane control.

The work of the Task Force is the result of collaborative efforts of the Steering Committee members, the Working Group, and external consultants. I wish to thank each one of them for their devotion to this complex and often demanding task.



Jacques H. Roy, M.D.
Director General
Health Care Services

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INTRODUCTION

There are a number of longstanding issues pertaining to the delivery of mental health care to offenders. Central to these concerns is the perceived need to develop and implement an integrated mental health strategy, aimed at the promotion of mental health and the delivery of a broad range of psychological and psychiatric services and programs, geared to the special needs of target groups of federal offenders.

Traditional mental health care delivery has largely focused on highly specialized facilities, concentrating on a relatively narrow group of offenders. While the Correctional Service of Canada has successfully implemented a wide range of specialized treatment initiatives, there is a need for a formal, organized strategy to ensure the necessary programs and services are offered in a consistent and uniform manner. There is a requirement to ensure the Correctional Service of Canada has a well defined mental health strategic framework, consistent with its Mission Statement, demographic variations and prevailing professional and community standards. This report is intended to provide long term direction and guidance to the Correctional Service of Canada in the implementation of a mental health framework, and provides short and medium term recommendations for the achievement of this goal.

MANDATE OF THE TASK FORCE

The prevalence of mental disorder among federal offenders provides clear evidence that mental health care is a major challenge to federal corrections. Given the current need to augment the range of mental health services to offenders, increasing demands for mental health services and programs, demands for more direction from mental health professionals, and the degree of public interest, the time appears opportune for the development of a comprehensive mental health strategy and policy framework.

To meet this objective, a Task Force on Mental Health Care was struck in June of 1989, with the mandate of defining the broad range of mental health services required, and designing a system to deliver same in the most appropriate manner and setting. Consideration was given to all phases of mental health care, from assessment and treatment to post-release follow-up care in the community. The need for a continuum of care from reception to warrant expiry cannot be overemphasized.

The mandate of the Task Force was, therefore:

* to examine the policy, process, standards and methods governing the development, delivery and evaluation of mental health programs and services, from date of admission to sentence expiry; and
* to develop a policy framework, strategy and action plan through which to direct and implement a comprehensive system for the delivery of mental health programs and services, based on the needs of the offender population and compatible with the Correctional Service of Canada Mission, community standards and professional requirements.

One of the Corporate Objectives set by the Correctional Service of Canada, for the three year period between 1990-1993, is to develop and implement policies and programs which address the specific mental health needs and reduce the potential recidivism of offenders. One of the primary goals of this Task Force was to achieve this objective.

METHODOLOGY

The Mental Health Strategy comprises two dimensions. The first is that of providing a process: a continuum of care including: intake assessment; pre/post treatment assessment; treatment planning and delivery; pre-release planning and assessment; and post-release follow-up. This process needs to be uniform and integrated with both the programming and decision-making processes.

The second dimension is that of content. This defines the needs of target offender population groups for programs and services, based on the prevalence of mental disorder, cultural and demographic variations, and the needs of special offender groups, including aboriginals and women. The results of a number of studies and task forces (e.g., Task Force on Aboriginal Peoples; Task Force on Federally Sentenced Women; Report of the Working Group on Sex Offender Treatment and Management; Study on Prevalence of Mental Disorder) were integrated to ensure a strategy consistent with parallel corporate initiatives and priorities.

From these two dimensions emerged a series of issues that needed to be addressed: these were originally divided into twenty-four sub-tasks, and are appended.

The management of the Task Force was structured as follows:

Steering Committee: comprised of senior officials from the Correctional Service of Canada, the Health Care Advisory Committee, the Correctional Service of Canada employees' unions, Health and Welfare Canada, the National Parole Board, the Ministry Secretariat, and other relevant agencies;

Working Group: comprised of staff representing all regions and sectors pertaining to the mental health field, with particular expertise in the subject.

The Steering Committee provided the overall direction, perspective and context for the Task Force. This included defining the terms of reference, establishing priorities and determining the time frame and benchmarks. The committee acted as an advisory body to the Working Group, and met at strategic intervals throughout the duration of the project.

The Working Group conducted the activities of the Task Force, including the definition of specific objectives, development of work plans, assessment of research needs, direction of research, consultation with relevant groups, scheduling of discussions and drafting of a series of discussion papers encompassing the various issues identified. The names of the Steering and Working Committee members are appended.

The Task Force adopted a matrix approach in addressing each of the twenty-four issues. The services of external consultants were retained to address specific areas of expertise, while members of the Working Group were each assigned the responsibility of coordinating one or more of the sub-tasks. The final result was a total of twenty-one discussion papers addressing the following subjects:

1. The development of a strategy to implement a broad range of programs to target offender groups, based on the prevalence of mental disorder among the offender population.

2. The development of a standardized programming process to ensure a uniform approach to program planning, design, resource allocation, follow-up and evaluation, in order to provide a basis for comparative evaluation of program outcome and effectiveness.

3. The development of a uniform process for the delivery of mental health programs and services, including: assessment, diagnosis, program planning, targeting, treatment, pre/post assessment, maintenance, risk assessment, release planning, post-release follow-up, evaluation; and the development of a program planning and delivery system consistent and integrated with the case management and pre-release decision making process.

4. The development of a service delivery system including the clarification of the roles of Regional Psychiatric/Treatment Centres, institutional and community based mental health staff, and contracted resources.

5. The development of a strategy to implement programs for psychiatric/psychological disorders: acute, chronic and marginal offenders.

6. The development of a strategy to implement specialized programs and services to meet the needs of aboriginal people.

7. The development of a strategy to implement programs for sex-offenders.

8. The development of a strategy to implement programs for behavioural disorders and anger control (including psychopathy).

9. The development of a strategy to determine the impact of "Dual Diagnosis" (substance abuse and mental disorder) on the assessment and treatment needs of offenders, in concert with the Task Force on Substance Abuse.

10. The development of a strategy to implement crisis management programs.

11. The development of a strategy to implement and evaluate programs and services aimed at suicide prevention.

12. The development, implementation and evaluation of programs and services aimed at reducing the incidence of self-injurious behaviour among both male and female offenders.

13. The development of a strategy to deal with the anticipated mental health needs of offenders in the testing, diagnosis and treatment of HIV infection.

14. The development of a strategy to implement specialized programs and services to meet the needs of federally sentenced women.

15. The development of standards for the delivery of psychological/psychiatric services and programs based on a hierarchy of needs and priorities, to provide a basis on which to set corporate objectives, plan programs and allocate resources;

16. The development of professional standards, staff selection criteria, recruitment strategies and professional development programs to recruit, motivate and develop a calibre of mental health professionals consistent with community and professional standards.

17. The clarification of the roles of the various health care professions in the planning, implementation, coordination, delivery and evaluation of mental health services and programs.

18. The development of a strategy to ensure the effective collation and dissemination of information.

19. The development of a communication network for the negotiation and implementation of agreements with provincial governments and academic facilities to: develop an expertise in forensic issues; initiate joint research, programs and services; maintain standards of excellence in keeping with those prevailing in the community and professions; and provide staff training and recruitment programs.

20. The development of a strategy to deal with the ethico-legal issues of mental health care within the Correctional Service of Canada.

21. The development of a research component aimed at meeting corporate and Ministerial priorities in mental health.

TASK FORCE REPORT

The Final Report of the Task Force comprises two volumes. The first is the Task Force Report itself, consisting of a Conceptual Framework: a mental health strategy consistent with the Correctional Service of Canada's Mission and its Strategic Objectives, governing the planning and delivery of mental health services and programs aimed at offenders. This framework is the core of the Final Report. A precis of each discussion paper is then presented, followed by a list of all recommendations emerging from these papers.

The Goal of Mental Health Care

Mental health is viewed as playing a pivotal role in the achievement of a certain quality of life. In order to achieve this, the Correctional Service of Canada must adopt a strategy that will not only foster mental health, but actively promote it. While the Task Force recognizes the importance of an integrated mental health strategy, it believes the issue of mental health also needs to be addressed from another angle: mental health promotion within corrections requires the creation of an environment which is conducive to the planning, delivery and evaluation of a broad range of services aimed at optimizing the mental well being of offenders.

To guide the work of the Task Force, the following statement of purpose was adopted:

Mental Health Care contributes to the Mission and Strategic Objectives of the Correctional Service of Canada – to reduce recidivism, assist the offender to become law-abiding, and facilitate reintegration into the community – by developing, implementing and evaluating an integrated continuum of mental health promotion, assessments, treatment, and relapse-prevention services from reception to sentence expiry, aimed at reducing the incidence and impact of psychological dysfunction, through social and cognitive skills development and the promotion of healthy, positive interactions between the offender, the Service and the community.

STATEMENT OF PRINCIPLES

The Task Force on Mental Health Care proposes that the following Statement of Principles be adopted:

1. The Correctional Service of Canada hereby adopts the Conceptual Framework as the core of its mental health care strategy for federal offenders.

2. The Correctional Service of Canada shall ensure that the mental health care of offenders is in keeping with the Correctional Service of Canada Mission, the Canadian Charter of Rights and Freedom, and community and professional standards of care.

3. The Correctional Service of Canada shall promote mental health by creating environments in which offenders are better able to take care of themselves and to offer each other support in managing and solving collective and individual mental health problems.

4. The Correctional Service of Canada shall implement a National Mental Health Strategy based on the recommendations of the Task Force on Mental Health Care.

5. It shall be the responsibility of National Headquarters of the Correctional Service of Canada to develop processes and policies that give guidance and direction in the overall planning, delivery and evaluation of mental health related services and programs.

6. It shall be the responsibility of each Region to develop, implement and evaluate a Regional Mental Health Plan for the respective offender population, based on the prevalence of mental disorder, the prevailing cultural and demographic factors, and resource levels.

7. The Correctional Service of Canada shall ensure that policies, programs and standards of service delivery respond to the needs of federal offenders, and target behaviour that will reduce the likelihood of recidivism.

8. The delivery of mental health services shall be integral with the overall programming philosophy of the Service, and the case management, decision-making and long term planning processes.

9. The Correctional Service Canada shall continue to develop linkages with provincial, federal, academic and community based agencies engaged in the delivery of mental health services.

10. The Correctional Service of Canada shall develop expertise and a level of excellence in forensic mental health services, enabling the Ministry to respond positively to public demands for improved services, and be proactive in its strategic planning.

11. The Correctional Service of Canada shall develop and implement a mental health strategy which optimizes the available resources, through the reallocation of same in accordance with current priorities, program effectiveness and cost efficiency.

CONCEPTUAL FRAMEWORK

Research on the Prevalence of Mental Disorder Among the Federal Offender Population

The Correctional Service of Canada's Mental Health Survey, conducted in 1989, was its first major attempt to estimate the prevalence, nature and severity of mental disorder among the offender population by applying objective diagnostic criteria.

The results of the survey revealed some remarkable facts about the lifetime prevalence of mental disorder in the federal offender population. Table 1 indicates the chance of offenders having had at least one episode of a psychotic disorder (i.e. schizophrenia, schizophreniform, mania), depressive disorders (i.e. major depression, dysthymia, bipolar), anxiety disorders (i.e. panic, generalized anxiety, phobia, agoraphobia, somatization), or psychosexual disorder (i.e. dysfunction, transsexualism, ego-dystonic homosexuality).

TABLE 1

PREVALENCE OF MENTAL DISORDER IN FEDERAL OFFENDER POPULATION

TYPE	PERCENTAGE
Psychotic	10.4
Psychosexual	24.5
Depressive	29.8
Anxiety	55.0

TABLE 2

ANTISOCIAL PERSONALITY AND ALCOHOL AND DRUG ABUSE DEPENDENCE

Antisocial + Alcohol + Drug	37.8
Antisocial + Alcohol	19.7
Antisocial + Drug	8.5
Antisocial alone	8.8
Alcohol and/or Drug alone	14.0

In devising a more focused approach to examine offenders' mental health, the study also looked at the lifetime prevalence of antisocial personality, alcohol and drug abuse dependence, and sought to determine the extent to which these three disorders were found independently, or in combination, among the offender population. The results seen in Table 2 show that nearly 40% of the total male offender population met the criteria for antisocial personality and had alcohol and drug abuse dependence. Significantly, nearly one out of five offenders met the criteria for a dual diagnosis of antisocial personality and alcohol abuse/dependence.

These results indicate the overwhelming need for a conceptual framework that sets the guidelines for the development and delivery over the next decade of a comprehensive array of mental health services and programs for offenders. Mental disorder has become a serious problem in federal correction.

The Mission

In February, 1989, the Solicitor General of Canada approved the Mission statement of the Correctional Service of Canada, its core values and strategic objectives. The main purpose of the Mission statement is to guide staff in carrying out their responsibilities. It is also intended to provide a focus when new strategies, policies and programs are being developed and implemented. The mission document depicts the goals the Service is striving to achieve, and outlines fundamental and enduring values. It states:

> **"The Correctional Service of Canada as part of the criminal justice system contributes to the protection of society by actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure and humane control." (CSC, 1989a:4)**

To achieve this, two long term objectives were set by the Executive Committee of the Service, in its Strategic Planning Session in January, 1990:

> **As the first long term objective, to actively pursue research and program strategies aimed at significantly reducing recidivism of offenders released in the community and therefore to reduce the relative use of incarceration as the prime correctional intervention for a larger proportion of the offender population.**

As the second long term objective, to concentrate the efforts of the Service to achieve a breakthrough on the understanding of the causes of violent and sex offender behaviour. These efforts will be the basis for the development and delivery of more effective treatment strategies which will prepare those offenders for a safe release and reduce the risk of recidivism.

To achieve these long term goals, and to support the corporate objectives set out by the Correctional Service of Canada for the next three years, three areas of strategic opportunity were identified:

- the need to create staff training and development programs adapted to the needs of staff engaged in correctional intervention and to provide them with enhanced quality work life in institutions, in the community, and elsewhere within the Correctional Service of Canada;
- the need to strengthen the community corrections component of the Service;
- the need for the Service, in a period of prolonged fiscal restraint, to be efficient and accountable, recognizing that major improvements in the management and development of corrections will have to be generated primarily through cost efficiency and increased productivity strategies.

Given the prevalence rates of mental health disorders and the stated objectives of the Service, there is a requirement to ensure the Correctional Service of Canada has a well defined mental health strategic framework,

consistent with its mission statement, regional and demographic variations and prevailing community and professional standards. The conceptual framework presented in this document adopts the mission statement as its primary source of guidance, the heart of which consists of five core values as shown below.

CORE VALUE 1

We respect the dignity of individuals, the rights of all members of society and the potential for human growth and development.

CORE VALUE 2

We recognize that the offender has the potential to live as a law-abiding citizen.

CORE VALUE 3

We believe that our strength and our major resource in achieving our objectives is our staff and that human relationships are the cornerstone of our endeavour.

CORE VALUE 4

We believe that the sharing of ideas, knowledge, values and experience nationally and internationally, is essential to the achievement of our Mission.

CORE VALUE 5

We believe in managing the Service with openness and integrity and we are accountable to the Solicitor General.

The strategic objectives linked to the core values of the mission statement, as well as the corporate objectives set for 1990-1993, form an integral part of this conceptual framework. The unit management concept, discussed later, also assumes a pivotal role in development and implementation of the Framework.

Defining Mental Health

Some forty years ago, the World Health Organization broadened the prevailing definition of health as merely being the absence of illness, and defined it as a "state of complete physical, mental and social well-being" (HWC, 1988a:4). Health and Welfare Canada, in a 1986 document, entitled "Achieving Health For All", extended this definition. It says health is a resource, a dynamic energy, influenced by our culture and our social, economic and physical environment, which endows people with the ability to control and alter their environment. This new definition makes us consider health as a state not solely and only experienced individually, but also collectively.

To ensure this perception is reflected in correctional policies and programs, the Task Force believes that consensus is required as follows:

- agreeing on a concept of mental health that invites collective and active involvement in mental health issues by professionals, offenders and the community;
- re-assessing the methods by which the Correctional Service of Canada presently sets its priorities and allocates its resources to mental health care;
- achieving the objective to provide, within the community, adequate and sufficient care for offenders with mental disorders, upon release; and
- encouraging initiatives aimed at mental health promotion and relapse prevention, while maintaining our commitment to the treatment of mental disorders.

MENTAL HEALTH PROMOTION

Health promotion is more than health education, health care, health administration or public health: health promotion includes all these elements.

> **"Health promotion implies a commitment to dealing with the challenges of reducing inequities, extending the scope of prevention, and helping people to cope with their circumstances. It means fostering public participation, strengthening community health services and coordinating healthy public policy. Moreover, it means creating environments conducive to health in which people are better able to take care of themselves and to offer each other support in solving and managing collective health problems." (HWC, 1986b:3)**

With the shift in focus from the individual to a broader environmental perspective, health promotion can encompass organizations which did not previously consider health as a fundamental part of their mandate, such as the Correctional Service of Canada. In this context, mental health becomes the mutual concern and shared responsibility of the Service, staff and the offender, and mental health promotion addresses the capacity of the environment to be a positive influence on the offender's mental health.

To develop an integrated mental health strategy and promote mental health, three challenges arise: to reduce inequities; to increase prevention; and to enhance coping. Correspondingly, three basic mechanisms can be used to meet these challenges: self-care, mutual aid, and the creation of healthy environments. Finally, a series of strategies, or guiding principles, can be proposed to implement these mechanisms.

A NEW DEFINITION OF MENTAL HEALTH

> **There is a compelling need in the Correctional Service of Canada for a well articulated definition of mental health. Such a definition would help shape enterprising, effective policies and programs in the field. It would also clarify the objectives of mental health promotion and mental health services. Furthermore, it would delineate the roles of the various agents such as professionals and community groups in promoting mental health. Essentially, this definition would allow the Service to "rank issues in order of their priority, articulate problems more precisely, design more effective strategies, and allocate available resources more appropriately and effectively" (HWC, 1988a:6).**

Until now, mental disorder has been the focus of the field of mental health: a recognized and medically diagnosed illness resulting in the impairment of one's cognitive, affective or relational abilities. Mental health was described in terms of psychological and behavioural characteristics, rather than in terms of the conditions of the social, economic and cultural environment. Mental health was defined as the absence of mental disorder.

In recent years, research has brought about an appreciation of the role of contributing factors to mental health, such as socio-economic situations, the physical environment, interpersonal relationships, and the family. The mutual influence of the offender, the organization and the environment on mental health is now being recognized, and is based on an underlying assumption of "systems theory": the belief that society can best be described as a "set of units with relationships among them" (Fitzpatrick, Whall, Johnston & Floyd, 1982:5). Most models take systems theory one step further and propose that the individual, as an integral part of society, is in constant interaction with the changing environment.

A striking parallel can be drawn between this vision of the role of an interactive, changing environment and the definition of mental health. This parallel is an important one, because it provides a bridge in transforming the

conceptual model into operational terms and practices. Today's definition of mental health has several key elements. These are an individual's:

- social and psychological integration and harmony,
- effective personal adaptation,
- quality of life and general well-being,
- self-actualization and growth, and
- the interaction between the individual, group and environment.

The common theme here is that mental health derives from individuals' personal happiness and their degree of success in adapting to their environment.

The mission statement believes that the offender is capable of and responsible for adopting pro-social values, such as personal happiness and adapting successfully to the environment, and that the correctional environment promote these values. This concept of mental health imposes on all correctional staff the responsibility to foster a positive environment.

Operationally, the concept of unit management plays a significant role in fostering staff-offender interaction and offender mental health. It is a decentralized approach to offender management and ensures that the lines of authority are well-defined, that decision-making processes are delegated to the unit level, and that extensive interaction between staff and offenders occurs. By describing the expanded roles of all correctional staff and emphasizing that their work is a means to achieve a healthier environment for both staff and offenders, unit management provides an operational link between the conceptual framework of mental health and correctional practice.

Case management strategies play an equally important role in showing how the conceptual definitions and goals can be transformed into practice. These strategies identify the needs and problems of the offender, define the short and long term goals essential to deal with these, and devise a plan of action to achieve expected results. This approach provides case managers with the necessary tools to be used in the case management process, and with direction to solve identified problems. By enabling correctional staff at all levels to know the offender better, the system ensures that correctional interventions obtain concrete results.

Mental life comprises both inner and interpersonal group experiences. All interactions with others take place within a framework of social values. The Task Force believes, therefore, that any definition of mental health must reflect the kind of people we are capable of becoming, the aspirations we consider desirable and the type of society we wish to live in. Such a definition must take into account the reciprocal relationship between the offender, the Service and the community. In response to this need for an interactive definition of mental health, Health and Welfare Canada has proposed the following definition:

> **"Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality." (HWC, 1988a:7)**

The Task Force adopts this definition of mental health, and uses it as a base for its conceptual framework. Subjective well-being means making it possible for offenders to feel well, maintain a positive self-image,

and experience satisfaction in living. To achieve these feelings, the physical environment as well as the social and organizational environment must be conducive to positive change, and both offenders and staff must be active participants. Barriers standing between offenders and growth must be identified and removed wherever possible.

These principles apply particularly to unit management. It says that the correctional officer's primary focus should be on inmate activity. All correctional staff are encouraged to play an active role in interacting with offenders and motivating them to take part in initiatives which enable self-development, a return to the community, and the achievement of well-being. Staff should be actively present in areas of inmate activity in order to encourage this interaction. By fostering positive interpersonal relationships, all correctional staff share in the responsibility for the planning and delivery of mental health intervention.

Fostering subjective well-being is consistent with Core Value 1 of the mission statement. By making it possible for offenders to maintain a positive self-image and experience satisfaction in living, the Correctional Service of Canada shows respect for the dignity of individuals and works towards providing a safe and secure environment, which fosters positive interaction between staff and offenders (Strategic Objective 1.4). Fostering subjective well-being, through positive interaction between staff and offenders, also reflects the mission statement's Core Value 3. Its strategic objectives concern the Service's belief that strength lies in its staff, and that human relationships are the cornerstone of its endeavour. As such, one operational objective is to ensure that staff spend as much time as possible in direct contact with offenders (Strategic Objective 3.4). The principles of unit management, and those contained in the conceptual framework for mental health, aim for this common goal.

Optimal development and use of mental abilities (cognitive, relational, and affective) means helping offenders create opportunities to challenge themselves and to assume responsibility for self-development. It also means removing stereotypes which could impede the development of offenders' mental abilities, (like believing that sex, race or religion determines one's capacity to think or feel.)

Helping offenders challenge themselves and assume responsibility for self-development is consistent with Core Value 2 of the mission statement. The Service recognizes that offenders have the potential to live as law-abiding citizens, and works towards providing programs to assist them in meeting their individual needs and enhancing their potential for reintegration in the community (Strategic Objective 2.3). At the same time, offenders are ultimately responsible for their actions and must bear the responsibility for their criminal behaviour. The Service believes that programs and opportunities which assist offenders in developing social and living skills will enhance their potential to become law-abiding citizens. The Service works towards ensuring that offenders are productively occupied and have access to a variety of work and educational opportunities to meet their needs for growth and personal development (Strategic Objective 2.4).

Whereas the mission statement and the conceptual framework provide the rationale, unit management provides the means by which staff works towards optimizing individual development. It urges correctional staff to foster a positive institutional environment and to promote responsibility for self-development.

Achievement of goals consistent with fundamental justice implies the need to choose equitable goals and reject those that imperil the rights and well being of others. Thus, promoting mental health may minimize the social, cultural, economic and physical hindrances that limit individual choice and responsibility.

Attainment and preservation of conditions of fundamental equality refers to mental life. If an offender experiences inequality and prejudice, mental health will not be promoted. Attaining equality is consistent with Core Value 1 of the mission statement and its objectives involving respect for the social, cultural and religious differences of individual offenders (Strategic Objective 1.7).

Certain factors prevent the offender and the Service from interacting effectively with the community and one another, and become barriers to the optimization of mental health. The Correctional Service of Canada needs to foster healthy interactive processes and ensure that the relationship between the offender, the Service and the community is positive. Inequities can undermine offenders mental health; promoting mental health means removing inequities wherever possible.

Given the constant interaction between the offender, the Service and the community, the definition of mental health must affirm certain societal values: human equality, justice, freedom of choice, and social responsibility. However, mental health can only be improved when social and legal environments advocate human rights and restrict destructive behaviour. The Service must support individuals and create conditions that contribute to health, and must see that offenders acquire skills and resources that permit them to contribute to communal life, meet personal needs and improve the environment. These conditions are implicit in the Service's mission statement and core values and must be respected.

MENTAL HEALTH AND MENTAL DISORDER

If mental health is no longer viewed as simply the absence of mental disorder, how does mental disorder relate to the concept of mental health? One way of illustrating their relationship is to see each as belonging on a different continuum (See Figure 1).

Figure 1

MENTAL HEALTH CONTINUUM

Optimal Mental Health

Individual, group and environmental factors work together effectively, ensuring subjective well-being, optimal development and use of mental abilities, achievement of goals consistent with justice, and attainment and preservation of conditions of fundamental equality

Minimal Mental Health

Individual, group and environmental factors conflict, producing subjective distress, impairment or underdevelopment of mental abilities, failure to achieve goals, destructive behaviours, and entrenchment of inequities

MENTAL DISORDER CONTINUUM

Maximal Mental Disorder
greatest severity, frequency and range of psychiatric symptoms

Range of impairment and distress
(From severe to negligible)

Absence of Mental Disorder
freedom from psychiatric symptoms, effective prevention or cure

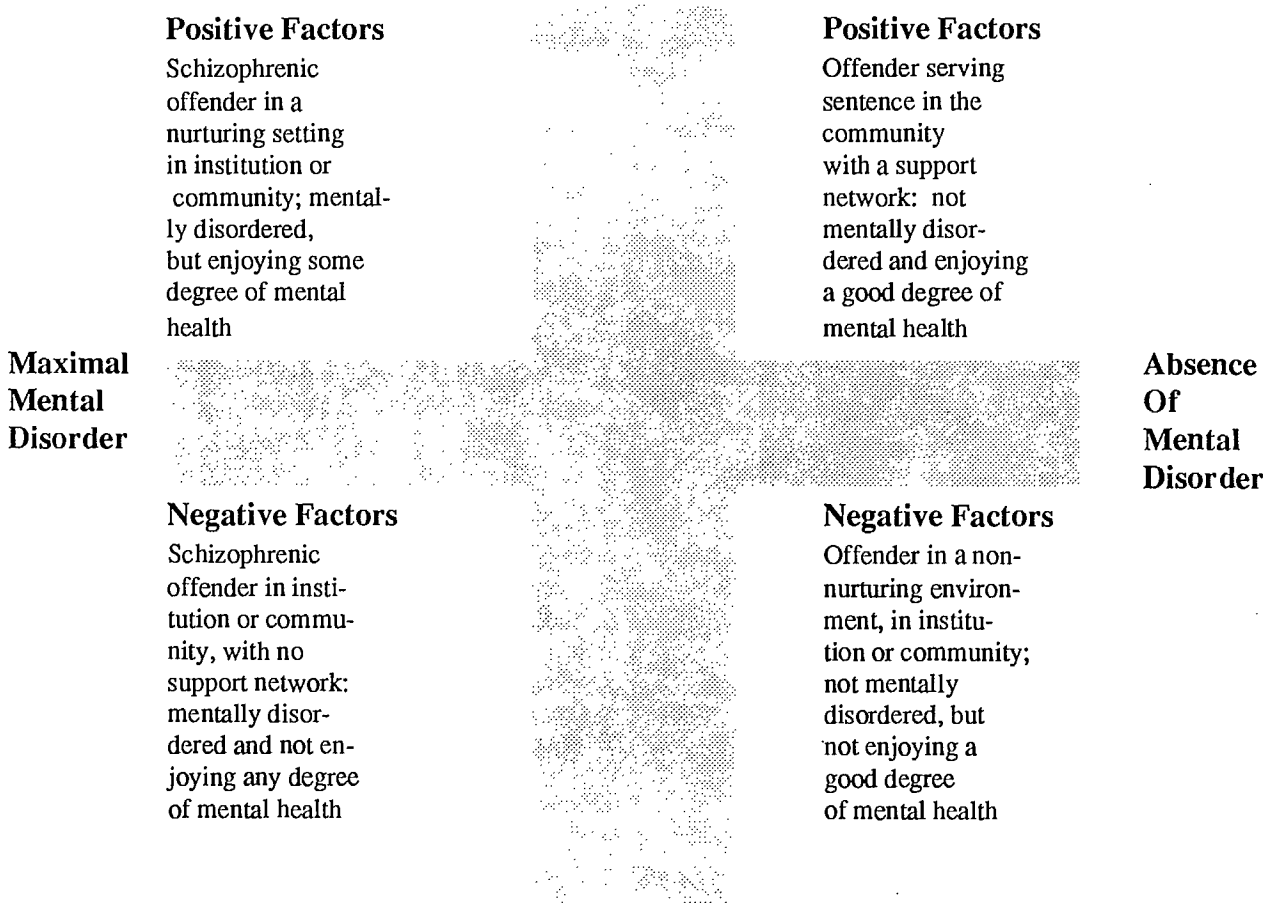
On the mental health continuum, one extreme denotes optimal mental health: a situation in which the demands and contributions of the offender, the Service and the community are balanced and support the values and objectives expressed in the definition of mental health. The opposite extreme denotes poor mental health: a situation where the demands and contributions of the offender, the Service and the community are in a state of detrimental imbalance.

On the mental disorder continuum, one pole marks an intense severity of symptoms such as impairment and anguish and the other indicates a total absence of symptoms or effects. A range of situations in which the symptoms of mental disorder vary in intensity lies between these two extremes. Despite suffering from some mental disorder, and individual can enjoy a certain degree of mental health. The opposite is also true, as an individual not suffering from any bona-fide mental disorder can still have poor mental health. For example, an offender serving his/her sentence in the community, without financial resources, few employable skills, who lacks an emotional support system, and is generally dissatisfied with life can have poor mental health.

Offenders suffering from a mental disorder hold the same mental health needs and aspirations as those who do not. Therefore, achieving mental health means eliminating obstacles that prevent offenders, the Service and the community from interacting in constructive ways. When this has been successfully realized offenders suffering from a mental disorder will enjoy better mental health.

Figure 2

OPTIMAL MENTAL HEALTH



MINIMAL MENTAL HEALTH

Consider the offender suffering from schizophrenia, whose illness is in remission or controlled, and who has just been released on parole. If he/she maintained adequate living conditions, experienced a nurturing setting which supported personal growth, and had meaningful social roles, his/her mental health would undoubtedly improve.

This is consistent with Core Value 2 of the mission statement, which recognizes that the offender has the potential to live as a law-abiding citizen, and its further objective of mobilizing community resources to ensure that offenders are provided with support and assistance upon release (Strategic Objective 2.12). The Service recognizes that the maintenance of positive community and family relationships assists offenders in their reintegration as law-abiding citizens. The involvement of community organizations, volunteers and outside professionals in program development is therefore actively encouraged.

The Service's view of mental health is that both positive and negative factors influence mental health, whether or not the offender is mentally disordered. Thus, the Service has a responsibility to create a healthy environment which fosters mental health. However, it also believes the offender is responsible for becoming an active participant in the attainment of his/her own mental health. No matter how favourable the environment, the offender needs to accept a share of responsibility for his/her well-being. The Task Force believes that this broad definition offers the Service the alternative of promoting mental health by no longer concentrating exclusively on treating and managing mental disorder. Mental health thus becomes a corrections issue. Its promotion is no longer aimed simply at the offender, but is directed towards the entire organization.

Challenges to be Addressed

As part of promoting mental health, three challenges occur: reducing inequities, increasing prevention and enhancing coping. To reduce inequities associated with factors such as education, sex and ethnicity requires a better understanding of the distribution, causes and risk factors associated with mental disorders. The Task Force believes that the criminal justice system must find better ways of sharing current information, and intensify research in areas that optimize mental health. The Service should also strive to facilitate a better coordination of the policies, objectives and programs of various provincial and community agencies. Finally, the Service needs to protect human rights and prohibit discrimination. These objectives areconsistent with the mission statement and, more specifically, with Core Values 1 and 4, respectively:

> **We respect the dignity of individuals, the rights of all members of society, and the potential for human growth and development. We believe that the sharing of ideas, knowledge, values and experience, nationally and internationally, is essential to the achievement of our Mission.**

The second challenge identifies a dual objective. Initially, there is a need to prevent mental health problems. These are defined as a stressful imbalance between the demands and resources of the offender, the Service and the community. This results in distressful, ineffective and destructive patterns of thought or behaviour (HWC, 1988a). Elimination of these problems requires both strengthening the offender and modifying the Service by teaching stress management skills to offenders and offering programs that allow them to challenge themselves. Making basic physical and psychosocial resources available, as well as removing environmental barriers to mental health, are key elements in this preventive approach.

Subsequently, to promote mental health it is also important to prevent mental disorder, as previously defined. Because the underlying causes of many mental disorders are still not well understood, it is sometimes difficult to devise primary prevention strategies. The Task Force believes that the Correctional Service of Canada needs to emphasize the importance of allowing research into causal and available factors to be made available to all members of the Canadian justice system. The Service also needs to coordinate and apply the knowledge it already holds. This is consistent with Core Value 4 of the Mission statement on the essential need to share ideas, knowledge, values and experience.

The third challenge focuses on enhancing offenders' ability to cope with mental health problems. Mental health problems and/or disorders are the result of multiple, interactive causal factors. Many experiences are beyond the offender's control. Therefore, the way the offender confronts such situations and the impact they have on his/her mental health and lifestyle becomes important issues.

There are two types of coping resources: intrapersonal and interpersonal. Intrapersonal resources are the offender's personality, self-confidence and self-esteem. Interpersonal resources are external resources such as family, friends and correctional staff.

Helping the offender to make use of these resources can be done in four ways. The task of enhancing coping comprises four dimensions. First, aiding offenders, families and communities to cope with foreseeable transitions of physical, social, psychological or economic nature. This could involve gradually preparing the offender and the community for reintegration, life skills instruction, using community resources, and ensuring the availability of support systems. Second, strengthening the offender's capacity to deal with disorders or disabilities and the mental health needs associated with them. Third, enhancing the offender's ability to cope with mental health problems. Fourth, supporting the efforts of families and health care professionals to manage mental disorders by providing a wide range of psychosocial resources.

The Task Force believes that aiding the offender to cope requires the Service to commit resources to community based programs in addition to the resources that are allocated to institutions; encourage inter-disciplinary action and advocate environmental change; and develop policies that support the offender's effort to cope.

THREE BASIC MECHANISMS

Self-Care

Self-care means having the offender become one of the primary resources of the mental health care system. The Task Force believes that mental health professionals and correctional staff should encourage the offender to assume responsibility for mental health and exercise the following steps necessary to self-care:

- Recognize lifestyle habits and their impact on mental health;
- Modify lifestyle habits which foster mental health problems and/or disorders;
- Identify symptoms and evaluate them as either normal or abnormal;
- Decide if short term action is necessary and choose an action to take;
- Carry out the treatment of choice; and
- Evaluate the consequences of the treatment initiated.

Self-care implies individual confidence and the ability to manage one's mental health and life. It also implies that the offender should assume responsibility for his/her life, and be encouraged to actively participate in all stages for regaining/ maintaining optimum mental health.

Mutual Aid

Individuals in one's social network who have had similar experiences often have a special understanding of life stressors and how to cope with them. To accept advice and support from these people may be a beneficial coping strategy. Health and Welfare Canada (1987c) defines mutual aid as follows:

> **"Mutual help (aid) occurs only when the helper and the person being helped share a history of the same problem. The essence of the process is mutuality and reciprocity. The helper may not be a peer in any other sense to the person being helped, but he or she is a 'survivor' who, having coped successfully with the problem has acquired a useful experience based on practical experience rather than special education.... Moreover, the sharing experience benefits both the person being helped and the helper." (:1)**

Although there are a variety of formal programs for supplying mutual aid, self-help groups have received the most public attention. Self-help groups are defined as small voluntary groups, generally formed by individuals with a common concern. They meet to provide mutual assistance and emotional support to overcome a common problem and bring about a desired change. Their primary benefits are to provide support and prevent relapse during and following treatment. Research suggests that this kind of collective support weakens the link between life stressors and illness. Self-help groups provide a range of social support and increase coping skills through the sharing of information and experiences. The following characteristics are common to self-help groups:

- common experiences of members;
- mutual exchange of help and support;
- helpers benefit by helping;
- collective will-power and belief;
- provision of information, education and anticipatory guidance; and
- constructive action towards shared goals.

The Task Force believes that self-help groups are an important mechanism to help offenders cope with their mental health/lifestyle problems, and promote mental health. This approach should not replace other treatment measures, but accompany professional intervention.

Creation of a Healthy Environment

Social and physical environments have an important effect on the mental health and well-being of individuals. The broad definition of mental health, as adopted by the Correctional Service of Canada, focuses on the capacity of the environment to positively influence the offender's mental health. The Service has an obligation to create environments which promote mental health. Healthy environments can be established by providing offenders with improved living conditions, offering better recreational services, fostering mutual aid, encouraging self-care in offenders, and increasing the number and accessibility of social/educational/vocational programs.

The Correctional Service of Canada has a unique opportunity to provide a healthy environment to the offender. Due to the nature of the correctional environment, the Service is in a position to control and alter the offender's environment in a positive way. Within the confines of the institution, as well as in community-based operations, the Service can offer the offender a variety of targeted programs. It can also provide opportunities for self-development and personal growth. As the following Strategic Objectives state, the Service has several responsibilities:

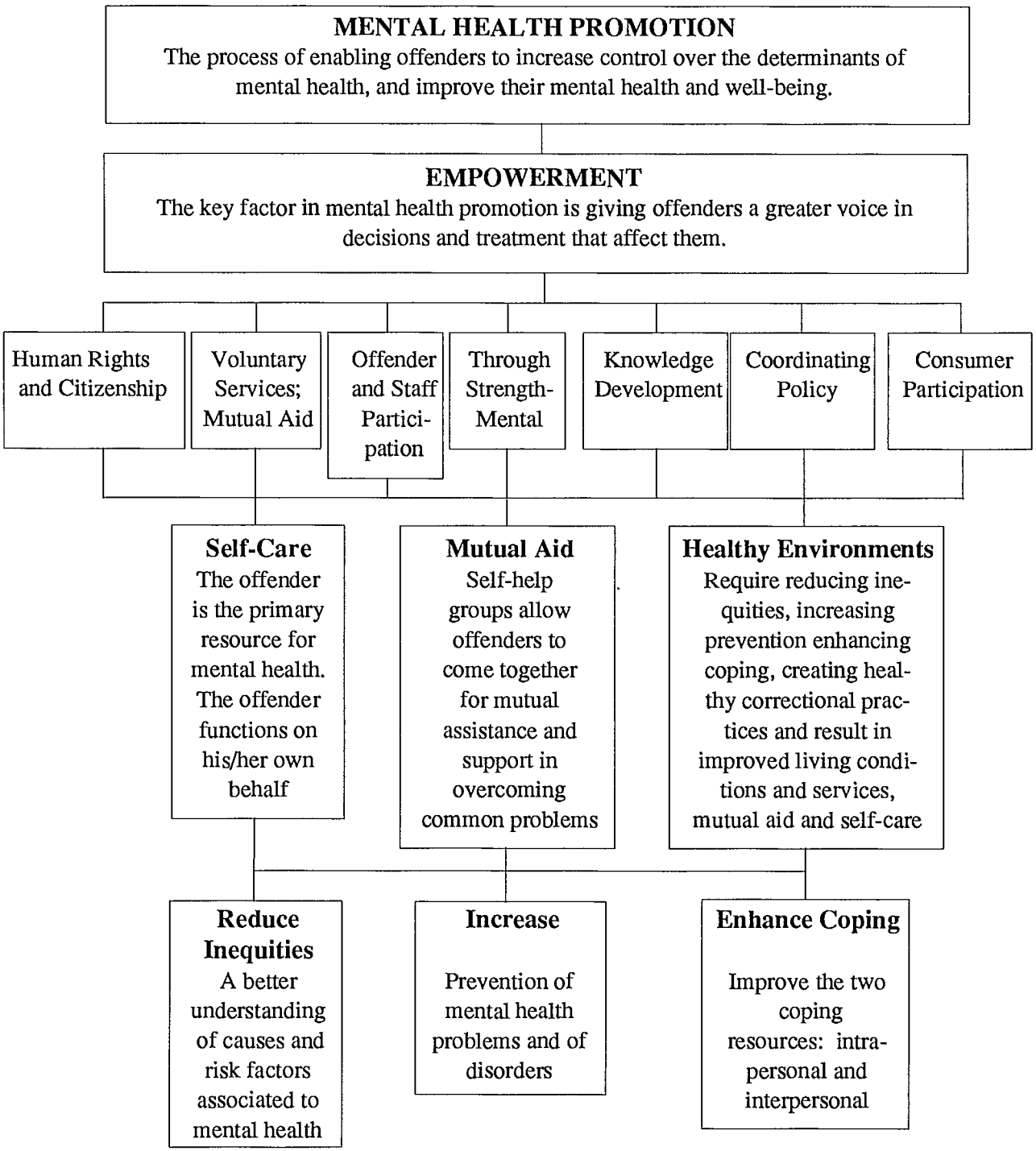
- To provide an environment that is safe, secure and clean and which fosters positive interaction between staff and offenders;
- To provide opportunities for offenders to contribute to the well-being of the community;
- To respect the social, cultural and religious differences of individual offenders;
- To provide programs to assist offenders in meeting their individual needs, in order to enhance their potential for reintegration as law-abiding citizens;
- To ensure that offenders are productively occupied and have access to a variety of work and educational opportunities to meet their needs for growth and personal development;
- To make available a range of recreation and leisure activities that will encourage offenders to use their free time constructively and develop skills and abilities to assist them on release;
- To mobilize community resources to ensure that offenders, upon release, are provided with support and assistance.

The Task Force believes that the Correctional Service of Canada has already begun to build healthier environments. By actively pursuing the objectives of its mission statement, the Service will ensure that the offender is provided with an environment that promotes mental well-being.

Implementation Strategies

The Task Force proposes a series of strategies, or guiding principles, to review and implement public policies that promote mental health (HWC, 1986, 1987, 1988). (See Figure 3)

Figure 3


MENTAL HEALTH PROMOTION
The process of enabling offenders to increase control over the determinants of mental health, and improve their mental health and well-being.
EMPOWERMENT
The key factor in mental health promotion is giving offenders a greater voice in decisions and treatment that affect them.
Human Rights and Citizenship
Voluntary Services; Mutual Aid
Offender and Staff Participation
Through Strength-Mental
Knowledge Development
Coordinating Policy
Consumer Participation
Self-Care
The offender is the primary resource for mental health. The offender functions on his/her own behalf
Mutual Aid
Self-help groups allow offenders to come together for mutual assistance and support in overcoming common problems
Healthy Environments
Require reducing inequities, increasing prevention enhancing coping, creating healthy correctional practices and result in improved living conditions and services, mutual aid and self-care
Reduce Inequities
A better understanding of causes and risk factors associated to mental health
Increase
Prevention of mental health problems and of disorders
Enhance Coping
Improve the two coping resources: intrapersonal and interpersonal

HUMAN RIGHTS AND CITIZENSHIP

> **"All Canadians have equal rights to participate in Canadian society, including the right to health and social services, education, employment, housing and recreation, and the right to be protected by the law." (HWC, 1988a:18)**

This principle aims to reduce inequities, increase prevention and enhance coping (individual and collective). Social attitudes that discriminate against individual offenders and collective groups are harmful to mental health. In order to reintegrate offenders effectively, it is necessary both to avoid excluding offenders with mental disorders, to create real opportunities for them to assume their roles and responsibilities as citizens. Human rights and citizenship are consistent with Core Value 1 of the mission statement, which emphasises respect for the dignity of individuals, the rights of all members of society, and the potential for human growth and development.

Mutual Aid and Voluntary Services

> **"The support and assistance that members of a community freely give to one another is an essential component of mental health promotion and mental health services." (HWC, 1988a:19)**

Offenders helping each other, pooling resources and providing mutual support through self-help groups are key to optimal mental health. Self-help groups and voluntary organizations perform crucial functions in the mental health field by offering emotional and practical support prior to and upon an offender's release into the community. As part of the strategic objectives of Core Value 2 of the mission statement, the Service wants to ensure that volunteers form an integral part of program delivery in institutions and the community. The Task Force believes that the Correctional Service of Canada should continue to promote and support these groups and organizations, especially in the area of aftercare.

Offender Participation

> **"Mental health services and health promotion activities are strengthened when those whom they are intended to benefit participate in their design and implementation." (HWC, 1988a:20)**

Fostering offender participation means encouraging offenders to become more involved in improving their environment. It emphasizes involving them in mental health issues and decisions and helping them assert control over factors which affect their mental health.

Policy that enables offenders to have control over factors that influence their mental health – the axiom of empowerment – is the core of mental health promotion. It is also consistent with the strategic objectives of Core Value 1 of the mission statement:

- to ensure that offenders are informed participants in the correctional process;
- to ensure that policies and procedures affecting offenders are communicated in such a way that they can be understood by offenders and are readily accessible to them; and
- to ensure that offenders, where possible, are provided with all the relevant information in a timely and meaningful manner and are given an opportunity to be heard when significant decisions affecting them are being made.

The Task Force believes that offenders should play an active part in the design, implementation and evaluation of programs and services. This will foster a sense of pride, provide offenders with the opportunity to put their skills and knowledge to use, and enable the Service to focus on offenders' real concerns. This aim is consistent with the objective of increasing the offender's sense of responsibility over his/her own welfare by providing the opportunity to share in the shaping of programs and services.

Two implications need to be considered in order to engage offender participation. First, because encouraging participation by offenders involves giving them a greater voice, the Service should make every effort to inform staff and offenders of the purpose of participation, and should illustrate the potential benefits. Second, if offender participation in mental health is to be successful, offenders need to experience participation in other spheres of their lives. It is unreasonable to expect the offender to become active and involved in mental health if the rest of the system does not foster this involvement. At present, responsibility for mental health care is largely assumed by professionals. This traditional approach offers little opportunity for offender participation. Encouraging meaningful participation requires a genuine acceptance by Service staff of the right of the offender to participate in decisions affecting his/her mental health care. Health professionals will no longer be perceived as the sole providers of health services, and clients will not remain voiceless. Consumer participation is a key element in the success of any mental health service.

Three components are necessary to achieve offender participation: listening to offenders, establishing a partnership model between professionals and offenders, and recognizing the importance of self-help groups. Mental health professionals in the correctional field acknowledge that offenders voice a reality which is often different from their own. Similarly, offenders seldom find the language of the professional similar to their own experience. Recognizing that diverging perceptions exist is a fundamental step towards encouraging offender participation.

The process involves having respect for the offender and his/her perspectives. To respect an offender's viewpoint allows correctional staff and mental health professionals to see the offender's capabilities as well as their deficiencies. It enables them to visualize how the offender's energy can be channelled most effectively. And, it creates the potential for dialogue and the development of a positive relationship between the professional and the offender. As described in other chapters, studies have shown that positive interaction between offenders and staff at all levels is a large contributor to the success of programs and services.

The Partnership Model

Much is to be learned from the sharing of ideas and experiences between offenders and mental health professionals. The partnership model – where offenders and professionals work together towards a same goal – is an important component in offender participation. While the leadership of professionals plays an important role, offenders provide some direction in this process.

To achieve an effective partnership, mental health professionals and correctional staff who work side by side with offenders should no longer maintain the distance which so often characterizes these relationships. However, it takes time to build trust before offenders are willing to share their concerns. By actively listening, this process can be facilitated.

Self-Help Groups

Self-help groups – programs which are directed and controlled by consumers (be they sex offenders, alcoholics, drug addicts, or manic depressives) – are an important component in achieving offender participation and health promotion. Many offenders are capable of directing their own lives and supporting others in need: the

growth of self-help groups since the 1970's supports this. These groups contribute in a positive way to personal growth and community participation. It is found that patients who participate in their own care get better more often than those who do not.

Stony Mountain Institution, Manitoba, pioneered a series of innovative self-help programs in the past two years. Offender participation is voluntary but interest keen because of offender enthusiasm by those who have completed programs. The programs are designed to help participants understand and improve the image they hold of themselves, to show that change is possible, to deal with stress, and to provide tools for personal enhancement. These self-help programs have not only proven to be an excellent tool for growth and change, they have also encouraged offenders to seek further help through other programs.

These self-help programs and groups, which involve offenders in their own rehabilitation, could have a profound impact on the Correctional Service of Canada. They are a positive and necessary step toward advancing the goals set out in the Mission statement.

Policy Statement On Offender Participation

The Consumer's Association of Canada designed, in October, 1989, a policy statement on consumers and health care. The basic principle of this policy is that consumer interest in enhancing, maintaining or regaining health status should be given a high priority. This process consists of recognizing basic rights, and adopting positive reforms to create a consumer-oriented health care system.

The Task Force believes that the following policy in Figure 4, which has been adapted to the Service from the Consumer Association's version, is essential to the promotion of mental health, and can be instrumental in developing and implementing an integrated mental health strategy.

Figure 4

Rights of the Offender	Responsibilities of the Offender
1. The offender has the right to be informed about his/her specific treatment programme.	1. The offender has the major responsibility for his/her own mental well-being. Offenders must rely on providers for advice regarding the effect of mental health care on health status.
2. The offender has the right to be respected as the individual with a major responsibility for his/her own mental health.	2. The offender has a responsibility to seek information: • about preventive mental health care; • about their own diagnoses and specific treatment programmes; • on how to lead healthy life-styles; and • on participating in decision-making with the mental health professionals and other correctional staff involved in direct mental health care, and on achieving opti-

mum effectiveness from the treatment programme to which he/she has consented.

3. The offender has the right to considerate and respectful care.

3. The offender has a responsibility to participate, through informed offender participation, in planning and evaluating the system of mental health services the types and quality of services, and the conditions under which they are delivered.

4. The offender has the right to participate in decision making affecting his/her well-being;
   - through offender participation in planning and evaluating mental health programs and services, the types and qualities of service, and the conditions under which they are delivered.
   - with the mental health professionals and other correctional staff involved in his/her direct mental health care.

As the Correctional Service of Canada and its mental health professionals give a greater voice to offenders and respect their rights, offenders can assume a more active participation in their own rehabilitation.

Staff Participation

> **"The delivery of mental health services and the promotion of mental health are strengthened when professionals bring to these tasks not only their specialized knowledge and skills but also an openness to collaborative approaches, and a breadth of vision concerning the overall needs of individuals and communities." (HWC, 1988a:20)**

The Task Force believes that staff also play an important part in designing, implementing and evaluating mental health programs and services. All correctional staff are encouraged to increase their participation in interdisciplinary study and action, to increase community outreach activities, to advocate positive environmental change, and to establish partnerships with offenders. This is consistent with the definition of mental health, and Core Value 3 of the mission statement: the belief that our strength and our major resource in achieving our objectives is our staff and that human relationships are the cornerstone of our endeavour.

By fostering offender and staff participation with those who had, in the past, little influence in shaping policy, the Service promotes mental health and encourages community involvement. To facilitate endorsement for any new program, staff and offenders who may be affected should be consulted and involved in its implementation and evaluation.

Strengthening Community Mental Health Services

> **"A community's capacity to promote mental health and to provide care for persons with mental disorders or disabilities is strengthened by a balanced allocation of resources, by removing obstacles to community-based programs, and by building consensus regarding the values and strategies that should govern mental health policy." (HWC, 1988a:21)**

Community mental health services already play an indispensable role in preserving mental health, as evidenced by the mutual aid groups, outreach programs and community-based services. Coping with future challenges will require a shift in priorities and a further expansion of both community and institutional services – especially those oriented towards promoting mental health and preventing mental health problems.

The Correctional Service of Canada must encourage and support increased community and institutional involvement in the planning, delivery and evaluation of mental health services. At the regional, community and institutional levels, the Service must also improve services and programs offered to groups with special needs: aboriginal offenders, sex offenders and women offenders. Further, the Service needs to better coordinate the planning and delivery of mental health and psychosocial services. It must ensure that the offender receives all services and treatment necessary to facilitate his/her reintegration into society. Improved coordination of these programs and services through an interdisciplinary approach is required.

Community mental health services form one part of a continuum of services, and research indicates that these services are effective. They can be distinguished from institutional services by the two criteria:

- They are provided to offenders who continue to reside in the community; and
- They are actively engaged in helping offenders maintain their independence and autonomy.

To strengthen the community, the Task Force believes that the allocation of resources, as well as the creation of services where they do not currently exist, must be balanced and consistent with identified needs, and that there is a need for increased depth in the services and programs offered. Ideally, institutions should develop close partnerships with offenders and communities, thereby creating a continuum of mental health care that spans each offender's sentence from reception to warrant expiry.

Knowledge Development

> **"Progress in the promotion of mental health and the prevention and treatment of mental disorders depends on increasing, integrating and sharing relevant knowledge from many fields." (HWC, 1988a:21)**

As stated, knowledge development means supporting and increasing mental health-related research and integrating current knowledge. The Task Force believes that researchers, administrators and mental health service providers need to work together to ensure that the available knowledge is properly applied. This principle demands the creation of linkages with the national research plan, and close linkage with academic facilities and centres of forensic excellence.

This endeavour is consistent with Core Value 4 of the mission statement, and its strategic objectives: that the sharing of ideas, knowledge, values and experience, nationally and internationally, is essential to the achievement of the Mission. The Service strives to seek out, maintain membership in, and participate in relevant local, provincial, national and international organizations (Strategic Objective 4.1); to establish and maintain mechanisms for staff exchanges and the sharing of methods, standards, and services (Strategic Objective 4.3); and

to encourage and support research and evaluation which will contribute to the continued development of our knowledge and information base (Strategic Objective 4.5). Furthermore, this will enable the Service to attain one of its corporate objectives: to develop and implement policies and programs to address the specific needs and reduce the potential recidivism of women, natives, violent offenders, sex offenders, inmates serving long sentences and mentally disordered offenders.

Coordinating Healthy Community and Institutional Policy

> **"Mental health is a major public health issue that requires coordinated policy and program responses from all sectors of society." (HWC, 1988a:22)**

This strategy is designed to improve the responsiveness and coordination of community and institutional mental health policies and programs. Healthy policy is distinguished from traditional medical care policy by being "ecological in perspective, multisectoral in scope, and participatory in strategy." (HWC, 1988b:iv) Until recently, attention has been paid primarily to individual efforts to change mental health behaviour rather than to enhance mental health through multisectoral approaches. The new, broader definition of mental health and mental health promotion has shifted toward the latter approach.

> **"The process of developing healthy [community and institutional] policy is marked by complex conceptual and practical demands: that it be multisectoral and multidisciplinary, that its problems are multifaceted, that it views human activity in environmental and ecological contexts, and that it should be participatory." (HWC, 1988b:v)**

Coordinating healthy community and institutional policy requires new arrangements between organizations to facilitate communication and cooperation. Coordination demands new approaches to policy development and implementation, and new structures to support such endeavour. The establishment of agreements with provincial agencies and universities is an important component of this endeavour.

The Task Force believes that such cooperation and collaboration is at the heart of mental health promotion. It believes that, to promote mental health, the Service must ensure that all sectors of the criminal justice system and the community work together to develop sound mental health policies.

Conclusions

The promotion and preservation of mental health for the offender has become a compelling priority. The Task Force believes that the conceptual framework presented above will help the Correctional Service of Canada reach its potential in the development, review and implementation of mental health-related policies and programs. Mental health is acknowledged as involving the capacity of the offender, the Service and the community to interact constructively with one another towards the achievement of a common goal: the safe reintegration of the offender into the community. Thus, to effectively promote mental health, a myriad of psychosocial factors need to be taken into consideration, challenges need to be addressed and guiding strategies need to be implemented.

Mental health promotion means that the Correctional Service of Canada will create environments conducive to mental health, in which offenders are better able to take care of themselves and to offer each other support in managing and solving collective and individual mental health problems. Mental health should no longer be viewed as the sole responsibility of the professional, but as a collective goal of our Mission.

The Task Force believes that the involvement of the offender on his/her own behalf – the axiom of empowerment – is the key element in the promotion of mental health. As the role of the offender progressively shifts from "client" to "consumer", it is believed that the offender will assume greater responsibility for his/her

mental health, therefore rendering mental health an achievable goal. Mental health, within the correctional context, can be facilitated through the establishment of a partnership between the offender and the provider, a partnership that may even minimize the inescapable imbalance of power that exists between the two.

As mental health is redefined, it becomes a multidisciplinary responsibility: all correctional staff, especially those having direct contact with the offender, play an essential part in the mental health care planning and service delivery. By recognizing their versatile roles, the Correctional Service of Canada fosters mental health and helps fulfil the objectives of its Mission.

The Task Force believes that this conceptual framework for mental health will be instrumental in the achievement of the first corporate objective of the Correctional Service of Canada:

To safely reintegrate a significantly larger number of offenders as law-abiding citizens in order to reduce the relative use of incarceration as a major correctional intervention,

- by effectively and efficiently managing the cases of offenders in order to assess, monitor and reduce their risk of re-offending;
- by increasing the level of offender participation in community and institutional programs relevant to their needs in order to reduce the risk of future criminal behaviour; and
- by increasing the quality of staff/offender interaction.

To be effective, however, it is important to place the broad approach to mental health promotion within the context of corrections. The provision of mental health care must therefore focus on the purpose of corrections – to impart positive change. To do this effectively requires the consideration of several factors when targeting programs and allocating scarce resources:

1. Risk: will the program or service reduce the risk of re-offending?
2. Need: does the program or service target criminogenic needs – i.e. those areas of behaviour that have been shown to be an integral part of the offence pattern?
3. Treatability: to what extent will the offender respond positively to the treatment or service offered?

Although it may seem presumptuous to say that offering uniform mental health-related services to offenders and promoting mental health will decrease the recidivism rate, it is clear that without assessment, treatment and community-support services, mental health care cannot create an environment which optimizes offenders' personal growth and minimizes the risk of re-offence.

LIST OF RECOMMENDATIONS

Planning Process

1. That each region develop a Mental Health Strategy for the delivery of a continuum of mental health services to offenders, from reception to sentence expiry, based on the prevalence of mental disorder among their respective offender population, by targeting specific offender groups, planning and delivering interventions, and evaluating results.

2. That each institution and parole district develop a Mental Health Plan, based on the unique needs of their respective offender profile, as part of the Regional Mental Health Strategy.

3. That the database on the Diagnostic Interview Schedule (DIS) be updated on an ongoing basis (e.g annually) to collect and maintain demographic information on which to set priorities, plan national and regional mental health services, and allocate resources.

Programming Process

4. That given the scarcity of resources, the Correctional Service of Canada establish programming and resource allocation priorities in terms of degree of impairment, risk of recidivism, and potential for long-term improvement.

5. That mental health programs and psychological treatment be developed, delivered and evaluated in consideration of risk, targeted and matched to identified criminogenic needs, and be in accordance with the assessment of treatability.

6. That a common nomenclature be developed in the Correctional Service of Canada regarding the concepts of risk, need and responsivity/treatability, to allow for a common understanding and consistency among case management, mental health and research initiatives.

7. That each mental health program be evaluated on an ongoing basis, to ensure that there is consistency among:

   a) the objectives of a program;

   b) mental health needs;

   c) mental health priorities;

   d) the Mission of the Service; and

   e) the case management process.

8. That a mental health programs' committee be formed in each institution, to discuss the priorities, needs and requirements in the area of programming. That this committee be chaired by the senior psychologist and include the Chief of Health Care Services, the clinical coordinator, the Assistant Warden, Correctional Programs, the chaplain, as well as representatives from the Unit Management Team, the Citizen Advisory Committee, and offenders. This committee should meet every trimester and submit its recommendations to the Warden of the institution. A similar committee should be established at each parole district.

9. That the initiation, planning and evaluation of new programs involve the Regional and National Research Committees, to ensure a linkage with the respective regional and national research plans, and a consistency with professional ethics and standards.

10. That the Correctional Service of Canada systematically adhere to the steps outlined in the Task Force report, when initiating, developing, implementing and evaluating a program.

11. That all staff and offenders affected by the program, be consulted and involved in a meaningful way in its planning, implementation and evaluation, and that their roles and responsibilities in this process be clearly defined.

12. That programs be designed in keeping with the setting in which they are delivered (the primary, secondary and tertiary levels), and utilize modes, styles and methods that correspond to the abilities of the target offender group, taking into consideration the treatability/responsivity of the offender, and cultural/ethical constraints.

Mental Health Assessments

13. That all offenders undergo an intake mental health assessment, regardless of their offence category.

14. That a test battery be developed to screen and test all offenders at reception for mental disorder and behavioural indices, to provide a range of tools for psychologists based on normative data, without restricting their professional discretion.

15. That a nationally coordinated strategy be developed to automate the administration, scoring and interpretation of standardized psychological tests.

16. That a triage (multiple-gating) assessment process be developed, to identify the pertinent risk/needs of the offender, and which is cognizant of but not determined by the Schedule of Offenses.

17 a) That an instrument similar to the Community Risk/Needs Management Scale be developed to serve as a screening and case management planning tool to be administered at reception, and used as the basis for referral to psychologists for assessment; and

b) That this instrument be implemented on a pilot basis with the aim of evaluating its potential as part of the ongoing initiatives of the Research, Offender Management and Health Care Services Branches.

18. That the respective complementary roles of the case manager, psychologist and Parole Board in the assessment process be delineated.

19. That the current case management process (Case Management Strategies and Force Field Analysis) be structured so as to be a useful tool for the referral of cases for psychological assessment and prediction of risk.

20. That the DIS instrument be assessed to determine its utility as a diagnostic instrument at reception.

21. That referrals to psychologists from case management officers be screened:

    a) by the immediate supervisor to verify the validity and completeness of the request;

    b) by a Senior Correctional Service of Canada psychologist to assess the necessity, priority and appropriate resources required; and

    c) that the need for a second psychological assessment be re-examined to ensure value for the resources expended.

22. That the purpose, focus, format, use, lifespan and dissemination of psychological/psychiatric assessments for the National Parole Board be delineated.

23. That psychological assessments have a shelf life of 24 months unless significant program participation and/or treatment has occured.

Treatment and Service Delivery

24. That the Correctional Service of Canada adopt and implement the model of multiple levels of care for the mentally disordered offender as part of the Mental Health Strategy, to meet the changing needs of individual patients. These four levels of care are:

    a) Acute/Transitional Care, at Regional Treatment/Psychiatric Centre;

    b) Special Program Units within the "normal" population penitentiary for the chronically mentally disordered;

    c) Outpatient Care through ambulatory services offered to offenders within the general population;

    d) Community based relapse prevention services.

25. That the Service adopt a policy on the timing of service delivery to offenders, based on the following:

    a) all offenders shall be assessed, including in-depth psychological/psychiatric assessments where required, by the One-sixth Review date; all institutions shall ensure that all newly admitted offenders are assessed to identify the presence of a mental disorder, and that referral and follow-up occurs as appropriate;

    b) treatment/program plans for offenders released at one-sixth of their sentence ("fast trackers") be delivered in the community where possible;

    c) treatment for candidates for Full Parole be completed by one-third of the sentence; and

d) for cases where release is contingent upon the successful completion of treatment, treatment be completed by the time of release, no later than two-thirds of the sentence.

26. That psychological treatment be delivered wherever possible as a defined program or module; and that group treatment be the preferred method of program delivery wherever possible.

27. That all Regional Treatment/Psychiatric Centers develop and test treatment programs for special problem groups, and assist other institutions to establish and evaluate programs.

Chronic Mentally Disordered Offenders

28. That the Correctional Service of Canada actively pursue the development and availability of community based alternatives, in conjunction with provincial mental health systems, to meet the changing needs of the chronic, mentally disordered offender in the community.

Aboriginal Offenders

29. That all current assessment procedures and techniques being used to evaluate offenders in the Correctional Service of Canada be evaluated to determine their validity for Aboriginal offenders.

30. That Elders and Native liaison workers be encouraged to participate as full members of the case management team.

31. That program opportunities for Aboriginal offenders include provision for them to gain an understanding of Aboriginal cultures, values and practices.

32. That mental health professionals within the Correctional Service of Canada become aware of the useful and complementary role that Native Medicine can play, and utilize Elders in the planning and evaluation in mental health service delivery.

Sex Offenders

33. That the Correctional Service of Canada increase the accuracy and comprehensiveness of the description of offence histories on inmate files, and that this file information serve to establish a computerized information system based upon behavioral descriptions of inmate offence histories that can be used to identify sex offenders in the correctional system.

34. That the Correctional Service of Canada develop a system of triage or streaming to identify offenders who require more detailed and extensive assessment, including phallometric assessment and measurement of psychopathy with the Psychopathy Checklist.

35. That uniformity in core assessment measures over sex offender treatment programs is both possible and necessary:

    a) a standardized protocol for the phallometric assessment of sexual age and gender preferences has been developed and should be adopted;

b) work is required on standardizing a protocol for the phallometric assessment of sexual interest in sexual coercion and sadistic practices;

c) core measures should be adopted in areas such as pro-criminal sentiment, sexual values, sexual knowledge, and so on; and

d) a common set of historical and demographic variables should be recorded in all programs.

This recommendation is meant to be permissive, rather than restrictive; treatment programs should be encouraged to experiment with new, but additional, measures.

36. a) That one or more specialized institutional treatment programs be implemented in each region, depending on number of sex offenders, including the Regional Treatment Centres and other large existing institutional programs (e.g. Warkworth); and

b) that the links between specialized institutional sex offender treatment programs be strenghtened through computer linkage, yearly conference, and the appointment of a coordinator of sex offender programs (Special Advisor, Mental Health Division, Health Care Services Branch).

37. That specialized institutional sex offender programs train professional staff, seconded from other institutions for time limited periods, and provide coordination and support for less specialized institutional sex offender treatment programs in their region.

38. That highest risk and most deviant cases be treated in specialized sex offender treatment programs.

39. That treatment programs be developed in other institutions for maintenance of treatment effects among offenders treated in more specialized programs, and for treatment of lower risk/less deviant cases. Where possible, treatment of sex offenders in regular institutions should take the form of modularized treatments that are not only offered to sex offenders (e.g., substance abuse, anger management, sexual values education).

40. That uniformity among institutional sex offender treatment programs across Canada is neither possible nor desirable at present time, although a general cognitive-behavioral model appears to be the most appropriate to use with sex offenders. The following principles should be observed by all programs:

a) most serious risks receive most intensive and specialized treatment;

b) treatments administered should be directed toward problems/needs specifically identified in assessment and specified in an individualized treatment plan;

c) pre-treatment and post-treatment measures of proximal outcome should be adopted for every treatment administered;

d) treatment should be directed towards establishing a workable post-release plan for community supervision, and should be expressed in the form of a contract; and

e) duration of specialized treatment interventions should be determined by the time it takes to reach specified treatment goals; in the interests of costs and availability of specialized treatment beds, specialized treatment time must be limited for any inmate.

41. That the Correctional Service of Canada develop contracts among the inmate, parole officer, and community service provider, for high risk sex offenders, and detailing the conditions of supervision and treatment. That a contract for an individual offender be negotiated and approved by the Parole Board before his release. That the negotiation of an appropriate contract be one of the goals of institutional sex offender treatment programs.

42 a) That released high risk offenders be subject to intensive supervision based on an individualized relapse prevention model;

b) That consideration of the use of electronic monitoring be given for this high risk group; and

c) That the initial period of supervision begin at community-based residential facilities.

43. That highest risk and most deviant sex offenders released to community be treated in specialized community sex offender programs located in large urban areas and associated with community-based residential facilities. That these specialized programs support and coordinate other community sex offender programs in their area.

Violent Offenders

44. That the assessment, targeting and administration of intervention for violent offenders be guided by the principles of offender risk, need and responsivity, and that intervention be carried out on a modular basis.

45. That developmental work on the design of data gathering instruments and on staff training requirements be carried out for the issues of anger, violence and psychopathy.

Dual Diagnosis

46. That the Correctional Service of Canada adopt the same diagnostic tool across the country (available in both official languages), for dual diagnosis offenders.

47. That the Correctional Service of Canada institute a program to coordinate the mental health and drug abuse services offered to offenders. This coordination must include a detailed description of each service, as well as collaborative discussions where individuals responsible for these services explain the philosophy and methods of treatment.

48. That the locus of responsibility for the dual diagnosis patient be determined on the basis of the following:

a) the severity of psychiatric symptoms;

b) the level at which the individual is functionning;

c) the need for supervision and the ability to live independently;

d) the need for medication;

e) the effect of medication on the individual's functioning;

f) the link between the psychiatric symptoms and the use of drugs; and

g) the ability and capability of the patient to overcome periods of stress, confrontation, and pressure that can be experienced during the treatment of drug abuse.

Crisis Management

49. That the Commissioner's Directives dealing with help provided to employees who are victims of violent acts (CD 252) and dealing with crisis management (CD 600) be amended to consider the following measures of immediate help:

    a) where the employee is the victim in a very stressful situation, he/she receives first aid and his/her physical and/or psychological state are assessed; and that a psychologist is available to meet with the employee;

    b) where the employee is a witness or an affected party to a very stressful situation, Critical Incident Stress Debriefing is available and is provided by a psychologist within 72 hours following the incident;

    c) regardless of the nature of the incident, or the degree of the trauma assessed by a third party, a minimum support service is available upon request; this service is offered by a psychologist or other individual competent in crisis management.

50. That a policy be developed to deal with emergency services offered to offenders in a crisis, both within the institution, and in the community, where locally not available.

51. That mechanisms be implemented to encourage the community to develop (or utilize existing) crisis management mental health services.

Female Offenders

52. That the Correctional Service of Canada develop a strategy and action plan for the delivery of mental health programs and services to federally sentenced women, based on:

    a) the prevalency, recency and severity of mental disorder among federally sentenced women; and

    b) the specific needs of female offenders, as outlined in this paper and detailed in the Report of the Task Force on Federally Sentenced Women.

Suicidal Offenders

53. That inmates identified by health care services staff as being at high-risk for suicide be transferred to an Acute Care Psychiatric Unit, and that he/she be provided with health care consistent with that offered to such patients in community hospitals. If placement in a camera cell in Segregation is judged to be a necessary measure in the interim, it is imperative that the offender receive appropriate counselling from staff capable of providing same.

54. Given that peers are often the first to notice a change in behaviour in a suicidal inmate, that the Correctional Service of Canada consider the implementation of an inmate self-help suicide prevention program, such as Con-Aid.

55. That in the absence of health care services staff, all categories of staff who have contact with inmates be authorized to initiate a system of formally alerting all staff in the matter of suicide prevention.

Self-Injurious Offenders

56. That subsequent to an evaluation of the self-mutilation program introduced at Edmonton Institution, a similar program be implemented in all Correctional Service of Canada institutions, with the exception of the Prison for Women.

57. That in the case of the Prison for Women, an appropriate program for the prevention of self-mutilation be implemented, geared to the special needs of federally sentenced women.

58. Given that self-injuring offenders often seek emotional support from their peers and that this support should be acknowledged and legitimized, that a program be developed to train a number of inmates as peer counsellors.

59. That all Correctional Service of Canada institutions be adequately resourced in terms of staff capable of providing appropriate mental health counselling prior to the implementation of a program aimed at reducing self-injurious behaviour (such as the one in Edmonton).

HIV Infected and AIDS Offenders

60. That, in view of the low seropositivity rate but high risk nature of offenders within the system, efforts be concentrated on prevention of transmission of HIV rather than on the establishment of activities such as mandatory HIV screening. Education programs of AIDS and other infectious diseases should, therefore, be provided to all offenders on their admission to the Correctional Service of Canada, and these should be reinforced at regular and frequent intervals.

61. That the Correctional Service of Canada establish a voluntary HIV testing and counselling program with emphasis on the following components:

    a) an atmosphere in which offenders will be willing and able to seek testing and counselling; this includes a staff educated about HIV transmission, and a commitment by the Correctional Service that HIV test results will truly remain confidential;

    b) pre-test counselling available to all offenders wishing to be tested ; and

    c) post-test counselling for all offenders having been tested to seek to change high-risk behaviours and that this program be developed by the interdisciplinary health care team in each institution with input and coordination from regional health care services personnel.

62. That the Correctional Service of Canada actively encourage community and self-help groups, such as community AIDS Committees, to provide support and information to HIV-infected offenders and their families. That efforts be made to involve them, as appropriate, in both staff and offender education programs, as well as in direct support to affected offenders.

Community Based Mental Health Services

63. That offenders in the community phase of the sentence access mental health services in the community; where necessary services are not readily available, that the Correctional Service of Canada make special provision for such services in the community. The offender shall not be returned to the correctional institution for mental health services unless it is necessary to prevent further criminal behaviour.

64. That half-way house accommodation be available in the community for those offenders in the community phase of their sentence who require additional support in coping with the pressures of living in the community.

65. That offenders in the community phase of their sentence who require in-patient psychiatric care, be admitted to local community psychiatric facilities for such care.

66. That Regional Treatment/Psychiatric Centers work closely with all institutions and parole offices to ensure continuity of care following discharge of offenders from the Centre, through the expansion of ambulatory services.

67. That development of ambulatory services (outpatient services) type duties for institutional psychologists be explored to broaden the scope of psychological services within the community.

Standards of Service

68. That all Regional Treatment/Psychiatric Centers obtain and maintain accreditation status from the Canadian Council on Health Facilities Accreditation.

69. That health professionals in Regional Treatment/Psychiatric Centers be appropriately registered/licensed in the province of practice, and that this be one of the conditions of employment for all Correctional Service of Canada professional staff.

70. That the Correctional Service of Canada confirm the following assessment and treatment standards for psychologists:

    a) that the role of the psychologist be focused on the assessment of needs, the provision of treatment, and the prediction of risk based on the effectiveness of treatment interventions;

    b) that psychologists be an integral part of treatment delivery systems providing direction to programs where appropriate;

    c) that the completion of full psychological assessments be limited to a contract registered psychologist, Correctional Service of Canada registered indeterminate psychologist or Correctional Service of Canada psychometrist (MA unregistered) supervised by a senior registered institutional psychologist, and that the total requirement for assessments be limited to 50% of the job description for non-reception Centre psychology positions;

    d) where practical and cost effective, that contract resources ($) be used for comprehensive psychological assessment requirements, and indeterminate PY psychology resources be used for treatment of offenders; and

e) that flexible staffing/hours of work be facilitated (e.g. 80% indeterminate positions and/or compressed work week schedules).

71. That each Parole District Office receive a PY to staff the psychologist position and sufficient O & M funds for special programming depending on the particular District Office's requirement for psychological/ mental health services.

72. That performance appraisal objectives of mental health practitioners be written in measurable, achievable and meaningful terms to reflect productivity expectations.

73. That the Correctional Service of Canada adopt the Practice Guidelines for Providers of Psychological Services (1989), for all CSC psychologists (registered and grandfathered unregistered MA's).

74. That the Psychological Standards for Case Management and their resource implications be reviewed and adjusted to reflect the changes resulting from the approved recommendations of this Report.

75. That the Regional Administrator, Health Care Services, approach the various provincial professional regulatory bodies with a view to clarifying their role and authority vis-a-vis the Correctional Service of Canada professionals.

Consumer Participation

76. That the Correctional Service of Canada actively encourage offender participation in the design and implementation of programs and services intended for the offender.

77. That the Correctional Service of Canada make every effort to implement three basic components necessary to the achievement of offender participation:

    a) to listen to and respect the viewpoints of offenders;

    b) to establish a partnership model between professionals and offenders, where professionals and offenders work together towards the same goal; and

    c) to recognize the importance of and actively support self-help groups i.e. programs which are directed and controlled by offenders.

Organizational Structure

78. That all institutions have a multi-disciplinary team to priorize mental health services.

79. That a Senior clinical position for Mental Health and Psychological Services (PS-05) be created at National Headquarters, Health Care Services Branch, to provide functional direction and quality assurance to the Director, Mental Health Programs.

80. That a similar position for Regional Mental Health and Psychological Services (PS-04) be created to provide functional direction to the Regional Administration, Health Care Services.

81. That a multi-level system for Psychological Services be implemented, wherein each institution is staffed and organized as follows:

    a) one Senior Clinician (provincially registered psychologist, MA or PhD) at the PS-04 level, who supervises new PS-02 unregistered MA level psychometricians and (grandfathered) unregistered PS-03 psychologists;

    b) psychologists registered in the province of practice, and specialist psychometrists (MA unregistered) who have developed a specific area of expertise and are supervised by on-site registered psychologists;

    c) current unregistered MA staff psychologists need to be grandfathered as Correctional Service of Canada psychologists, so as not to affect their present title, duties, classification and remuneration; MA level psychometrists (PS-02) will be psychological associates; and

    d) all future staffing actions to require provincial registration for psychologist positions (PS-03); psychometrist positions (MA PS-02 level) be established in major institutions where duties warrant, or if the requirement for registered psychologists cannot be met in a timely manner.

82. That the 1973 Treasury Board Agreement be re-negotiated in order to ensure that it is consistent with the proposed structure for the delivery of psychological services.

Staff Training and Development

83. That staff training programs be reviewed with a view to providing enriched learning opportunities on all facets of mental disorders, and that staff having direct contact with the offender be appropriately trained to recognize offenders suffering from serious mental health problems, and make the appropriate referrals. That Unit managers be trained and sensitized to a non-abusive use of security measures for this type of offender. 84.That case management officers be provided with an orientation on how to identify areas of psychological need and the necessity for referral, based on the principles of differentiation, discretion and judgment.

85. That the Correctional Service of Canada staff having contact with Aboriginal offenders, be provided with enriched programs on Aboriginal cultures, values, and practices.

86. That the Correctional Service of Canada offer a training package to its staff to assist and guide them in the assessment, treatment and management of sex offenders, comprising the following three levels:

    a) a general orientation of sex offenders and their treatment, aimed at all staff, to assist them in understanding and meeting the special needs of this population;

    b) a more intense, skills-oriented training package for case managers, aimed at developing and improving interviewing techniques, assessing abilities, and supervision strategies; and

    c) an intensive training program for all mental health professionals and adjunctive therapists involved in the delivery of services and programs for sex offenders. This training should include an internship at a Regional Psychiatric/Treatment Centre, specializing in sex offender treatment.

87. That mental health professionals within the Correctional Service of Canada receive specific training to assist them in detecting and treating offenders with dual diagnosis.

88. That each region identify and train within its staff, individuals capable of delivering various crisis management services, and that these services be made readily accessible.

89. That a pertinent training package be developed for all institutional staff, for the reduction of self-injurious behaviour.

90. That in order to recognize potential attempters, the Suicide Prevention Training Program implemented by the Correctional Service of Canada be provided to all staff who have contact with inmates, and that refresher courses be offered at regular intervals.

91. That health care services staff be provided the opportunity to access current knowledge on the psychological and psychiatric aspects and treatment of patients with AIDS. That attendance at appropriate conferences and subsequent sharing of information on a regional and national basis be authorized.

92. That professional staff be represented on Regional Training Committee to ensure the development and provision of relevant training strategies.

93. That a clearly defined training and recruitment program for MA and PhD level psychologists be developed in the Regions; and that the staff development process make accessible an upgrade to the PhD level for those with the interest and capability.

94. That professional development conferences be held for the Correctional Service of Canada mental health staff, beginning in 1991, focusing on clinical issues and research. Regional conferences should be held annually and a national conference should be held every two years.

95. That the role of Correctional Officers, Case Managers and Nurses be expanded to include program and service delivery as co-therapists.

Communication

96. That a communication network for mental health staff be established at the local, regional and national levels, through the staffing of regional and national coordinating position, annual conferences and the creation of a newsletter or similar publication.

Gathering and Dissemination of Information

97. That adequate coverage of the mental health issues be given in the case management file, by mental health professionals, and that the treatment plan of the offender suffering from mental health problems be accessible to all professionals and staff involved with the offender. Appropriate mechanisms will need to be developed to ensure the dissemination of such information.

98. That the information needs required by the case management process, related to mental health care of offenders, be clearly determined in terms of timeliness, content, format, and stated purpose; and that the roles of correctional and mental health staff in the creation, gathering, dissemination and control of this information be clearly delineated.

99. That the case management team approach be reviewed, to ensure that information is efficiently distributed to and shared with all parties involved in the decision-making process, in an expedient and appropriate manner.

100. That case conferences be held periodically, chaired by the case manager, bringing together all professionals and staff involved with the offender suffering from mental health problems. These conferences will facilitate the coordination of the treatment and ensure the treatment plan of the offender is respected.

101. That in order to alert the receiving institutions and districts, suicidal tendencies be recorded on Transfer Summary Sheet (Form 377).

102. Given that in the majority of completed suicides in the Correctional Service of Canada the history of previous attempts and/or substance abuse was unknown, that this information be documented and appropriately disseminated.

103. That the Correctional Service of Canada develop a system of communication, including confidentiality safeguards, to insure that community service providers have access to inmate histories on file.

104. That the Correctional Service of Canada and the National Parole Board actively facilitate the resolution of some fundamental ethical-legal issues regarding the gathering and dissemination of information.

105. That meetings at the national level be held involving case managers, members of the National Parole Board, psychologists, psychiatrists, and representatives from both the Legal, Health Care Services, and Privacy branches, to develop policies and standards regulating the gathering and dissemination of information, regarding the mental health care of offenders.

106. That a protocol be developed on which staff can render judgments on the gathering and dissemination of information, which respects the rights of the offender and third parties, and is in keeping with legal, ethical and professional standards.

107. That an information base be established at local, regional and national levels to provide up-to-date data on treatment and assessment waiting lists, timeliness of service delivery, and resources.

Agreements with Provinces and Academic Facilities

108. That a communication network and an infra-structure be developed in each region, through the establishment of joint planning groups with each Province, to identify areas of mutual need for assessment, treatment, follow-up, and research services, and plan for mutual cooperation in service delivery and evaluation of outcome.

109. That these Regional Planning Groups have direct and ongoing liaison with the Branches of Health Care Services, Research, and Offender Management at National Headquarters, to ensure plans are consistent with the Corporate Objectives, the Research Strategies, and the Mental Health Standards.

110. That, as part of the mental health plan of each region, agreements of reciprocal benefit be established between the Service, the Provinces and the academic facilities, with the objectives of increasing the quantity and quality of research, service delivery, and the recruitment and training of staff.

111. That the Service strive towards the development and implementation of tripartite agreements with the academic facilities and the Provinces, with the aim of achieving a level of excellence in the forensic/mental health field.

112. That Affiliation Agreements and collaborative working relationships with academic facilities be established at each Regional Psychiatric/Treatment Centre, to improve the services and programs offered to offenders, facilitate the recruitment and training of staff, enhance teaching and research, and maintain accreditation standards.

113. That the Correctional Service of Canada and the provinces work together to ensure in-patient psychiatric facilities of high standard are available to all parts of the Criminal Justice System.

114. That a mental health ambulatory services program be installed in all Regions along with a Doctoral Residency Program in health care related fields, with an accredited University Psychology Department and a Psychiatric Residency Program with an accredited medical school.

115. That efforts be made to facilitate university cross-appointment for PhD level psychologists and other mental health care professionals.

Research Needs

116. That each region develop a Regional Research Plan, in concert with the National Research Plan, which identifies local, regional and national research priorities and plans related to Mental Health Care for a two year period, and which is updated annually.

117. That Regional Treatment/Psychiatric Centers maintain an active research role, provide leadership in mental health research in the region, and develop a research plan focused on forensic issues as part of the Regional and National Research Plans.

118. That research efforts among Regional Treatment/Psychiatric Centers be coordinated to:

    a) establish research priorities and develop areas of expertise;

    b) test efficacy and effectiveness of alternative treatment modalities; and

    c) provide a basis for comparative outcome analysis on the efficacy of treatment based on multi-site studies.

119. That research and program evaluation objectives be incorporated into each psychologists position description.

120. That the following initiatives be considered as priorities for inclusion in the Regional and National Research Plans:

    a) significant basic research on criminal violence and psychopathy (as measured by the Psychopathy Checklist) and on the relationship of criminal violence to release decisions;

    b) further research on the development of additional intervention modules for violent offenders, and on their most appropriate delivery;

    c) further research in the field of dual diagnosis, to develop specialized treatment for this population;

    d) background information on age, high risk behaviours, sentence length, and crime of the HIV infected offender as to assist research in the identification of future needs of the HIV infected offender; and

e) research to determine whether the provision of work leads to symptomatic improvement in the chronically disordered offender.

121. That core assessment data on sex offenders be recorded in the same format in each treatment program using the same computer program, to facilitate outcome studies using multi-site data. Standardized core data gathered as part of treatment and assessment programs that are funded by the Correctional Service of Canada should be available to the Correctional Service of Canada for purposes of research and evaluation. A system needs to be worked out to ensure that proper credit is given for individual scientific effort in any written reports and that the use of standardized data by the Correctional Service of Canada for evaluative purposes does not interfere with individual professionals publishing data they have collected on their own.

SUB-TASK #1 DISCUSSION PAPER

"The development of a strategy to implement a broad range of programs to target offender groups, based on the prevalence of mental disorders among the offender population."

Author – Larry Motiuk

This paper describes the design of the survey commissioned by The Correctional Service of Canada (CSC) in September, 1988 to assess the prevalence, nature and severity of mental health problems among the male offender population, and provides tabular information on preliminary prevalence rates at national and regional levels for the main categories of mental disorder. Key background detail on the survey and the most important tables and interpretative comments are provided below.

The survey had the special character of relying on a structured interviewing instrument – the Diagnostic Interview Schedule (DIS) – and of employing the objective diagnostic criteria described in the Diagnostic and Statistical Manual (DSM III) of the American Psychiatric Association (Appendix A of the paper comprises a composite list of articles published on the DIS). The design of the survey involved a systematic sample of all male inmates in CSC custodial facilities with the exception of High Maximum Security Units, Regional Psychiatric Centres and Regional Treatment Centres where a completed census was attempted. The population was stratified by region with eligible respondents listed by institution and ordered by age. Strata sample sizes were chosen to yield a 5% margin of error for a 99% confidence interval.

Of the 3,224 inmates selected for the survey, 2,812 (87%) were actually sampled in the five CSC regions. The overall response rate was 68.5% and only a very few institutions had response rates below 50%. The overall response rate for the census institutions was 63% (Appendix C indicates response rates by institution for each CSC region). With respect to security levels, minimum security institutions had the highest response rate, 73%, compared with 66% for maximum security institutions.

The results of the survey are organized around eight groups of diagnosis: organic brain syndrome; psychotic; depressive; anxiety; psychosexual; antisocial personality; substance abuse/dependence; and alcohol abuse/ dependence (Appendix B of the paper describes these mental disorders in detail).Prevalence rates are measured with respect to two defining parameters: reference period and breadth of criteria employed. The reference period can be either lifetime, past year or past two weeks. Breadth of criteria can be either wide or severe and exclusive. Exclusive criteria remove from prevalence figures those diagnoses which may have been due to other mental

health problems; severe criteria include only those cases where all identifying behaviours are present. Severe and exclusive criteria are referred to jointly as stringent. In this paper prevalence rates for all three reference periods and for both wide and stringent criteria are presented.

Table 1 presents prevalence rates for the three reference periods using wide criteria for each of the diagnostic groups.

TABLE 1

NATIONAL PREVALENCE RATES ACCORDING TO THE DIS USING WIDE CRITERIA (WEIGHTED)

DISORDER	LIFETIME	WITHIN ONE YEAR	WITHIN TWO WEEKS
ORGANIC	4.3	n/.a	n/.a
PSYCHOTIC	10.4	6.8	4.6
DEPRESSIVE	29.8	15.6	9.1
ANXIETY	55.6	34.8	15.4
PSYCHOSEXUAL	24.5	n/.a	n/.a
ANTISOCIAL	74.9	n/.a	n/.a
SUBSTANCE	52.9	16.8	4.2
ALCOHOL	69.8	13.1	0.6

Note: n/a = not available

Table 2 shows lifetime rates using wide criteria for the regions; major differences in this table are thought more likely due to the idiosyncrasies of data collection rather than intrinsic inter-regional differences in prevalence rates.

TABLE 2

REGIONAL PREVALENCE RATES ACCORDING TO THE DIS USING WIDE CRITERIA (WEIGHTED)

DISORDER	ATL.	QUE.	ONT.	PRA.	PAC.
ORGANIC	6.9	4.3	2.3	4.6	6.2
PSYCHOTIC	10.8	11.3	11.8	9.6	6.5
DEPRESSIVE	28.2	34.3	26.9	28.5	29.4
ANXIETY	50.6	70.4	51.0	47.0	48.9
PSYCHOSEXUAL	28.8	19.0	23.9	30.2	26.9
ANTISOCIAL	79.3	74.9	72.7	77.7	73.3
SUBSTANCE	52.5	57.6	48.4	53.7	50.9
ALCOHOL	76.0	66.6	69.3	75.8	65.8

Table 3 contrasts lifetime prevalence rates using wide criteria for each type of correctional setting. For most diagnostic groups, rates are as expected: highest in security units and higher in treatment centres than they are in the general offender population.

TABLE 3

PREVALENCE RATES ACCORDING TO THE DIS FOR GENERAL POPULATION, TREATMENT CENTRES AND SECURITY UNITS

USING WIDE CRITERIA (WEIGHTED)

DISORDER	GENERAL POPULATION	TREATMENT CENTRES	SECURITY UNITS
ORGANIC	4.3	2.3	8.5
PSYCHOTIC	9.9	25.3	29.3
DEPRESSIVE	29.3	51.1	47.6
ANXIETY	55.3	64.6	73.2
PSYCHOSEXUAL	24.3	37.6	23.2
ANTISOCIAL	74.8	78.7	86.6
SUBSTANCE	52.7	56.7	72.0
ALCOHOL	69.6	72.5	81.7

Tables 4, 5 and 6 present the same information, this time using the most stringent criteria for meeting a particular DSM-III diagnosis. These tables provide lower-bound estimates of mental health problems among the federal inmate population.

TABLE 4

NATIONAL PREVALENCE RATES ACCORDING TO THE DIS USING STRINGENT CRITERIA (WEIGHTED)

DISORDER	LIFETIME	WITHIN ONE YEAR	WITHIN TWO WEEKS
ORGANIC	0.1	n/a	n/a
PSYCHOTIC	7.7	5.0	3.6
DEPRESSIVE	21.5	9.9	5.4
ANXIETY	44.1	27.0	11.8
PSYCHOSEXUAL	21.1	n/a	n/a
ANTISOCIAL	56.9	n/a	n/a
SUBSTANCE	40.9	13.1	3.0
ALCOHOL	47.2	9.8	0.5

Note: n/a = not available

TABLE 5

REGIONAL PREVALENCE RATES ACCORDING TO THE DIS USING STRINGENT CRITERIA (WEIGHTED)

DISORDER	ATL.	QUE.	ONT.	PRA.	PAC.
ORGANIC	0.3	0.2	0.0	0.0	0.3
PSYCHOTIC	6.9	8.6	9.3	7.2	4.1
DEPRESSIVE	20.4	23.3	17.7	22.4	24.2
ANXIETY	41.7	57.5	39.5	34.6	40.1
PSYCHOSEXUAL	24.0	16.0	20.9	25.7	24.0
ANTISOCIAL	61.9	56.7	52.1	61.1	58.1
SUBSTANCE	40.5	48.6	36.2	39.3	36.8
ALCOHOL	51.4	45.8	46.0	51.6	43.8

TABLE 6

PREVALENCE RATES ACCORDING TO THE DIS FOR GENERAL POPULATION, TREATMENT CENTRES AND SECURITY UNITS USING STRINGENT CRITERIA (WEIGHTED)

DISORDER	GENERAL POPULATION	TREATMENT CENTRES	SECURITY UNITS
ORGANIC	0.1	0.0	0.0
PSYCHOTIC	7.4	22.5	19.5
DEPRESSIVE	21.2	38.2	22.0
ANXIETY	44.1	41.6	61.0
PSYCHOSEXUAL	20.9	29.8	19.5
ANTISOCIAL	57.1	49.4	51.2
SUBSTANCE	40.8	41.6	59.8
ALCOHOL	47.0	49.4	64.6

It is clear from these tables that a significant reduction in the prevalence rates takes place when severity and

SUB-TASK #2 DISCUSSION PAPER

"The development of a standardized programming process to ensure a uniform approach to program planning, design, resource allocation, follow-up and evaluation, in order to provide a basis for comparative evaluation of program outcome and effectiveness."

Authors – Bram Deurloo and Caroline Cyr Haythornthwaite

This paper deals with the programming process as the critical vehicle for the appropriate delivery of mental health services to offenders in the Correctional Service of Canada (CSC). It presents the fundamental considerations that bear on the development of specific programs and the implementation and evaluation process involved, with particular emphasis on the need for uniform programming standards.

Effective programming should have as its goals the social reintegration of the offender, the minimization of risk to the community and the reduction of recidivism. Substantive program development should, therefore, be predicated on principles of rehabilitation that lead to the incremental realization of these goals. Effective programming should also have an elaborated programming process that will ensure the standardized implementation and evaluation of programs across the Correctional Service of Canada.

Effective program development is a major issue addressed by the authors of the paper. Criminal sanctioning will only lead to the reintegration of the offender, the minimization of risk to the community and the reduction in recidivism if it is accompanied by rehabilitation programs that are based on clinical principles.

Three principles of functional rehabilitation are cited, beginning with risk of recidivism. Higher (more intensive) levels of service should be reserved for high risk offenders; low risk offenders do not benefit more from intensive service than they do from minimal service.

Second, with respect to criminogenic needs, programs should be targeted and matched to the specific criminogenic needs of offenders: that is, to characteristics of the offender that, when influenced, are associated with the likelihood of reduced recidivism. Not all offender characteristics are appropriate as program targets, and different offenders require different programs, thereby making effective assessment and offender-program matching an indispensable aspect of this principle. Some of the most promising targets include changing anti-social dispositions, reinforcing familial connectedness, promoting pro-social role model identification, increasing self-management skills and shifting the reward/cost balance in favour of non-criminal activities. Dispositions to be avoided as targets in their own right include self-esteem, feelings of guilt/anxiety, different emotional problems and antisocial peer cohesiveness. In developing target programs, emphasis should be placed on cognitive skills training – moving the cognitive disposition of the offender towards greater self-control and towards the adoption of pro-social values.

Third, concerning treatability/responsivity of the offender, the matching, timing and sequencing of target programs should correspond with the extent to which individual offenders have been determined to be able to benefit from particular interventions. Considerations respecting responsivity include conceptual and maturity levels, degree of inter- and intra-psychic sensitivity, level of anxiety, degree of anti-social disposition, level of motivation, level of risk and degree of psychiatric complication. Assessment of offender treatability should, ideally, take place at the pretrial stage, thereby allowing the widest range of intervention/dispositional options.

In addition to the three principles of rehabilitation, effective programming is dependent on a number of other influential factors: a facilitating staff who promote pro-social values and attitudes in exercising their authority (this consideration should be given weight in the selection and training of personnel); recognition of the particular social and cultural characteristics of offender groups; the creation of a positive, interactive environment in the exercise of control and surveillance, in the delivery of service and in the administration of treatment; the need to reconcile such program dimensions as resource allocation and deployment, number of offenders served, program-organization capacity, innovation and experimentation, and offender reinforcement; and the importance of a facilitating the Correctional Service of Canada environment overall.

Previous Solicitor General reports, Programming in the Federal Corrections (1976) and Program Planning System for the Canadian Corrections Service (1977), have emphasized the need for programming standards. The Planning System model which follows is likely to foster productive and uniform programming within the Service. It is composed of three phases.

Phase I, Strategic Planning, calls for a positive evaluation, which identifies those objectives of the Service that are not being fulfilled and that the proposed programs could address, and an environmental analysis, which anticipates how the proposed program will be influenced by and, in turn, will impact on prevailing issues and philosophies, assisting programs, other agencies and the deployment of resources.

Phase II, Program Design and Approval, calls for setting clear objectives; situating the program within the contexts of the Correctional Service of Canada environment, its philosophy and future objectives; diagnosing policy issues associated with the program and the criminogenic needs it addresses; searching for the best program option to meet those needs; carrying out a feasibility study; and, through the integration of information from all of these steps, preparing a program proposal detailing the program's activities, its context, goals, service connections, roles and evaluation component.

Phase III entails Implementation and Evaluation, which involves an implementation plan; an identification of the human-capital resources required; a specification of the role relationship, staffing, training, and consideration of staff and offender attitudes; the implementation activity itself; and a dynamic, ongoing post-implementation monitoring and evaluation strategy.

Conclusions drawn in the paper suggest it is important that the CORRECTIONAL SERVICE OF CANADA have a uniform programming process aimed at delivering standardized mental health programs and services to offenders. Programs should be developed on the basis of risk, need and responsivity of client offenders.

The authors make eight recommendations respecting the programming process within the Correctional Service of Canada. Given the scarcity of resources, the Correctional Service of Canada should establish programming and resource allocation priorities in terms of degree of impairment, risk of recidivism, and potential for long-term improvement. Mental health programs and psychological treatment should be developed, delivered and evaluated in consideration of risk, targeted and matched to identified criminogenic needs, and should accord with the assessment of treatability. A common nomenclature should be developed by the Correctional Service of Canada, regarding the concepts of risk, need and responsivity/treatability, to allow for a common understanding and consistency among case management, mental health and research initiatives. Each mental health program should be evaluated on an ongoing basis, to ensure consistency among program objectives, mental health needs, mental health priorities, the Correctional Service of Canada Mission, and the case management process. Initiation, planning and evaluation of new programs should involve the Regional and National Research Committees to ensure a linkage with the respective area research plans, and consistency with professional ethics and standards. The Correctional Service of Canada should systematically adhere to the steps outlined in the Task Force report when initiating, developing, implementing and evaluating a program. All staff and offenders affected by a program should be consulted and involved in a meaningful

way in its planning, implementation and evaluation, and their roles and responsibilities in this process should be clearly defined. Finally, programs should be designed in keeping with the setting in which they are delivered (the primary, secondary and tertiary levels), and should utilize models, styles and methods that correspond to the abilities of the target offender group, taking into consideration the treatability/responsivity of the offender, and cultural/ethical constraints.

SUB-TASK #3 DISCUSSION PAPER

"The development of a uniform process for the delivery of mental health programs and services, including: assessment, diagnosis, program planning, targeting, treatment, pre/post assessment, maintenance, risk assessment, release planning, post-release follow-up, evaluation; and consistent and integrated with the case management and pre-release decision making process."

Authors – Bram Deurloo and Caroline Cyr Haythornthwaite

The paper discusses two parallel issues: the relationship between psychologists and case managers and the development of a uniform process to deliver mental health programs and services, from assessment to the post-release evaluation stage, to reintegrate offenders in the Correctional Services of Canada (CSC) into society.

Reference is made to the increasing legal and policy demands on the system, and to the problematic impact of these on tasks and resources. Shifting emphasis from program delivery to risk assessment is highlighted, particularly with respect to the increased involvement of psychologists to the detriment of their intended role as agents of change and as team participants in case management. This undermines principles expressed in Core Value 2 of the Correctional Service of Canada Mission Statement, as opportunities and evaluative instruments are not available for psychologists to properly assess offenders on entry to the Correctional Service of Canada system, nor to meet the needs and enhance the potential for social integration of offenders through treatment programs that address dynamic and changeable rather than static factors in their personal make-up.

The argument is made for developing a case management process that includes a diagnostic risk/needs assessment at the beginning of an offender's sentence for the dual purpose of determining the necessary security level and identifying criminogenic needs and targeting programs to alter them. Such a revamped case management process would clarify roles for case managers, psychologists and Parole Board members and facilitate their working in a complementary manner to, respectively, assess risks and develop intervention strategies, deliver treatment and assess changes, and determine release requirements to successfully reintegrate offenders. The corollary benefit of this approach would be a reduction of the importance of the Schedule of Offences in assessing offenders on arrival. The Schedule can prove unreliable because of the often unrelated nature of offences to behaviour, intent, need or risk; the inexactness andvariability of sentencing; the tendency to allow misclassification of low risk/low need offenders as significant risks ("false positives") or high risk/high need offenders as low risks ("false negatives"); and the disservice done to special inmate groups such as women, aboriginals, sexual or violent offenders, substance abusers and the mentally disordered.

The operation and benefits of the Triage Model of assessment are then explained. It consists, initially, of a risk/needs screening process carried out at reception by case management officers to determine essential, consistent information on offenders' needs. It would also constitute the basis for referral to a psychologist, for formulating case management strategy and treatment, and, ultimately for assessing positive change and risk factors prior to release.

Its second stage would encompass a routine intake assessment for all offenders on entry. Perhaps based on the Millhaven Transfer Unit process, this would entail a standard, automated battery of tests, determining such things as presence of mental disorder and level of intelligence, used to produce an assessment report outlining needs and recommending treatment.

Stage three would be an in-depth assessment involving a clinical interview and selected tests to identify needs. Information derived at previous stages would form the basis for this assessment, with risk management being the objective of this final investigative stage. Triage Model advantages cited are its capacity to identify a common set of risk/need factors, to place responsibility for primary assessment and referral with case management officers and delegate subsequent assessment to psychologists, and to employ staff resources in an optimum integrated manner to ensure all offenders are thoroughly assessed. To support the Triage Model and the requirement for improved information coordination which would evolve from it, the new electronic Offender Management System (OMS) is suggested to gather and disseminate written information.

The paper asserts that a fundamental shift in organizing and operating the assessment and case management process is required. This would enable offenders to achieve positive changes more easily, make better use of skills of psychologists and case managers in performing their respective, yet integrated tasks, and provide more useful and comprehensive predictive data to decision-makers concerned with parole.

Six long term and seven short term recommendations are made. The former suggest that all offenders receive an intake assessment regardless of offence; assessment roles for case managers, psychologists and the Parole Board be delineated; the Triage assessment process be developed as described above; a community risk/needs management instrument be devised and implemented on a pilot basis by the Research, Offender Management and Health Care Branches; and that Psychological Standards for Case Management and their resource implications be reviewed and adjusted to reflect changes. The latter, short term recommendations are that a battery of tests be developed to screen all offenders at reception for mental and behavioral indices; a national plan be instituted to automate the administration, scoring and interpretation of standardized psychological tests; the case management process be structured to assist in making referrals for psychological assessment and risk prediction; case managers' referrals for psychological assessment be verified by their supervisor; case-management officers receive an orientation on psychological need and necessity for referrals; psychologists renew their focus on needs assessment, treatment and risk prediction based on treatment interventions. The final short term recommendation is that the Correctional Service of Canada adopt a policy on timing service delivery which ensures all offenders are fully assessed by the one-sixth review date; offenders released at one-sixth of their sentence undertake treatment/programs available in the community, where possible; candidates for full parole complete treatment within one-third of their sentence; and for those for whom release is contingent on successful treatment completion that it will be completed by the time of release or no later than two-thirds of sentence, whichever is sooner.

SUB-TASK #4 DISCUSSION PAPER

"The development of a service delivery system including the clarification of the roles of Regional Treatment/Psychiatric Centers, institutional and community based mental health staff, and contracted resources."

Author – Robert Gillies

The paper outlines and makes recommendations on mental health service delivery at the primary, intermediate and intensive levels of care in the Correctional Service of Canada (CSC). Roles of Regional Psychiatric Centres/Regional Treatment Centres (Regional Treatment/Psychiatric Centers) in the CSC system and in the community are also described.

Accepted definitions and principles of mental health care are provided as background: Health and Welfare Canada's (HWC) 1988 description terms mental health an interactive concept which encompasses the individual's physical and mental capacities interrelating with one another, other individuals, and the external environment. The fundamental tenet underlying CSC principles is that offenders have the right to access a full range of physical and mental health services compatible with local community standards for the duration of their sentence.

Primary service for the general institutional population, for inmates with mental disorders, and for offenders in the community phase of their sentence is outlined regarding basic needs. Specialized institutional programs for addiction, anger and stress management, and mental disorders are proposed to deal with particular needs of offenders who are able to remain functional at the primary service and treatment level. Accompanying recommendations suggest that basic mental health services be provided in institutions on an ambulatory basis for offenders in the general population, and that community-based mental health services always be used for offenders who do not exhibit further criminal behaviour while serving the community phase of their sentence.

The intermediate level of service is discussed for offenders among the general prison populace who are unable to cope, or for those in the community who require enhanced service. Recommendations made for this service level are that each region have specialized programs and dedicated program and accommodation space for needy offenders who are incarcerated, and that half-way house settings with accommodation be available to mentally disordered offenders requiring additional support. An intensive level of service is proposed for offenders who are in-patients under psychiatric care and offenders in the community phase of their sentence who come to require in-patient psychiatric care.

Recommendations specify that the former group receive treatment regionally, either in Regional Treatment/ Psychiatric Centers or in contracted outside facilities, and that the latter group be admitted for care in community facilities when needed.

Community and/or regional responsibilities extending beyond the CSC treatment role for inmates are listed for Regional Treatment/Psychiatric Centers, beginning with the need for them to acquire status as designated psychiatric in-patient facilities under mental health legislation of the province where they are located. Responsibilities involving treatment for CSC offenders in the community include the provision of beds for in-depth assessments to assist with decisions about parole; the development and testing of treatment programs for special offenders (sexual offenders, substance abusers, etc.); and an outreach role to offenders, other institutions and parole officers. An active research role is also advocated for Regional Treatment/Psychiatric Centers, which should become regional "centres of excellence" with the necessary "critical mass" of highly trained mental health professionals. To achieve this, cooperation with area universities and provincial correctional authorities is suggested, consistent with, respectively, Core Value 4 of the CSC Mission Statement and the 1976 Law Reform Commission Report "Mental Disorder In the Criminal Process".

Seven recommendations are made about Regional Treatment/Psychiatric Centers. They should obtain and maintain accreditation status from the Canadian Council on Health Facilities; develop and test special group treatment programs, and assist other institutions to establish and evaluate them; work with institutions and parole officers to ensure continuity of care for offenders through ambulatory services following their discharge from Regional Treatment/Psychiatric Centers; collaborate with universities to enhance teaching and

research; maintain an active regional research role and develop a research plan on forensic issues in conjunction with Regional and National Research Plans; ensure their health professionals are provincially registered/ licensed; and plan with the provinces to provide high-standard, in-patient psychiatric facilities available to all parts of the Criminal Justice System.

Four additional recommendations concerning mental health service delivery and CSC standards are that institutions assess newly admitted offenders to identify mental disorders, and follow-up as necessary (Standard 302); organize multi-disciplinary teams to prioritize mental health services (Standard 405); provide appropriate care to offenders exhibiting signs of serious mental illness (Standard 408); and review staff training progress to ensure enriched learning opportunities are available on all facets of mental disorders (Standard 503).

SUB-TASK #5 DISCUSSION PAPER

"The development of a strategy to implement programs for psychiatric/psychological disorders: acute, chronic and marginal offenders."

Authors – Bram Deurloo and Caroline Cyr Haythornthwaite

The paper discusses the effect of environment on functional psychoses by examining research on offenders exhibiting its most common form, schizophrenia, in the Correctional Service of Canada (CSC). Variations of this disorder are noted; however, treatment and management of schizophrenic offenders are not differentiated according to symptoms. Tabular data and a bibliography are included in the paper.

To determine schizophrenia prevalence rates (i.e. the total number of cases, new and old, known to exist) among the federal offender population, a survey was carried out using the Diagnostic Interview Schedule (DIS). For comparison, a study on diverse population groupings within various countries was inserted at the outset: Table 1 shows some of the findings. Particularly noteworthy is the high prevalence rate of schizophrenia among Canadian native offenders who, despite the acknowledged limits of the sample, demonstrate a dramatically elevated frequency of this disorder.

TABLE 1
PREVALENCE OF SCHIZOPHRENIA

LOCATIONS*	CHARACTERISTICS OF THE POPULATION	PREVALENCE PER 1,000 POPULATION	AGE CORRECTED PREVALENCE	PREVALENCE PERIOD
Canada	Non-Indians	1.6	2.4	point
Canada	Indians	5.7	11.0	point
Canada	Hutterites	1.1	2.1	lifetime
U.S.A.	Urban	4.7	6.41	year
Australia	Aborigines	4.7	9.3	point

* Locations shown are excerpted from a broader range of countries listed in the corresponding table in the original paper.Data gathered on federally-sentenced male and female offenders in Canada is provided in Table 2. While survey results are preliminary and subject to change in future as refinements are made with respect to the sample size, age groupings and techniques, the evidence indicates a substantially greater level of disturbance among women offenders than among men. This contrasts with similar prevalence rates among males and females in the general populace, although rates for men aged 15 to 24 – an important age grouping vis-à-vis corrections – are twice that of women of the same age.

TABLE 2

PREVALENCE RATE FOR FEDERALLY-SENTENCED MALES & FEMALES

	WIDEST CRITERIA		STRINGENT CRITERIA	
	MALE	**FEMALE**	**MALE**	**FEMALE**
Schizophrenia	4.9%	13.0%	4.4%	11.7%
Schizophreni-form	0.8%	1.3%	0.5%	1.3%
Dysthymic Disorder	14.3%	24.7%	7.9%	5.2%
Bipolar Disorder	3.6%	7.8%	1.6%	2.6%

The relationship between functional psychoses and the correctional environment is stated and followed by the idea of using the control inherent in this environment to treat and manage afflicted offenders in ways that engage them in pro-social activities optimizing self-control. Various theories for treating schizophrenia offenders are outlined, ranging from Kraeplin's work early in the century which was pessimistic about the influence of environment to help ill prisoners recover, to Bleuler's later views on the potential for assisting schizophrenic offenders through community rehabilitation and work programs, and finally to Freeman's recent, optimistic ideas that propose treating offenders with functional psychoses by addressing genetic, environmental and social factors in a balanced manner. CSC is urged to generate the will and resources necessary to structure and control environmental stimuli to make disorders less intense and more treatable over time.

Work and deinstitutionalization are then discussed as therapies. Despite strong beliefs in, and some anecdotal evidence in support of, the therapeutic role of work to develop self-esteem and shape social roles for psychotic individuals, definitive research remains to be done. CSC's current vocational rehabilitation programs to treat chronic, mentally disordered offenders – such as sheltered workshops, vocational and volunteer placements – may provide clinicians with needed research opportunities. In examining deinstitutionalization, the role of anti-psychotic drugs and the development of community welfare programs are reviewed and followed by an assessment of the effects of such policies. After noting that studies mentioned are based on the U.S. experience, the authors cite the return of chronically hospitalized patients to the community as a positive feature of deinstitutionalization, while the isolation of patients without social, financial or moral support is identified as a negative result of the policy, often causing a repetitive cycle of treatment and release in which patients often end up in the criminal justice system for treatment.

To aid chronic, mentally disordered offenders to become socially integrated in future, a continuum of care, from incarceration to the Warrant Expiry Date and beyond, is proposed as a means to eliminate the "revolving

door" syndrome and provide social opportunities along with a sense of self-worth. In the absence of a formal, integrated network of community-based residences offering this extended care, foster care in private residences or supervised apartments (group houses) are suggested as alternatives. Benefits noted include cost reductions for the prison system and a distancing from institutions for offenders. Expansion of outreach programs and community-based treatment is in line with CSC Health Care Standards, but requires cooperation with the judiciary and the National Parole Board to arrange smooth progress through each stage of rehabilitation, at the optimal moment in appropriate settings, for mentally disordered offenders.

Proper management and treatment of offenders during the part of their sentence served in an institution requires a full health status assessment on admission and referral, as necessary, to mental health care suited to their needs. Three levels of service and four stages of care are proposed. Primary service is provided on an ambulatory basis to offenders remaining in the general population, and includes community-based services and programs. Intermediate service is a special program offered within specialized units of federal institutions, and delivered in a dedicated living space within the institution. Tertiary service, as available in Regional Psychiatric/Treatment Centres, refers to in-patient beds in either facilities designated under mental health legislation or general hospitals.

Acute (and sub-acute) care takes place within a psychiatric facility, offering a structured setting. It aims at stabilizing patients and preparing them for eventual transfer to secondary level care in an institution where they function among the "normal" penitentiary population.

Transitional care is given in transitional units allied with psychiatric facilities for the purposes of managing medication and monitoring the condition of patients who are either between acute episodes prior to transfer to a penitentiary, or suffering a relapse. Individualized assistance is available to offenders, as required, in the form of counselling, psychotherapy, self-help programs, educational services, recreational activities and work assignments. Existing models for transitional care treatment are the Bow Unit at the Prairies Regional Psychiatric Centre and the Transitional Unit at the Dorchester Treatment Centre.

A third type of environment for therapeutic care in penitentiaries is provided in Special Program Units. These are staffed by multi-disciplinary teams of nurses and correctional staff, and operate with a reduced level of ambulatory support from psychiatric facilities to monitor, as part of a continuum of care, offenders' treatment, medication and overall progress. Occupational and social skills training is offered and work placements are sought for offenders. In-service training for staff includes instruction in the symptomatology, treatment and management of the mentally ill; charting, reporting and summarizing patient progress; and interviewing and assessment techniques. Advice given about establishing these Units states that they should match the profile of the general population, optimize proximity to tertiary care facilities, and achieve compatibility with the overall milieu in the host institution. Saskatchewan Penitentiary's Special Program Unit is discussed as an example for this type of care. Outpatient treatment through Ambulatory Care Teams is open to any chronically mentally ill offender able to function within the "normal" prison population.

The final stage of treatment is community-based care for offenders upon release and after sentence expiry. Facilities such as residences, group or foster homes, or individual accommodation are used as dictated by the individual's needs and demands. Since problems arising from the offender's disorder may be compounded by poverty, unemployment, negative public attitudes and a limited social support network, community-based services need to create an environment to address these and any other difficulties through comprehensive, coordinated and continuous treatment with counselling, programs and social support geared to the individual's situation. The Hamilton Program for Schizophrenics is highlighted for its treatment approach with outpatients. An outline of needs common among mentally disordered and low functioning offenders at all levels of care is accompanied by a list of corresponding treatment and management programs, as shown in Table 3.

TABLE 3

NEEDS, TREATMENT AND MANAGEMENT

NEED	TREATMENT/MANAGEMENT
Education	Basic literacy
Financial management	Money management
Recreational management	Structured recreational therapy
Vocational skills	Structured occupational and vocational activities
Life/Social skills	Basic life skills; basic social skills; anger management; assertiveness; stress management
Insight and awareness	One-to one counselling; group therapy
Non-compliance	Behaviour management; positive reinforcement
Accountability and personal responsibility	Token economy
Stabilization	Psychiatric treatment
Therapeutic milieu	Supportive environment

To improve treatment for mentally disordered offenders, three recommendations are made to CSC: that the four level model of care adaptable to changing individual needs be adopted and implemented, entailing acute/transitional care at Regional Treatment/Psychiatric Centres, special program units within the "normal" penitentiary population, outpatient treatment through ambulatory care teams, and community-based services; that community-based alternatives be pursued, in conjunction with provincial mental health systems, to meet the needs of disordered offenders in the community; and that research be encouraged to determine if work leads to symptomatic improvement and helps social functioning in offenders exhibiting these disorders.

SUB-TASK #6 DISCUSSION PAPER

"The development of a strategy to implement specialized programs and services to meet the needs of aboriginal people."

Author – Robert Gillies

The paper reviews mental health issues concerning aboriginal offenders in the Correctional Service of Canada (CSC), with the goal of involving them in positive mental health programs that respect their religions and cultural values. Background documents and studies in and outside the Service which refer to aboriginal cultural and health issues are outlined in the text, accompanying tables and bibliography.

The Correctoinal Service of Canada Mission Statement's objective to address, inter alia, "special needs of ...native offenders" provides the general context for the review. Several observations from the 1988 Report of the Task Force on Aboriginal Peoples in Federal Corrections (Task Force) are cited which bear on the analysis: the disproportionately high number of aboriginal offenders, their uneven regional distribution across the CORRECTIONAL SERVICE OF CANADA system, the variation in the characteristics and needs of this group because of their cultural and experiential diversity and, crucial to this paper, the holistic view of health held by aboriginal people.

Four concerns raised by the Task Force are reiterated and addressed by new recommendations. The lack of valid assessment mechanisms for aboriginal offenders is dealt with by recommending a full evaluation of current assessment procedures and techniques. The longstanding objective to involve elders and native liaison workers in the assessment process is stated with a recommendation to encourage their full participation in case management. The somewhat limited understanding of aboriginal people and culture in theCorrectional Service of Canada system is responded to with a recommendation that Service staff receive appropriate cultural training. The final, related issue from the Task Force report alludes to the often poor understanding by aboriginal people of their own culture, countered by a recommendation that programs be provided to aboriginal offenders to rectify this.

Before outlining nine common values which a Mohawk psychiatrist has arguably identified as affecting behaviour in aboriginal people, two health-related CSC standards are listed. One notes that offenders retain primary responsibility for their own health status; the other emphasizes CSC's responsibility to deliver health services appropriate to offenders' individual needs and values. Common aboriginal values cited are: non-interference in others' lives or actions, a requirement to suppress visible anger, the aboriginal concept of time, the principle of sharing as an expression of group rather than individual orientation, unwritten protocol that governs behaviour in each aboriginal group, the shaping of behaviour through modelling not instruction, responding to anxious situations by verbal withdrawal, and the drive for independence of thought and action. Some problems mentioned which result from these values in relation to CSC's provision of health care are: repressed hostility and explosive reactions, conflict with rigid time schedules, apparent ingratitude, rejection of instruction, misdiagnosis of aboriginal patients, and misperceptions concerning dependency of aboriginal people.

Because aboriginal concepts of medicine and health are defined as requiring a holistic balance of physical, mental, emotional and spiritual elements, the need is stated for CSC to extend its understanding of aboriginal spiritual and cultural activities to include medical practices. Reference is then made to a study comparing values of traditional Indian medicine with Western medicine. Many values noted are diametrically opposed. On one hand, for example, emphasis among aboriginals is on integrated and holistic health, sickness prevention, responsibility for personal well-being, the relationship of personal well-being and balance with natural law and sustenance from the Earth as governed by the Creator, and medicine as a gift to be shared by medicine men who are accountable to the Creator, the elders and their people, and supported by them. On the other hand, respectively, western medicine is characterized as emphasizing an analytic and corporal focus on health, disease treatment, a scientific approach to personal well-being, the relationship of health to scientific data and man's ability to control physical nature, and medicine as a closed, professional industry supported by the consumer, tax-payer and government, and accountable to the latter.

The paper suggests, however, that increasing recognition of the limits of the western approach to medicine, and the corresponding move towards emphasizing lifestyles, health promotion and illness prevention, provides an opportunity for cooperation between traditional native medicine and western medicine. In conclusion, the paper recommends that CSC mental health professionals consider the complementary role native medicine can play, and use elders to plan and evaluate mental health service delivery to aboriginal offenders.

SUB-TASK #7 DISCUSSION PAPER

"Development of a strategy to implement and evaluate programs and services aimed at suicide prevention."

Author – Odette Pellerin

This report provides data and textual analysis on individual characteristics and causal factors of suicides by inmates in the Correctional Service of Canada (CSC), and presents strategies with accompanying recommendations aimed at suicide prevention. Statistical tables, references and a bibliography are included in the paper.

After noting the much higher incidence of suicide among inmates than in the general populace, the author cites statistics for federal institutions for the period 1985 to 1989 which show 77 inmate suicides: 4 in the Atlantic region, 30 in Quebec, 26 in Ontario, 4 in the Prairies, and 13 in the Pacific region. Notable groups among those committing suicide were 4 females, 8 natives, 11 inmates serving life sentences and 11 sex offenders. The majority of suicides were male in the 20 to 39 age group, had a history of federal incarceration, and were serving longer sentences.

Hanging was by far the predominant method of suicide, with most deaths occurring in general cells on week days between the hours of 6pm and 8am. Suicides were completed twice as often by inmates with a known history of suicide attempts; however, in the majority of cases no records existed of the inmate's personal history regarding suicide.

Security classification, transfers and marital status did not seem to influence suicides. The role of alcohol or drug abuse was indeterminate since the history of a large number of inmates with respect to these substances was unknown.

Inmates were identified as a high-risk group to choose suicide in response to environmental restriction and frustration, extended isolation, peer influence, or as a means to relieve tension, to retaliate, or ultimately, to escape. Other causal factors mentioned included physical illness, guilt, a predisposition towards violence, mental disorder, gambling activities and sexual difficulties of various types. Young, impulsive and violent inmates, first offenders, and perpetrators of crimes of passion were most likely to be suicidal.Proven strategies said to reduce suicides were a suicide prevention training program, commonly known as the Alberta model, and a unit management plan. The training provides correctional staff with the ability to recognize verbal and behaviourial signals of suicidal inmates; to assess the degree of risk; to demonstrate care-giving attitudes, knowledge and skills; and to implement appropriate action either by staff intervention or by referral to CSC mental health professionals. Augmenting this training are management procedures that ensure high-risk inmates are noted on admission, and that stipulate a referral, diagnosis and treatment process which involves case management officers in the unit to which potentially suicidal inmates are assigned. Enhanced communication between staff and inmates and an improved institutional environment have resulted from these training and managerial initiatives, with only occasional difficulties developing in informing health care centres of diagnoses and in overburdening institutional psychologists.

The six recommendations made are that suicide prevention training and regular refresher courses be conducted for all CSC staff in contact with inmates; that, in the absence of health care professionals, all staff be permitted to alert colleagues about potential suicides; that high-risk inmates be transferred to acute care psychiatric units, receive care consistent with community hospital standards and receive appropriate counselling when segregation is required in treatment; that consideration be given to implementing inmate self-help suicide prevention programs; that suicidal tendencies be recorded on transfer summary sheets when inmates change districts and institutions; and that any historical information on inmate suicide attempts and/or substance abuse be documented and disseminated as needed.

SUB-TASK #8 DISCUSSION PAPER

"Anger, violence and psychopathy: offender categories and their implications for intervention."

Author – Dr. Lorcan Scanlon

The paper addresses the area of criminal violence. Violence constitutes a major dimension of offender status: roughly half the penitentiary population is considered violent, and assessments of the potential for violence play a major role in decisions respecting conditional release. Criminal violence has also been empirically linked with psychopathy, a clinical syndrome highly resistant to successful intervention.

The paper takes the position that its information will be reconciled and integrated with the content of reports on other aspects of mental health, such as sex offences, psychosis, schizophrenia, suicide and depression, and with certain characteristics of offenders that warrant special consideration, such as ethnic status, gender and use of alcohol or drugs.

Existing research and clinical literature does not contain an empirically-derived intervention-oriented system for categorizing violent offenders. The typology to be used is as described in Table 1.

TABLE 1

An Intervention-Oriented Typology of Violent Offenders
1. Offenders whose violence is attributable to functional or organic pathology (seriously mentally ill)
2. Non-psychotic violent offenders seriously in need of psychological therapy.
3. Offenders who have serious character disorders (e.g. psychopaths, sex offenders, arsonists) and for whom violence is instrumental to the fulfilment of other needs.
4. Offenders socialized to a violent sub-culture and lifestyle.
5. Normal offenders whose violence was precipitated by situations or circumstances, endogenous or exogenous.

With respect to psychopathy and its established link with criminal violence, much of the analytic focus is on the Psychopathy Checklist (PCL) constructed by Robert Hare as a measure of the Cleckley syndrome of psychopathy. While one does have in the PCL an instrument with which to assess psychopathy which has stable psychometric properties and which has a demonstrated relationship with criminal violence, considerable ambiguity surrounds the clinical interpretation of the scores and the (arbitrary) cut-off groups that it yields. In view of the connotations of resistance to intervention which psychopathy as a label holds, its use for intervention or in release decisions is currently problematic.

In the absence of an empirically ready-made intervention-oriented typology of criminal violence, and in view of the prudent hesitation to employ the psychopathy concept before its measurement, intervention and release implications are more clearly elucidated, the paper recommends the adoption of an element-by-element approach. Using this approach, the domain of behaviour – anger, violence and psychopathy – can be conceptualized in terms of its constituent elements. Once these elements have been identified, the offender can be assessed with respect to each one of them within the limits imposed by available information. Change opportunities or interventions can then be targeted, delivered and evaluated on an element-by-element basis, taking into account offender risk, need, responsivity and overall amenability to intervention. Typologies and the use of terms such as psychopathy become an empirical end-product of this strategic approach.

The following preliminary list of elements from the paper was constructed on the basis of a review of the research and clinical literature on anger, violence and psychopathy, and on the basis of consultations with psychologists experienced in assessment of offenders. It includes beliefs concerning the value of violence, violence as a preferred way of dealing with problems, proneness to outbursts of angry/violent expression (poor impulse control), membership in and identification with a violent sub-culture, early behaviour problems involving violence, characteristic mode of relating – empathy, criminal history, range of offences, anger or violence instigated by external situations or circumstances, violence planned or instrumentally employed for the achievement of other goals, episodic versus indiscriminate use of violence, violence precipitated by substance abuse, and violence directly attributable to mental illness or organic dysfunction.

Assessment of the offender is envisioned as taking place on three levels. Assessment at level one takes place at intake and is carried out by case management officers. Since not all the elements identified as relevant to this component will be amenable to extraction from offender files, a second level of assessment is undertaken by the psychologist during the course of an interview with the offender. Primary information gathered at this level is the rating by the psychologist of the quality of interpersonal relating characteristic of the offender. These ratings will not only throw light on the kind of violence engaged in, but also will provide indications for appropriate intervention. In the case of some offenders, a further third level of individualized in-depth assessment by the psychologist may be required in order to complete a diagnosis and point to the need for specific interventions.

Since assessment procedures designed for an element-by-element approach do not exist at present, a considerable degree of research and development will be required to determine which of the component's key elements can be readily accessed and reliably and validly operationalized, and which elements should be addressed at each level of assessment. Work is needed on the design report forms, and on the development and validation of risk/need scales and other psychometric instruments. With respect to staff training, a need exists to identify further formation necessary for the case management officer and the psychologist to carry out competent information gathering at their respective levels of assessment.

Assessment will conclude at either level two or level three with a report outlining the specific interventions and the order of their application that would benefit each individual offender. The targeting of interventions should be closely guided by the principles of risk, need and responsivity. Interventions should be based on an assessment

of the extent to which the offender is likely to recidivate and with what degree of violence: higher levels of service should go to higher risk cases (risk principle). Interventions should be element-specific and should be predicated on a distinction between those offender characteristics that can be changed (dynamic factors) from those that are essentially unalterable (static historical factors). Only elements that reduce recidivism directly should be targeted; those elements which are only vaguely or generally related to criminal violence should not be targeted (need principle). Finally, interventions and their sequencing should also take into account the response style of the offender (responsivity principle).

In order to accomplish these treatment objectives, a need exists to develop and try out a series of interventions to supplement the relatively small number of specific modules currently available. In addition, research and development projects will be required to determine the appropriate order of interventions in the case of those offenders with multiple needs. Lastly, information on the location and phasing for different interventions must be generated, to assist in taking decisions on whether interventions are more suitably located in minimum security institutions or within the larger community.

The literature on anger, violence and psychopathy suggests three broad groups of intervention which differ in terms of professional orientation, intervention modality and targeted elements. These are as follows in Table 2.

TABLE 2

Group	School	Modality	Elements
I	Forensic Psychiatry	Support and Psychopharmacology	Mental illness
II	Psychotherapy	Relationship (re-bonding)	Residual
III	Cognitive-Behaviour	Therapy/Restructuring and controlling cognitions, behaviours and affects	Specific elements from which offender dis-identifies himself/herself

Psychosis and schizophrenia are usually treated by group I. While some targeted elements may find their most appropriate intervention in group II (e.g. identification with sub-culture of violence), it is among group III that the present elemental approach will find its greatest development. Specific elements – behaviours, thoughts and feelings – can be identified and targeted for separate modification. However, elements requiring intervention by group I must be addressed before moving to those found in groups II and III.

Additional training for psychologists will probably be required in order that they administer interventions in a flexible manner. It may also be possible to identify co-therapist or co-facilitator roles which other professional staff can play in interventions.

Extending beyond the requirements pertaining to assessment and to the targeting and delivery of interventions, the paper indicates that further research will be necessary to evaluate intervention outcomes, to develop typologies of the violent offender, and to establish the operational utility of psychopathy as a construct in dealing with violent offenders. Other outstanding research issues include: determining what level of offender integration with respect to violence is required for different degrees of conditional release; developing empirically based guidelines connecting different degrees of crime-related violence with institutional design and security requirements; and carrying out empirical research studies on the prediction of violent behaviour.

Four recommendations are made in the paper. The first is that the assessment of violent offenders and the targeting and administration of suitable interventions be carried out on an element-by-element basis. Second is that assessment be carried out at several levels involving both the case management officer and the psychologist. Developmental work on the design of data gathering instruments and on staff training requirements also needs to be done. The third recommendation states that targeting of intervention should be guided by the principles of offender risk, need and responsivity. Further research is needed on the development of additional intervention modules and on their most appropriate delivery. Finally the paper recommends that significant basic research on criminal violence and psychopathy, and on the relationship of criminal violence to release decisions, should continue.

SUB-TASK #9 DISCUSSION PAPER

"Review of the literature on dual diagnosis of drug addiction and mental disorder".

Author – Dr. Serge Brochu

The paper (and its accompanying bibliography) reviews the recent research literature on the subject of dual diagnosis of drug addiction and mental disorder, and summarizes what is known about the relationship between them to address problems arising in treatment. Increasingly, the importance and magnitude of the problems associated with a dual diagnosis of drug addiction and mental disorder are being recognized by treatment professionals; at the same time, however, they acknowledge that relatively little is known about this double diagnostic disposition. Considered separately, drug addiction and mental disorder are major issues in the provision of health services within the Correctional Service of Canada (CSC), and they currently form the respective subjects of two separate Task Forces, the mandate for which is to recommend more effective means of delivery for health services.

Dual diagnosis is defined in terms of the symptoms of drug addiction and mental disorder. Drug addiction can be viewed as physical dependence, and characterized as a bio-psycho-social phenomenon of multiple origin having a major impact on the lifestyle of the individual. Mental disorder goes beyond mental illness to include problems of adaptation, family stress, difficult life events, etc. In causal terms, the nature of the joint relationship is unclear and no consensus exists concerning approach. Some professionals maintain that the presence of mental disorder leads to alcohol and drug abuse because of the individual's need to control or suppress excessive feeling; other researchers, fewer in number, take the opposite position that drug abuse leads to mental disorder.

While relatively little is known about the prevalence of dual disorders in the general population, more readily available statistics for psychiatric populations probably under-estimate the occurrence of drug addiction/mental disorder problems. Moreover, reported prevalence rates vary considerably from one study to another. However, the presence of the dual disposition is considered universal.

There are three categories of mental disorder associated with drug abuse. Affective disorders are those in which persistent problems of feeling and emotional expression are manifested without apparent reason: alcohol-related suicide or suicide attempts belong to this category, as do depression, anxiety and the phobias. Schizophrenia is the condition in which an individual tends to be withdrawn from social reality and given to paranoid reactions and hallucinations. Whether schizophrenic individuals show a higher rate of drug and alcohol abuse than the general population is unclear, as is the prevalence of dual diagnosis for this group. A substantial percentage of men and women diagnosed as alcoholic have also been classified as having personality disturbances. Anti-social character is a frequent form of this disorder.

In an attempt to sort out the causal intricacies of dual diagnosis, some authors have suggested two types of personality susceptible to drug abuse: those for whom drug abuse is secondary and compensatory to a pre-existing neurotic or psychotic condition; and those in whom drug abuse appears prior to any mental disorder, and for whom drug consumption is a means for the development of their psychopathology. This classification system allows an ordering of the temporal appearance of symptoms, and provides, thereby, a clearer view of the relationship between drug abuse and psychiatric symptoms which facilitate its development. Moreover, it promotes the design of research aimed at assessing the importance of a variety of causal and prognostic factors.

Many recent independent studies addressing alcohol dependence and the abuse of a variety of drug types have failed to clarify the temporal (causal) relationship between mental illness and drug abuse. According to some researchers, further, longitudinal studies are required.

Establishing the joint presence of drug abuse and mental disorder is difficult. Under-detection due to inexperience in handling symptom complexity is often a problem for professionals, and symptoms of one category often mask those of the other. Problems of symptom definition and symptom intensity also abound, and some categories of mental disorder, such as psychopathy, have similar symptom profiles to those for drug abuse. Assessment difficulties are further compounded by the variety of assessment instruments employed, yielding inconsistent prevalence rates of drug abuse and mental disorder.

While little research has been carried out on the relationship between a dual diagnosis and criminality, the limited research literature does suggest these variables are closely associated. Most of the studies, however, report only on the magnitude of associations observed, and fail to address the actual nature of these interrelationships.Research on the management of cases of joint drug abuse/mental disorder is in its early stages; therefore, treatment is still often based on primary symptoms. Psychiatric treatment personnel tend to lack knowledge and experience in the drug abuse area. Drug abuse treatment centres, on the other hand, tend to refuse admission to hard-to-manage psychiatric cases, or to individuals that resort to alcohol/drugs to alleviate their symptoms and who, in consequence, refuse to comply during treatment with the cornerstone principle of abstinence. The seven criteria established by some treatment centres in considering admission of patients with psychiatric symptoms are: the intensity and nature of symptoms; the adaptive capacity of the treatment environment; the competence of the staff to handle cases of dual diagnosis; the competence of the staff to readily identify symptoms; the option to resort to medication; the availability of specialized interventions; and the option to refer difficult patients to psychiatric services.

In general, managing patients with a dual diagnosis has moved from an approach that addresses two distinct problems to one that recognizes the need to coordinate psychiatric and drug abuse treatment modalities. Such coordination requires description and specification of treatment methods with a view to establishing an integrated approach, without which individuals being treated can find themselves in "ping-pong" therapy, caught between different treatment goals. The overriding issue is which treatment service should be given priority, the psychiatric or the rehabilitative. Treatment personnel are still not sure.

Several clinicians have insisted that those treating individuals given a joint diagnosis of drug abuse and mental disorder should receive special training. Psychiatric hospital personnel tend to lack information on drug abuse, while those working in rehabilitation centres tend to be poorly informed in matters of psychiatric practice. Treatment personnel should be emotionally stable, and either not have an alcohol or drug problem or have been sober at least two years; be capable of empathy and unconditional positive acceptance; have good communication skills; be able to interpret verbal and non-verbal signals; and be able to maintain a distance from clients.

Determining whether drug abuse is a cause or consequence of mental disorder in the treatment of cases of dual disorders is a primary consideration. It is important, therefore, to observe the patient for several days in order to proceed in the most effective manner. Use of psychotropic medication as a treatment component, though common, is controversial. Many clinicians resort to its use only when it becomes clear that psychotherapy alone will not solve the patient's problems. Similar concerns are raised with respect to the use of an antabuse.Individual and group therapy are the most commonly employed interventions. Group psychotherapy involves the peer group as a means of support and is a strategy used for reinforcing resolve. Confrontation is also a major element of this modality. In addition to treatment, the importance of patient education is crucial, particularly with regard to the effects of drug consumption on mental health. While treatment of patients diagnosed with a joint drug abuse/ mental disorder condition should ideally be geared to the specific nature of the drug consumed (alcohol, cocaine, etc.) and the psychiatric condition identified (depression, schizophrenia etc.), extant literature on this important aspect of patient/treatment matching is meagre.

Conclusions reached in the paper indicate that the association of drug abuse with a variety of mental disorder groups is sufficiently large to warrant serious attention. The exact nature of this association is unclear, although five categories of association are suggested: psychopathology may be a risk factor for drug abuse; with respect to onset, course and outcome, psychopathology may be a modulating factor for drug abuse; symptoms of mental disorder may develop in the course of drug abuse; some mental disorders result from drug abuse and persist after drug abuse has been controlled; and mental health problems and drug abuse are inextricably interrelated over time.

An approach to diagnosis based on the temporal appearance of symptoms may clarify the association between drug abuse and mental disorder. As to assessment, the clinician should rely on details of the patient's history, and specialized training should be provided to enhance diagnosis and intervention.

Several instruments for assessment of psychiatric disorders are available, but it is important that CSC adopt a uniform, standardized, bilingual assessment instrument. Past treatment of patients given a dual diagnosis has proceeded on the basis that there are two separate problems. Now the increasing number of patients makes it necessary to coordinate the treatment modalities for mental disorder and drug abuse, and involves detailed descriptions of treatment components with a view to reconciling and integrating their elements.

With respect to specific mental disorders, it is inappropriate to offer simple solutions. Treatment should be geared to the symptomatology of individuals as much as to the type of drug being abused. As research continues, it is important that CSC health professionals remain abreast of evaluation outcomes.

Six recommendations are made in the paper. CSC mental health professionals should receive special training in the diagnosis and treatment of patients with multiple symptoms. The Correctional Service of Canada psychologists should adopt a standardized, bilingual diagnostic instrument for use across Canada. Treatment services for drug abuse and for mental illness should be reconciled through sharing detailed descriptions on each treatment program, including the philosophy and the various treatment methods employed. Patient responsibility should be determined on the basis of the severity of psychiatric symptoms, the individual's functional ability, the level of supervision and the patient's capacity for independence, the need for medication, the effects of medication on the individual's capacity to function, the relationship between psychiatric symptoms and drug consumption, and the patient's capacity to survive periods of stress and confrontation which may occur in the course of treatment. Psychiatric service should not resort to prescribing psychotropic medication unless it is clear that the patient's problems cannot be solved solely through psychotherapy. Finally, CSC should establish a working relationship with researchers in the area of dual diagnosis of drug addiction and mental disorder in order to remain informed of new developments and methods for treating this patient group.

SUB-TASK #10 DISCUSSION PAPER

"Developing a model of crisis management for employees and offenders."

Author – Lynne Bernier

The paper sets out procedures to enable the Correctional Service of Canada (CSC) to address the effects of crisis situations on employees and offenders. Actions and treatment proposed deal with health care in general and mental health in particular.

Because CSC employees are subject to physical and psychological problems of varying degrees that are job-related, and which can affect their work performance and personal lives, a comprehensive treatment model is suggested. It evaluates whether the employee is either a victim or a witness to a crisis situation, and whether the level of stress experienced is extreme or serious.

Victimized employees suffering from extreme stress are to receive immediate treatment, a full medical and psychological examination, and subsequent treatment and counselling by appropriate health care personnel, if necessary. Immediate hospitalization is proposed for injured employees, at their request. Employees who witness a crisis and suffer extreme stress as a result are to be given a critical incident stress debriefing (CISD) within 72 hours by a health care professional. The employee may be accompanied by a support person if desired. Employees who are either victims or witnesses and who suffer serious stress are to have the voluntary option of using the services of a health care professional in a confidential counselling session involving a crisis simulation.

Responses to the needs of offenders in crisis situations differ, depending on whether the offender is incarcerated or in the community. When the mental state of an institutionalized offender in a crisis situation makes the individual a threat to security or to other inmates, procedures outlined propose that employees noticing attitudinal or behavioural problems in the inmate should notify the responsible case manager. In turn, the case manager ensures the necessary security and surveillance for the inmate and refers the inmate for appropriate health care treatment. Treatment entails an evaluation of the inmate's condition by appropriate health care and mental health staff and professionals, and a recommendation to assign the inmate within the institution. The case worker coordinates all security aspects, and the director of health all clinical aspects to deal with the inmate's crisis.For an offender in the community, any deterioration of mental health noticed by the parole officer is to be reported to the Correctional Service of Canada psychologist. A mental health evaluation may then be required, following which the offender's treatment plan should be revised, if necessary, by the parole officer to keep the offender functioning in the community where full counselling, treatment, education and housing facilities are to be provided. Offenders in crisis who become threats to themselves or others in the community are to have their freedom revoked by a letter from the parole officer detailing the risk. The parole officer must also inform the offender's institutional case worker of the circumstances and consult with the Correctional Service of Canada district psychologist in preparing an evaluation of the case.

Five recommendations are put forward. Concerning assistance to employees, the author proposes that existing Service directives on crisis management be amended to incorporate treatment procedures outlined above, and that each CSC region identify resource persons to encourage the use of and to provide crisis management services. Concerning assistance to offenders, the author recommends that a directive be promulgated explaining services offered in crisis situations, that CSC employees in direct contact with offenders be instructed to seek out and refer for treatment those suffering severe mental health problems, with non-abusive security measures being applied, and that communities be encouraged to offer appropriate mental health services to offenders in crisis situations.

SUB-TASK #11 DISCUSSION PAPER

"Development of a strategy to implement programs for sex offenders."

Author – Dr. V. Quinsey

The implementation strategy described in this paper is largely based on the recommendations of The Management and Treatment of Sex Offenders report, whose author visited key treatment sites and sought advice from clinicians and offenders. The strategy is not founded on a clear-cut treatment recipe, since such a prescription does not exist; rather it emphasizes the development of programs and makes recommendations that are administratively feasible and consistent with the Correctional Service of Canada's intervention philosophy.

Current Status of Sex Offender Treatment

The three main approaches to treating sex offenders are discussed: pharmacological, where deviant sexual arousal and fantasy are controlled through the administration of anti-androgens; evocative psychotherapy, where offenders are encouraged to develop empathy for their victims and take responsibility for their own behaviour; and cognitive-behavioural, where offenders learn to remedy skill deficits and alter deviant cognitions and patterns of arousal or preference. These approaches are often combined in a treatment program and can be supplemented with a relapse prevention module through which offenders learn to identify, and cope with or eliminate, what for them are precursors of relapse.

Although there is substantial literature on all three forms of treatment, scientific evaluation of the effectiveness of sex offender treatment is not yet available. The few studies which have been carried out using quasi-experimental or convenience designs yield inconclusive results. The relative effect of a particular treatment approach versus no treatment cannot be separated from the influence of the particular treatment program in which it is operationalized or from legal, administrative and post-treatment supervisory circumstances. The best one can conclude is that treatment can reduce recidivism but to an, as yet, unknown extent.

Despite the unsatisfactory results in evaluation research, it is possible to identify some progress in the current treatment of sex offenders. This serves to promote program development and facilitate the future evaluation of treatment programs. Five developments in the treatment of sex offenders are: 1) advances in establishing the discriminant validity of phallometric assessment; 2) documentation of treatment procedures and demonstration of their effects in measures of preference, knowledge and skill; 3) differentiation of offenders into subgroups to allow specific treatment and better offender-treatment matching; 4) broadening of the sex-offender treatment perspective to incorporate ideas and concepts from general offender management, the addictions field, decision theory, and psychopathy research; and 5) the impact of a reduction in the recidivism rate on administrative costs and on preventing sexual victimization.

Evaluation methodology can be expected to progress as treatment programs are systematically described, assessment and administrative procedures are standardized, and outcome criteria are made more sensitive and are distinguished from post-treatment contingencies.

Developing Programs for Sex Offenders

The current state of knowledge on sex offenders yields more information on their characteristics than on the cause of the behaviour or efficacy of treatment. In developing programs to treat sex offenders treatment must, therefore, be dynamic and its efficacy assessed in relation to the implementation of programs.

Treatment adopted for inclusion in program development should have the following characteristics: a convincing theoretical rationale consistent with what is known about sex offenders; consistency with the treatment of other offenders; demonstrated effects in theoretically relevant measures; administrative credibility with respect to cost and ethical issues; a detailed description of procedures; and consistency with CSC's administrative and philosophical policy.

Treatment programs must be also be based on an adequate typology of sex offenders and should recognize the influence of other possible offender characteristics on treatment outcome, such as alcohol abuse and psychopathy. Treatment should be tailored to the individual offender through the delivery of integrated modules.

This individualized treatment approach is best implemented using the cognitive-behavioural treatment model. Its interventions are, with the exception of anti-androgenic or castration procedures, the only ones that have proven effective. The approach is widely employed by clinicians, and is the best documented and most accessible for training purposes. Whether administered individually or in a group it is also the approach most preferred by offenders. Cognitive-behavioural treatment of sex offenders is indirectly supported by the literature dealing with offenders in general. It concludes that successful programs incorporate a cognitive skills training module and model pro-social behaviour and attitudes. These programs tend to be non-punitive but directive, and focus on modifying the steps that lead to criminal behaviour. They include supervision in the community in order to teach high risk participants realistic skills.

In the absence of literature that evaluates the treatment of sex offenders, these general findings can be employed to assess specific, but yet to be evaluated programs. One example is the self-help groups organized by offenders in some institutions. Although self-help programs differ from other programs, the issue is not who provides the intervention, but the rationale and organization of the program.

The final issue on developing treatment programs concerns the importance of supervising offenders in the community, since it is there that they must learn to control behaviour. In high risk cases, treatment may require the use of anti-androgenic drugs or electronic surveillance. Community treatment involves teaching the offender to avoid high-risk situations and to acquire skills for dealing with them when they occur. The causes of supervisory failure need to be studied and treatment should be concentrated on high-risk cases, where intensive supervision and use of an urban minimum security facility are essential.

Conclusions and Recommendations

At present, cognitive-behavioural treatment strategies for sex offenders have no serious rivals. This is due to the empirical support of this approach, the high number of treatment programs in place, the existence of treatment manuals, the relatively short-term nature of the intervention, the compatibility with intensive supervision, anti-androgenic medication and relapse prevention strategy, and the general support of offenders.

However, serious limitations and reservations do exist. The follow-up literature on cognitive-behavioural treatment is not convincing, and reduction in recidivism among serious offenders has not been demonstrated. As well, cognitive-behavioural programs vary in detail, intensity and duration, and it is unknown which, if any, of these differences are associated with success.

Despite this, there is a growing consensus that sex offender programs should focus on the integration of the sex offender into the community. The Correctional Service of Canada is in an advantageous position to produce high quality evaluative data on sex offender programs, since it is committed to sex offender treatment, and it has well developed programs and considerable expertise within and outside the Service.

Specific recommendations made in the paper may be categorized as follows:

Information Systems

Increase the accuracy and comprehensiveness of offence histories in inmate files.

Use file information to establish a computerized information system based on behavioural descriptions of inmate offence histories that can be used to identify sex offenders.

Develop a system of triage or streaming to identify offenders who require more detailed and extensive assessment.

Assessment

Establish uniformity in the core assessment measures of sex offender treatment programs and adopt the standardized protocol for the phallometric assessment of: sexual age, gender preferences, pro-criminal sentiment, and sexual values and knowledge. Identify a common set of historical and demographic variables in all programs.

Record assessment data in the same format, with the same computer program in all treatment programs, to facilitate outcome strategies using multi-site data.

Treatment Programs

Prior to releasing high-risk offenders, develop contracts involving the inmate, parole officer and community service provider, and detail the conditions of supervision and treatment.

Ensure that high risk offenders have intensive supervision using the individualized relapse prevention model, including the use of electronic monitoring where appropriate.

Establish specialized institutional treatment programs in each region and link them through computers, yearly conferences, and by appointing a coordinator of sex offender programs.

Create specialized institutional sex offender programs to train professional staff seconded from other institutions and to provide coordination and support for less specialized institutional sex offender treatment programs in their region.

Save specialized sex offender treatment programs for the highest risk and most deviant cases. Develop treatment programs in other institutions to maintain treatment effects of offenders from in more specialized programs, and to treat lower risk/less deviant cases.

Adopt general cognitive-behavioural model principles in all programs across Canada, with high-risk offenders receiving the most intensive and specialized treatment directed toward problems and needs identified in assessment and set out in an individualized treatment plan; ensure pre- and post-treatment measures of proximal outcome are determined for every treatment administered; have treatment directed toward establishing a workable post release plan for community supervision; incorporate treatment expressed in the form of a contract; and determine specialized treatment interventions by the time it takes to reach specified goals.

Community Involvement

Develop a system of communication and confidentiality to ensure that community service providers have access to offender histories.

Treat the high risk/most deviant sex offenders in specialized community sex offender programs located in large urban areas and associated with urban minimum security facilities.

SUB-TASK #12 DISCUSSION PAPER

"The development, implementation and evaluation of programs and services aimed at reducing the incidence of self-injurious behaviour among male and female offenders."

Author – Odette Pellerin

The paper discusses reducing self-injurious behaviour among male and female offenders in the Correctional Service of Canada (CSC). The rate of incidence is examined, along with methods of self-injury, likely settings for this behaviour, ways to identify potential self-mutilators as well as means to prevent harmful actions, and treatment strategy and recommendations. References and a bibliography accompany the analysis.

Non-fatal, self-inflicted injury in federal prisons is reported to occur at twice the rate as for the general populace and is three times more likely among female offenders. Nine methods for direct self-injury are listed, with cutting the most commonly used, particularly among women offenders.

Prevalence increases in restrictive settings, such as medium or maximum security prisons and isolation cells; other contributing physical factors are minimal out-of-cell time and limited human contact with correctional and counselling staff. Personal backgrounds of self-mutilating offenders often include physical and/or sexual abuse as children, a violent family setting, and loss of a parent at an early age. Intellectual and emotional factors noted are average or above-average intelligence, innate anger and poor self-control, underlying personality disorders (excluding psychosis), immaturity, difficulty in making direct requests of others while being demanding of them, use of threats to achieve need satisfaction, low self-esteem, rejection by others, frequent visits for medical care, and a history of alcohol/drug abuse. Additional environmental factors shown to influence self-mutilation, particularly for women, are length of time incarcerated (though not length of sentence), tension level in the prison, a tendency to imitate other incidents of self-mutilation, and long waiting lists for psychological counselling.

Observing offenders' behaviour is identified as the best means to prevent self-injury. Prison staff, trained inmates, case management officers and institutional psychologists can all be involved in watching for signs such as increased anxiety, pacing, withdrawal, verbal threats of self-injury and increasing visits for medical care for minor, non-specific complaints. Increased opportunities for verbalization and human contact are suggested as a means to deter offenders from acts of self-mutilation.

The treatment strategy proposed is based on a Georgia program adopted successfully by Edmonton Institution. It considers inmates' behaviour their own responsibility, eliminates any psychotropic medication, and places them under observation and evaluation for a month (in mental health facilities if required). Incidents of self-injury receive only basic treatment of physical needs; may result in isolation, physical restraint or criminal charges, if repeated; and counselling is denied until personal responsibility for self-injury is accepted.

Recommendations made in the paper are that, following evaluation, a treatment program based on the Edmonton example be implemented across CSC institutions, except for the Prison for Women; that institutions be staffed adequately to address counselling needs prior to program implementation, with training made available for all staff; that a self-mutilation prevention program be devised for the Prison for Women after release of the Task Force Study on Federally Sentenced Women and the Diagnostic Interview Survey of Female Offenders; and that a program be developed to train inmates as peer counsellors for self-injuring offenders.

SUB-TASK #13 DISCUSSION PAPER

"The development of a strategy to deal with the anticipated mental health needs of offenders in the testing, diagnosis and treatment of HIV infection."

Author – Laurie Fraser

The paper examines implications for testing, counselling and providing mental health services in the Correctional Service of Canada (CSC) for offenders who are at risk from or infected with Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS). A bibliography citing Canadian, U.S. and British sources accompanies the text.

After describing the medical basis, symptomatic progression, drug treatment, and ways of transmitting the virus, the author notes the increasing need to target education and counselling programs not only on those involved in homosexual activity and intravenous drug use, but also to the general heterosexual population where infection is increasing. Predictions about the incidence of the virus among offenders in the CSC system are difficult to make because of the absence of firm data on the seroprevalence rate in the inmate population, the group's use of intravenous drugs, and the rapid turnover of inmates in the system. Following a listing of data drawn from studies on HIV and AIDS infection for the prison and non-prison population in Canada and the U.S., CSC information quoted indicates that, as of February 1990, 26 inmates were HIV-positive, 2 had AIDS, and that, since 1985, 49 HIV-positive inmates plus 8 more with AIDS had been identified, 2 of whom had died.

Special circumstances occuring in carceral environments are examined with respect to HIV testing and counselling. Pre-test counselling is advocated to address the medical, psychological and social implications of HIV testing for inmates able to cope with the results. (Some may be unsuitable and should be referred for evaluation.) The three main objectives are: to assess the "at risk" behaviour of inmates, particularly concerning drug abuse and sexual practices, and the likelihood of behaviour change where necessary; to ensure inmates are informed about the infection and understand the nature of the test, the potential implications of being tested, and the confidentiality practices of CSC; and to allow an opportunity for instruction about safe behaviours regarding sexual activities, alcohol and substance abuse, and tattooing.Post-test counselling is proposed for inmates irrespective of whether their HIV test results are negative or positive, since monitoring anxiety and stress associated with testing is necessary. Those with negative results require guidance to change, or at least minimize, high risk behaviour. Male inmates testing positive need counselling in behavioural change to help themselves and others, to receive treatment options, and to learn about anxiety management, which is particularly crucial in a carceral environment where isolation restrictions and potential violence are factors. HIV positive female inmates, in addition to requiring counselling for many of the same reasons as their male counterparts, need guidance on family planning if not pregnant, or, if pregnant, on the implications of having an infected child.

The paper states that counselling and education programs offered during incarceration and after release ought to involve not only correctional health care personnel, but also community groups with expertise with HIV and AIDS infections. With the inmate's consent (to respect his or her right to privacy), direct individual contact between the inmate and appropriate support groups is recommended. Documents cited to assist with counselling are the Canadian Medical Association's guidelines entitled "Human Immunodeficiency Virus Antibody Testing", the Ontario Ministry of Health's handbook "AIDS and HIV Infection. Psycho-Social Issues: Information for Professionals", and the article "HIV Counselling in Prisons" by L. Curran et al in AIDS CARE.

Current CSC policy is that HIV testing is available only to inmates who request it and for whom the institutional physician judges it clinically appropriate. The proposed new policy, created in light of the success of zidovudine (AZT) in treating the disease, is to offer testing as part of the reception process. This demands a

commitment by CSC to ensure confidentiality, and by each institution's interdisciplinary health care team to plan and provide necessary counselling services. Data influencing this approach (based on a conservative estimate of a seroprevalency rate of 1%) suggests there are 120 potential HIV positive inmates now in the system, with an additional 30 to 40 afflicted offenders to be admitted yearly.

The psychiatric/psychological ramifications of infection affect the inmate as well as the medical and administrative management of institutions. Ninety percent of HIV positive patients have neurological manifestations of the virus, including encephalopathy, sub-acute encephalitis and AIDS Dementia Complex (ADC). Health care staff must, therefore, consider the possibility that psychiatric or organic brain disorders are AIDS-related among inmates exhibiting high-risk behaviour. Sociopathic traits, primitive behaviour, delusions/hallucinations inducing fear and aggression, and attitudes of anger and resentment can create disturbances within the inmate populace, and institutional managers are advised to consider whether problems occurring with an inmate are related to the disease. Cooperation between mental health personnel and administrators is urged to determine custodial placement of infected patients on an individual basis.

Community release for infected offenders, whether through regular parole or under exceptional medically justified circumstances, must entail consultations with the parole officer who, ideally, should be informed of the inmate's affliction but only with the inmate's consent. Linkages with local support groups familiar with the disease are recommended, both for the inmate and for community release staff. Parolees are to be counselled on their responsibility to avoid infecting others, but the sharing of information by parole staff with third parties about an offender's condition is severely circumscribed. Community health is to be protected by the institutional physician informing the local medical health officer of a parolee's condition.

In order to create an atmosphere in which offenders seek testing and counselling, education programs for inmates should concentrate on prevention and not be supplanted by mandatory testing. Corresponding training for staff should develop their knowledge base of the disease and skills for counselling about it, allow them opportunities to share information with colleagues. It should also help them explore their own feelings and values to reduce possible apprehension about dealing with infected offenders and to facilitate relationships where communication is possible. In addition to counselling and training, information gathering mechanisms must be developed for two purposes: to amass statistical data on high-risk and infected offenders, and to compile details on resultant psychiatric problems and their treatment. This needs to be achieved without creating a new paper burden for staff and without compromising confidentiality.

To deal with the implications of HIV infection among the offender population, five recommendations are made to CSC: that prevention of transmission, rather than mandatory screening, be a goal of the Service pursued through education programs provided to offenders on admission, and regularly reinforced; that an HIV testing and counselling program be developed cooperatively with regional health care personnel by each institution's interdisciplinary health care team in order to establish an atmosphere conducive to testing by trained CSC staff, and to provide pre-test and post-test counselling with absolute assurance of confidentiality; that appropriate community support groups be involved in educating staff and offenders and in directly supporting needy offenders; that access to current knowledge on the psychological/psychiatric aspects and treatment of AIDS patients be available to health care staff through regional and national information sharing, and through attending relevant conferences; and that background information (i.e. age, risk factors, sentence length and crime) on HIV-infected offenders be accumulated to assist research that identifies their future needs.

SUB-TASK #14 DISCUSSION PAPER

"The development of a strategy to implement specialized programs and services to meet the needs of women."

Authors – Bram Deurloo and Caroline Cyr Haythornthwaite

TABLE 1
INCIDENCE OF MENTAL AND BEHAVIOURAL DISORDERS FOR FEDERALLY SENTENCED OFFENDER POPULATION*

Disorder	Male Offenders	Female Offenders
Major Disorders:		
Organic Brain Syndrome	4.3	3.9
Schizophrenia	4.9	13.0
Schizophreniform	0.8	1.3
Mania	5.7	9.1
Major Depressive Episode	21.4	49.4
Dysthymic Disorder	14.3	24.7
Bipolar Disorder	3.6	7.8
Other Behaviour Disorders:		
Panic Disorder	3.7	13.0
Generalized Anxiety	46.7	55.8
Agoraphobia	13.8	41.6
Phobia	28.3	62.3
ObsessiveCompulsive	8.7	14.3
Somatization	0.6	3.9
Psychosexual Dysfuncion	23.1	55.8
Transsexualism	1.0	10.4
Ego-dystonic Homosexuality	2.1	13.0
Pathological Gambling	3.8	2.6
Bulimia	-	4.0
Anorexia Nervosa	-	6.5
Post Traumatic Stress	-	29.9
Antisocial Personality:	53.7	57.1
Alcohol Abuse/Dependence:	20.8	39.0
Substance Abuse/Dependence:	19.2	22.1
Barbiturate	20.8	28.6
Opioid Abuse/Dependence	19.5	36.4
Hallucinogen Abuse	10.0	6.5
Cannabis Abuse/Dependence	30.8	26.0
Tobacco dependence:	65.6	65.7 (51)

* **Lifetime Prevalence Estimates** Table 2 provides data on how recently (from within two weeks to within one year) female offenders in the sample group experienced mental and behavioural disorders. (The entry n/a means that the Diagnostic Interview Schedule (DIS) does not score this respective disorder, while disorders without asterisks accompanying them do not have exclusion and/or severity criteria. Numbers in this table cannot be correlated with those in Table 1, since women who experienced a disorder more than a year before the recency survey are not included in Table 2.) Categories to note in Table 2 are schizophrenia, because of its often severe impact on the sufferer, and major depressive episode, phobia and post-traumatic stress, because of their prevalence and continuing occurrence during incarceration.

TABLE 2
INCIDENCE OF MENTAL AND BEHAVIOURAL DISORDERS FOR FEDERALLY SENTENCED WOMEN BY RECENCY

DIS/DSM-III Disorder	Within 2 Weeks % (#)	Within1 Month % (#)	Within 6 Months % (#)	Within 1 Year % (#)
Major Disorders:				
Organic Brain Syndrome	n./a	n./a	n./a	n./a
Schizophrenia*	5.2 (4)	6.5 (5)	6.5 (5)	10.4(8)
Schizophreniform*	1.3 (1)	1.3 (1)	1.3 (1)	1.3 (1)
Manic Episode*	1.3 (1)	1.3 (1)	3.9 (3)	3.9 (3)
Major Depressive Episode*	19.5 (15)	19.5 (15)	24.7 (19)	29.9 (23)
Dysthymic Disorder	n./a	n./a	n./a	n./a
Bipolar Disorder	1.3 (1)	1.3 (1)	3.9 (3)	3.9 (3)
Other Behaviour Disorders:				
Panic Disorder*	1.3 (1)	1.3 (1)	3.9 (3)	3.9 (3)
Generalized Anxiety*	1.3 (1)	6.5 (5)	10.4 (8)	14.3 (11)
Agoraphobia	n./a	n./a	n./a	n./a
Phobia*	19.5 (15)	23.4 (18)	31.2 (24)	36.4 (28)
ObsessiveCompulsive*	3.9 (3)	6.5 (5)	6.5 (5)	6.5 (5)
Somatization*	2.6 (2)	3.9 (3)	3.9 (3)	3.9 (3)
Psychosexual Dysfuncion	n./a	n./a	n./a	n./a
Transsexualism*	2.6 (2)	3.9 (3)	5.2 (4)	6.5 (5)
Ego-dystonic Homosexuality*	10.4 (8)	10.4 (8)	10.4 (8)	10.4(8)
Pathological Gambling*	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)
Bulimia*	0.0 (0)	2.7 (2)	2.7 (2)	2.7 (2)
Anorexia Nervosa	n./a	n./a	n./a	n./a
Post Traumatic Stress*	13.0 (10)	15.6 (12)	16.9 (13)	26.0 (20)
Antisocial Personality:*	2.6 (2)	2.6 (2)	6.5 (5)	19.5 (15)
Alcohol Abuse/Dependence:	1.3 (1)	1.3 (1)	2.6 (2)	10.4 (8)
Substance Abuse/Dependence:	1.3 (1)	3.9 (3)	6.5 (5)	20.8 (16)
Tobacco dependence:	61.0 (47)	61.0 (47)	62.3 (48)	66.2 (51)

* Last met criteria for DSM III diagnosis taking into account exclusion and/or severity criteria

Table 3 shows three predominant disorders – schizophrenia, major depressive episode and substance abuse/dependence – and degrees of severity for each as affecting women offenders. 11.7% of women surveyed met all criteria for schizophrenia, 32.5% met all criteria related to major depressive episode, and 37.7% met all criteria for substance abuse/dependence disorders. Overall, only 5% of women offenders surveyed showed no evidence of serious disorder, and nearly 50% were subject to multiple disorders.

TABLE 3

SEVERITY BY TYPE OF MENTAL/BEHAVIOURAL DISORDER

MENTAL/ BEHAVIORAL DISORDER	DIAGNOSES	#	%
Schizophrenia	Absent	67	87.0
	Full Criteria Met	9	11.7
	Full Criteria met except for exclusion	1	1.3
Major Depressive Episode	Absent	39	50.6
	Full Depressive Episode Criteria Met	25	32.5
	Full Depressive Episodes, Bereavement; Severe	3	3.9
	Full Criteria Met Except for Exclusion	10	13.0
Substance Abuse Disorders Summary	No Abuse or Dependence	33	42.9
	Abuse, Severe	7	9.1
	Dependence, Severe	33.9	
	Dependence, Not Severe	3	3.9
	Abuse and Dependence, Severe	29	37.7
	Abuse and Dependence, Not Severe	2	2.6

Evidence amassed in the three tables on the prevalence, recency and severity of mental and behavioural disorders indicates that CSC needs to address the mental health of female offenders.

The paper addresses the special mental health issues of female offenders in the Correctional Service of Canada (CSC). It draws on two CSC studies – the 1989 Mental Health Survey of Federally Sentenced Female Offenders at Prison for Women, and the 1990 Task Force Report on Federally Sentenced Women – and states principles and recommendations to promote improved mental health programs and services for female offenders.

The Mental Health Survey investigates the incidence of mental and behavioural disorders among female (and male) offenders in the CSC, as shown in Table 1. While the data is drawn from a preliminary version of the Survey, and represents only a cross-section of the offender population in Prison for Women, evidence is conclusive that the prevalence rate of disorders for females is substantially greater overall than for men. The only categories showing exceptions are organic brain syndrome, pathological gambling, antisocial personality and alcohol abuse/dependence. Disorders are much higher among women than men with regard to schizophrenia, major depressive episodes, and anxiety, phobic and sexual disorders, the latter often resulting from abuse.

The Task Force report suggested a comprehensive approach to programs and mental health initiatives for women offenders, five of which are highlighted in the discussion paper. The need for a women-centred approach to designing programs and services for female offenders was paramount. Community-based services and alternatives to incarceration were recommended to eliminate hardship and emotional upheaval experienced by women offenders imprisoned great distances from home. The importance of contact with families and children for female offenders was noted, not only to alleviate the difficulties inherent to imprisonment but also to improve prospects for successful reintegration on release. Mental health services oriented to the needs of women offenders were proposed because of the specific kinds of disorders which they experience. Also, better release and follow-up planning and training is suggested for women who frequently are not employable because they lack marketable skills and have no work history.

Five principles promoting mental well-being and providing direction for change as articulated in a touchstone statement by the Task Force are repeated in the discussion paper. CSC, with community support, has responsibility to create an environment that empowers federally sentenced women to make meaningful and responsible choices in order to live with dignity and respect. Low self-esteem and lack of self-direction among women offenders are to be countered by introducing the principle of empowerment, which encourages individuals to accept responsibility for actions and personal choices. The principle of providing women with meaningful options to arrive at responsible choices is enunciated, and takes into account women offenders' past experience, culture, morality, spirituality, abilities and skills. The mutually supportive elements of respect and dignity are combined as a principle to encourage the adoption of a respectful attitude among offenders, among staff, and between offenders and staff, and to lead to responsible actions by women offenders. The principle of establishing a supportive environment to assist female offenders is stated and interpreted to encompass all aspects influencing lifestyle, whether political, physical, financial, emotional, psychological, social and/or nutritional. The final principle stated stresses the need for shared responsibility among the CSC, community and volunteer groups, the family and the private sector to integrate women offenders into the community.

The paper concludes with a recommendation reiterating the special needs of federally sentenced women and the requirement for CSC to address these in planning and delivering mental health programs and services.

SUB-TASK #15 DISCUSSION PAPER

"The development of standards for the delivery of psychological/psychiatric services and programs based on a hierarchy of needs and priorities, to provide a basis on which to set corporate objectives, plan programs and allocate resources."

Author – Dr. Carson Smiley

The paper discusses the development of standards affecting health care generally and mental health care particularly across the Correctional Service of Canada (CSC), and examines the impact of standards on specific programs, services, and human resource groups. Extensive reference sources are provided in three parts of the paper: the executive summary lists source materials on standards derived from within and outside the service; the penultimate part of the text consists of two excerpts from articles to demonstrate the basis for bringing only doctoral level specialists in applied psychology into the CSC in future to hold psychologist positions; and the paper's final section provides in its entirety the Canadian Psychological Association's 1989 Practice Guidelines for Providers of Psychological Services.

Part One of the paper outlines professional qualifications for CSC health care and mental health staff by referring to corporate directives and standards that delineate the scope of and accessibility to services to which offenders are entitled, the jurisdictional and legislative framework governing all types of health care, the prevailing model and ethos underlying the CSC system, and registration/licensing requirements for the various health disciplines and professions. The author notes that no requirement currently exists for CSC psychologists to register in their province of practice, although contracted professionals must do so.

Citing further CSC directives and standards, Part Two surveys institutional facilities, care levels and some associated services for offenders. The fundamental role and responsibilities of Regional Psychiatric/Treatment Centres are stated, followed by descriptions of primary, intermediate and tertiary care, access to those levels of services, and criteria covering standards for various types of assessments, external referrals and discharge screening.

Accreditation standards for psychologists is the focus of Part Three. Drawing on a submission to the Canadian Council of Health Facilities Accreditation (CCHFA), the author quotes excerpts proposing that psychologists should not be clinically accountableto a member of another profession, that psychological services should be universally available at institutions in the CSC systems, and that psychologists should be registered/licensed in the jurisdiction of their practice and listed in the Canadian Register of Health Service Providers in Psychology.

Part Four deals with standards for evaluating the mental health of offenders and refers to the 1988-89 CSC Mental Health Survey which used the Diagnostic Interview Survey (DIS). The incidence of lifetime prevalence of mental disorders among offenders is noted and leads to the author's conclusion that a "significant proportion" of offenders have serious and chronic disorders of various types.

Standards regarding types of psychological services required in different CSC institutional situations are discussed in Part Five. A number of corporate directives are mentioned which stipulate the normal availability of these services in operational units, to parolees, for consultation purposes, on admission and at subsequent assessments of offenders, and in routine and emergency care situations. Rules governing the rendering of psychological services to offenders, victims, staff and family members of those affected during and after institutional crises are briefly explained. Service standards required by the integrated sentence management model are also listed. Included are requirements for assessments at intake, prior to pre-release, for referrals from the National Parole Board (NPB), and as part of regional quality control through "peer review" panels.

Part Six of the paper details requirements for several specific psychological services: screening intake assessments, comprehensive intake and pre-release assessments, and NPB psychological/psychiatric assessments. The purpose, methodology and report content of these various kinds of assessments are explained at length. Because of the often delicate implications of NPB assessments for society, offenders and the CSC system, a thorough outline of assessment requirements is provided with reference to offenders' type of sentence (i.e. life, preventive detention) and category of offence. A comprehensive list of offences and their categorization under the 1985 Revised Statues of Canada (cross-referenced with the 1970 Statutes) concludes this segment.

Policy issues which arise from mental health care standards are covered in Part Seven. Assessment and treatment requirements are defined and the roles of CSC psychologists, as well as of other permanent and contract mental health care professionals and staff, are discussed. Related managerial issues and possibilities for resource savings are noted. The terms"service" and "program" are defined in conjunction with an outline and examples of how these different types of operation could function more effectively – particularly in the case of group programs – to benefit offenders and save resources. Standards regarding the number of assessments needed and the valid duration of their findings are mentioned, along with the need for better consultation among various institutional groups once changes are made. Changed assessment demands, expected as a result of administrative restructuring, are explained along with the implications for using CSC psychologists and other mental health staff as opposed to contract psychologists. Person year allocations, resource savings, benefits to offenders, and allegiance to the Service are the key issues raised. Improved functional management and coordination of mental health programs across the CSC regions and at national headquarters are discussed, followed by a review of the

need for assigning CSC psychologists to provide necessary services in all parole districts. Productivity targets – with considerable detail on assessment and treatment time allocations – are proposed for CSC psychologists. Subsequently, a need for professional development opportunities for CSC psychologists is expressed before completing Part Seven by stating the benefits of establishing ambulatory services programs along with training linkages with university psychology departments and medical schools.

To improve standards for delivering CSC psychological/psychiatric services and programs, fourteen recommendations are made as follows. Full psychological assessments should, wherever practical and cost effective, be done either by a registered psychologist on contract or with indeterminate CSC status, or by a CSC psychometrist (MA unregistered) supervised by a senior registered institutional psychologist. Psychological treatment should be delivered, wherever possible, as a defined module or program. Group treatment should be, wherever possible, the preferred method of program delivery. Psychological assessments should be valid for 24 months unless the offender has had significant program participation and/or treatment. Requests for non-mandatory psychological assessments should be screened by senior CSC psychologists to determine need, priority and resource implications. Treatment of offenders should be done by CSC psychologists. A Regional/ Senior Clinical Psychologist position (PS-04 level) should be created for a registered psychologist at each regional headquarters to manage the region's mental health program. A Chief, Psychological Services position (PS-05 level) should be established for a registered psychologist at national headquarters to manage and provide quality assurance for the National Psychology Program. Parole District Offices requiring psychological services should have a CSC psychologist on staff and sufficient funding for special program needs. Performance appraisal objectives for mental health practitioners should be written to reflect measurable and achievable productivity expectations. Employment satisfaction for CSC psychologists should be enhanced by ensuring that: only 50% of job time is allotted to psychological assessments for those working outside reception centres; flexible staffing and hours of work are permitted; ambulatory (out-patient) service duties are explored; a clearly defined training program for MA and PhD-level psychologists in the regions is developed; university cross-appointments are facilitated for PhD level psychologists and other mental health care professionals; relevant treatment and program initiatives (i.e. for sex offenders and substance abusers) are to include psychologists; research and program evaluation opportunities are incorporated into all psychologist jobs; and that an annual professional development conference on clinical issues and research be initiated in 1991 for all CSC mental health staff. Ambulatory services programs should be installed in all regions along with a health care-related doctoral residency program, accredited to either a university psychology department or medical school psychiatric department. Finally, the paper recommends CSC develop a two level staffing system in institutions for psychological services: one tier would consist of provincially registered CSC psychologists with a PhD, unregistered staff psychologists with an MA who would be grandfathered to remain in this group, psychometrists (MA unregistered) with specialized expertise working under the supervision of on-site registered psychologists, and with future jobs staffed at the PS-03 level only by those with a PhD and provincial registration; the second tier would comprise psychometrists with an MA who operate as psychological associates at the PS-02 position level.

SUB-TASK #16 DISCUSSION PAPER

"The development of professional standards, staff selection criteria, recruitment strategies and professional development programs to recruit, motivate and develop a calibre of mental health professionals consistent with community and professional standards."

Author – Jean-Guy Léger

The paper explores ways to improve recruitment and development of mental health professionals by the Correctional Service of Canada (CSC) to promote community and professional standards within the Service. Discussion is placed in the context of the Corporate Mission Statement and related principles which recognize the value of staff as a resource, the need to achieve high professional standards, and the requirement for CSC to match community standards in delivering professional services.

Six issues are addressed, the first three of which pertain largely to psychologists, while the balance also relate to doctors, psychiatrists, nurses, social workers and occupational therapists. Concerning standards for qualification for professional practice, Public Service Commission (PSC), and thereby CSC, requirements often vary from those set for professionals by provincial regulatory bodies. The example noted is psychologists who qualify for federal employment with a master's degree, as contrasted with some provinces' requirement that practitioners hold a doctorate. Some CSC psychologists, therefore, qualify and practice as psychologists only in the course of their employment within a federal institution, and not in the province where they work.

To meet community standards CSC must hire only professionals registered under provincial legislation or through recognized associations. This has been achieved for all groups other than psychologists. Melding national and provincial standards is accepted as an ambitious goal which will take time to achieve, and which will require changing some delivery structures for psychological services.

Among the means cited to effect change are the renegotiation of the 1973 Treasury Board Agreement. This would allow the creation of a Chief Psychologist position at the PS4 level in major institutions to monitor professional standards, permit non-supervising psychologists to remain at PS3 level but with the requirement to register in the province of practice, and retain PS2 entry-level positions for psychologists with a master's degree. Grandfathering provisions, plus upgrading opportunitiesthrough educational leave, are suggested for CSC psychologists not registered in provinces. Staff taking new positions would be required to hold registration in the province of practice.

Professional ethics codes are established and enforced by professional associations. While CSC does not require its professionals to hold association memberships, standards set by CSC could be improved by clarifying the role and rules of provincial regulatory bodies, endorsing their rules or standards, and insisting that CSC professionals adhere to these irrespective of whether they register individually as a member.

Elements to be considered prior to recruiting professionals to the CSC are the applicable provincial and/or association standards, the organizational and position requirements in a correctional setting, and personal factors such as knowledge, skills and suitability to function as a member of a multidisciplinary team. Better organized, more aggressive recruitment is advocated, using not only traditional advertising vehicles but also by fostering closer links with universities, teaching hospitals and community mental health facilities through internships, placements and fellowships established in CSC. Improving the self-image of CSC professionals is also necessary to recruit and retain competent people. Issues to be dealt with are salary improvements (particularly for psychiatrists and social workers), adjunct appointment to universities, research and sabbatical opportunities, support for continuing education and attendance at professional conferences, and public education on the roles of CSC mental health professionals.

Training for professionals is said to be rare at present but should be provided from orientation onward on a regular basis. Representative participation by CSC mental health professional groups in Regional Training Committees is suggested to ensure training needs are identified and to provide resource persons for training program development.

Eleven recommendations conclude the paper: that registration/licensure within the province of practice be a condition of employment for CSC professionals; that a Chief Psychologist position (PS4) be established in each major institution; that a psychometrist entry-level position (MA-PS2) be established in major institutions if the requirement for registered psychologists cannot be met in a timely manner; that all currently employed psychologists be "grandfathered" so their present title, duties, classification and remuneration are not affected; that the Regional Psychologist position be at PS4 level or higher; that the 1973 Treasury Board Agreement be re-negotiated to ensure it does not interfere with the proposed structure for delivering psychological services; that theRegional Administrator, Health Care Services, approach provincial professional regulatory bodies to clarify their role and authority vis-à-vis CSC professionals; that regions establish affiliation agreements with universities to assist in the recruitment and development of CSC professionals; that recruitment tools (information brochures, video tapes, etc.) on all professional groups be developed; that professional staff be represented on Regional Training Committees to ensure relevant training programs are developed and instituted; and that CSC corporate management make representation to Treasury Board regarding inadequate salary levels for psychiatrists and social workers.

SUB-TASK #17 DISCUSSION PAPER

"Outlining the roles of professionals and other participants involved with mental health care for offenders."

Author – Lynne Bernier

The paper describes the roles played by different professionals and other staff in the Correctional Service of Canada (CSC), and by non-employee groups, in treating the mental health of offenders. Discussion is placed in the context of the Service's accepted definition and core values concerning mental health which promote a collaborative approach to treatment by CSC staff in various positions.

The medical/psychological staff responsibilities discussed involve doctors, psychiatrists, psychologists and nurses. Doctors evaluate and treat offenders' general health needs, with particular emphasis on problem identification, reduction, prevention, and on coordination of treatment and services such as medication, hospitalization and housing arrangements. Psychiatrists identify and attempt to reduce offenders' psychiatric problems affecting overall health by means of evaluations, diagnostic tests, medication as appropriate, and consultation with other mental health, program and services staff.

Psychologists' roles depend on whether they are carried out in an institution or in the community. Institutional psychologists identify and try to reduce offenders' psychological difficulties by means of diagnostic evaluations, counselling, therapy, programs, and crisis intervention when necessary. Consultation opportunities are also provided for case managers. Psychologists operating in the community ensure that local resources are adequate, that programs and services are accessible to offenders and that new ones are developed with their consultation and participation. Crisis intervention is another of their tasks.

CSC nurses participate with all mental health professionals in dealing with the general well-being of offenders. They are active in diagnostic procedures, treatment, prevention and monitoring, and in advising and helping offenders adapt to reintegration into society.

Non-medical/psychological staff groups whose responsibilities are discussed include social workers and clinical staff, case managers, correctional officers, various program personnel, and chaplains. Specialists such as social workers and clinicians minister to particular needs of offenders, and develop and evaluate associated rehabilitation programs and services. Case managers are the central figures in all aspects of the handling of offenders. They not only identify and attempt to reduce risk factors influencing the possibility of recidivism, but also act as key resource persons for offenders, formulate and monitor treatment plans in accordance with offender needs and system resources, and observe the overall functioning of offenders. Correctional officers monitor offenders throughout their sentence and play a support role in observing, evaluating and consolidating their progress. When working in special units they help to coordinate activities for offenders and assist in counselling if required. Program personnel, such as teachers and instructors of various subjects and skills, foster the abilities of offenders and create a milieu for learning and personal growth. Spiritual counselling is provided to offenders by chaplains, who also offer guidance in human values and an outlet for confidential consultation.

The final two groups cited in aiding offenders' mental health are inmate self-help groups and community service organizations. Self-help groups encourage the sharing of ideas, information, experience and problems among offenders, while local service groups sensitize the community to offenders' mental health and other needs, speak on behalf of offenders to the system and the community, and assist offenders in social reintegration.

The author concludes by reiterating the need for integrated action among the resource groups noted above to deliver effective mental health treatment to offenders. Actions taken should comply with the needs of the offender as identified in the treatment plan, and those involved in treatment should be given the platform to make recommendations on mental health programs and services.

Four recommendations are made in the paper. Adequate information on the case management process for each offender should be compiled and forwarded to all individuals involved in mental health treatment. Case conferences should be convened periodically by the case manager to include all individuals involved in mental health treatment for an offender and to assure that the treatment plan is followed and coordinated. Each institution should establish a mental health programs committee under the chairmanship of the senior institutional psychologist to meet three times a year and report its recommendations to the director of the institution; committee membership should comprise, in addition to the presiding psychologist, the institutional director of health, clinical coordinator, assistant director of programs, and chaplain, as well as a representative from unit management, local citizens' committees, and the inmates' committee. The role of correctional officers, case managers and nurses should be expanded to include therapeutic assistance in services and programs for offenders.

SUB-TASK #18 DISCUSSION PAPER

"The development of a strategy to ensure the collation and dissemination of information."

Authors - Bram Deurloo and Caroline Cyr Haythornthwaite

The paper reviews key background topics and suggests improvements for the gathering and dissemination of information on the mental health of offenders in the Correctional Service of Canada (CSC). The analysis is done in the context of complex and often conflicting medical, legal and corporate issues which have arisen over the past decade, and which now require an integrating strategy to ensure that comprehensive mental health information

is efficiently gathered and disseminated to individuals across the CSC. The need to balance confidentiality with accessibility in health care information is also addressed. Reference is made to external legislation and to specific internal values, objectives and codified standards that apply to offenders, third parties, and CSC health care and other staff.

Following the general overview of the factors affecting confidentiality of information, a number of issues are highlighted, beginning with offenders' rights regarding access to information. A dichotomy is noted between the requirement to provide fundamental justice to offenders by making them or their legal representative privy to information used by the National Parole Board (NPB) in decisions concerning them, and the authority of the NPB to withhold potentially dangerous information to safeguard the interest of the public and/or offender.

A similar conflict arises between recent laws and regulations such as Access to Information, Privacy and the Charter, and CSC internal policies on information gathering and dissemination. Absence of agreement or consensus among officials is said to constrain information sharing.

The paper emphasizes that crucial information on offenders about to be released should be provided to prospective parole supervisors, and reference is made to recommendations from three public inquests: the Pepino Inquiry, the Conter Inquest, and the Ruygrok Inquest. Generally, recommendations include the need to: ensure ready access to offender records by CSC Duty Officers and Review Committee members before release decisions are taken; assure that confidentiality concerns do not impede information sharing among CSC, NPB, law enforcement and community agency officials; develop user guidelines and standardization mechanisms for mental health reports on offenders; clarify or resolve differences of opinion among CSC officials before sending cases to the NPB; establish regional case preparation departments to compile master files on offenders and disseminate information to appropriate authorities; institute post-trial summary reports by judges and the Crown on sentenced offenders for forwarding to the appropriate inmate reception centre; and ensure that release plans are comprehensive and are discussed with the family and community and support persons of parolees. Conflicts between inquest policy recommendations and existing CSC standards and regulations are mentioned as factors which can complicate information gathering and dissemination.

A further conflict identified involves the ethics codes of CSC medical professionals and CSC policy on confidentiality of information. To address this concern, the development of protocol and policy to assist staff in making informed judgements is proposed.

Possible problems regarding information usage in case management involve personal versus written communication among staff, perceptions about common goals, and predictive assessments by medical staff. Personal interaction between case managers and professional staff in order to mutually appreciate both the substance and tone of information is recommended. This would foster a sense of teamwork during treatment, clarify common objectives, and encourage offenders' progress. Cautionary remarks note the risk of relying on predictive assessment information in managing cases.

The final problem noted concerns the need to recognize the rights of and protect third parties (families, spouses and victims) when divulging case information. Again, the need to codify protocol and policy is identified in order to assist CSC staff in making informed judgements on information dissemination.

The report concludes that problems exist in CSC's information gathering and dissemination on mental health issues. These are due to medical, legal and systemic policy overlaps, and to a lack of an integrated corporate strategy to resolve resultant conflicts. To provide focus, a series of questions are raised about information requirements, responsibilities for the accumulation, control and circulation of material to various audiences, and about intra- and extra-organizational factors and conflict resolution.

The eight recommendations address the necessity to: determine the information needs of staff; delineate roles for fulfilling information requirements; institute clear policies and standards through national meetings involving NBP members and CSC staff from all branches; develop protocol to assist staff in making judgements while respecting the rights and standards of all individuals and groups involved in mental health care; share information among case management team members; clarify the requirements for predictive assessments; facilitate joint CSC-NPB resolution of ethical-legal issues concerning information usage; create and staff local, regional and national communication networks using various information vehicles; and establish an interactive local, regional and national data information base to facilitate timely mental health assessment and treatment.

SUB-TASK #19 DISCUSSION PAPER

"The development of a communication network with universities, provincial ministries and professional associations to develop an expertise in forensic issues, initiate joint research programs and services, and maintain standards of excellence in keeping with those prevailing in the community and professions; and the negotiation and implementation of agreements with provincial governments and academic facilities for the provision and/or exchange of mental health services including assessment, treatment, research and staff training."

Authors - Bram Deurloo and Caroline Cyr Haythornthwaite

The paper discusses interaction by the Correctional Service of Canada (CSC) with universities and the provinces to foster, through an expansion of existing agreements, the sharing of expertise and the improvement of research, training, standards, and exchange opportunities to develop more effective programs and services to benefit the mental health of offenders. An appended bibliography lists agreements negotiated by CSC.

Two primary CSC objectives are cited as background: to provide offenders with timely and appropriate mental health services throughout their sentence, and to reduce recidivism by enabling offenders to be reintegrated into the community as law-abiding citizens. Since CSC staff are deemed responsible for achieving those objectives, expanded research opportunities and special forensic/correctional training are proposed through formalized cooperation among the Service, provinces and universities. The need to include reciprocal benefits for all parties is highlighted, and the inter-organizational liaison occurring in the Prairies because of affiliation agreements among CSC, academic institutions and provincial governments is noted as an example that has produced, in a cost-efficient manner, a synergy of knowledge, resources, services and programs to assist offenders. Expanded research cooperation to create and share new knowledge for the benefit of staff and offenders, plus the chance to attract, train and retain more qualified CSC personnel with a background in forensic/ correctional work, are two of the stated results of organizational interaction.

A broad overview is offered by region of some of the most significant CSC agreements currently in force with universities and provinces. Reference is made not only to mental health programs and services but also to other cooperative initiatives provided under Exchange of Services Agreements that CSC has with each province and territory.

Agreements in the Pacific Region exist with several post-secondary institutions. The CSC's Abbotsford Regional Psychiatric Centre offers ambulatory care for former patients in conjunction with Simon Fraser University; the British Columbia Institute of Technology cooperates in curriculum and program development for

CSC nurses and other health care staff; and the University of British Columbia's Health Sciences Centre Hospital, Schizophrenia Unit, carries out research and provides expertise for the CSC Regional Psychiatric Centre.

Because the Prairies include three provinces, CSC has several agreements and liaison activities across the region. The Saskatoon Regional Psychiatric Centre is involved in all three provinces with several post-secondary institutions and with the Saskatchewan provincial government. The Centre's arrangement with Saskatchewan provides mental health services in a secure, in-patient facility for various types of provincial cases requiring psychiatric evaluation. Future interaction in forensic research and programs may also occur in light of the provincial offenders' needs identified in the 1989 Forensic Service Task Force Report. The Saskatoon Centre's post-secondary links include involvement with the University of Saskatchewan to operate a hospital for assessing and treating mentally disabled offenders, and to provide research and training opportunities for faculty and students interested in forensic mental health issues; with the University of Regina to jointly appoint the Chief of Social Work and to offer social work student placements; and with the Saskatchewan Institute of Applied Arts, Science and Technology (Wascana Campus) to provide training placements for psychiatric nursing students. Out of province, the Centre has agreements with the Universities of Manitoba and Alberta for field placements for occupational therapy students.

In Manitoba, the CSC recently agreed with the University of Manitoba's Psychiatry Department to establish a forensic psychological post-doctoral training program at Stony Mountain Institution. Benefits described for university psychologists include the opportunity to acquire a practical knowledge of federal corrections and the professional qualifications for such work; benefits for the CSC include the chance to attract experienced, qualified psychologists, the development of institution-based research, and the capacity to deliver mental health services at a variety of clinical sites throughout all stages of an offender's sentence.

The CSC's 1986 agreement with Alberta allows access to provincial mental health services for all federal offenders. In return, the province is permitted to send their offenders to federal institutions.

Several existing linkages and potential agreements involving CSC in Ontario with the provincial government and with academic and research institutions are noted. Possible cooperation with Queen's University includes an umbrella agreement for forensic/correctional services stemming from the existing arrangement under which sex offenders are assessed and treated at Warkworth Institution; a tripartite agreement which would include provincial participation in developing a Centre of Excellence for research and education in forensic/correctional psychiatry and psychology; and a joint agreement to provide clinical services to offender patients institutionalized across Ontario. Benefits of cooperation between the CSC and Queen's University would accrue for both institutions in terms of research, training and job opportunities, standards and professional development, and better services to offenders.

Agreements in force between CSC and other Ontario institutions include one with the Clarke Institute of Psychiatry by which psychiatrists conduct pre-release assessments for consideration by the National Parole Board, and another with the University of Ottawa to participate in treating adult, and particularly native, offenders placed in the Northern Treatment Centre, a facility jointly funded by Ontario and CSC under a 1988 Exchange of Services Agreement, but administered by the province. Sharing resources and facilities to improve programs and treatment for offenders and training and development for staff is the purpose behind the agreement. The CSC also works with the province to use Ontario's psychiatric and local general hospitals for treating needy offenders.

Since 1977, CSC has annually renewed an agreement with Quebec to use L'Institut Philippe Pinel in Montreal. Psychiatric assessment and treatment is thereby provided as required (up to an agreed maximum bed-days) for federal offenders in the province.

In the four Atlantic provinces negotiations are planned with the provincial governments and several universities about establishing a Regional Treatment Centre at Dorchester, New Brunswick. The outcome is expected to provide assessment and treatment services for acute and chronically mentally disordered offenders, to foster research and staff training services, and to allow for community follow-up.

The paper concludes by restating the need for reciprocal benefits for all partners in existing and planned agreements, and by reiterating the current and potential benefits of agreements for the Service, the provinces, post-secondary institutions, and for offenders themselves. Offenders receive a wider range of mental health services implemented by well trained professionals, and are likely to be reintegrated into communities with better coping mechanisms and less chance of recidivism.

To achieve the level of cooperation envisioned, a strategy is outlined comprising five recommendations: that a communication network and infra-structure be developed regionally, through establishing joint Regional Planning Groups (RPG) with each province, to identify areas of mutual need for assessment, treatment, follow-up and research services, and plan for mutual cooperation in service delivery and outcome evaluation; that RPGs have direct, ongoing liaison with the Branches of Health Care, Research, and Offender Management at national headquarters, to ensure plans are consistent with corporate objectives, research strategies and mental health standards; that, as part of each region's mental health plan, agreements of reciprocal benefit be established between the Service, the provinces and academic facilities, with the objectives of improving the quantity and quality of research, service delivery, and staff recruitment and training; that affiliation agreements with academic facilities be established at each Regional Psychiatric/Treatment Centre, to improve services and programs for offenders, facilitate staff recruitment and training, and maintain accreditation standards; and that the Service strive to develop and implement tripartite agreements with academic facilities and the provinces to achieve excellence in the forensic/mental health field.

SUB-TASK #20 DISCUSSION PAPER

"The development of a strategy to deal with the ethico-legal issues of mental health care within the Correctional Service of Canada."

Authors - Bram Deurloo and Caroline Cyr Haythornthwaite

The paper reviews ethico-legal issues relating to the assessment and treatment of offenders, and makes recommendations for improving information flows to assist policy development in the Correctional Service of Canada (CSC). The analysis takes place in the context of the basic principles and values underlying Mental Health Care which promote healthy interactive processes; encourage positive relationships among offenders, CSC and the community; and ensure respect for human equality, justice, freedom of choice and social responsibility. The goals, consistent with Core Value 1 of the Corporate Mission Statement, are to reduce inequities resulting from social attitudes that deny offenders' rights and/or exclude them from society, increase prevention, and enhance individual and collective coping.

Eight ethico-legal issues affecting assessment and treatment are identified, and existing CSC measures dealing with them are noted. The first issue concerns confidentiality and disclosure as related to medical confidentiality, information disclosure to and use by non-professionals and lay decision-makers, and employing information for purposes other than originally intended. CSC Health Care Standards 103 to 106, inclusive, address elements of confidentiality and disclosure including, respectively, access to health care records, consent by

offenders concerning the dissemination of personal information to third parties, the release of health care information to assist in case management, and confidentiality exceptions when threats of grave injury or institutional security exist.

Ethico-legal issues of due process and consent to treatment are then discussed: the former address rights to in-person hearings and rules of evidence, to challenge and call expert witnesses, and to solicit alternative opinions; the latter raises whether uncoercive treatment in a correctional setting is possible, and whether authorities are empowered to impose contingent conditions on treatment and release. Health Care Standards 101 and 102 – stipulating, respectively, provisions for informed consent (or the right of refusal) by a mentally competent offender before treatment commences, and for involuntary treatment to be governed by provincial legislation applying to the treatment facility – are noted, and then the issue of timely access to treatment by offenders is also mentioned in relation to the question of consent and conditional release. Two dimensions of professionalism raise ethico-legal concerns. One element is the potential conflict between organizational demands and professional standards, the other concerns the legal status of practising CSC psychologists who are not – despite Health Care Standard 107's recommendation – provincially licensed.

The final three issues deal with violence, risk assessment and the use of assessment information by lay decision-makers; victims and their role in the decision-making and reconciliation process; and patient advocacy vis-à-vis their mental competence to consent to, and determine methods of, their own treatment.

Recommendations on these ethico-legal matters highlight the general need to improve the exchange of information among correctional, medical and legal professionals, as stated in Core Value 4 of the CSC Mission Statement. To achieve this, the establishment of a forum of international experts in corrections, law and mental health is proposed to guide policy making, as well as an annual gathering of CSC, National Parole Board, Ministry Secretariat, and mental health and legal professionals.

SUB-TASK #21 DISCUSSION PAPER

"The development of a research component aimed at meeting corporate and ministerial priorities in mental health."

Author – Larry Motiuk

The paper outlines the organizational structure, mandate and plan for applied mental health research in the Correctional Service of Canada (CSC), examines associated assessment and service requirements, and recommends ways to coordinate research across the Service.

The role described for the National Headquarters (NHQ) Research Branch is to coordinate regional and national work in developing research knowledge, encourage collaboration with academic researchers, and disseminate findings. Research by CSC regional committees across Canada is also mentioned. Both Regional Psychiatric and Treatment Centres participate, and research projects undertaken in other settings are noted.

National and regional mental health research focuses on major themes that comprise, in part, the National Research Plan (1989-1991), which strives to balance practical, operationally-oriented research with longer-term strategic research. Among the Plan's broad themes mentioned are: case management and the development

of new assessment technology, understanding violence, motivation of staff and offenders, the impact of programs on offenders' community adjustment, and targeted surveys and assessment analyses.

Information gleaned in the 1988 Mental Health Survey of offenders is said to form the basis of current research knowledge, and to show a higher prevalence of mental disorder than previously known. The increased numbers of offenders in the system is reported to require not only improved assessment technology, but also more and better mental health services.

Assessment leading to effective mental health intervention with offenders throughout the CSC requires that data be gathered on incidence of mental disorder, age of onset, recency and level of severity, comorbidity, previous mental health care and offenders' response to it. To employ assessment information to shape future mental health services and programs, study will be required on both individual and system needs and priorities.

To address mental health issues across the Service the paper recommends that: under NHQ coordination, regions develop research plans which coincide with the National Plan while setting local and regional priorities; Regional Psychiatric and Treatment Centres develop plans which focus on forensic mental health issues and which establish research priorities, test alternative treatment modes, and provide a basis for comparative outcome analysis; regions develop mental health strategies to address prevalent mental disorders in their offender populations and sub-groups; data on mental disorders be compiled, updated and assessed regularly; and that the Diagnostic Interview Schedule (DIS) be evaluated to determine its usefulness.

APPENDIX

STEERING COMMITTEE

The Steering Committee was chaired by Dr. Jacques H. Roy, Director General of Health Care, Correctional Service of Canada, and comprised of the following members:

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