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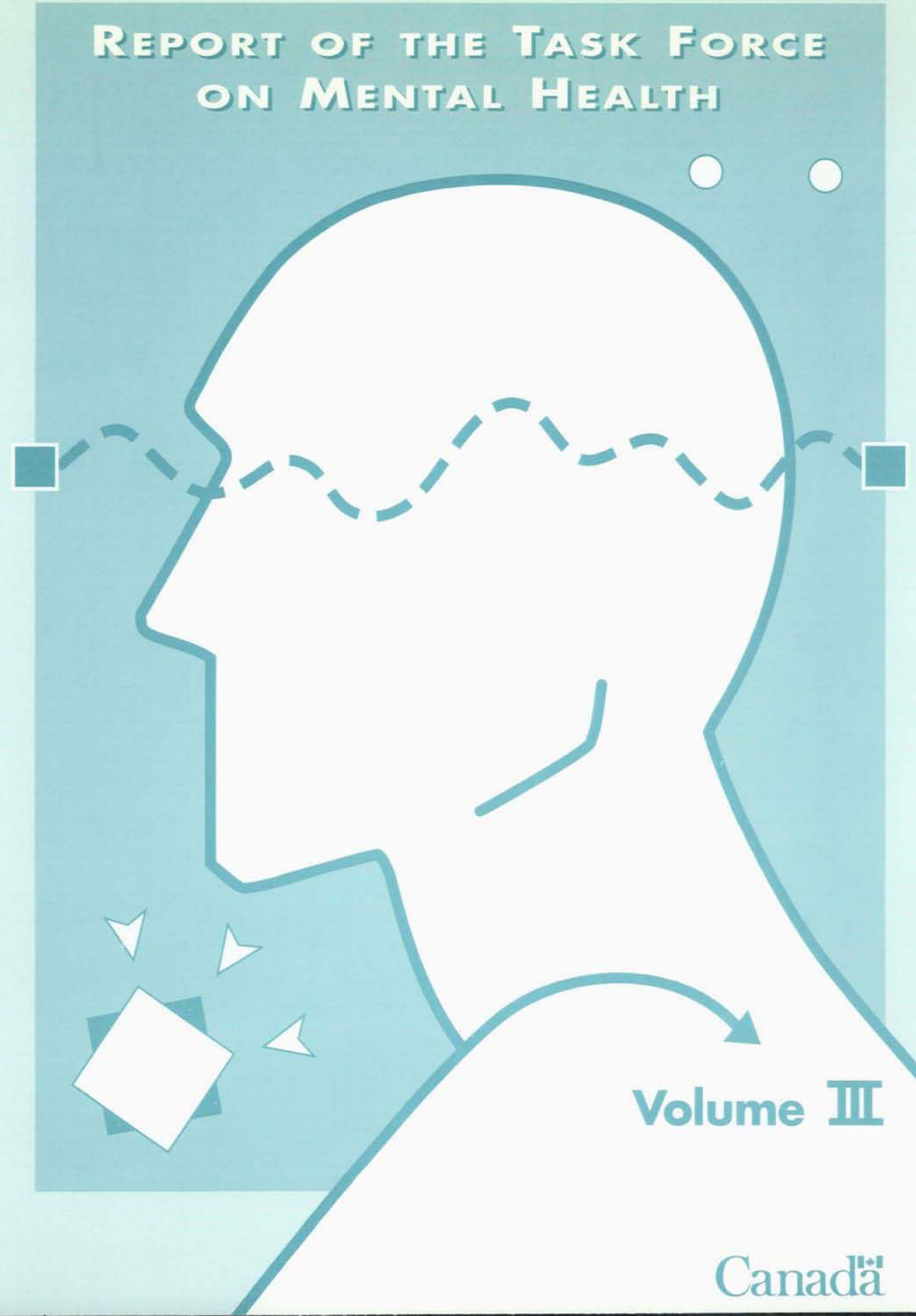
Report of the Task Force on Mental Health



Volume III

Canada

REPORT OF THE TASK FORCE ON MENTAL HEALTH

THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

VOLUME THREE

SEPTEMBER 1991

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THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

GROUPE DE TRAVAIL SUR LES SOINS DE SANTÉ MENTALE

Revue de la littérature concernant les doubles diagnostics

soumis par: Dr. Serge Brochu

AVRIL 1990

REVUE DE LA LITTÉRATURE

CONCERNANT

LES DOUBLES DIAGNOSTICS

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Rapport remis au groupe de travail sur la santé mentale
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POSITION DU PROBLÈME

Depuis longtemps, la prestation de soins de santé adéquats pour les détenus fait l'objet d'une attention particulière de la part du Service correctionnel canadien. Bien qu'on ait jusqu'ici mis sur pied tout un éventail de traitement spécialisé, deux types de problèmes retiennent toujours l'attention: l'usage de psychotropes et la santé mentale. Ces thèmes font d'ailleurs l'objet de deux groupes de travail distincts sous les auspices de la direction de la santé.

Par ailleurs, les intervenants font de plus en plus état de la lourdeur accrue de la clientèle et en particulier du problème de double diagnostic (santé mentale et toxicomanie). Les deux groupes de travail mentionnés ci-haut devront donc se pencher sur cette question. Pourtant, nous ne connaissons que très peu l'état de la question concernant les double diagnostics.

OBJET DE L'ÉTUDE

La présente étude a pour objet de faire une revue de la littérature sur l'état des connaissances concernant les doubles diagnostics et de faire des recommandations relatives à la gestion des détenus présentant des doubles diagnostics.

MÉTHODE

La dispersion des ouvrages a rendu nécessaire l'utilisation de la méthode de repérage de l'information faisant appel aux bases de données informatisées. Sept banques de données fournirent l'ensemble des références pertinentes: CC LIFE; CC CLIN; CC SOCS; SCISEARCH; et MEDLINE. Un total de 325 références furent ainsi repérées.

La bibliographie des références obtenues a fait l'objet d'un trie manuel afin de dépister certains titres qui ont pu échapper à la recherche bibliographique informatisée.

DOUBLE DIAGNOSTIC:
TOXICOMANIE ET PROBLÈMES DE SANTÉ MENTALE

Comment définir la nature des relations entre toxicomanie et santé mentale? Il s'agit là d'une question qui a piqué la curiosité de bien des checheurs. Depuis une quinzaine d'années environ, ce sujet connaît un regain de popularité, intéressant de près les spécialistes des maisons de traitement pour alcooliques et toxicomanes, les médecins aussi bien que les spécialistes des sciences criminologiques qui sont en contact constant avec la population judiciarisée.

Historiquement, les études reconnaissent une association assez importante entre l'abus de psychotropes et les troubles mentaux. Des études récentes révèlent à ce sujet qu'environ 60% des individus admis en psychiatrie présentent les signes d'une consommation pathologique de psychotropes (Attia, 1988). La nature de la relation entre usage de psychotropes et troubles mentaux reste cependant très controversée et porte même à de terribles confusions. Un défi de taille reste à relever par les chercheurs: les troubles mentaux précipitent-ils l'usage des psychotropes ou l'usage des psychotropes déterminent-ils les désordres psychiatriques? Une autre histoire de la poule et de l'oeuf diront certains.

Cette confusion qui persiste quant à la nature du lien entre usage de drogue et troubles mentaux influence grandement les méthodes de traitement des sujets doublement diagnostiqués; il s'agit là d'une question très complexe et l'on s'interroge encore à savoir qui devrait prendre en charge ces personnes: le psychiatre ou l'intervenant en toxicomanie?

Ce texte se donne donc pour objectif de synthétiser certaines études récentes sur les relations entre toxicomanie et désordres mentaux tout en ayant la préoccupation de poser les problèmes de traitement liés au double diagnostic.

DÉFINITIONS

Diagnostic

Pour bien comprendre à quoi réfère la notion de double diagnostic, sans doute serait-il pertinent de définir d'abord ce qu'est un diagnostic et son emploi.

Ce mot d'origine grecque "djagnostik" signifie distinguer. Distinguer quoi se demandait Del Vivo (1961). Il s'agissait alors de distinguer les éléments qui permettent de saisir la nature et la raison d'être ou le "quoi" et le "pourquoi" d'une réaction donnée, soit psychique, soit physique, soit sociale (p. 9). En fait, il s'agit de déceler le problème et ses origines.

Le Petit Robert définit le diagnostic comme étant "l'action de déterminer une maladie d'après ses symptômes". Cette définition amène à constater que ce terme a été utilisé pour la première fois dans le domaine des sciences médicales et plus tard fut repris par les professionnels des sciences sociales qui le définissaient alors comme étant "une étude mentale, une forme de réflexion permettant au travailleur social de saisir les éléments essentiels sur lesquels bâtir le traitement" (voir Del Vivo, 1961). Le diagnostic dans le domaine du travail social sert donc à saisir exactement une situation sociale et à définir la personnalité du sujet aux prises avec des problèmes d'ordre personnel.

Une fois la notion de diagnostic saïsie, on peut dès à présent passer à la définition du double diagnostic, notion directrice de la présente étude.

Double diagnostic

À travers la littérature, on peut noter combien la définition de ce terme est floue ou imprécise. Les termes les plus souvent employés faisant référence à la notion du double diagnostic sont les suivants: abus de drogue et psychopathologie (Westermeyer, 1985); abus de drogue et désordres affectifs (Mayfield, 1985); abus de drogue et désordres psychiatriques (McLellan et coll., 1985); abus de drogue et santé mentale (Gelberg, 1988).

Les auteurs qui emploient directement le terme double diagnostic, le définissent de la façon suivante: "Il s'agit de patients qui présentent les symptômes d'intoxication aux drogues (toxicomanie) et de maladie mentale" (Lett, 1987; Harrison et coll., 1987; Meniccuci et coll., 1988).

Dans un souci de clarté, il serait pertinent de définir les composantes de la notion du double diagnostic: toxicomanie et maladie mentale.

Toxicomanie

De façon générale, la toxicomanie se définit comme étant un "état d'assuétude ou de dépendance" qui survient après une consommation répétée de psychotropes. La toxicomanie implique une dépendance physique donc des manifestations somatiques en cas de privation du produit.

Cormier (1988) conçoit la toxicomanie en terme de phénomène "bio-psycho-social", un phénomène multivarié dont la cause ne saurait être unique. D'autres auteurs partagent la conception de Cormier quant à la perception de la toxicomanie: Baeza (1983), Cox (1986), Savada (1978). Pour ces auteurs, la toxicomanie est comprise en terme de facteurs multiples: biologique, psychologique, social qui interagissent

et qui déterminent le mode de vie de l'individu. C'est pourquoi Cormier propose de voir la toxicomanie comme étant "un style de vie intégré". L'individu consomme pour faire face à certaines difficultés personnelles et ceci lui semble être la meilleure solution à ses problèmes. Selon Hull (1987), l'individu choisit de réagir par son organisme plutôt que d'agir sur son environnement. La personnalité du sujet joue un rôle important dans le processus d'intoxication.

Santé mentale et trouble mental

Santé et Bien-Être Social Canada établit une distinction claire entre problème de santé mentale et trouble mental. Le trouble mental se rapporte au concept élargi de la santé mentale et est défini comme une maladie caractérisée qui peut-être diagnostiquée et qui peut faire l'objet d'intervention comme dans les cas de maladie physique.

Les problèmes de santé mentale sont définis sous l'angle des rapports que l'individu entretient avec son milieu, son entourage. Il s'agit de perturbations au niveau de l'individu pouvant découler d'une maladie physique ou mentale ou encore d'une incapacité à s'adapter. Les conditions de vie pénibles, des tensions familiales ou autre peuvent également amener des problèmes de santé mentale.

Cette distinction amène à préciser que dans le cadre du présent travail, on ne fera pas uniquement référence au trouble mental ou maladie, mais aussi au concept élargi de la santé mentale.

ALCOOLISME, TOXICOMANIE ET SANTÉ MENTALE

À cause du caractère compulsif et destructeur de l'assuétude, l'abus des psychotropes est classé, selon la grille d'analyse DSM III-R, comme une maladie mentale (Alterman, 1985). Bourdages (1989), se

référant à certaines études historiques dont Sherfey (1955) et Tyndel (1969), relevait cependant que l'abus des psychotropes est directement relié à d'autres formes de désordres psychiatriques. La théorie des auteurs à ce sujet est que les comportements liés à l'abus des psychotropes ne sauraient se manifester si, à la base, d'autres désordres psychiatriques n'étaient présents. Une étude plus récente de Pelc (1984) conteste la théorie de Sherfey et Tyndel en apportant comme argument qu'il n'a pas été établi clairement et de façon définitive que l'abus des produits toxiques serait une conséquence de diverses autres pathologies pré-existantes.

Comme on peut le contater, il n'y a pas de consensus quant à la nature des relations entre abus de drogue et problème de santé mentale. Pour la plupart des théoriciens contemporains, il s'agit là d'un problème complexe dont l'étiologie reste encore brumeuse. Laissons-là pour l'instant le problème de relation entre ces deux types de désordres psychiatriques, on y reviendra un peu plus tard dans le travail.

L'ÉTENDUE DU PROBLÈME

Dans la littérature, on constate qu'il y a peu de données disponibles quant au taux d'incidence des doubles désordres psychiatriques dans la population en général. Par contre, les statistiques concernant la population psychiatrisée, c'est-à-dire les individus en traitement dans un service psychiatrique interne ou externe, semblent plus explicites. En effet, on a vu ces dernières années se dessiner une tendance quant à la nature des admissions en unité psychiatrique. Les doubles désordres semblent sur-représentés chez les sujets admis en psychiatrie. Il s'agit là d'un important problème au niveau de l'administration de ces cas, et le problème va en s'accroissant notaient Ridgley, Goldman et Talbott (1986). Les statistiques en témoignent.

La co-existence des problèmes liés à la consommation des psychotropes et les troubles mentaux a été rapportée par maints auteurs. Suivant les observations de Quitkin et coll. (1972), il apparaît qu'entre 5 à 10% des sujets aux prises avec des phobies ont également eu des épisodes alcooliques et/ou toxicomaniaques.

Crowley et coll. (1974) s'intéressant au processus d'admission dans une unité psychiatrique retenaient que parmi les 42 sujets dernièrement admis, 60% de ceux-ci présentaient un problème de consommation de drogues. Plus du tiers de ces sujets étaient polytoxicomanes et un peu plus du quart consommaient de l'alcool.

Fisher et coll. (1975) étudiant la fréquence des problèmes de consommation de psychotropes chez des patients psychiatrisés de tout âge trouvaient que ceux-ci étaient sujets à haut risque d'intoxication. Les auteurs évaluaient la prévalence du phénomène chez ce groupe à 15%.

Weissman et coll. (1980) se sont penchés sur l'incidence des doubles désordres dans le "New Haven" aux États-Unis et relevaient que parmi les sujets diagnostiqués alcooliques, 70% avaient déjà eu au moins un épisode psychiatrique autre que l'abus de l'alcool durant leur vie.

Interrogeant un groupe de patients, qualifiés de jeunes adultes dans un hôpital psychiatrique de New York, Sheet et coll. (1982) trouvaient que 25% des sujets consommaient de l'alcool et faisaient un usage abusif d'autres produits toxiques.

Pour Gottheil et Waxman (1982), il ne fait pas de doute que les problèmes d'alcool parmi les malades mentaux, de même que les problèmes psychiatriques chez les alcooliques soient courant. Examinant des sujets en traitement en service interne ou externe, Gottheil et Waxman trouvent que 10 à 15% des sujets diagnostiqués alcooliques sont aussi schizophrènes et ajoutent que 10 à 15% des patients schizophrènes hospitalisés présentent de sérieux problèmes de boisson.

Une étude s'intéressant aux doubles désordres dans l'ensemble de la population à Philadelphie relevait qu'environ 80% des sujets interrogés ont déjà eu des maladies mentales et que 70% présentaient, lors de l'enquête, des symptômes courant de désordres psychiatriques (O'Brien et coll., 1984).

Bergman et Harris (1985), s'intéressant à 65 jeunes malades chroniques d'un programme de traitement communautaire, soutenaient qu'avant leur admission en traitement, 34 de ces sujets (52%) avaient dans leur passé un problème d'abus de drogue et d'alcool et que leur consommation constituait une cause directe de leurs problèmes psychiatriques.

Kofoed et coll. (1986) estimaient que près de 25 à 40% des sujets hospitalisés dans des unités psychiatriques sont également des usagers abusifs d'alcool ou d'autres types de substances psychotropes. Kelvy, Kane et Kellison (1985) estimaient à ce sujet que près de 60% des admissions dans les hôpitaux psychiatriques sont liés à des problèmes d'abus de drogue.

Avant de poursuivre, remarquons la variabilité au niveau de la prévalence des désordres. D'une année à l'autre, les taux diffèrent considérablement. D'après certains auteurs, dont Dorus et coll. (1987) cette variabilité dépend également des périodes d'entrevue. Dans la population alcoolique, par exemple, la boisson cause des changements physiques majeurs affectant l'individu sur le plan psychologique. Malheureusement, très peu d'études spécifient le niveau de l'utilisation de l'alcool lorsque les tests sont faits. Il faudrait indiquer systématiquement, par exemple, qu'il s'agit d'un groupe de sujets avant traitement, ou en désintoxication, etc.

Griffin (1988) relevait, d'après les études de Rownsaville et coll. (1982), Kleber et Gold (1978), que parmi les sujets qui se présentent pour un traitement pour cause d'abus d'alcool ou de drogue,

dans un hôpital du Massachussetts, qu'une minorité non négligeable de ces individus présentaient certains symptômes psychiatriques.

De façon générale, toutes les études consultées s'accordent à dire que l'abus des psychotropes et les troubles mentaux sont omniprésents dans la population et particulièrement chez les sujets psychiatrisés.

LES DIFFÉRENTES PATHOLOGIES LIÉES À L'ABUS DES PSYCHOTROPES

Les désordres affectifs

Les troubles affectifs sont définis comme étant des symptômes gravitant autour des sensations et des expressions émotives (Krech, Crutchfield, Livson; 1979). Lorsqu'il s'agit de troubles affectifs sérieux, on remarque de fréquents changements d'humeur et des sentiments exagérés allant "d'une exaltation normale à une exaltation extrême, d'un désespoir normal à un désespoir extrême ou d'une extrême exaltation à un désespoir extrême" (Krech et coll., 1979). On distingue trois formes de troubles affectifs courant, ce sont la manie, la dépression et les troubles biphasiques. L'individu maniaque est décrit comme ayant de brusques changements d'humeur. Cet individu peut graduellement devenir dérangé et même dangereux pour lui-même et son entourage. L'individu dépressif, lui, passe d'une humeur normale à une extrême tristesse, il peut même penser au suicide. La personne aux prises avec des troubles biphasiques est caractérisée par dès périodes d'abattements extrêmes suivant un cycle de période maniaque.

En fait, on ne parle de troubles affectifs que lorsque de profonds changements d'humeur persistent sans cause apparente. Il faut alors intervenir auprès du sujet.

Plusieurs études se sont intéressées aux troubles affectifs chez les sujets qui font usage d'alcool ou d'autres types de psychotropes.

Mayfield (1985) s'est attardé à la recherche des premières études qui ont été faites dans ce domaine et découvre que celles-ci débutent vers les années 1900 avec East et Sullivan. Ces auteurs, à partir de leurs enquêtes, concluaient qu'il existe une forte association entre l'alcoolisme et le suicide. Plusieurs autres études corroborent par la suite les résultats de East et Sullivan. Robins et coll (1959: voir Mayfield, 1985) trouvaient une incidence élevée de l'alcoolisme chez des individus ayant fait des tentatives de suicide. Un taux d'incidence élevé de suicide a également été rapporté lors d'une étude longitudinale chez un groupe d'alcoolique par Lemere (1953: voir Mayfield, 1985). Plus récemment, Mayfield et Montgomery et Durkam (1972: voir Mayfield, 1985) trouvaient que parmi les 34 patients admis dans un hôpital général des États-Unis pour tentative de suicide, 29 étaient des alcooliques.

Murphy et coll. (1979) examinant les dossiers de 50 sujets ayant fait une tentative de suicide relevaient que 26% de ces sujets avaient déja fait un usage abusif de boissons alcooliques.

Jaffe, Ciraulo (1986) écrivaient que l'alcoolisme est hautement associé au suicide. Selon eux, entre 5 à 27% de toutes les morts, chez les alcooliques, sont des suicides. Les auteurs spécifiaient que 15 à 25% des suicides ou tentatives de suicide sont le fait d'individus alcooliques.

La dépression a également fait l'objet de plusieurs recherches chez les individus aux prises avec des problèmes de drogue ou d'alcool. Behar et Vinokur (1979) mentionnaient que jusqu'à 98% des sujets alcooliques admis en traitement présentaient des symptômes dépressifs. Hesselbrook et coll. (1983), de même que Woodruff et Guze et Clayton (1973), déclaraient que la majorité des patients dépressifs ont un passé alcoolique.

À partir d'entrevues cliniques réalisées auprès de patients alcooliques, Keeler et coll. (1987) rapportaient que 8.6% des sujets rencontrés sont également dépressifs.

Weissman, Myers, Harding (1980), également à partir d'entrevues cliniques, s'intéressant à 510 patients en traitement trouvaient que parmi les 34 sujets diagnostiqués alcooliques, 44% présentaient les symptômes de dépression moyenne, 18% une dépression mineure.

La plupart des travaux qui ont été consacrés aux relations entre abus de psychotropes et troubles d'anxiété ou troubles phobiques s'accordent à dire qu'il y a une corrélation positive entre ces deux formes de pathologie (Bowen et coll., 1984; Weiss et Rosenberg, 1985).

L'anxiété est un problème psychologique qui se manifeste par un état de tension interne ou de la peur. Dans la littérature, on relève que l'anxiété est plus souvent associée à l'alcool qu'à d'autres types de substances. Adès (1988) suggérait que les sujets très anxieux sont prédisposés à l'alcoolisme. Rivinus (1988) soutenait de son côté que les patients anxieux qui consomment des drogues dans le but de se libérer de certaines tensions ou peurs sont plus susceptibles de développer des problèmes d'abus.

En ce qui concerne la prévalence des troubles anxieux ou phobiques observés chez des individus ayant des problèmes de consommation, Quitkin et coll. (1988), de même que Sims (1975), estimainet qu'entre 10 à 15% des sujets alcooliques présentant des troubles d'anxiété. Bowen et coll. (1984), pour leur part, croient que de façon générale on peut s'attendre à ce que au moins 44% des patients alcooliques soient également très anxieux. Smail et coll. (1984) évaluant un groupe de 60 alcooliques en traitement estimaient que plus de 50% de ces sujets étaient phobiques.

Quoique les résultats varient d'une étude à l'autre quant au taux de prévalence des doubles troubles, la plupart des études s'entendent cependant sur le fait que l'association entre alcoolisme et désordres affectifs est complexe. Divers problèmes surviennent à cause des problèmes de définition. Par exemple, la distinction entre consommation abusive et alcoolisme ne semble pas claire dans la littérature écrivait

Shuckit (1986), d'autre part, on confond encore tristesse et désordres affectifs majeurs.

Schizophrénie

Kretch et coll. (1979) rapportaient que de toutes les psychoses, la schizophrénie est le trouble le plus fréquent. Les auteurs estimaient que près de 25% des malades admis dans les hôpitaux psychiatriques pour une première fois présentent des symptômes de schizophrénie. Kretch et coll. spécifiaient que les schizophrènes représentent la moitié de tous les malades hospitalisés en tout temps.

Avant de passer à l'étude de l'incidence de la schizophrénie chez les sujets abusant de drogue ou d'alcool, définissons brièvement les caractéristiques ou symptômes de la schizophrénie. Le schizophrène semble être un individu insensible, exprimant peu ou pas d'émotions ou de réactions. La schizophrénie est décrite comme étant une rupture entre les émotions et la réalité. Le schizophrène peut devenir un individu très replié sur lui-même gardant peu de contacts avec son entourage, il peut avoir des réactions de paranoia, des hallucinations et peut avoir une perception de la réalité tout à fait déformée.

D'après Galanter, Castaneda et Ferman (1988), il n'a pas été prouvé que l'abus de produits toxiques a lieu plus souvent chez des sujets psychotiques que dans l'ensemble de la population. Rimmer et coll. (1977) vont dans le même sens en ne dénombrant que 3% des schizophrènes hospitalisés qui présentaient des problèmes liés à l'usage abusif de l'alcool.

D'autres études par contre semblent apporter des résultats très différents. McLellan et Druley (1977) identifient parmi 141 sujets schizophrènes hospitalisés, 44 (31%) sujets qui ont eu un passé alcoolique. McLellan et coll. croient que ce pourcentage est plus élevé parmi les schizophrènes en traitement externe.

Richardson et Thomas (1985) ont étudié 56 jeunes adultes schizophrènes qui ont commencé leur traitement dans une ère de désinstitutionnalisation. Treize pour cent (13%) de ces sujets ont déjà fait de la prison. Cinquante-cinq (55%) d'entre eux ont un passé relié à l'abus des drogues psychotropes et 27% prenaient de l'alcool. Un seul sujet abusait à la fois de drogue et d'alcool.

Damron et Simpson (1985) examinant 100 sujets diagnostiqués schizophrènes admis dans un hôpital de la Californie (97 hommes et 3 femmes) trouvent chez 54% de ces patients des symptômes d'intoxication aux drogues. Chez 47 sujets, on trouve les signes d'une récente utilisation d'alcool, 35 sujets ont été diagnostiqués comme étant de récents abuseurs de psychotropes.

Les désordres de la personnalité

D'après Schuckit (1983), 10 à 20% des sujets de sexe masculin et 5 à 10% des sujets du sexe féminin qui sont diagnostiqués alcooliques et qui font l'objet d'un traitement en institution peuvent également être diagnostiqués comme présentant des symptômes de désordre de la personnalité. Woody et coll. (1983) identifiaient, parmi une cohorte de sujets abusant des opiacés, que 15% des sujets de sexe masculin présentent une personnalité antisociale.

Rownsaville et coll. (1980) trouvaient 20% de sujets dits anti-sociaux chez des hommes alcooliques inscrits à un groupe communautaire.

LA RELATION ENTRE TROUBLES MENTAUX ET TOXICOMANIE

La section suivante tentera d'apporter certains éclaircissements sur la nature de la relation entre troubles mentaux et toxicomanie.

Les associations entre alcoolisme, toxicomanie et problèmes de santé mentale sont manifestement complexes. Dans la littérature clinique traditionnelle, on a tendance à penser que la présence de comportements d'intoxication est une conséquence de certaines pathologies pré-existantes. Pour certains chercheurs, en effet, il apparaît évident que les troubles mentaux causent l'utilisation abusive des substances toxiques. Freed (1969) est l'un de ceux qui soutient que des sujets aux prises avec des problèmes psychiatriques peuvent abuser des toxiques afin de combattre des états d'âmes négatifs. Kolb (1962) appuyait Freed; les drogues servent de mécanisme de défense contre l'anxiété, contre l'inconfort et contre des émotions. Adès (1988) a également discuté du "rôle initiateur" des facteurs psychiques dans la dépendance alcoolique. Hall et coll. (1979) concluaient au sujet des relations entre abus de psychotropes et problèmes de santé mentale que l'abus des psychotropes est plus souvent le résultat plutôt que la cause de désordres psychiatriques. Lett (1987) cependant semble dire que pour l'instant il y a un manque certain au niveau des recherches permettant de soutenir de telles hypothèses.

Par ailleurs, d'autres études, quoique peu nombreuses, soutiennent à l'inverse de Freed, Hall et coll. que les désordres psychiatriques ou déficience de la personnalité sont une conséquence de l'utilisation de produits toxiques au lieu d'être des facteurs prédisposants (Zimberg, 1975). D'autres chercheurs soutenaient à propos de la nature des liens entre assuétude et désordres mentaux que, selon le cas, la dépression par exemple peut précéder l'alcoolisme et dans d'autres cas être une conséquence de l'alcoolisme (Murray et coll., 1984). O'Brien et coll. (1984) et Westermeyer (1979) partageant la théorie de Murray et coll. croient que plusieurs facteurs concomitants de l'abus des drogues: perte, maladie, malnutrition, grands changements dans les habitudes de vie, etc. peuvent précipiter les désordres psychiatriques. De même, plusieurs facteurs concomitants des désordres psychiatriques: insomnie, dysphorie, isolement, peuvent favoriser l'abus des toxiques.

Si la co-existence des désordres au niveau de la consommation des toxiques et les désordres mentaux est établie, la nature de cette relation demeure d'autre part ambigue. La plupart des enquêtes qui ont été menées sur le sujet visaient à répondre à certaines questions spécifiques:

1) L'utilisation, l'abus des toxiques, prédisposent-ils à d'autres formes de troubles mentaux?

2) Les désordres psychiatriques précipitent-ils l'usage des produits toxiques?

Le problème, expliquait Pennick et coll. (1984), Weissman et coll. (1984) est que plusieurs symptômes peuvent se manifester chez un même individu, c'est-à-dire: problèmes de consommation; troubles affectifs; ou désordre de la personnalité ... Comment donc comprendre la relation entre ces diverses formes de pathologies? Lequel est le principal problème?

La littérature a beaucoup insistée sur ce dernier point et c'est ainsi que plusieurs auteurs en sont venu à proposer un système de classification des symptômes (Robin et Guze, 1969; Schuckit, 1979; Valladon, 1988). Cette classification devrait aider à cerner avec plus de précision quelle pathologie génère l'autre. Pour cela, les auteurs proposent de distinguer entre désordres primaires et désordres secondaires.

Il existerait deux types de personnalités prédisposés à la toxicomanie:

1) Ceux qui affichent une toxicomanie réactionnelle ou secondaire, c'est-à-dire que l'usage des psychotropes sert de compensation à un état pré-existant peut-être de type névrotique (deuil, séparation, blessure narcissique, etc.) ou encore de type psychotique (Schizophrénie).

2) Ceux qui présentent une toxicomanie primaire alors que l'usage des psychotropes apparaît comme: "une forme d'entrée dans la maladie sous forme névropathique ou psychopathologique", c'est-à-dire que l'usage des psychotropes apparaît avant les désordres mentaux (Valladon, 1988).

Selon Adès (1988), on retrouve plusieurs avantages à une telle classification des symptômes. Elle permet:

1) D'établir une hiérarchie au niveau de l'apparition des symptômes procurant une vision plus claire des relations entre les problèmes de consommation et les désordres psychiatriques qui semblent les favoriser. À ce sujet, Adès écrivait:

> "Ainsi peut-on mieux différencier, par exemple, les alcoolisme apparus secondairement à un désordre de la personnalité ou à un trouble psychiatrique manifeste, pour lesquels on suppose, sans pouvoir l'affirmer, une relation possible entre l'alcoolisation et le trouble mental, et les désordres psychiatriques apparus après le début de la conduite alcoolique dont on peut supposer qu'ils interviennent comme une conséquence psychique éventuelle de l'alcoolisation excessive et prolongée." (p. 19).

2) De favoriser la mise sur pied de projets de recherche mettant en évidence "des différences notables quant au spectre génétique, à l'âge du début de l'alcoolisme, à son aspect clinique, à son prognostic médical et social, aux types de complications présentées entre alcoolisme primaire et alcoolisme secondaire aux maladies affectives ...

CLASSIFICATION DES SYMPTÔMES (PRIMAIRES - SECONDAIRES)

Les relations entre alcoolisme et problèmes de santé mentale semblent plus souvent traitées dans la littérature que celles portant sur

les toxicomanies et les troubles mentaux. La principale raison à cela semble être que l'alcoolisme est le trouble le plus commun chez les sujets qui se présentent aux services de santé, probablement parce que l'utilisation de ce produit n'est pas illégale et qu'il est, par conséquent, plus facile d'accès (Ridgley, Goldman et Talbot, 1986).

Comme il a déjà été mentionné dans le présent travail, beaucoup de clinicien reconnaissent le caractère antérieur des désordres mentaux aux désordres liés à l'usage des substances toxiques. Weissman et Myers (1980), à partir d'une étude longitudinale, trouvaient que parmi 34 sujets alcooliques, 15 d'entre eux étaient en proie à une dépression majeure et que, pour 60% de ces patients, cette dépression précédait l'alcoolisme.

Rund et coll. (1981) identifiaient, parmi 200 sujets en consultation à l'urgence d'un hôpital général, que 40 de ces patients étaient alcooliques et que 35% de ceux-ci présentaient des troubles affectifs préalables à l'intoxication. S'intéressant à la relation entre phobie et alcoolisme Franklin et coll. (1989) rencontraient 98 sujets chez qui on avait relevé des symptômes phobiques. Seize (16) de ces sujets étaient doublement diagnostiqués: alcoolisme et phobie. D'après les données recueillies par les chercheurs, il semble que les symptômes phobiques précédaient l'alcoolisme chez 15 de ces sujets. Les troubles phobiques survenaient à un âge moyen de 10.4 ans alors que l'alcoolisme survenaient autour de 20.7 ans.

Hesselbrook et coll. (1985) déclaraient pour leur part que l'ordre d'arrivée de l'alcoolisme et des troubles mentaux peut varier selon le sexe. Chez les hommes, les troubles tels que les phobies, les personnalités antisociales, les troubles paniques sont souvent antérieurs à l'abus d'alcool. Chez les femmes, ces troubles sont également antérieurs à l'alcoolisme mais dans des proportions plus élevées. Dans le cas des dépressions majeures par exemple, elles sont antérieures à l'alcoolisme dans 65% des cas chez les femmes et dans seulement 47% des cas chez les hommes.

La littérature consultée révèle cependant que les sujets alcooliques n'ont pas tous des troubles mentaux préalables à l'alcoolisme. Schuckit et coll. (1969) se sont intéressé à un groupe de 70 femmes alcooliques. L'évaluation de ces sujets a démontré que dans 56% des cas, l'alcoolisme était un trouble primaire ou antérieur aux troubles mentaux.

Woodruff et coll. (1973) pensaient de leur côté que la majorité des patients alcooliques dépressifs ont une histoire reliée à l'abus d'alcool avant l'apparition des symptômes de dépression.

Schuckit (1985) menant une étude s'étalant sur une période de trois ans rencontrait 577 sujets alcooliques entrant dans un programme de traitement à San Diego. Les sujets étaient interrogés dans les 72 heures suivant leur admission. Les données recueillies révélaient que 78% des sujets admis en traitement présentaient un alcoolisme primaire.

McKelvy et coll. (1987) soutenaient qu'environ 20% de tous les diagnostics de doubles désordres présentent des troubles primaires liés à leur consommation.

Dans une unité psychiatrique pour anciens combattants on évaluait 533 sujets en regard de l'usage des substances toxiques (alcool, drogue). Dix-huit pour cent (18%) de ces sujets paraissaient avoir eu jadis des problèmes liés à un usage abusif de drogue et d'alcool et 40% de ces sujets ont eu des problèmes liés à l'usage d'alcool seulement. Quarante-deux pour cent (42%) de l'ensemble des sujets ne rapportaient aucune consommation excessive de drogue ou d'alcool. Les données révélaient que parmi les usagers d'alcool seulement, 83% des sujets avaient reçu un diagnostic primaire de troubles schizophréniques. Les utilisateurs de drogue et d'alcool à la fois étaient tous classés comme étant paranoiaque et schizophrénique (Alterman et Laporte, 1982).

Breakey et coll. (1974) s'intéressaient à 46 patients admis dans un hôpital psychiatrique de New York étiquetés schizophrènes. Parmi ces sujets, 32 étaient également des usagers de drogues. Dans seulement six cas, l'usage des drogues survenait après le début des troubles de schizophrénie. Les auteurs concluaient donc que l'usage des drogues est un facteur précipitant les troubles schizophréniques.

Dans une étude portant sur les relations entre désordres psychiatriques et cocainomanie, Nunes et coll. (1989) faisaient ressortir que parmi les 30 sujets cocainomanes admis dans une unité psychiatrique de New York, 63% rencontraient les critères d'un désordre primaire lié à l'abus de la cocaine.

Une étude de Rownsaville et coll. (1982) évaluaient 157 sujets en traitement. Les patients abusaient d'opiacés. Les résultats révélaient que 48% de ces sujets étaient dépressifs et que 94.5% d'entre eux présentaient un trouble de consommation primaire.

D'autres études documentaient les relations entre toxicomanie et troubles mentaux: McLellan et coll. (1979) s'intéressant aux origines des maladies psychiatriques observées chez les toxicomanes concluaient à partir de l'étude de 51 anciens combattants, abusant de différents types de drogue admis dans une unité de désintoxication que les drogues peuvent jouer un rôle majeur dans le développement de certaines maladies mentales. Day et Leonard (1985) pensent également que certaines drogues produisent des désordres psychiatriques spécifiques.

Concernant l'usage de la marijuana, les études quoique peu nombreuses démontrent que des états dépressifs prédisent l'usage de la marijuana (National Commission of Marihuana and Drug Abuse, 1972; Paton, Kessler et Kandel, 1977).

Halikas, Godwin et Guze (1972) s'intéressant à 100 usagers de marijuana trouvent que parmi les cas de maladie mentale, 75% précèdent

l'utilisation de la marijuana. Les auteurs concluaient donc que l'usage de la marijuana est un symptôme relié à des désordres mentaux primaires. Notons que les résultats de cette étude contredisent ceux du National Commission of Marihuana and Drug Abuse, et celles de Paton, Kessler et Kandel mentionnées précédemment.

D'autres études, Richek et coll. (1975), n'ont trouvé aucune corrélation entre l'usage de la marijuana et les désordres psychiatriques chez un groupe d'étudiants. Une étude de Harmatz et coll. (1972) trouvait d'autre part que les désordres psychiatriques étaient plus présents chez les usagers de marijuana et encore plus présents chez des sujets qui font un usage multiple de psychotropes. Cette étude ne mentionnait pas cependant quel désordre précipitait l'autre.

Les associations entre troubles mentaux et d'autres types de drogues illicites tels que le LSD, la cocaine ou l'héroine n'ont pas non plus été systématiquement étudiées. Day et Leonard (1985) de même que Kandel et coll. (1978) et Paton et coll. (1977) arrivaient aux conclusions que dans un premier temps, la dépression, par exemple, pouvait être reliée au début de l'utilisation multiple de drogues et que, dans un deuxième temps, les dépressions pouvait faciliter l'initiation aux drogues.

En ce qui concerne l'usage des stimulants, des sédatifs, des tranquillisants mineurs, la relation entre l'utilisation de ces produits et les troubles mentaux est plus difficile à établir. Cette relation est confrontée à des problèmes majeurs. Les produits, particulièrement les sédatifs et les tranquillisants mineurs, sont prescrits contre l'anxiété, la dépression ou le stress qui sont des symptômes courants de troubles mentaux. Dans le cadre de la présente étude ce qui nous intéresse, c'est la relation entre ces produits et les troubles mentaux lorsque ces produits n'ont pas été prescrits par un clinicien. Là encore, les recherches sont restreintes à ce sujet et les résultats de ces études tendent à démontrer que l'usage des stimulants, des sédatifs, des

tranquillisants mineurs est relié de près aux problèmes de santé mentale. L'usage de ces produits peut déclencher certains types de désordres mentaux.

Le problème des relations entre toxicomanie, alcoolisme et maladie mentale n'est donc pas résolu à l'aube des années 90. D'après certains auteurs, dont Day et Leonard (1985), la compréhension des relations entre ces variables nécessite plus d'études longitudinales qui feraient un suivi systématique des sujets depuis les premiers symptômes quels qu'ils soient. Robins (1974) consultait des dossiers cliniques de certains sujets qui avaient été suivi depuis l'enfance. A travers l'étude de ces dossiers, cet auteur constatait que ceux qui plus tard devenaient alcooliques avaient, dès l'adolescence, des caractéristiques particulières qu'il décrivait comme des problèmes de comoprtements, de même que des problèmes au niveau de la famille. Kandel, Kessler et Margulies (1978) corroborraient les résultats de Robins en soutenant que les prédicateurs les plus importants dans l'initiation des boissons et drogues sont les caractéristiques présentes à l'adolescence. Ceux qui, à l'adolescence, présentaient des signes de désordres de la personnalité sont plus susceptibles de développer une dépendance aux drogues ou à l'alcool.

Il faut conclure de concert avec Meyer (1986) qu'on ne peut pas traiter du problème simplement en terme de relation de cause à effet. Il existerait plutôt cinq types de relations possibles entre l'assuétude et les désordres mentaux.

1) La psychopathologie peut constituer un facteur de risque pour la toxicomanie.

2) La psychopathologie peut modifier le cours de la toxicomanie en termes de rapidité de développement, de réponses au traitement, de présentation de symptômes et des conséquences à longue échéance.

3) Des symptômes psychiatriques peuvent se développer au cours d'une intoxication chronique.

4) Certains désordres psychiatriques apparaissent comme une conséquence de l'usage de drogues et persistent après l'arrêt de la consommation.

5) L'abus de drogues, les comportements d'utilisation et les symptômes psychopathologiques (qu'ils soient antérieurs ou ultérieurs) deviendront significativement liés à travers le temps (Meyer, 1986).

LE DIAGNOSTIC DES DOUBLES DÉSORDRES: PROBLÈMES ET MÉTHODES D'ÉVALUATION

Établir chez un individu la co-occurence des désordres liés à l'usage des psychotropes et les troubles psychiatriques est une tâche ardue. Selon Lett (1987), plusieurs individus chez qui co-existent les symptômes de ces doubles désordres ne sont pas détectés. Plusieurs raisons expliquent ce fait: d'abord, certains services de santé, expliquait Lett, ne sont pas adéquatement équipés pour établir ce genre de diagnostic. Le clinicien peu expérimenté face au patient présentant plusieurs symptômes peut ne pas reconnaître chez celui-ci les signes d'une consommation problématique de toxique et même lorsqu'il est en mesure de le faire, il n'est pas toujours facile de déterminer si ces symptômes résultent de l'abus des drogues. En effet, l'abus des produits toxiques peut masquer des problèmes de santé mentale et l'inverse est tout aussi vrai. Cette tâche est d'autant plus difficile précisait Straussman (1985) que certains sujets utilisent différents types de drogues dont certains ont des effets secondaires qui s'estompent après une période d'abstinence et d'autres qui contribuent à augmenter l'intensité des symptômes psychiatriques pré-existant. Alors, comment discerner avec précision la relation causale entre abus de drogues et d'autres formes de pathologies?

L'évaluation clinique d'un sujet implique donc que le clinicien se renseigne à fond sur l'histoire du patient: ses habitudes de vie, l'âge d'occurence des différents symptômes etc. ... Lorsque le clinicien établit qu'un sujet fait un usage abusif de psychotropes, il lui faut bien circonscrire l'âge des premières périodes de consommation de même que les périodes d'abstinence.

D'autres types de difficultés se présentent lors de l'évaluation clinique d'un patient. Le chevauchement des symptômes affectifs et des désordres liés à l'usage des psychotropes conduit à certaines confusions précisait Schuckit et coll. (1988), de même que Galanter et Castaneda (1988). Certains problèmes de définitions viennent obscurcir le tableau. En effet, les cliniciens rencontrent souvent certaines difficultés lorsqu'il s'agit de faire la différence entre l'alcoolisme et la consommation d'alcool. Dans certains cas, la consommation de deux à trois verres d'alcool peut affecter le sujet sur le plan psychologique. Par ailleurs, on a également tendance à confondre les sentiments de tristesse avec certains désordres affectifs majeurs.

La complexité de l'évaluation clinique des patients se présentant avec divers symptômes vient souvent des symptômes eux-mêmes. Par exemple, précisait Lett (1987), alcoolisme et schizophrénie paraissent avoir des manifestations communes: anxiété, faible estime de soi, faible tolérance à la frustration. Kofoed et coll. (1986) rapportaient les mêmes faits concernant l'usage du LSD, la consommation de la marijuana et la schizophrénie. Dans un contexte d'abus primaire de stimulants, Schuckit (1988) précisait que les gens peuvent développer des symptômes secondaires caractérisés par des épisodes paranoiaques et des hallucinations.

Schuckit (1985), Lewis, Rice et Helzer (1983) s'intéressant aux relations entre alcoolisme et personnalité antisociale découvraient que ces deux pathologies partagent souvent plusieurs caractéristiques cliniques comme des problèmes de consommation d'alcool, une histoire familiale reliée à l'abus d'alcool et des actes antisociaux.

L'évaluation clinique des patients qui se présentent aux différents services de santé demeure donc une entreprise assez délicate. Selon Lett (1987), les psychiatres, les psychologues, les thérapeutes et tous les autres spécialistes qui travaillent dans le domaine de la santé mentale devraient recevoir un entraînement particulier leur permettant de détecter et d'intervenir auprès des patients qui présentent des symptômes multiples. Il faudrait d'autre part élaborer des définitions claires et précises des différentes formes de pathologie pouvant co-exister avec l'usage des psychotropes, ce qui pourrait faciliter le diagnostic.

La diversité des méthodes d'évaluation

Adès (1988) écrivait au sujet de la diversité des méthodes d'évaluation, les mots suivants:

> "Ainsi peut-on voir co-exister, pour décrire la ou les personnalités des alcooliques, des approches quantitatives ou qualitatives psychométriques, elles-mêmes hétérogènes par le nombre et le type des instruments utilisés, tests projectifs classiques, questionnaire de personnalité, questionnaires centrés sur la recherche de telle ou telle dimension psychologique ou comportementale, des approches neuropsychologiques plus récemment."
> (p. 27)

Les instruments d'évaluation semblent donc nombreux. Parmi les plus courants, on peut citer le MMPI destiné à préciser certains traits spécifiques de la personnalité.

Par ailleurs, le SADS-L (Schedule for Affective Disorders and Schizophrenia - Life Time Version) et le DIS (Diagnostic Interview Schedule) servent à déterminer la présence ou l'absence de désordres psychiatriques à partir de l'histoire de vie des patients. Le DIS n'est pas nécessairement administré par un clinicien. Il s'agit d'un

questionnaire lu par l'administrateur qui doit rapporter les réponses du patient pour être compilées par ordinateur. Pour sa part, le SADS-L doit être obligatoirement administré par un clinicien car chaque réponse du patient, dépendamment des scores obtenus, doit être interprétée.

La grande diversité des techniques d'évaluation pose certains problèmes, rapportait Adès (1988). Selon les méthodes utilisées, les résultats varient considérablement. Une étude de Keeler et coll. (1979), rapportée par Adès, confirme les difficultés liées à la diversité des techniques d'évaluation. Keeler et coll. menaient une enquête auprès des hommes alcooliques, hospitalisés et sevrés. Les résultats de l'étude sont les suivants: les chercheurs rapportaient que 66% des alcooliques sont diagnostiqués dépressifs selon le questionnaire de Zung, 43% en fonction des scores du MMPI, 28% selon l'échelle de Hamilton et seulement 8.6% si l'on tient compte des critères diagnostiques cliniques (RDC de Spitzer). D'après Adès, les différences observées étaient attribuables à l'imperfection de certaines de ces mesures et, écrivait-il, "aux limites arbitrairement fixées des scores témoignant d'un état dépressif". Le manque de pertinence de certaines échelles serait également une cause des différences observées.

ALCOOLISME, TOXICOMANIE, TROUBLES MENTAUX ET CRIMINALITÉ

Très peu d'études se sont intéressées aux relations entre l'usage excessif des substances psychotropes, les troubles mentaux, la délinquance et la criminalité. La littérature traitant de cette question laisse cependant sous-entendre que ces différentes variables seraient étroitement associées.

Gelberg, Linn et Leake (1988) rapportaient que sur un total de 529 individus des deux sexes interrogés dans le but d'analyser les facteurs associés à l'apparition des maladies mentales, 232 sujets avaient déjà été hospitalisés pour des problèmes de santé mentale et d'abus de drogues et que 76% d'entre eux avaient déjà été arrêtés.

Lewis et coll. (1982) analysaient 66 sujets du sexe féminin dans un établissement pénitentiaire et trouvaient que 58% de ces femmes étaient alcooliques et répondaient également aux critères de personnalité antisociale.

Pepper et coll. (1981) ont étudié un groupe de 152 jeunes adultes présentant à la fois des troubles mentaux et des problèmes liés à un usage excessif de psychotropes. Les auteurs identifiaient que 7% de ces individus avaient été impliqué dans des crimes de violence et que 11% avaient été impliqué dans d'autres types de délit: vol, entrée par effraction, etc.

Test et coll. (1985) rapportaient que chez 100 jeunes adultes schizophrènes traités dans une unité psychiatrique et présentant également des problèmes de consommation, 41 d'entre eux avaient déjà été arrêtés et que 33% de ces derniers avaient déjà été incarcérés.

Towber et Ladner (1985) s'intéressant à des sujets itinérants révélaient que, parmi les 6,113 individus qui présentaient des doubles désordres, 64% d'entre eux avaient déjà fait de la prison.

La plupart des études consultées précisaient la fréquence des relations observées entre consommation excessive, désordres mentaux, délinquance et criminalité, sans toutefois traiter de la nature de ces relations.

LA GESTION DES CAS DE DOUBLE DIAGNOSTIC

Ridgely, Osher et Talbott (1987) se sont intéressés de près à la question des méthodes de traitement chez les patients doublement diagnostiqués. D'après ces auteurs, depuis environ une dizaine d'années, plusieurs cliniciens se sont penchés sur le problème tentant de préciser certaines approches de traitement pour le patient présentant les

symptômes d'abus de substances chimiques et des signes de trouble mental. Néanmoins, la recherche à ce sujet est encore au stade embryonnaire, précisaient Ridgely et coll. (1987). Kofoed et coll. (1986), en accord avec Ridgely et coll., faisaient remarquer que les données concernant la gestion des doubles diagnostics sont encore peu nombreuses. D'autres chercheurs, dont Ziegler et coll. (1980) soutenaient que les modèles de traitement proposés jusqu'ici ne résolvaient pas le problème des doubles désordres, ces méthodes étant peu adaptées aux besoins particuliers des patients doublement diagnostiqués.

Une récente étude de Menicucci, Wermuth et Soviensen (1988) interrogeant huit chefs d'unité d'un hôpital psychiatrique faisaient ressortir qu'il n'existait aucun plan de traitement bien articulé pouvant répondre au problème des doubles diagnostics. D'ailleurs, rapportaient Menicucci et coll., la majorité des patients qui se retrouvaient dans les huit unités concernées et qui avaient également des problèmes de consommation n'étaient même pas identifiés au départ comme porteurs de symptômes multiples. Beaucoup de cas d'intoxication ne se révèlaient que durant les entrevues cliniques, ou tout simplement au hasard d'une conversation avec le patient ou un membre de sa famille.

Les chefs d'unité interrogés par Municucci et coll. (1988) rapportaient que le traitement était d'abord axé sur les symptômes primaires qui avaient motivé le placement du patient. Ces chefs d'unité mentionnaient par ailleurs que les places disponibles pour les patients ayant un diagnostic primaire de surconsommation de psychotropes étaient limitées.

D'après certaines informations recueillies par Menicucci et coll. (1988), le personnel psychiatrique non nécessairement familier avec les problèmes de drogues, trouve difficile d'offrir des services aux patients doublement diagnostiqués, probablement par manque de connaissance et d'expérience.

La littérature révèle que ce n'est pas uniquement du côté des hôpitaux psychiatriques qu'on refuse de s'occuper des patients doublement diagnostiqués. Il apparaît, en effet, que les maisons de traitement pour alcoolisme et toxicomanes refusent elles aussi de prendre soin du patient qui se présentent avec d'autres types de troubles psychiatriques. Foley et Francis (1988) croient effectivement qu'il ne faudrait pas admettre certains patients psychiatrisés dans des programmes de traitement pour alcoolisme et toxicomanie. Ce sont des cas trop lourds, soutiennent-ils. Les auteurs faisaient référence particulièrement à un sous-groupe de patients qu'ils décrivaient comme étant "superparanoiaque" qui ne présentait que peu ou pas de contrôle sur les impulsions.

D'après ce qui a été jusqu'ici rapporté dans la littérature, il semble évident que plusieurs patients ayant des doubles désordres ne reçoivent pas les services que nécessitent leur condition. Le Dr Zoza (1987), cité par Weinstein et Gottheil (1978), croit que les services de traitement ne devraient pas refuser les cas de patients alcooliques ou toxicomanes chez qui des symptômes autres seraient présents. D'après Zoza, le personnel de traitement devrait être apte à reconnaître et à fonctionner avec certains symptômes tels que: la dépression, les états paniques, la pensée suicidaire, les réactions paranoiaques et les états de confusion qui sont d'ailleurs fort souvent des effets secondaires de l'abus de substances chimiques. Selon Zoza, le succès de tout traitement avec des patients doublement diagnostiqués dépend avant tout de l'entraînement et de l'expérience du personnel traitant.

D'autre part, la question de l'abstinence, dont traitent plusieurs auteurs (Pepper et coll, 1984; Sobel, 1978), demeure la plaque tournante, le point critique incitant les thérapeutes à refuser de s'occuper de patients qui en plus d'être alcooliques ou toxicomanes, présentent d'autres troubles. Les maisons de traitement ont fondé leur approche d'abord sur le principe de l'abstinence. Or, certains patients avec des troubles psychiatriques doivent recourrir à des substances psychotoniques afin de réduire les troubles d'anxiété, les épisodes d'hallucinations et

autres. Mis à part la philosophie des centres de traitement au sujet de l'abstinence, Pepper et coll. (1984) croient qu'une période d'abstinence de six à huit mois est nécessaire afin de s'assurer que les troubles psychiatriques qui se manifestent ne sont pas simplement des effets de la surconsommation.

Weinstein et Gottheil (1978) présentent sept caractéristiques pour déterminer les possibilités qu'un individu ayant des troubles psychiatriques soit admis dans une maison de traitement pour alcooliques ou toxicomanes:

1) L'intensité et la nature des symptômes. Certains auteurs tels que Fine (1980) pensaient également que l'intensité des symptômes devaient déterminer la nature du traitement.

2) L'habileté et la capacité du milieu de traitement d'interagir avec l'individu qui présentent certains comportements inhabituels ou déviants.

3) La compétence du personnel à gérer des cas de double diagnostic tout en sachant individualiser les traitements.

4) La compétence du personnel à pouvoir promptement identifier les symptômes qui se manifestent.

5) La possibilité pour le personnel traitant d'administrer des substances psychotoniques lorsque l'état du patient le nécessite.

6) La disponibilité de techniques thérapeutiques spécialisées.

7) La possibilité d'établir une étroite relation avec les services psychiatriques et de savoir identifier quand un patient devient trop lourd pour le système et savoir le référer à temps (Weinstein et Gottheil, 1978).

Le traitement des patients doublement diagnotiqués était jadis géré comme s'il s'agissait de deux problèmes distincts nécessitant deux types d'intervention (Gottheil et McLellan, 1978). Cependant, avec l'augmentation constante des sujets portant le diagnostic des doubles désordres (toxicomanie et problèmes de santé mentale), il a fallu reviser les relations possibles entre l'usage des psychotropes et les troubles mentaux afin d'adapter les plans de traitement. Aujourd'hui, les différents cliniciens ont une vision plus globale des problèmes de toxicomanie et de santé mentale et sont conscients de leur interaction. Certains ont donc établi des programmes de coordination entre le traitement pour troubles psychiatriques et pour désordres de consommation. Il en est ainsi des travaux de Ridgely, Osker et Talbott (1987) qui se sont penchés sur la possibilité de coordonner le traitement.

Tout programme de coordination nécessitait la description et la compréhension des méthodes de traitement en santé mentale et en toxicomanie. Par la suite, on étudie de quelle façon on peut jumeler ces différentes techniques afin de mettre sur pied le programme de traitement des doubles diagnostics. Ce programme, tel que le définissaient Harrison et coll. (1985), offrait aux patients l'opportunité de réaliser jusqu'à quel point les problèmes de drogues et les problèmes psychiatriques modifiaient le cours de leur vie pour les amener en conséquence à développer des alternatives à la consommation.

Bachrack (1983) définissait ainsi les objectifs du traitement en santé mentale. Le but premier du traitement pour les désordres mentaux est de réduire les symptômes psychiatriques de façon à amener l'individu à atteindre une qualité de vie supérieure. Le traitement des symptômes se fait souvent à l'aide de neuroleptiques qui permettent de contrôler l'anxiété, les hallucinations, etc. Par ailleurs, on développe également dans le système de santé mentale un programme de traitement psychosocial qui tient compte des besoins du patient.

Les objectifs du traitement pour abus de produits chimiques sont centrés sur l'arrêt de la consommation chez le patient. Les programmes d'aide dépendent des besoins du patient. Ainsi, pour certaines personnes, la première étape de traitement pourrait être la désintoxication pour, par la suite, offrir à l'individu des alternatives à la consommation, soit: la participation à des meetings A.A., des services de thérapie individuelle et des services de thérapie de groupe.

D'après plusieurs cliniciens, le traitement des doubles diagnostics doit tenir compte et des techniques d'aide en santé mentale et des techniques d'aide en alcoolisme et toxicomanie. Ridgely et coll. (1987) décrivent le traitement des doubles diagnostics en termes de "ping-pong therapy". Le patient est pris par les deux systèmes de traitement, ce qui aura pour conséquence de faciliter la compréhension des deux types de désordres.

Le principal problème posé par le traitement des doubles désordres est le suivant: quel service doit réellement prendre en charge le traitement du patient doublement diagnostiqué: les services de santé mentale, ou les services de réadaptation pour alcooliques et toxicomanes? Ridgely et coll. (1987) rapportaient que la position des cliniciens à ce sujet était encore ambivalente. Certains croient que les services de traitement pour ce type de patients devraient être dispensés en milieu psychiatrique compte tenu du fait que, par définition, alcoolisme et toxicomanie constituent des formes de pathologie mentale. Un autre point de vue soutient que le personnel des services de réadaptation pour alcooliques et toxicomanes est plus à même de faire face à certaines composantes de la personnalité assujetties aux drogues, faisant ici référence à la manipulation et au déni chez certains patients. De plus, les patients doublement diagnostiqués ont quelquefois un passé criminel assez lourd et certains ont fait de la prison. Ceci, selon Ottenberg (1979), contribue à dresser certaines barrières psychologiques entre personnel et patient. Le personnel traitant n'est pas toujours préparé à travailler avec une clientèle judiciarisée.

D'autre part, les patients présentant des symptômes de doubles désordres ont besoin de services d'éducation, d'un support constant face à l'abstinence, alors que ces services ne peuvent pas toujours être dispensés par les unités psychiatriques.

Pour Ottenberg (1979), Ridgely et coll. (1987) et Fine (1980), le traitement peut s'opérer indifféremment dans l'un ou l'autre système pourvu qu'une évaluation adéquate des problèmes du patient soit effectuée avant l'étape du traitement. D'après Fine (1980), la nature du milieu de traitement qui doit recevoir le patient doublement diagnostiqué doit être déterminé à partir de la sévérité des symptômes. Ridgely et coll. (1987), pour leur part, croient que la motivation du patient à investir dans un programme de traitement détermine le système de traitement. Ainsi donc, pour le patient peu motivé à entreprendre une démarche thérapeutique, on recommande un traitement en milieu hospitalier de façon à éviter que l'individu ne se soustrait aux séances cliniques par manque de motivation. Il s'agit également d'une façon de retirer le patient du milieu dans lequel il évoluait et où il se procurait de la drogue.

Ottenberg (1978) reprenant Zoza (1978) considérait que sept facteurs devaient être pris en considération lorsqu'il s'agissait de déterminer la nature du traitement chez le patient doublement diagnostiqué:

1) La sévérité des symptômes.

2) Le niveau de fonctionnement de l'individu.

3) Le besoin de supervision, l'habileté à vivre de façon indépendante.

4) Le besoin de médication.

5) Les effets de la médication sur le fonctionnement de l'individu.

6) La relation entre les symptômes psychiatriques et le fait de consommer des drogues.

7) L'habileté, la capacité du patient à surmonter les périodes de stress, de pression, de confrontation, particulièrement l'il doit évoluer en communauté thérapeutique.

LES DOUBLES DIAGNOSTICS ET LE PERSONNEL TRAITANT

Plusieurs cliniciens ont insisté sur le fait que le personnel affecté au traitement des cas de double diagnostic devrait être spécialement entraîné et posséder à la base certaines qualités (Driscool et coll., 1978; Ridgely et coll., 1987; Lett, 1987; Menicucci et coll., 1988). D'après Driscool et coll. (1978) une évaluation soigneuse du personnel traitant doit être effectuée. L'intervenant doit être très stable sur le plan émotionnel et ne doit pas présenter de problèmes de consommation de drogue ou d'alcool. Toutefois, si son passé présente des problèmes liés à l'usage des toxiques, il doit être sobre depuis au moins deux ans. Par ailleurs, le personnel devra faire preuve de beaucoup d'empathie, d'acceptation inconditionnelle d'autrui, de communication adéquate avec les autres et se montrer capable de décoder tant les messages verbaux que non-verbaux. Le personnel doit également être en mesure de prendre ses distances sur le plan émotionnel afin de ne pas se laisser envahir par les problèmes des autres.

D'autre part, le choix du personnel traitant doit, selon Driscoll et coll., s'appuyer avant tout sur l'expérience des individus face aux problèmes humains en accordant la préférence à l'individu qui a connu diverses problématiques.

Pour Ridgely et coll. (1987), on devrait mettre l'accent sur la formation et l'entraînement du personnel traitant. Le personnel

travaillant dans les hôpitaux psychiatriques manque d'information sur le problème de consommation de drogue et, inversement, le personnel des maisons de réadaptation pour alcoolique et toxicomane sait peu de choses des troubles mentaux qui caractérisent beaucoup d'alcooliques et de toxicomanes.

LES MÉTHODES DE TRAITEMENT

Pour certains patients, le point de départ du traitement, c'est la désintoxication qui se fait généralement en milieu hospitalier. Le personnel des unités de désintoxication doit être équipé pour faire face à l'alcoolique ou au toxicomane qui présente également des symptômes de troubles mentaux (O'Brien et Woody, 1978; Ridgely et coll., 1987).

Avant d'opter pour une méthode de traitement, soutenaient O'Brien et Woody (1978), le clinicien doit pouvoir déterminer quelles sont les causes psychologiques ayant conduit à l'abus des drogues. Il n'est pas toujours facile de déterminer avec certitude si la consommation est une cause ou une conséquence du désordre mental, mais le fait de le savoir permet au thérapeute de choisir quel type de traitement appliquer. Parfois, il est nécessaire d'observer le patient pendant plusieurs jours avant de pouvoir faire un diagnostic sur son état, et commencer le traitement.

O'Brien et Woody (1978), Ridgely et coll. (1987), ainsi que Adès (1988) se sont attardés à cet aspect du traitement qui utilise les substances psychotoniques pour faire disparaître les symptômes. D'après les chercheurs, l'usage de ces substances est trop courant. Adès (1988), O'Brien et Woody (1978), de leur côté, croient qu'avant d'opter pour ce type de traitement, il faudrait s'assurer que les problèmes présentés par le patient ne peuvent pas être résolus par l'intermédiaire de la psychothérapie. Adès (1988), de son côté, restait très sceptique quant à l'utilisation des tranquillisants chez l'alcoolique. Selon lui, les

risques "d'interactions pharmacologiques" sont grands entre alcool et tranquillisants, sans compter que l'usage des tranquillisants peut amener une autre forme d'abus. O'Brien et Woody (1978) croient, comme Adès, que les risques d'abus des substances utilisées comme médication sont grands. D'autres cliniciens se sont également penchés sur cette question. Bailly et coll. (1987), s'intéressant à 194 sujets hospitaliers durant un an pour des problèmes d'alcool, retrouvaient un usage pathologique de médicaments chez 20% de ces sujets.

L'utilisation d'antabuse ne fait pas l'unanimité chez les cliniciens: certains n'encouragent pas l'usage de ces substances qui peuvent avoir d'autres effets psychiatriques; d'autres, par contre, croient qu'il est nécessaire de traiter d'abord le patient avec ces substances de façon à faire diminuer l'intensité des symptômes, ce qui permettra au patient de participer à d'autres méthodes de traitement telles que la thérapie de groupe (Ridgely et coll., 1987; Woody et coll., 1983).

Néanmoins, les techniques d'aide les plus couramment utilisées avec les patients doublement diagnostiqués sont la psychothérapie de groupe et individuelle. D'après Woody et coll. (1983), il s'agit là d'une méthode de traitement assez significative dans les cas de double diagnostic.

La psychothérapie de groupe utilise les pairs. Ils ont un rôle important à jouer dans le processus, fournissant le support dont chacun a besoin pour rester abstinent. D'après Bergman et Harris (1985), les pairs ont une influence considérable sur la décision d'un individu de faire usage des drogues alors pourquoi cette influence n'agirait pas inversement, c'est-à-dire amener l'individu à ne plus consommer. Cohen et Klein (1970) avaient auparavant apporté les mêmes conclusions concernant le traitement de jeunes adultes psychiatrisés faisant usage de psychotropes. Certains programmes insistent particulierement sur le fait d'utiliser les pairs comme groupe de référence pour l'atteinte d'un but

fixé: l'abstinence (Ridgely et coll., 1987). D'autres programmes fonctionnent même avec deux groupes dans le traitement: un groupe de sujet commençant la thérapie et un autre groupe qui est à la fin de sa démarche thérapeutique qui sert en quelque sorte de parrain à l'équipe qui commence le traitement. C'est un peu le processus utilisé par les Alcooliques Anonymes. D'ailleurs, lorsque cela est possible, les patients sont fortement encouragés à adhérer aux A.A., N.A. Ces groupes apportent au patient tout le support dont il a besoin afin de persister dans sa démarche.

La thérapie de groupe utilise fortement les confrontations comme technique. Les patients sont confrontés à leurs faiblesses.

L'éducation des patients est également une technique d'intervention très utilisée. Des informations concernant les effets physiologiques des produits psychotropes sont données au patient. Dans le cas de patients doublement diagnostiqué, le personnel insistera sur les conséquences de l'utilisation des psychotropes sur la santé mentale de l'individu. Certains cliniciens croient que cette technique comporte un aspect dissuasif (Bergman, Harris, 1985).

Selon Adès (1988), affirmer le caractère secondaire ou primaire des troubles observés est primordial afin d'intervenir. En effet, précisait-il, un alcoolisme secondaire aux troubles paniques par exemple peut justifier un traitement spécifique. Ainsi, l'alcoolisme secondaire aux troubles paniques demande qu'un traitement à base d'antidépresseurs soit fait afin d'atténuer les excès d'angoisse qui amènent le patient à faire usage d'alcool. Chez plusieurs de ces patients, des méthodes psychothérapeutiques sont fortement recommandées car, selon Adès, l'alcoolisme en lui-même ne doit pas être négligé; on doit intervenir aussi directement sur ce problème.

Les travaux de recherche consultés dans le cadre de la présente revue de littérature ont abondamment discuté des la prévalence des

troubles mentaux associés aux problèmes d'intoxication. Certaines études ont discuté de la nature des associations entre troubles mentaux et processus d'intoxication, mais peu ont discuté des attitudes thérapeutiques qu'on doit adopter envers les patients doublement diagnostiqué, spécifiquement en fonction du type de produit consommé et du type de pathologie associé.

Adès (1988), pour sa part, a longuement discuté des différentes méthodes de traitement applicables aux patients alcooliques présentant d'autres pathologies. Concernant les pathologies dépressives, Adès a discuté de quatre stratégies d'intervention dépendamment des caractéristiques des états dépressifs.

1) Les dépressions primaires, antérieures à l'alcoolisme, nécessiteront chez beaucoup de patients la prescription d'un traitement antidépresseur et même une hospitalisation.

   Adès soutenait que dans le cas de dépression secondaire, une période de sevrage de deux à trois semaines contribue à faire diminuer de façon significative les états dépressifs.

2) Il faut prendre en considération l'intensité de la dépression. Ainsi, lorsqu'on observe chez un patient alcoolique des signes de dépression majeure, son état nécessite une hospitalisation dans une unité psychiatrique, ce qui permettra selon Adès "la réalisation d'un sevrage protégé et réel et la mise en oeuvre si nécessaire d'une chimiothérapie antidépressive à doses efficaces" (p. 121).

3) L'importance de l'intoxication alcoolique a également des conséquences au niveau du traitement. Lorsque l'intoxication alcoolique persiste, les symptômes dépressifs font leur apparition et durent aussi longtemps que dure l'intoxication. La prescription de chimiothérapie antidépressive est parfois dangereuse dans ces cas, car les interrelations avec l'alcool provoquent certains effets secondaires négatifs: irritabilité, confusion, tremblements, etc.

4) On observe chez certains patients la présence de trouble somatiques liés à l'alcoolisme. Dans ces cas, il faut s'abstenir de prescrire des traitements antidépresseurs qui peuvent alors aggraver ces troubles.

Adès s'est également intéressé aux états schizophréniques de l'alcoolique. L'auteur précisait que l'usage abusif d'alcool ne précipitait ou ne favorisait en rien les troubles schizophréniques, mais que l'intoxication peut précipiter l'hospitalisation du patient et "obscurcir le diagnostic" et peut également modifier le jugement du médecin quant à l'issue de la pathologie.

Les traitements pharmacologiques, psychothérapeutiques et sociothérapeutiques de la schizophrénie peuvent s'en trouver modifiés. Les conséquences médicales de l'alcoolisme peuvent gêner la mise en oeuvre des thérapies habituelles de la schizophrénie, écrivait Adès. Au niveau de la prise en charge de ces patients, Kesselman (1980), Alterman et coll. (1980) notaient que les milieux hospitaliers réagissaient plutôt négativement face à la présence de ce genre de patients. A ce propos, Alterman remarquait que près de 10% des patients schizophrènes alcooliques hospitalisés interromptaient prématurément leur traitement. Les auteurs faisaient ressortir de plus qu'environ 80% de ces patients n'avaient jamais reçu de traitement spécifique lié à leur consommation d'alcool.

Le traitement des schizophrènes alcooliques devraient donc, en plus de s'occuper des problèmes de schizophrénie, traiter également de façon spécifique les problèmes d'alcoolisme. Cependant, précisait Adès (1988), les méthodes de traitement classique de l'alcoolisme, c'est-à-dire sevrage dans une institution de réadaptation pour alcoolique, thérapie de groupe, sociothérapie, ne semblent pas adaptés à la clientèle schizophrènique et alcoolique. Certains auteurs dont Kesselman et coll. (1982), Panepinto et coll. (1970) se sont penchés sur

les problèmes de traitement des schizophrènes alcooliques par l'approche de thérapie de groupe. Panepinto et coll. rapportaient que la thérapie de groupe est trop directive pour ce genre de patients. L'approche de groupe n'est pas toléré par ces patients qui ne supportent pas le rapprochement ou l'établissement d'un lien quelconque avec d'autres individus.

D'après Kesselman et coll. (1982), la cure des patients schizophrènes alcooliques devrait avoir lieu en milieu hospitalier plus spécifiquement dans une unité psychiatrique.

Parmi le peu de travaux qui se sont intéressés au traitement des doubles diagnostics en fonction des produits consommés, on retrouve les recherches de O'Brien et coll. (1984) qui ont discuté des approches thérapeutiques applicables aux patients présentant des troubles mentaux et qui font un usage abusif des dérivés de l'opium. Selon les auteurs, le point de départ du traitement avec ce type de patient nécessite une prescription de méthadone afin de prévenir des comportements désagréables qui pourraient survenir chez ce type de patient. Cette intervention doit être doublée d'une approche psychothérapeutique précisait O'Brien et coll. (1984) précédé par un travail thérapeutique portant sur les problèmes de consommation. D'autres techniques thérapeutiques pourront compléter le traitement soit ce que O'Brien et coll., appellent le "drug counseling plus supportive - expressive psychotherapy" qui est défini comme étant une forme de traitement mettant l'accent sur les difficultés relationnelles vécues par ces patients. Une attention particulière est portée au sens que prennent les comportements d'intoxication chez ces sujets. Une troisième technique utilisée: "Drug counseling plus cognitive-behavioral psychotherapy" qui est une approche plutôt directive conduisant le patient à se découvrir, à identifier et comprendre les idées négatives qui l'habitent et qui le poussent à adopter des comportements auto-destructeurs. Le patient est donc amené à penser plus positivement et à voir la réalité.

CONCLUSION ET RECOMMANDATIONS

La prévalence d'abus d'alcool ou d'autres psychotropes parmi des cohortes de gens présentant des désordres affectifs, des troubles de personnalité ou même des symptômes de schizophrénie est suffisamment importante pour qu'on y porte une attention particulière. La nature de cette relation n'est certainement pas univoque. En effet, il existerait cinq types de relation possibles entre l'assuétude et les désordres mentaux:

1) La psychopathologie peut constituer un facteur de risque pour la toxicomanie.

2) La psychopathologie peut modifier le cours de la toxicomanie en termes de rapidité de développement, de réponse au traitement, de présentation de symptômes et de conséquences à longue échéance.

3) Des symptômes psychiatriques peuvent se développer au cours d'une intoxication chronique.

4) Certains désordres psychiatriques apparaissent comme une conséquence de l'usage de drogues et persistent après l'arrêt de la consommation.

5) L'abus de drogues, les comportements d'utilisation et les symptômes psychopathologiques (qu'ils soient antérieurs ou ultérieurs) deviendront significativement liés à travers le temps.

Un diagnostic qui spécifie une hiérarchie (primaire ou secondaire) au niveau de l'apparition des symptômes procure une vision plus claire des relations entre les problèmes de consommation et les désordres mentaux. Durant l'évaluation, le clinicien devrait s'informer de l'histoire du patient: ses habitudes de vie, l'âge d'occurence des

différents symptômes, etc. Pourtant, il faut garder en tête que l'évaluation clinique des patients qui se présentent aux différents services de santé demeure une entreprise délicate. Les personnes qui travaillent dans le domaine de la santé mentale devraient recevoir un entraînement particulier leur permettant de détecter et d'intervenir auprès des patients qui présentent des symptômes multiples.

De nombreux instruments peuvent servir à l'évaluation de troubles psychiatriques. Pourtant, par souci de constance, le Service correctionnel devrait recommander l'adoption d'un même instrument à travers le Canada. Cet instrument devrait, bien sûr, être disponible dans des versions adaptées dans les deux langues officielles du Canada.

Le traitement des patients doublement diagnostiqués était jadis géré comme s'il s'agissait de deux problèmes complètement séparés nécessitant deux types d'intervention. Cependant, avec l'agumentation constante des sujets portant le diagnostic de doubles désordres, les cliniciens ont dû envisager une position plus globable et établissent des programmes de coordination entre le traitement pour désordre psychiatrique et consommation abusive.

Tout programme de coordination nécessite la description et la compréhension des méthodes de traitement. Par la suite, on doit étudier de quelle façon on peut mettre ensemble ces différentes techniques afin de mettre sur pied un programme de traitement intégré.

Sept facteurs devraient être pris en considération lors de la détermination du locus de responsabilité quant au traitement du patient doublement diagnostiqué:

1) La sévérité des symptômes psychiatriques.

2) Le niveau de fonctionnement de l'individu.

3) Le besoin de supervision et l'habilité à vivre de façon indépendante.

4) Le besoin de médication.

5) Les effets de la médication sur le fonctionnement de l'individu.

6) La relation entre les symptômes psychiatriques et le fait de consommer des drogues.

7) L'habilité et la capacité du patient à surmonter les périodes de stress, de pression, de confrontation, particulièrement, s'il doit évoluer en communauté thérapeutique.

Il est préférable d'éviter de prescrire des médicaments psychotropes à ce type de clients, et ne le faire qu'après s'être assurer que les problèmes présentés par le patient ne peuvent être résolus par la psychothérapie uniquement.

La psychothérapie de groupe semble donner de meilleurs résultats que la psychothérapie individuelle. La confrontation apportée par les pairs constitue alors un ingrédient important. L'adhésion à des groupes d'entraide semble être positive car ces groupes apportent aux patients tout le support dont il a besoin afin de persister dans sa démarche. Le fait d'éduquer les patients sur les conséquences de l'utilisation de psychotropes sur leur santé mentale peut avoir un effet dissuasif et ainsi contribuer à éviter la rechute. Pourtant, ces conclusions doivent être revisées en fonction des désordres psychiatriques spécifiques. Il n'existe donc pas de recettes faciles et il est alors impossible de recommander des façons de gérer ces cas. Le traitement doit plutôt être adapté aux symptômes psychiatriques présentés de même qu'aux produits consommés par le personnel. La recherche en ce domaine est en progression et les résultats des évaluations de programmes devront être connus par les responsables des Service de santé et du Service correctionnel du canada.

RECOMMANDATIONS

Il est recommandé que:

1) que les professionnels de la santé mentale du Service correctionnel du Canada reçoivent un entraînement particulier leur permettant de détecter et d'intervenir auprès des patients présentant des symptômes multiples;

2) que les services de psychologie du Service correctionnel du Canada adopte un même instrument diagnostic à travers le Canada (disponible dans des versions adaptées dans les deux langues officielles);

3) que le Service correctionnel du Canada mette sur pied un programme de coordination des traitements des patients psychiatriques et des personnes toxicomanes. Cette coordination implique une description détaillée de chacun des programmes, ainsi que la mise sur pied d'une table de concertation où les responsables de chacun des programmes pourront expliquer les philosophies de même que les méthodes de traitements mis en place;

4) que le locus de responsabilité du patient soit déterminé en fonction:

   a) de la sévérité des symptômes psychiatriques;

   b) du niveau de fonctionnement de l'individu;

   c) du besoin de supervision et de l'habilité à vivre de façon indépendante;

   d) du besoin de médication;

   e) des effets de la médication sur le fonctionnement de l'individu;

   f) de la relation entre les symptômes psychiatriques et le fait de consommer des drogues; et

   g) de l'habilité et de la capacité du patient à surmonter les périodes de stress, de pressions et de confrontation pouvant être vécues durant le traitement de la toxicomanie;

5) que les services psychiatriques du Service correctionnel du Canada ne prescrivent des médicaments psychotropes aux patients doublement diagnostiqués qu'après s'être assurés que les problèmes présentés ne peuvent être résolus par la psychothérapie uniquement; et

6) que la direction des services de santé du Service correctionnel du Canada établisse des contacts avec des chercheurs réputés dans le domaine des doubles diagnostics afin de connaître les nouveaux développements dans le domaine de l'intervention spécifique auprès de cette population.

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TASK FORCE ON MENTAL HEALTH CARE

DISCUSSION PAPER

SUB-TASK # 10

THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

COMITE D'ETUDE SUR LA SANTE MENTALE

Développement d'un modèle de gestion de crise pour les employés et pour les délinquants

soumis par: Lynne Bernier

AVRIL 1990

TABLE DES MATIERES

Aide immédiate aux employés

En raison de la nature de leur travail, les employés du SCC sont confrontés à des situations susceptibles de les ébranler physiquement et psychologiquement.

Il n'est ainsi pas rare que des employés éprouvent non seulement des problèmes personnels, mais aussi des difficultés de fonctionnement au travail. Démotivation, absentéisme, démission sont autant de conséquences au stress avec lequel ces employés doivent composer.

Afin de préserver leur santé physique et mentale, il est indispensable d'offrir à ces employés des services d'aide immédiate.

Pour répondre aux besoins, ces services doivent être de nature variée et tenir compte du degré d'exposition de l'employé à la situation stressante (victime vs. témoin) ainsi que de l'intensité du stress causé ou susceptible de l'être par la situation (insultes vs. prise d'otage).

A partir du diagramme ci-dessous, le comité de santé mentale préconise que les services suivants d'aide immédiate soient offerts aux employés.

	Employé victime	Employé témoin ou affecté
Situation causant un stress profond (possibilité de réactions post-traumatiques)	I	II
Situation causant un stress important	III	IV

I. Lorsqu'un employé est victime d'une situation causant un stress profond (c'est-à-dire possibilité de réactions post-traumatiques), il reçoit immédiatement les premiers soins et fait l'objet d'un examen médical portant sur son état physique et psychologique. S'il est grièvement blessé ou s'il le demande, on le fait transporter immédiatement à l'hôpital le plus proche. Un psychologue ou un employé compétent en relation d'aide est disponible pour rencontrer immédiatement la victime. Au besoin, la victime est invitée à demander des soins médicaux ou psychologiques subséquents.

II. Une procédure de désensibilisation connue sous le nom de "Critical incident stress debriefing" (C.I.S.D.) est mise en place pour venir en aide aux employés témoins ou affectés par une situation reconnue comme engendrant un stress profond (c'est-à-dire la possibilité de réactionss post-traumatiques). Le C.I.S.D. est un modèle structuré d'intervention de groupe à connotation éducative et préventive. Il vise à outiller les employés de façon à leur

permettre de composer avec les réactions normales mais inhabituelles suscitées par la situation anormale à laquelle ils ont été exposés. Le C.I.S.D. prend place en-deça des 72 heures suivant l'incident critique. Il est effectué par un psychologue ou un professionnel de la relation d'aide en collaboration avec des pairs. En raison des réactions post-traumatiques prévisibles et compte tenu que ces dernières ne sont pas toujours apparentes ou que certains employés peuvent hésiter à rechercher de l'aide pour y faire face, le C.I.S.D. est obligatoire. Il pourra s'accompagner, au besoin, d'un support individuel tel que décrit en III et IV.

III et IV. Indépendamment de la nature de l'incident ou de l'évalua- tion du et traumatisme de l'employé par une tierce personne, un service minimum d'écoute est disponible pour tous les employés désireux de partager un vécu de travail stressant et de ventiler les émotions qui l'accompagnent. Ce service est offert par un psychologue ou une personne compétente en relation d'aide. Il est fourni à la demande de l'employé et s'effectue sous le sceau de la confidentialité. Le recours à cette forme d'aide est volontaire et s'inscrit dans une perspective de support ponctuel et à court terme.

Recommandations

1) Que les Directives du Commissaires traitant de l'Aide aux employés victimes d'actes de violence (DC 252) et de la gestion des cas d'urgence (DC 600) soient amendées de façon à tenir compte des mesures d'aide immédiate proposées.

2) Que chaque région identifie et forme les personnes ressources habilitées à donner ces services et que l'accès à ces derniers soit facilité et encouragé.

Situation de crise - délinquants

Lorsque la santé mentale d'un délinquant est menacée au point où celui-ci représente un risque pour sa sécurité ou celle d'autrui, le Comité d'étude sur la santé mentale considère que des services d'urgence doivent être disponibles pour répondre à la situation de crise.

S'inspirant de la norme de santé 408, il est suggéré que les mesures suivantes soient adoptées en pareilles circonstances.

En institution

1. La personne ayant observé les perturbations de l'humeur ou du comportement du délinquant soumet le cas à l'attention du gérant d'unité responsable.

2. Le gérant d'unité ou le surveillant correctionnel, assure au délinquant l'encadrement sécuritaire approprié. Le délinquant peut ainsi être gardé sous surveillance constante ou intensive, en cellule pavillonnaire, en cellule de ségrégation régulière ou en cellule d'isolement protecteur avec caméra.

3. Le gérant d'unité, ou le surveillant correctionnel, réfère immédiatement le cas à un professionnel du centre de soins et communique avec l'Agent de gestion de case et l'Agent de correction. Il est responsable du cas pour qu'un suivi approprié soit accordé au délinquant.

4. Le professionnel du centre de soins qui rencontre le délinquant, évalue sommairement son état mental et fait les recommandations ainsi que les références qui s'imposent.

5. Au besoin, le délinquant est vu par le médecin, le psychologue ou le psychiatre pour préciser le diagnostic, établir le plan d'intervention et recommander, s'il y a lieu, l'admission du délinquant en milieu psychiatrique.

6. En tout temps, le gérant d'unité, ou le surveillant correctionnel, est responsable d'adapter les mesures d'encadrement sécuritaire de façon à assurer la protection de l'environnement d'autrui tout en répondant aux besoins du

délinquant tels qu'identifiés par les différents professionnels de la santé mentale. S'il s'agit d'un délinquant suicidaire, le gérant d'unité, ou le surveillant, doit s'assurer qu'il reçoive des services de counselling appropriés.

7. Le gérant d'unité est imputable de toutes les actions relatives à la sécurité et à la gestion du cas.

8. Le Chef santé coordonne toutes les activités cliniques. A ce titre, il doit présenter au Gérant d'unité, en deça des cinq jours suivant la situation d'urgence, un résumé administratif des interventions faites auprès du délinquant par les professionnels de la santé mentale.

<u>En communauté</u>

Si un AGCC identifie des indices de détérioration de la santé mentale d'un délinquant:

1. L'AGCC consulte son responsable de secteur. S'il y a lieu, le psychologue de district est invité à se joindre à la discussion de cas.

2. Au besoin, une évaluation de la santé mentale du délinquant est demandée.

3. L'AGCC révise le plan de traitement du délinquant de façon à tenir compte des recommandations faites par le psychologue de district et/ou contenues dans l'évaluation demandée.

4. Toutes les mesures sont mises en oeuvre pour permettre aux délinquants ayant des problèmes de santé mentale de fonctionner en communauté.

5. A ce titre le SCC doit s'assurer que les services suivants sont accessibles aux délinquants qui présentent des problèmes de santé mentale:

- Services de santé mentale offerts aux citoyens de la communauté;
- Traitement psychologique ou psychiatrique;
- Accompagnement par un groupe communautaire;
- Familles d'accueil;
- Maison de transition spécialisée;
- Atelier de travail adapté aux besoins de cette clientèle; et
- Surveillance intensive.

Si en dépit des mesures prises et à la lumière des consultations demandées, l'AGCC évalue que la santé mentale d'un délinquant est menacée au point où celui-ci représente un risque immédiat pour la sécurité d'autrui:

1. L'AGCC procède à la suspension de la libération du délinquant. La lettre de confirmation de mandat indique clairement que le délinquant a des problèmes sévères de santé mentale.

2. Dès que l'AGCC est avisé que le mandat a été exécuté, il communique avec une personne responsable du lieu de détention où se trouve le délinquant afin de l'informer des problèmes de santé mentale de ce dernier.

3. Lors de la réétude du cas, l'AGCC tient compte de l'influence des problèmes de santé mentale du délinquant dans l'évaluation du risque. A cet effet, il consulte le psychologue de district et reflète l'opinion de celui-ci dans le rapport de post-suspension.

L'emphase est alors mis sur la restructuration des projets de sortie en tenant compte des besoins spécifiques en santé mentale du délinquant ainsi que des ressources disponibles en communauté telles que citées précédemment.

<u>Recommandations</u>

1) Elaborer une Directive du Commissaire traitant des services d'urgence à offrir au délinquant en situation de crise.

2) Former les employés qui ont un contact direct avec la population carcérale de façon à ce qu'ils puissent dépister les délinquants ayant des problèmes sévères de santé mentale et faire les références appropriées. Former les gérants d'unité et les surveillants correctionnels afin de les sensibiliser à l'utili-sation non-abusive de mesures d'encadrement sécuritaire avec ce type de clientèle.

3) Identifier et/ou encourager la communauté à offrir les services de santé mentale suggérés.

TASK FORCE ON MENTAL HEALTH CARE

DISCUSSION PAPER

SUB-TASK # 11

THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

TASK FORCE ON MENTAL HEALTH CARE

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

submitted by: Odette Pellerin

APRIL 1990

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INTRODUCTION

The incidence of suicidal behaviors is higher in prisons, jails and detention centres than in the general population of this country. For the period between 1971 - 1984, the average rate of completed suicides in federal prisons was approximately eight times that of the general population; 97% of the inmates in Canadian prisons are male and average twenty-three years of age. Compared to the same age sex group in the general population, inmates complete suicide more than 3.5 times as often. (1)

CHARACTERISTICS OF THE SUICIDE POPULATION IN CSC INSTITUTIONS

Perusal of statistics collected by C.A. Searle, Coordinator, Suicide Prevention Program at NHQ reveal that a total of 77 inmates committed suicide in a federal institution during the last five years (1985-1989), with the regional distribution as follows: Atlantic, 4; Quebec, 30; Ontario, 26; Prairies, 4; and Pacific, 13.

TABLE 1

SUICIDES BY REGION AND YEAR

	1985	1986	1987	1988	1989	TOTAL
ATLANTIC	1	1	-	1	1	4
QUEBEC	12	4	6	4	4	30
ONTARIO	4	11	4	2	5	26
PRAIRIES	4	-	-	3	1	4
PACIFIC	6	-	1	4	2	13
TOTAL	27	16	11	14	13	77

Of this total, four were female, eight were native and eleven were serving a life sentence.

TABLE 2

SPECIFIC GROUPS WHO COMMITTED SUICIDE

	1985	1986	1987	1987	1988	TOTAL
Lifers	2	5	3	1	-	11
Females	1	-	-	1	2	4
Sex Offenders	4	3	2	2	-	11
Natives	3 1 N.A. STATUS 2 Métis	1 N.A. STATUS	-	3 2 Métis 1 Inuit	1 1 Métis	8

Table 3 would seem to indicate that security classification is not a variable. The majority of inmates having committed suicide fall in the 20-39 age group, with the bulk

of suicides occuring between the hours of 1800 - 0800. Again, according to this table, known history of mental illness is most probably a definite factor.

TABLE 2

SUICIDE POPULATION

	1985	1986	1987	1988	1989	TOTAL
SECURITY CLASSIFICATION						
MINIMUM	4	-	2	3	3	12
MEDIUM	12	4	1	4	4	25
MAXIMUM	9	6	4	2	2	23
MULTI-LEVEL	2	6	4	5	4	21
TOTAL	27	16	11	14	13	79
TIME & WEEKDAY						
08:00-18:00	15	10	3	2	2	32
18:00- 08:00	7	4	7	10	8	36
Not Known	5	2	1	2	3	13
During Week	18	8	8	7	9	50
Week-end	7	8	3	7	4	29
Not Known	2	-	-	-	-	2

TABLE 3

SUICIDE POPULATION

	1985	1986	1987	1988	1989	TOTAL
BY AGE						
20-29	13	8	5	8	7	41
30-39	7	4	3	5	4	23
40-49	5	3	3	-	1	12
50-59	-	1	-	1	-	2
60-69	1	-	-	-	-	1
70 and over	1	-	-	-	-	1
KNOWN HISTORY OF MENTAL ILLNESS						
Had	7	8	4	2	4	25
Had None	16	2	4	-	-	22
Not Known	4	6	7	12	9	38

In Table 4 we find that most suicides were committed in general cells, with preferred method being hanging. The number of suicides amongst those offenders with a known history of federal incarceration is but marginally higher than amongst those serving their first federal sentence. On the other hand the incidence of suicide appears to increase with the length of sentence.

TABLE 4

SUICIDE POPULATION
1985-1989

	1985	1986	1987	1988	1989	TOTAL
TYPE OF SECURITY						
General Cells	9	12	8	9	6	44
All other with greater security	10	4	-	3	3	20
Known to be outside institution	1	-	3	2	4	10
Not Known	7	-	-	-	-	7
METHOD OF SUICIDE						
Hanging	22	15	10	12	10	69
Slashing	-	-	-	-	1	1
All Other	2	1	1	1	2	7
Not Known	3	-	-	1	-	4
KNOWN HISTORY OF PREVIOUS FEDERAL INCARCERATION						
Had	19	11	6	5	3	44
Had Known	7	5	5	9	10	36
Not Known	1	-	-	-	-	1

TABLE 4

SUICIDE POPULATION

1985 - 1989

	1985	1986	1987	1988	1989	TOTAL
TIME SERVED ON CURRENT SENTENCE						
3 months or less	6	3	1	2	1	13
4 to 6 months	4	2	1	-	2	9
7 to 12 months	4	2	2	3	3	14
13 to 24 months	4	6	2	6	3	21
25 months or greater	9	3	5	3	4	24
Not known	-	-	-	-	-	0

Information gleaned from Table 5 would indicate that suicides are more prevalent amongst offenders serving sentences of 2-3 years, 6-10 years and life. Suicides were completed by inmates with a known history of previous suicide attempts at least twice as often as those who had none. It is worthy of note that of the total sample, a history of previous attempts was unknown in 51 cases.

TABLE 5

SUICIDE POPULATION

1985 -1989

	1985	1986	1987	1988	1989	TOTAL
TRANSFERRED WITHIN SIX MONTHS OF SUICIDE						
Yes	6	7	3	6	4	26
No	20	9	6	7	9	51
Not Known	1	-	2	1	0	4
NUMBER OF SUICIDES BY LENGTH OF SENTENCE						
Under 2 years	3	-	-	-	-	3
2 - 3 years	4	1	1	5	2	13
3 - 4 years	1	4	1	-	1	7
4 - 5 years	2	-	1	2	1	6
5 - 6 years	-	1	1	2	2	6
6 - 10 years	6	4	2	2	5	19
10 - 15 years	5	1	1	2	-	9
15 - 20 years	-	-	-	-	-	0
20 years plus	-	-	-	-	-	0
Life	3	5	2	1	2	13
Indeterminate	1	-	1	-	-	2
Not Known	2	-	1	-	-	3

TABLE 5

SUICIDE POPULATION

1985 -1989

	1985	1986	1987	1988	1989	TOTAL
KNOWN HISTORY OF PREVIOUS SUICIDAL ATTEMPTS						
Had	9	6	2	2	1	20
Had None	7	3	-	-	-	10
Not Known	11	7	9	12	12	51

Marital status does not appear to be a factor in the incidence of suicide. As per Table 6, suicides occurred approximately equally amongst single and married inmates. It is difficult to determine the role of alcohol/drug abuse, according to these statistics, since in the majority of these suicides, the history was not known.

TABLE 6

SUICIDE POPULATION

1985-1989

	1985	1986	1987	1988	1989	TOTAL
MARITAL STATUS						
Married or Common-Law	8	8	2	6	7	31
Single	12	7	8	6	6	39
Divorced	2	1	-	1	-	4
Separated	2	-	1	1	-	4
Widowed	2	-	-	-	-	2
Not Known	1	-	-	-	-	1
HISTORY OF ALCOHOL/ DRUG ABUSE						
Had	10	7	1	-	-	18
Had None	-	-	-	-	1	1
Not Known	17	9	10	14	12	62

CAUSAL FACTORS

Suicide is the end result of a process, not the process itself. Penitentiary inmates form a high-risk group with respect to suicide for a variety of reasons. Many consider suicide to be an expression of environmental restriction and frustration, a response to extended isolation. Initiation/conformity to peer influence, retaliation, and tension relief are also commonly-held explanations of the prevalence

of prison suicides. Dr. Fred Dalton, Chief Forensic Psychiatrist, Virginia State Department of Corrections and Associate Professor of Psychiatry at the University of Virginia Medical School believes that for many offenders, suicide offers escape from prison, often the only one. (2) The inmate may feel that he has little to lose, given the conditions, especially segregation. Ironically, when inmates threaten suicide, we segregate them. This fact is emphasized in the Report of the National Task Force on Suicide in Canada. (3)

A review of the literature pertinent to suicides in prison yielded the additional characteristics of individuals at increased risk for suicide: physically-ill; guilt-ridden; young impulsive, usually charged with a violent crime; homosexual or subjected to homosexual rape; first offenders; and those charged with a crime of passion. A study conducted in the Atlantic Region in 1984 identified the presence of violent-prone offenders in the general population as well as the prevalence of gambling activities as definite contributing factors in the incidence of suicide in that region. (4)

A recent survey of the lifetime prevalence of mental disorder among male offenders in the Correctional Service of Canada revealed that 10.4% had had at least one episode of a psychotic disorder, while the incidence for depressive

disorders was 29.8%, for anxiety disorders, 55% and for psychosexual disorders, 24.5%. The female sample surveyed, a cross-section of the population at the Prison for Women, showed a substantially greater level or disturbance than the men, the incidence of anxiety and phobic disorders higher, the schizophrenia three times more prevalent, a psychosexual dsyfunction rate of 55.8% and percentages suffering post-traumatic stress, 29.9.

THE PREVENTION OF SUICIDES IN CSC INSTITUTIONS

Following the occurrence of seven inmate suicides in as many months in 1983, in the Atlantic Region, a study was conducted and several recommendations made, (5) one of which was the establishment of a training program for all staff dealing with inmates. This Suicide Prevention Training Program, implemented by the Correctional Service of Canada in all regions, was developed in Calgary by Ramsey, Tannery, Tierney and Lang, under the auspices of the Canadian Mental Health Association. Popularly referred to as the Alberta model, it consists of the provision of a four-day workshop to selected candidates who in turn train their colleagues during a two-day program. The program provides a common foundation for the prevention of suicidal behaviors, with an emphasis on the caregiving attributes of attitudes, knowledge and skills. Given that approximately 80% of all attemptors communicate

verbally their desire to die prior to the attempt, and that many believe that all attemptors communicate their suicidal ideation behaviorally, the identification of high risk inmates is of prime concern. (6) In addition to the recognition of the suicidal inmate, emphasis is placed on the assessment of the risk and the implementation of appropriate action. (7)

A follow-up study in the Atlantic Region found that the program resulted in increased referrals of at-risk inmates to professionals, increased interventions involving incidents of suicidal behavior and a reduction in the number of suicides by interrupting attempts. (8) At the present time, this program is being offered to all new employees in the Quebec, Prairies and Atlantic Regions. In the Ontario and Pacific Regions, only new correctional officer recruits are trained, and this during CORP (Correctional Officer Recruitment Program)training.

In addition to suicide prevention training, it is accepted procedure in all institutions to "red-flag", upon admission, the psychology file of inmates at high risk for suicide. If an offender exhibits signs/symptoms which would lead one to believe that he or she may be suicidal, the offender is immediately referred to a psychologist and usually placed in a camera cell in segregation. The

psychologist, having seen the inmate, then writes a draft memorandum, consisting of tentative diagnosis and treatment plan, and forwards it to the Chief Security Officer who in turn posts it on a bulletin board. A copy of this memorandum is sent to the inmate's case management officer and Unit, where correctional officers document the contents in their log books. However, this information is not always relayed to the Health Care Centre, and health care staff may remain unaware of the inmate's status/history of suicidal tendencies. This eventually results in the failure to "flag" the medical file and to record the information on the Transfer Summary Sheet (CSC Form 377) when the inmate leaves the institution.

The implementation of the Unit Management model in all institutions has proved conducive to enhanced communication between staff and staff and inmates. Correctional officers work more closely with offenders than was previously the norm, and are in a better position to observe individual behaviors. Institutional psychologists appear to be coping relatively well with the admission psychological assessments of inmates; however, many bemoan the fact that little time is left for counselling, or programming, a particularly frustrating dilemna given the number of mentally/behaviorally disordered offenders in the prison population and the stress of incarceration in a dangerous milieu. Unit Management has

also improved the general environment in the institutions but in some cases, it would appear that there remain inmate aggressors and homosexual predators in the general population. Furthermore, gambling activities are also common, with Substance Abuse during incarceration a widespread phenomenon. (9)

SUMMARY

The statistical data presented has enabled us to depict a portrait of the offender who commits suicide: the majority of offenders having committed suicide are males between the ages of 20 and 39; known history of mental illness is a definite factor; the incidence of suicide appears to increase with the length of sentence; and penitentiary inmates form a higher risk group with respect to suicide.

Incarceration is conducive to suicide; we will never completely eliminate it. However, it is possible to prevent a good number of suicides in prison by providing a safe, humane environment, and assuring constant vigilance of offender behavior. The prevention of suicide should primarily be aimed at staff training. The Suicide Prevention Training Program - known as the Alberta Model - has been implemented in all regions of the Correctional Service of Canada. Staff are trained to recognize the suicidal inmate and emphasis is

placed on the assessment of the risk and the implementation of appropriate action. Such efforts should not only continue but be augmented.

Many argue that suicide is the severest crime of all because it is a crime against hope. One can help change the decision to commit suicide by offering alternative solutions, by introducing the concept of hope via timely counselling and appropriate programming.

RECOMMENDATIONS

The Task Force on Mental Health Care recommends the following for the prevention of suicide in Correctional institutions:

1. that in order to recognize potential attemptors, 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;

2. that in the absence of health care staff, all categories of staff who have contact with inmates be authorized to initiate a system of formally alerting all staff;

3. that inmates identified by health care 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;

4. given that peers are often the first to notice a change in behavior 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;

5. that in order to alert the receiving institutions and districts, suicidal tendencies be recorded on Transfer Summary Sheet (CSC Form 377);

6. given that in the majority of completed suicides in the CSC the history of previous attempts and/or substance abuse was unknown, that this information be documented and appropriately disseminated.

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TASK FORCE ON MENTAL HEALTH CARE

DISCUSSION PAPER

SUB-TASK # 12

THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

TASK FORCE ON MENTAL HEALTH CARE

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

submitted by: Odette Pellerin

APRIL 1990

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INTRODUCTION

Deliberate self-injurious behavior is of great concern in correctional institutions. The average rate of non-fatal, self-inflicted injuries in federal prisons is more than twice the estimated rate found in the general population, with the incidence of these behaviors amongst female offenders at least three times as great. (1) Jan Heney, during the course of her study on self-injurious behavior in the Prison for Women found that 59% of the sample population interviewed indicated that they engaged in, or have engaged in this type of behavior. (2)

CHARACTERISTICS OF SELF-MUTILATION INCIDENTS

Methods

Ross and McKay have described nine categories of direct, self-injurious behavior: cutting, biting, abrading, severing, inserting, burning, ingesting/inhaling, hitting and constricting. (3) Of these, cutting appears to be most common method used. This fact is corroborated by Ann Jones, of the Virginia Department of Corrections, who found that 46% of the injuries involved wrist cutting, followed by forearm cutting at 17%. With the addition of the number of slashes to other parts of the body, cutting constituted 76% of all self-mutilating incidents. (4) Heney reports that 92% of the women hwo have engaged in self-injurious behavior have used slashing as the method of self-

injury, with head banging, starvation, burning and/or tatooing as alternatives. (5)

Settings

Self-mutilation is more likely to occur in restrictive settings. Jones found that only two of 68 self-mutilation incidents took place outside of medium or maximum-security prisons, and that the majority occurred in isolation cells,(6) as did Heney (7) and Dalton. (8)

IDENTIFICATION OF SELF-MUTILATORS

Self-injurious behavior is most frequent in institutional settings, where individuals have little control over their environment. In the correctional setting this behavior is viewed within the context of the interaction between certain personality characteristics and the total social-physical environment of the institution.

Clinical research and observation generally identifies several factors in the self-mutilating individual's developmental history which correlate with the behavior itself. These offenders, both male and female, are likely to have been physically and/or sexually abused as children, and frequently have been reared in a violent family setting. The loss of a

parent at an early age is common. Self-injurious behavior often begins in the adolescent years, to continue through the twenties with increasing frequency. Thereafter, the behavior tends to become less frequent and is rarely seen by the fourth decade of his/her life.

The majority of self-injurers are of average intelligence, with some scoring higher than the norm on intelligence tests. Many are angry individuals with poor self-control. Characteristically, the self-mutilating is not psychotic (although he/she may have confirmed symptoms and/or diagnosis) but often suffers from an underlying personality disorder of varying subtypes. In the few cases where the individual is psychotic, preoccupations with religious ideas or beliefs that they are controlled by outside forces are common. For the majority, these offenders are often highly immature, and traditionally experience difficulty in requesting what they want from others in a direct fashion. According to W.A. Sutton, State Consultant in Forensic Psychology (Georgia), they tend to be demanding of others, and usually have learned that threats are a prime way of achieving need satisfaction. (9) Ross and McKay found that 64% of the sample of self-mutilating inmates were held in low esteem and rejected by other inmates; they were also considered nuisances by staff. As one way of assessing their nuisance value, medical records were consulted to determine to correlation with visits to the Health Care Centre. The average number of contacts was at least five

times greater than that of the general prison population and the complaints invariably minor : headache, earache, epigastric distress, flu symptoms, cut fingers, rashes, diarrhea, constipation, hemorrhoids, "bad nerves", insomnia etc. They also found that 68% of their sample had a history of alcohol/drug abuse. (10)

As for the environmental factors, in addition to a maximum security and/or segregation setting, Jones found that the severity of disciplinary reports a prisoner had received appeared to be the most important variable in predicting self-mutilation, in combination with the discovery that self-mutilators were likely to have a more assaultive record while in prison. (11) H. Toch had also concluded in a similar study that self-mutilators were more likely to have a history of violence, (12) while Ross and McKay found that 68% of a sample of 158 had assaulted other people. (13) Heney, in her study of offenders incarcerated at the Prison for Women found a significant relationship between time spent in the Prison for Women and self-injury. In essence, self-mutilators had been in this institution three times longer than those in the general population. On the other hand, the sentence length did not seem to be related to self-injurious behavior. However, it is worthy of note that 50% of prisoners stated that outbreaks of self injury were due to tension in the prison. Policy changes, the attitudes of certain correctional officers and mass punishment were often cited as the reasons for the

tension. According to 30% of staff, tension in the prison was identified as the main cause of outbreaks of self-injury, while 1.5% believed drugs and muscling/peer pressure accounted for many incidences. Imitation or the "copy cat" syndrome was also mentioned as a cause. Eight month waiting lists for psychological counselling were cited as a serious deficiency in the provision of assistance to these women.

In summary, the inmate at high-risk for self-mutilation will in all probability be the one who, in addition to being housed in a maximum security unit, is allowed only minimal out-of-cell time and afforded but limited human contact with correctional and counselling staff.

THE PREVENTION OF SELF-INJURIOUS BEHAVIOR IN CORRECTIONAL INSTITUTIONS

Early identification and prevention of self-mutilation in the inmate population can be achieved through focusing the close attention of correctional and counselling staff on the inmate's observable behavior. General increases in the inmate's level of tension and arousal, as expressed through signs of anxiety, pacing, withdrawing from others, and verbal threats of self-injury should all alert the observant staff person. Of particular importance is the inmate who increasingly presents him/herself to the Health Care Centre with minor, non-specific physical complaints.

Utilization of other inmates to assist correctional staff in the early identification and prevention of self-injuries presents an additional valuable resource. Peers are often the first to recognize a pending overt act. Indeed, Heney found that self-injuring women often seek emotional support from other inmates. (15) Ross et al describe a peer therapist program where young female inmates were trained in the principles of positive reinforcement and encouraged to act as therapists for each other. In four months, self-injury completely ceased. (16) Staff should therefore be sensitive to the concern of fellow inmates and should attempt to contain the mounting anxiety in the inmate at risk for self-injury. Verbalization should be encouraged before self-mutilation occurs. The inmate's case management officer and assigned institutional psychologist should be involved on a regular, consistent basis at this early stage as well.

Increasing human contact for the inmate through out-of-cell time, increased recreation and/or other assignments is critical in the prevention of self-mutilation. Inmates who are at risk need appropriate mental health counselling <u>before</u> the act of self-mutilation occurs, not after the act when it is too late.

TREATMENT STRATEGIES

In 1988/89, Edmonton Institution had a very high number of self-injuries. It was decided to implement in this institution a

treatment program developed by the Georgia Department of Offender Rehabilitation. This program had reduced self-mutilating behavior by 80% at the Georgia Industrial Institute, a state correctional facility which houses 1,700 inmates (14-24 years) and by 60% within the Tennessee Department of Corrections who have also adopted the program. On admission, inmates on psychotropic medications or with a history of mental helth problems are referred to the psychiatrist and the Mental Health Unit for assessment. Psychotropics are discontinued and the inmates closely observed by health care and correctional staff. During this period of evaluation, one month in length, admission to the Mental Health Unit is occasionally necessary. The result of this aspect of their program is that out of 1,700 inmates, only 18 are on essential psychotropic or mood altering drugs.

The basic principle of the Georgia Program is that the inmate's behavior is the responsibility of the inmate and that behavior which is rewarded tends to repeat itself. If an inmate receives a lot of attention during and after self-mutilation, he/she comes to recognize self-mutilation as being a means to manipulate or exercise control over staff. Appropriate staff responses to a threat or act of self-mutilation are critical to success in prevention. Any increased attention and appropriate counselling occurs before the act of self-injury. Counselling after the act occurs only when the inmate accepts responsibility for his actions and when he understands that the demands/needs

which motivated the act will not be addressed by staff. The inmate receives essential medical attention such as dressings or sutures in a basically non-sympathetic or matter-of-fact manner. He/she receives neither medication nor counselling, and is advised that he/she is responsible for whatever action he/she takes. If the threat continues, the inmate is then given the choice of behaving appropriately or of being restrained.

In the experience of the Mental Health staff in Georgia, this approach to treatment has been the most difficult to teach to managers and staff, particularly nurses, since the latter consider it unethical to tender to the physical needs of a patient while ignoring other aspects of care. However, the significant reduction in incidents convinced reluctant staff that the approach worked and that their neglect of the inmates' psychological needs was in fact therapeutic. At the present time, inmates are being charged for self-mutilating; however, this issue is being debated, as is the quandary over the use of restraints. A synopsis of the treatment protocol may be referred to in Annex 1.

SUMMARY

Excluding those individuals who are declared mentally incompetent or who are suicidal risks, self-mutilators commonly injure themselves in an attempt to control their environment.

The consequences are often highly desirable for the individual who typically receives a fair bit of attention from institutional staff. This perspective raises obvious deficiencies in traditional institutional treatment strategies. An alternative therapeutic regimen, namely the Georgia program, may provide the appropriate approach to the reduction of incidences of disturbing, highly-disruptive self-mutilations.

Annex 1

SELF-MUTILATION

SUMMARY OF TREATMENT PROTOCOL

FOR SELF-MUTILATING INMATES

SYMPTOMS

1. General increases in inmate's level of tension and arousal, as expressed through signs of anxiety, pacing, withdrawing from contact with others, agitation and verbal threats of self hearm
2. Especially important is increasing use of health care clinic consultations presenting with physical complaints that are either non-specific in nature and generally undiagnosable, or very minor in nature.

TREATMENT

Early Treatment - Before Self-Mutilation:

1. Encourage verbalization and conversation.
2. Involvement of inmate's counselLor on a regular and consistent basis.
3. Increasing human contact through out-of-cell time.
4. Increased recreation and/or other assignments.

After Self-Mutilating Act:

1. Physical welfare of inmate. Medical care should be provided in the appropriate setting. When medically

feasible, it should be provided in-cell.

NOTE: THE HEALTH CARE STAFF MEMBER SHOULD APPROACH THE INMATE IN A MATTER-OF-FACT MANNER, ATTENDING TO PHYSICAL NEEDS. AVOID ANY "COUNSELLING" WITH THE INMATE e.g., DO NOT DISCUSS MOTIVATIONS, UNMET NEEDS, ETC.

If repeated within 24 hours, give inmate necessary medical care and move him/her to a strip cell, his/her own cell is stripped, or physical restraints are applied. Continue until the inmate verbally agrees to refrain from self-mutilating behavior.

2. Chemical restraints are not recommended.

   Drugs may be justified in the case of psychotic inmates who are self-mutilating. However, drug use for those psychotic inmates should involve psychiatric consultations to assist in making that decision.

3. Psychologists and case management officers should approach the inmate with the attitude that the behavior is the responsibility of the inmate and should not give supportive counselling.

4. Self-mutilating inmates need attention and firm control from the staff. Specific attention and concern should be provided before the act occurs and during periods when self-mutilation has not taken place.

5. Provide staff training, particularly on principles of social learning theory.

RECOMMENDATIONS

The Task Force on Mental Health Care recommends the following in order to reduce the incidences of self-injurious behavior among both male and female offenders:

1. 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;

2. that all CSC institutions be adequately resourced in terms of staff capable of providing appropriate mental health counselling prior to the implementation of the program, and that a pertinent training package be developed for all institutional staff;

3. that in the case of the Prison for Women, consideration be given to the implementation of an appropriate prevention of self-mutilation program following the release of the Task Force Study on Federally Sentenced Women and the Diagnostic Interview Survey of Female Offenders.

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

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TASK FORCE ON MENTAL HEALTH CARE

DISCUSSION PAPER

SUB-TASK # 13

THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

TASK FORCE ON MENTAL HEALTH CARE

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

submitted by: Laurie Fraser

APRIL 1990

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INTRODUCTION

Since the identification of the first case in 1981, AIDS (Acquired Immune Deficiency Syndrome) has created a multitude of problems, moral, legal and logistical, for health care and administrative authorities in the community.

In a carceral setting where care and coercion exist simultaneously, these problems are often magnified. To date, there has, of necessity, been much emphasis on infection control. This included policy decisions on placement of HIV infected inmates and intensive education programs for staff and inmate to decrease the fear and ensuing retaliation that often accompanies awareness of an HIV-infected person.

There is, however, need now to examine some of the other implications created in the Correctional Service of Canada by persons infected with HIV. The opportunity, through an inmates deciding to be tested for HIV, will be present for intervention on lifestyle-related issues. What will be the concomitant counselling requirements of this action? Current literature indicates that, in addition to the well-defined opportunistic infections which characterize AIDS, there are significant psychiatric and psychological sequelae. What will be the implications for CSC's mental health services and the way in which these are delivered? Some of these issues are explored in the following pages.

NATURE, TRANSMISSION AND PREVALENCE

NATURE:

The term AIDS describes only the most serious form of infection which is caused by a specific virus called Human Immunodeficiency Virus (HIV). The virus weakens the immune system, making the individual susceptible to a range of "opportunistic" infections, malignancies and other diseases which would not generally be life-threatening in persons with normally functioning immune systems. The virus can also affect the nervous system, causing significant changes in behaviour.

Generally, the infection may be characterized by three stages. During the first stage, the person has no symptoms of the disease but harbours the virus and is infectious to others. Tests taken to detect the disease, by identification of the HIV virus antibody, may or may not be positive. Seropositivity may not be identifiable until six to eight months after a contact with the disease, and recent research indicates that this period may exceed a year. This fact has major implications for the nature of the counselling offered to persons who have engaged in high-risk activity and who may feel it safe to resume their activities, relying on the assurance of a, perhaps temporarily, negative test. The second stage is characterized by mild to moderate symptoms, such as generalized swollen glands, significant weight loss and fatigue. The third stage is characterized

by opportunistic infections, such as pneumonia, thrush and a particular malignancy, Kaposi's sarcoma. The latter, while involving other sites in the body, is often typified by purplish lesions on the face and other skin surfaces, a vivid indication to others of the disease. To date, these opportunistic infections have been treatable, but frequent recurrences leave the body too weak to defend itself.

Progression from asymptomatic infection to AIDS may be very slow and has not been demonstrated to happen in all cases. Information gathered from cohort studies at the San Francisco city clinic indicates that 48% of HIV infected individuals will develop AIDS after 10 years.

To date, zidovudine (AZT) is the only antiviral agent of proven efficacy in HIV infection. This treatment has significantly decreased the incidence and severity of opportunistic infection. However, the toxicity of this drug is significant. Minor adverse effects, such as nausea, headache and insomnia usually resolve quickly. But bone marrow toxicity may occur in 30% of patients, thus necessitating multiple blood transfusions.

TRANSMISSION:

The HIV is transmitted primarily during sexual contact, intravenous exposure to blood and blood products, and from an

infected mother to the fetus. In Canada, AIDS has been found predominantly in those engaging in homosexual or bisexual activity. Fewer than one per cent of those infected report having used injection drugs; this contrasts with 20% in the United States. A major area of concern, however, is heterosexual transmission. In 1987, this mode of transmission accounted for 2.4% of infected persons; in late 1989, this figure had risen to 7% of cases. This has implications for counselling on lifestyle and issues such as spousal notification. It will no longer be enough to target only the those involved in homosexual activity and intravenous drug use, but rather education and counselling must also address the partners of these people, and the heterosexual population in general.

PREVALENCE:

Although information exists as to the number of cases of AIDS and seropositivity in the Canadian population at large, prediction of the number of AIDS cases the Correctional Service may encounter is complicated by several factors:

1) the undefined probability of seropositivity progressing to AIDS. In 1985, estimates of HIV infected persons who would go on to develop AIDS ranged from 3% - 5%. Recent research indicates that 48% will develop AIDS after 10 years, and present estimates predict that as high as 100% of seropositive persons will eventually develop AIDS;

2) the absence of solid data as to the actual seroprevalence rate within the inmate population. The Correctional Service of Canada has decided not to implement mandatory screening for HIV. This is consistent with community practice, recommendations from groups such as the Royal Society, and with Sections 7 and 8 of the Charter of Rights and Freedoms;

3) although recent surveys suggest that at least 70% of CSC inmates have substance abuse problems, within this group the percentage of those using **intravenous** drugs is unknown;

4) the effect of "throughput", that is, the fact that inmates enter the Service, remain for a period of time and then leave. The average time spent by a federal inmate in an institution is 1-1.5 years. Given the periods of time between exposure and seroconversion and subsequently between seroconversion and potential progression to AIDS, it is difficult to predict how many infected inmates the Correctional Service can anticipate having, and at what point in their disease.

Nonetheless, the following information provides some direction.

1. To March 1990, there have been 3,580 cases of AIDS in Canada. Because HIV infection is not reportable in all provinces, statistics do not exist on national seroprevalence rates, but the Federal Centre for AIDS estimates that there are 30,000 - 50,000 seropositive people in Canada.

2. The province of British Columbia, with a population approaching three million, has a seroprevalence rate of 3.5% for some 94,400 individuals tested, and 637 cases of AIDS. The rate of increase in the cases of AIDS has declined from a factor of 3.57 in 1983-1984 to a factor of 1.3 in 1988-1989.

3. A 1988 study by John Hopkins/CDC showed the seroprevalence rate of new entrants to the Los Angeles County Jail Systems to be 2.6%.

4. In Oregon, of 977 newly admitted prisoners, 1.2% were seropositive. However, 62.5% were identified as being at risk for HIV by being persons using intravenous drugs, engaged in homosexual activity or carrying Hepatitis B antibodies (Hepatitis B is transmitted by the same routes as HIV).

5. The United States Federal Bureau of Prisons randomly tests 10% of its inmates on admission. At a recent meeting with CSC, officials from the Bureau indicated that there has been a 2.7% seroprevalence rate.

6. Within the Correctional Service of Canada, there were 26 HIV positive inmates at the end of February 1990 and 2 cases of AIDS. Since 1985, there have been 49 HIV positive inmates identified and 8 cases of AIDS, two of whom died within CSC's jurisdiction.

Despite the difficulty in accurately predicting the prevalence of HIV and AIDS within the Correctional Service of Canada, the Service must be prepared to address issues of HIV testing, counselling, specific mental health interventions and other preventative measures designed to help inmates protect themselves from contracting HIV and providing care for those who have.

HIV TESTING AND COUNSELLING

PRE-TESTING COUNSELLING:

The implications of the potential results of HIV testing (social, employment, housing, and, in carceral environments, chance of threats and violence) mandate pretest counselling and

education as components of any HIV antibody testing program. This counselling is a process which addresses the medical, psychological and social implications of HIV antibody testing as they relate to the individual patient. (CMA, 1990)

There are three main objectives to such counselling: 1) to assess the degree to which the inmate is engaged in "at risk" behaviour; 2) to ensure that the inmate understands the nature of the test and the implications of being tested; and 3) to provide an opportunity to counsel safer behaviours.

The assessment of "at risk" behaviour is important in identifying the need for and likelihood of behaviour change. The obvious behaviours to be explored are drug abuse and sexual practices. It is essential that the client understand the basics of HIV transmission and the development of AIDS. This information should include the difference between being infected by the HIV virus and AIDS itself; how HIV is and is not transmitted; the fact that an infected person remains persistently infectious even though there are no symptoms; and the implications of both a positive and a negative test. The inmate needs to understand, too, to what extent the results of the test will be shared. Beyond the immediate health care personnel involved, there may be a need to report it to public health authorities. Within the Correctional Service, the test result will be communicated, on a confidential basis, to the warden or superintendent of the institution.

Counselling in safer behaviours must be geared to the kinds of behaviours engaged in by the individual and may include safer sexual practices, alcohol and substance abuse, and tattooing.

Assessment must be made of the individual's coping skills and capacity to tolerate the stress of testing and possibly receiving a positive result (CMA 1990). It may be necessary to postpone testing and refer the inmate for further counselling or a psychiatric evaluation.

POST-TESTING COUNSELLING:

Both positive and negative results from the HIV test will continue to require significant post-test counselling. Monitoring is necessary to identify continuing high levels of anxiety and distress caused by the awareness of the potential results of some past risk behaviour. These "worried well" may require formal psychological or psychiatric referral.

The individual who has received a negative test must understand that it provides no cause for complacency. Counselling on changes to high-risk behaviours must continue. While it is important that efforts be made to advise inmates on high risk behaviours to avoid, counselling must also realistically address the methods by which the risks inherent in certain behaviours can be minimized. This will include how to clean intravenous equipment and use of condoms during sexual activity.

For the individual diagnosed as HIV positive, supportive counselling focussing on anxiety management and behavioural change is necessary. "Anxiety Management is given priority in counselling HIV positive inmates because the nature of imprisonment with implicit physical constraints and social isolation makes anxiety a more powerful response in prison than in other environments" (Curran, 1989). In addition to "normal" separation from family and friends brought about by incarceration, the HIV positive inmate risks severing those ties which continue to exist by sharing information about HIV status. Response from other inmates can range from indifference to hostility and threats of violence. Heightened anxiety and sensitivity may also lead to violent incidents both to themselves and others. People with HIV may also feel a degree of anger and frustration at their condition. This may be expressed in a variety of ways, but the restrictions of imprisonment reduce the number of acceptable outlets, and counselling inmates to cope with this anger is of particular importance.

In addition to the needs created by the anxiety and anger at the situation, support will also be needed as decisions regarding AZT and a possible course of treatment are embarked on.

Counselling on behavioural change must concentrate on knowledge and acceptance of practices which will not endanger others.

Women who are HIV positive pose special problems and needs. The probability that the mother may infect her fetus is quite high: 20% to 50% for a first child and 50% to 65% if she has already given birth to an infected child. Accordingly, in addition to coming to terms with her own condition, the pregnant woman also needs to be able to explore the implications of having an HIV infected child. For the HIV positive female who is not pregnant, family planning information is crucial. It is also important that these women come to terms with the fact that they cannot bear children without concurrent great risks for the baby, and indeed may not be able to have a family. The fact that HIV can be transmitted from women to men mandates education on sexual practices which the woman may enjoy without endangering her partner.

While health care personnel; psychologist, nurse, physician and psychiatrist, will play key roles in the counselling and support of the seropositive inmate, there are a number of community groups who can also provide support and information to these inmates and their families. These include the local AIDS Committees and PWA (Persons with AIDS) groups. Efforts should be made to involve them, as appropriate, in both staff and inmate education programs and also, with the consent of the inmate, in direct support to affected inmates. Their ongoing liaison can continue to provide information resources and support when the individual returns to the community. Careful exploration should

be made, as well, of the potential for inmate self-help groups within and between the institutions. The right of the inmate to privacy about his condition must be respected in such a process. Furthermore, recognition must be given to the differences in institutional "environment" which will determine whether such a program will succeed and if,indeed, it is safe.

There is no single "package" available to provide pre- and post-test counselling. However, there are two documents which provide a major resource for such programs. "Human Immunodeficiency Virus Antibody Testing" is a set of guidelines issued by the Canadian Medical Association. It offers step-by-step advice on counselling a patient about HIV and clearly identifies the information which must be shared. Although targeted at physicians, the guidelines are equally applicable to other health professionals. "AIDS and HIV Infection, Psycho-Social Issues: Information for Professionals" is an excellent handbook issued by the Ontario Ministry of Health. It identifies key information about AIDS and the psycho-social concerns of persons infected with HIV, those who have AIDS, and those of their families and friends. These two documents, together with "HIV Counselling in Prisons" (Curran et al.) from which much of the information in this paper is derived, should be circulated to all health professionals within the Correctional Service of Canada. They form a nucleus of guidance for all staff which can be augmented by brochures and audio-visual aids, as appropriate.

HIV TESTING:

At the present time, HIV testing has only been available to those inmates who requested it and for whom the institutional physician judged it clinically appropriate. In light of the evidence indicating the success of AZT in ameliorating the course of the disease, the Service is proposing to offer this testing to inmates as part of the reception process. This will provide a valuable opportunity to establish communication with those inmates who identify themselves at risk for the disease, and to initiate lifestyle counselling. If a conservative estimate of seroprevalency of 1% is adopted, there will be a potential 1200 HIV positive inmates presently in CSC's population, with an additional 30-40 being admitted each year. It will be the responsibility of the interdisciplinary health care team in each institution, with input and coordination from regional health care personnel, to develop a plan to provide these counselling services within their institution.

A key factor in the success of this program, and the resultant opportunity for early lifestyle intervention with the inmates, is the ability of the Correctional Service of Canada to make the commitment to both inmates and staff that the results of HIV testing will truly remain confidential.

PSYCHIATRIC/PSYCHOLOGICAL SEQUELAE OF AIDS

The HIV appears to be neurotropic with 90% of patients ultimately having neurologic manifestations directly related to the virus. Encephalopathy, sub-acute encephalitis and AIDS dementia occur in over one third of patients with AIDS (Rachlis, 1990). The AIDS Dementia Complex (ADC) is characterized by a combination of cognitive, motor and behaviour disturbances. Initial complaints of poor concentration and mental slowing, impairment of recent memory, lack of co-ordination and unsteady gait, malaise, and social withdrawal and apathy may be overlooked and attributed to a possible depressive disorder. The mood disturbances common among sufferers from AIDS may also mask the onset of dementia. This syndrome is quite frequently punctuated by episodes characterized by psychotic features which may mimic functional disorders such as schizophrenia. Symptoms may include delusional thinking, hallucinations, suspiciousness, grandiosity, rambling and repetitive speech and blunted affect.

Two important considerations thus arise. Firstly, it will be important to be alert to the possibility of AIDS-related psychiatric disorder when a major functional psychosis occurs in a patient whose history indicates high-risk behaviours. Second, when an apparent functional psychosis occurs in an AIDS patient, serious organic brain disorder will have to be considered (Fenton, 1987).

Davies has identified implications not only for the person with AIDS, but also for the management of an institution:

a) disinhibition in early HIV encephalopathy leading to increased sociopathic traits;

b) a more profound dementia resulting in release of primitive behaviours;

c) functional psychoses in which the delusions and hallucinations produce fear and agression; and

d) anger and resentment in patients who see themselves as having nothing to lose.

Thus, patients with ADC, who are unaware of the scale of the problem, have the potential for creating a focus of infection for other inmates within the institution and of disturbance within the population (Davies, 1988).

The institutional mental health team, as established by Standard 405 of the "Standards for Health Care", provides an appropriate vehicle through which placement decisions can be made. Assessment of the individual AIDS patient will need to determine whether custodial treatment in a special or psychiatric unit is appropriate or whether housing should continue in the general population or the health care centre. In the case of the latter option, significant coordination with program areas will be necessary to ensure that this placement is indeed in the patient's best interest and does not result in the termination of access to education, recreation and social opportunities. To

date, the small number of AIDS cases experienced by CSC would appear not to justify a formal and central policy on institutional placement; the Service should, however, continue to monitor the situation at both the regional and national level.

COMMUNITY RELEASE

It is essential that the parole officer be involved in the planning for the care and continuing counselling of the seropositive and AIDS offender on release. To this end, the offender should be encouraged to consent to the sharing of this information with his/her parole officer as early in the process as possible. Early parole by exception may be justified by the medical condition of the offender and arrangements must be made for appropriate community placement. Linkages with local AIDS and PWA committees should be established and maintained by community release staff; they provide a unique support network to AIDS patients and their families and friends. The parolee should be counselled regarding his/her responsibility to avoid infecting others.

A frequent concern of parole staff is the extent of their responsibility to warn third parties who may be infected if the offender is malicious or negligent in spreading the disease. Recent legal advice indicates that only in certain very limited

cases might there be justification in the parole officer sharing this information. In general, however, information about the HIV status of an inmate may not be shared with other persons by parole officers. There is, nevertheless, a mechanism by which the community health may be protected. HIV infection, as well as AIDS, may be reported to the local medical officer of health who has the responsibility, under provincial legislation, for protection of the public against communicable diseases. Reporting this information is usually done by the institutional physician and so involvement of health care personnel in release planning is crucial. Dependent on the practice in a particular region or institution, the multidisciplinary mental health team with the addition of the parole officer may be an appropriate mechanism by which this communication can take place.

IMPLICATIONS FOR EDUCATION AND TRAINING

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

In addition to physicians and psychologists, nursing staff in the Correctional Service will play a key role in the pre and post-test HIV counselling of inmates. It is important that the HIV infected offender be able to establish a relationship with health care personnel which will facilitate communication of concerns and need for information and reassurance. CSC nursing staff are present in most institutions during both the day and evening hours.

Although there are excellent guidelines available on counselling HIV infected persons, formal staff training opportunities must be provided to assist nursing staff to develop the knowledge base and skills to offer this counselling. At such training sessions, staff must have an opportunity to explore their own feelings about the disease, caring for someone with AIDS, and, as the majority of cases have arisen through intravenous drug use and homosexual activity, their own values and identification.

Case management and correctional staff need to be able to explore and resolve their feelings about people who are infected with HIV. While working with drug addicts and dealers is not new, AIDS has been identified with homosexual activity and homophobia is no less in evidence in a correctional environment than in the

Canadian population. The use of members of community AIDS Committees to work with staff in small groups - the unit management structure provides an excellent mechanism for this- would be one effective method.

The Correctional Service of Canada must create an atmosphere in which offenders will be able to seek testing and counselling on AIDS. Staff training on AIDS and infectious diseases must not only continue but be augmented. This will this help staff to become more comfortable in dealing with offenders identified as infected with HIV. Furthermore, as staff can provide role models to the offenders with whom they interact, a decrease in their apprehension could affect offender attitudes.

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

FUTURE DIRECTIONS

At the present time, CSC collects only basic statistics regarding numbers of inmates who are seropositive or who have AIDS. These numbers, in effect a "snapshot" picture of the

situation on the last day of each month, are used in consideration of policies and practices concerning AIDS and are provided to both internal and external requests. There is presently, however, no information available concerning the offenders who are infected with HIV. Background on age, high-risk behaviours, sentence length and, possibly, crime would assist in the identification of future needs of the HIV infected offender. As more offenders take advantage of the opportunity to be tested, a mechanism must be developed to gather this information without creating an unbearable paper burden on institutional staff or compromising the confidentiality of the information.

It will also be important to identify the psychological and psychiatric problems associated with HIV infected offenders, and the nature of the counselling offered. To date, while CSC experience with these problems has been limited, the sharing of this information among the mental health care professionals will significantly assist in the assessment and treatment of future AIDS patients. Surveys might be good initial mechanisms to gather this information; regional workshops of mental health professionals would provide additional opportunities to share both experience and expertise.

SUMMARY

AIDS has the potential for becoming problematic in the Correctional Service of Canada. Emphasis must be placed on educational programs about the disease in lieu of mandatory testing programs. However, with the availability now of a treatment (AZT) which will significantly increase life expectancy and quality of that life, CSC has the responsibility to provide the information and create the environment in which offenders will seek testing. In addition to providing counselling which will enable offenders to make an informed decision about being tested for HIV, CSC must provide follow-up counselling to both seropositive and seronegative offenders. This should be viewed, not only in the medical context of preventing transmission of the disease, but also of assisting offenders to choose healthier lifestyles and practices which will support their successful reintegration into the community.

RECOMMENDATIONS

The Task Force believes that the Correctional Service of Canada should implement the following recommendations:

1. 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.

2. That the Correctional Service of Canada establish an HIV testing and counselling program with emphasis on the following components:

   - 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;
   - pre-test counselling available to all offenders wishing to be tested ; and
   - 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 coordinationfrom regional health care personnel.

3. That the Correctional Service of Canada actively encourage Support Community 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.

4. That health care 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.

5. That background information on age, high risk behaviours, sentence length, and crime of the HIV infected offender be accumulated to assist research in the identification of future needs of the HIV infected offender.

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TASK FORCE ON MENTAL HEALTH CARE

DISCUSSION PAPER

SUB-TASK # 14

THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

TASK FORCE ON MENTAL HEALTH

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

submitted by: Bram Deurloo and
Caroline Cyr Haythornthwaite

APRIL 1990

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INTRODUCTION

Studies have shown that mental health is a growing concern for the Correctional Service of Canada. The prevalence rates of mental disorders among male offenders illustrate that the Service has an obligation to develop a continuum of mental health care services and programs, from reception to warrant expiry. The prevalency, recency and severity of mental disorders among female offenders only reaffirms the need for such services within corrections.

Notwithstanding mental health needs similar to those of their male counterpart, female offenders have special mental health needs. The Task Force on Federally Sentenced Women provides an overview of these needs, and proposes a series of recommendations in an attempt to alleviate the negative impact of the correctional environment on women.

This paper first depicts a statistical portrait of mental disorders among female offenders. The data presented is drawn from preliminary results of the Mental Health Survey conducted at Prison for Women, and undertaken by the Correctional Service of Canada, Research Branch, from June to September, 1989. The second section of this paper gives a general overview of the findings and recommendations of the Report of the Task Force on Federally Sentenced Women, in an attempt to outline needs specific to female offenders.

PREVALENCE OF MENTAL DISORDER AMONG FEMALE OFFENDERS

The Mental Health Survey at Prison for Women was undertaken by the Correctional Service of Canada, Research Branch from June to September, 1989. Along with the DIS Study on male offenders, it provides a nationwide study of the incidence of mental and behavioural disorders among both male and female, federally-sentenced offenders. The results of the DIS Study on male offenders are included in another discussion paper.

It should be noted that all statistical data, and the analysis of same, are drawn from a preliminary report available through the Research Branch: extrapolations based on these results should therefore be made cautiously. Furthermore, the sample is representative of a cross-section of the population at Prison for Women - 77 out of 130 - and should not necessarily be seen as being representative of all federally-sentenced women.

The basic data provided by the DIS is Lifetime Prevalency for each of the disorders diagnosed: the percentage of the population that has had incidence of disorder at any time in their lives.

Lifetime Prevalency

The findings profiled in Table 1 show that for every Major Disorder and Other Behaviour Disorder with the exception of

Organic Brain Syndrome and Pathological Gambling, the women show a substantially greater level of disturbance that the men. In the case of Schizophrenia, the order of magnitude from the female sample is almost three times greater that that of the male, while for Major Depressive Episode the lifetime prevalency for the women is twice that of the men.

Among the Other Behaviour Disorders, the women show a much higher incidence of Anxiety and Phobic disorders, the percentage for female Agoraphobia being more than tree times that of males. The percentages of women with Psychosexual Dysfunction (55.8%) and Ego-dystonic Homosexuality (13.0%), compared to the men (23.1% and 2.1% respectively) indicate a serious level of psycholsexual distress among the female sample. The percentage of women with Post-Traumatic Stress is also very high, 29.9%, and in most cases, the incidence of this disorder is due to early and/or continued sexual abuse, physical abuse and sexual assault.

The women tend to be less Antisocial as a group than the men, though this percentage (59.7%) is still very high. It should be noted that in the DIS, gender disparity is built into the measurement. So, for Antisocial Personality, women need to score positive on a greater number of characteristics than the men.

While the women have a lower level of Alcohol Abuse/Dependence, their Substance Abuse/Dependence is somewhat higher overall than the men's (57.1% to 53.7%). In this case different patterns of use are evident, the women showing a greater preference for Barbiturates and Amphetemines.

Table 1. Incidence of Mental and Behavior Disorders for Federally Sentenced Offender Population*

Disorder	Federally Sentenced Male Offenders	Federally Sentenced 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
Obsessive-Compulsive	8.7	14.3
Somatization	0.6	3.9
Psychosexual Dysfunction	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:	75.4	59.7
Alcohol Abuse/dependence:	70.1	62.3
Substance Abuse/dependence:	53.7	57.1
Barbiturate	20.8	39.0
Opioid Abuse/Dependence	19.2	22.1
Cocaine Abuse	20.8	28.6
Amphetamine Abuse/Dependence	19.5	36.4
Hallucinogen Abuse	10.0	6.5
Cannibis Abuse/Dependence	30.8	26.0
Tobacco Dependence:	65.6	67.5

* Lifetime Prevalence Estimates

Recency

Table 2 gives the cumulative percentage and numbers of the sample who met full criteria for the disorders from within two weeks to within one year. Where n/a is shown, it means that the DIS does not score for recency with these disorders. The absence of * with the disorders means that they do not have exclusion and/or severity criteria. It should be noted that the numbers do not compare with those in Table 1, as the women with episodes occurring more than a year ago are not included in the recency table.

As Table 2 shows, 5.2% or 4 women experienced an episode of schizophrenia meeting all severity and exclusion criteria (meaning that the symptoms were not attributable to Mania, Depression or Organic Brain Syndrome) within the last two weeks of being interviewed, while eight women experienced an episode within the last year.

Schizophrenia, characterized by psychotic symptoms, is a benchmark disorder in that those suffering from it are normally not able to function without intervention, usually in the form of medication.

Table 2 also shows that 19.5% or 15 women at Prison for Women experienced a Major Depressive Episode, meeting full severity and exclusion criteria, within the last two weeks of

being interviewed. The DSM-III criteria for Major Depressive Episode as measured by the DIS is not to be compared with normal mood changes. To meet full criteria for this disorder, the respondent would have had two weeks of feeling depressed, plus at least four additional symptoms, plus a positive response to one of four additional criteria: told a doctor; told another professional; took medication more than once; or it interfered with life or activities a lot. Moreover, the episodes profiled in this table do not include those brought on by the death of someone close.

Table 2 also shows that more than half (36.4%) of the women with lifetime prevalency of Phobic Disorder experienced an episode within the last year of being interviewed. This includes both simple and social phobia where the individual would have to have avoided a particular situation or object and where having to avoid it interfered with life or activities a lot. Ten women (13.0%) experienced full severity criteria for Post-Traumatic Stress within the last two weeks of being interviewed, while 20 (26.0%) experienced an episode within the last year of being interviewed.

Table 2

Incidence of Mental and Behaviour Disorders
for Federally Sentenced Women by Recency

DIS/DSM-III Disorder	RECENCY			
	Within 2 Weeks	Within 1 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)
Obsessive-Compulsive*	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 Dysfunction	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 (20	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.

Severity

Table 3 shows the criteria of severity for three selected disorders - Schizophrenia, Major Depressive Episode and Substance Abuse/Dependence - and the breakdown of women meeting the different criteria.

In the case of Schizophrenia, 11.7% or nine women met full criteria, while one other woman met all criteria except exclusion. This means that she exhibited symptoms of Schizophrenia which may be due to mania, depression, or Organic Brain Syndrome.

The majority - 25 - of the women with Major Depressive Episode met all of the criteria, while ten women met all criteria except for exclusion (Organic Brain Syndrome and certain psychotic symptoms occurring in the absence of depression).

In the case of Substance Abuse Disorders, Table 3 does not include the diagnostic category of "abuse, not severe" since there was no incidence of this in the sample. Table 3 shows that 29 women, or 37.7% met the criteria for severe substance abuse and dependence, while 33 or 42.9% had "no abuse or dependence".

TABLE 3

SEVERITY BY TYPE OF MENTAL/BEHAVIOURAL DISORDERS

MENTAL/BEHAVIOURAL DISORDER	DIAGNOSES	N	%
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 were 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	3	3.9
	dependence, not severe	3	3.9
	abuse and dependence, severe	29	37.7
	abuse and dependence, not severe	2	2.6

Multiple Disorder

Overall, only 5% of the women show no evidence of serious disorder. On the other hand, close to 50% clearly show evidence of having multiple disorders. 59.8% of the sample have Major Mental Disorder; 57.2% have Major Mental Disorder and Other Behavioural Disorder; 49.4% have Major Mental Disorder and Other Behavioural Disorder and Alcohol/Drug Dependency; while 39.0% have all of the above as well as Antisocial Personality. Conversely, 39.7% have no Major Mental Disorder; 15.0% have no Other Behavioural Disorder and no Major Mental Disorder; and only 5.2% have no Major Mental Disorder, Other Behavioural Disorder, Alcohol/Drug Dependency or Antisocial Personality.

In brief, prevalency, recency and severity of mental disorder among federally sentenced women cleary indicates that the Correctional Service of Canada needs to address this issue, and implement mental health services and programs targeted and priorized to this population.

REPORT OF THE TASK FORCE ON FEDERALLY SENTENCED WOMEN

The Task Force on Federally Sentenced Women was commissioned in the spring of 1989 to develop a plan to respond to the special circumstances of women under federal sentence. The report

describes the requirements for a more comprehensive approach to the unique program needs of federally sentenced women, and the importance of bringing them closer to their families, cultures, and home communities. It should be noted that the following paragraphs are, for the most part, directly drawn from the Report of the Task Force on Federally Sentenced Women.

Various areas of concern were identified, and changes recommended. The following issues are relevant to the fostering and promotion of mental well-being for female offenders, and are, therefore, endorsed by the Task Force on Mental Health Care.

Women Centred Approach

Male models of corrections should not simply be superimposed on female penitentiaries. Such an approach has proven inadequate in the larger society: it is event more inadequate when applied to women's prisons. A women centred approach to corrections is needed for female offenders, where programs and services are designed by and for women.

Community-based alternatives

"Undue hardship and significant emotional upheaval is suffered as a result of women being incarcerated great distances from their homes. Federally sentenced women must have the opportunity to serve their sentence as close to their

families/release communities as is possible"[1]. Community-based services, and community alternatives to incarceration must not only be considered, but created.

Isolation and Distance

The isolation of women from their families created by the existence of only one central federal institution for women is unacceptable, especially for women with young children. The distant geographic separation of female offenders from their families and community support not only makes the pain of imprisonment harsher than reasonable, but also undermines their prospects for successful reintegration. The negative impact on mental well-being of distance barriers and isolation must be addressed.

For most women, contact with their children is of crucial importance to them regardless of the ages of their children. Those without children feel equally the need for greater contact with their families. Women in the Prison for Women want visits with their families. Because the distances between the Prison for Women and many of the women's families are so great, women are often restricted to other means of contact. There is an urgent need to facilitate family contacts for female offenders: this endeavour is at the heart of fostering mental well-being.

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1 Andrew Graham, Deputy Commissioner, Ontario Region, Correctional Service of Canada.

Mental Health Services

Women in prison feel they have lost control over their own bodies and the kinds of advice and medication which would normally be available to them. They express a strong need for better access to mental health services.

The findings of the Mental Health Survey commissioned by the Correctional Service of Canada also indicated that the types and incidences of mental health disorders are different for men and women and that a number of mental health problems experienced by federally sentenced women can be linked directly to past experiences of early and/or continued sexual abuse, physical abuse and sexual assault. There is, therefore, an urgent need to provide appropriate mental health services oriented to the specific needs of federally sentenced women.

Release and Post release

Most female offenders feel they need far more help with release planning than they currently receive. Lack of money to pay basic living expenses is a major problem for those women who do not find a reasonably paying job at the start of their parole, or who have no real work history. In general, women who had good, well-paying jobs prior to their imprisonment, find successful employment on release. But women without good job experience and/or who have been living on the street, find it more difficult to cope on release. There are also many women who

are not employable in terms of the job market and for whom specific job training is particularly important. There is a need to provide meaningful and useful job/skills training for female offenders, and actively assist them in the planning of their release. Mental well-being depends a great deal on positive interaction between the individual and the environment: should female offenders be unable to work and/or make ends meet once released in the community, mental health is endangered.

PRINCIPLES FOR CHANGE

Having identified these areas of concern, the Task Force on Federally Sentenced Women put forth five principles to be respected in addressing the needs specific to female offenders. These principles can provide strong direction for immediate action, and are consistent with the strategic framework the Task Force on Mental Health Care has proposed.

Empowerment

The inequities and reduced life choices encountered by women generally in our society, and experienced even more acutely by many federally sentenced women, have left these women little self-esteem and little belief in their power to direct their lives. As a result, they feel dis-empowered, unable to help create or make choices, unable to help create a more rewarding,

productive future, even if realistic choices are presented to them. Empowerment augments the ability to accept and express responsibility for actions taken and future choices, utimately fostering mental well-being.

Meaningful and Responsible Choices

In order to have a sense of control over their lives whcih will foster mental health, women need meaningful options which allow them to make responsible choices. These choices must relate to their needs and must make sense in terms of their past experiences, their culture, their morality, their spirituality, their abilities or skills, and their future realities or possibilities. Meaningful and responsible choices can be provided only within a flexible environment which can accomodate the fluctuating and disparate needs of federally sentenced women. Through real choices which make sense to them, women will gain control over their lives, and maintain better mental health.

Respect and Dignity

This principle is based on the assumption that mutuality of respect is needed among prisoners, among staff and between prisoners and staff if women are to gain the self-respect and respect for others necessary to take responsibility for their futures. This principle is based on the observation that behaviour among prisoners is strongly influenced by the way they are treated; that if people are treated with respect and dignity

they will be more likely to act responsibly. Disrespect contributes to a sense of powerlessness: this feeling leads to an overwhelming sense of hopelessness and a total lack of motivation. Respect and dignity, conversely, contributes to mental well-being.

Supportive Environment

Environment can best be understood in terms of a constellation of many types of environments: political, physical, financial, emotional, psychological, etc. A positive lifestyle which can encourage the self-esteem, empowerment, dignity and respect for self and others so necessary to live a productive, meaningful life, can only be created in an environment in which all aspects of environment are positive and mutually supportive. The environments in which federally sentenced women exist are frequently inadequate physically, psychologically, and spiritually. They have too little access to fresh air, to light, to adequate nutrition, to social interactions based on dignity and respect, to ongoing relationships with those important to them outside the institution. The quality of an environment can promote physical health, psychological health, and personal development.

Shared Responsibility

In order to develop the support systems and continuity of service which will enable women to take responsibility for their

lives, federally sentenced women must be integrated within their communities. To accomplish this goal, the responsibilities which federally sentenced women have for children and other family members in the community must be recognized and supported. In addition, volunteers and community groups can provide a vital link for women between correctional systems and communities. Further, all levels of government, business, voluntary sector and private sector groups must accept the responsibility to develop and implement, monitor and evaluate correctional options.

In brief, the Task Force on Federally Sentenced Women proposes the following as its overall statement of principle. The Task Force believes that the respect of this statement is an important element to the achievement of mental well-being, for both female and male offenders:

> **The Correctional Service of Canada with the support of communities, has the responsibility to create the environment that empowers federally sentenced women to make meaningful and responsible choices in order that they may live with dignity and respect.**

CONCLUSIONS

Mental disorder among federally sentenced women is a reality. Their disturbances are generally more severe and more frequent that in their male counterparts. Their needs also

differ. Mental health services and practices need to acknowledge these differences, and address them in their planning and delivery. The distance, isolation and separation barriers that female offenders presently face must be alleviated; the pain must be eased. As an attempt to meet this goal, the Task Force on Federally Sentenced Women recommends the closure of the Prison for Women in favor of small regional facilities for women, including an Aboriginal facility. It also recommends the expansion of community-based services for women released from federal custody.

The Task Force on Mental Health Care endorses the findings and recommendations of the Task Force on Federally Sentenced Women. While recognizing the needs specific to women offenders, it also believes that offenders in general, both male and female, need services and programs that will foster their mental well-being. Female offenders, like male offenders , need to be empowered, respected, given meaningful choices and responsibilities. They all need to be given the opportunity to share positive interactions with the Correctional Service of Canada, its staff, their environment, and the community.

In brief, the Task Force on Mental Health Care believes that the needs expressed in the course of this paper, while at times specific to women, are not always exclusive to them. It is imperative that the Correctional Service of Canada recognize the needs of women, the needs of men, and the often mutual needs of both groups.

RECOMMENDATION

The Task Force on Mental Health Care recommends the following:

1. 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.

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TASK FORCE ON MENTAL HEALTH CARE

DISCUSSION PAPER

SUB-TASK # 15

THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

TASK FORCE ON MENTAL HEALTH CARE

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.

submitted by: Dr. Carson Smiley

APRIL 1990

EXECUTIVE SUMMARY

PROBLEM DEFINITION

The Correctional Service of Canada has an obligation to provide the following psychological services (assessment; counselling; therapy; program development, delivery and evaluation; crisis intervention and case consultation) to meet the needs of the offender population throughout their sentences (commencement to warrant expiry). In addition, the services must be sufficient to meet the demands of (a) the Integrated Sentence Management Process; (b) the National Parole Board's risk assessment protocol; (c) offenders needs for treatment to facilitate subjective well-being, optimal use of cognitive and emotional abilities; and (d) achievement of individual correctional treatment plan goals. Similarly, Psychiatric Services are required by a sub set of offenders from initial sentencing through to their warrant expiry. Psychiatric care will be required in specialized treatment facilities - RPC (Pacific), RTC (Ontario), RPC (Prairies), and the RTC (Atlantic); specialized program care facilities (i.e. Prince Albert Chronic Care Unit), community psychiatric day parole/ halfway houses (proposed); and through Regional Ambulatory Care Services to regular CSC Institutions. The Psychiatric Services required are: assessment of mental illness; drug treatment of acute and toxic psychotic disorders; maintenance programs supervision of the chronic psychiatric population; medical/drug treatment of emotional disorders; crisis intervention and case consultation. We will identify the nature and type of resources required in order to provide these services either through contract professionals or C.S.C. psychology staff.

REFERENCE

CD #800 Medical, Dental, and Health Care Services
CD #840 Psychological Services
CD #850 Mental Health Services
C.S.C. Standards For Health Care (March 1989)
Standards for Providers of Psychological Services 1978 (BDPA, OBEP)
Ethical Standards of Psychologists 1978 (BCPA, OBEP)
Standards for Professional Conduct (Revised December 1986 - OBEP)
Guidelines for Supervision of Non-Registered Personnel (Revised April 1989)
A Canadian Code of Ethics for Psychologists (CPA 1986)
Canadian Council of Health Facilities Accreditation - Standards Required at RPC (Pacific), RPC (Prairies)
Provincial Mental Health Acts of B.C., Saskatchewan and Ontario for RPC (Pacific), RPC (Prairies) and KTC (Ontario) respectively
Practice Guidelines for Providers of Psychological Services (1989)

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PART SEVEN

PART EIGHT

PART NINE

PART ONE: PROFESSIONAL QUALIFICATIONS OF CSC HEALTH CARE/MENTAL HEALTH CARE STAFF AS DETERMINED BY CD's AND C.S.C. HEALTH CARE STANDARDS

The following C.S.C. Directives, standards and principles determine the scope of practice, licensed acts and protected titles of C.S.C. Health Care professionals.

POLICY OBJECTIVE

CD 800

#1. To ensure that offenders are provided with medical, dental and health care services in keeping with generally accepted practices in Canadian society.

HEALTH CARE DELIVERY

CD 800

#2. Health Care shall only be provided by personnel who are registered or licensed in a province or territory of Canada or who are eligible for such certification.

RESPONSIBILITIES

CD 850

#7. Health care staff shall provide guidance, as subject matter specialists, regarding the provision of mental health services and programs.

CSC STANDARDS FOR HEALTH CARE (MARCH 1989)

"A standard is a desired and achievable level of performance corresponding to a criterion." Health and Welfare Canada, 1988

PRINCIPLE 3

The offender is entitled to reasonable access to the full range of health services, including prevention, treatment and rehabilitation, in accordance with generally accepted community standards.

PRINCIPLE 8

The health delivery system within CSC must meet the requirements of existing federal laws and applicable provincial legislation.

PRINCIPLE 9

The health delivery system shall be based on the community health model, with a focus on the health of the prison community as a whole, by intervention at the individual and group level. The curative and preventive services offered shall be coordinated to encourage continuity of care for the duration of the sentence.

PRINCIPLE 10

The health services shall be provided by health professionals/ practitioners currently registered/licensed (or eligible for registration/licensing) in Canada and preferably in the province of practice.

STANDARD 107:
PROFESSIONAL QUALIFICATIONS

As required, health professionals shall be appropriately registered/ licensed or be eligible for registration/licensing with a Canadian provincial authority, preferably in the province of practice.

CRITERIA:

Personnel files shall contain documentation to verify current registration/licensing.

There is Health Professions Legislation in every province/territory of Canada. Health care is a provincial responsibility under existing legislation and each province has a legal mandate to regulate the following health disciplines/professions.

GROUP

Osteopathy
Chiropody
Midwifery
Dental Technicianry

Optometry
Massage Therapy
Ophthalmic Dispensing
Chiropractic
Dental Hygiene
Medical Laboratory Technology
Radiological Technicianry
Pharmacy
Registered Nursing/Registered Nursing Assistantry

Podiatry
Denture Therapy
Respiratory Therapy
Speech-Language Pathology/Audiology
Occupational Therapy
Dietetics
Opticianry
Psychology
Physiotherapy

Dentistry
Medicine

CSC requires current professional provincial registration for indeterminate practitioners/staff providing services to offenders in the majority of these health disciplines (for example, medicine, psychiatry, nursing, dentistry, optometry, pharmacy). There is currently no requirement for CSC psychologists to be registered in the province of practice. Current provincial registration is a mandatory requirement for all contracted professional services within C.S.C. across Canada.

Provincial registration of Health Care Professionals ensure that each health discipline has a set of agreed upon Standards of Practice and Code of Ethics. Consequently all CSC Health Care professionals who are required to meet and maintain provincial licensing criteria as a condition of employment will be governed by their respective provincial discipline/licensing bodies. In the case of psychology, both provincial and national associations and licensing bodies have adopted the following documents as guidelines/requirements for the practice of psychology:

a) Ethical Standards of Psychologists,
b) Standards for Providers of Psychological Services/Standards of Professional Conduct, and
c) A Canadian Code of Ethics for Psychologists.

(See Appendix for copies of (a) above.)

Should CSC psychologists become licensed in their province of practice, they would come under the professional scrutiny of their community based peers in professional practice. However, provincial registration is not currently required for psychologists within Corrections Canada.

PART TWO: PROGRAM/PROFESSIONAL SERVICES COMPONENTS OF THE CSC STANDARDS FOR HEALTH CARE

REGIONAL PSYCHIATRIC SERVICES

CD 850

#6. Region Psychiatric Centres and Regional Treatment Centres shall be responsible for the planning and implementation of psychiatric services for the institutions in their respective regions in collaboration with regional medical personnel and appropriate Regional Managers.

STANDARD 201:
LEVELS OF SERVICE

The Correctional Service of Canada shall ensure the provision of a range of health services for offenders including mental health and general health care. Services shall be available at a primary, intermediate and intensive or tertiary service level.

CRITERIA:

1. Primary level of service shall be provided on an ambulatory basis to offenders who remain in general population.
2. Intermediate level of service shall be a specialized program delivery in a dedicated living space within a regular institutional setting.

3. Intensive/tertiary level of service refers to in-patient beds in a facility designated under mental health legislation or to in-patient beds in a general hospital.

STANDARD 202:
THERAPEUTIC TREATMENT PROGRAMS

Programs shall be designated and implemented to meet the needs of a significant number of offenders with similar treatment requirements.

STANDARD 203:
ACCESS TO SERVICES

Offenders shall have access to health services on a 24-hour basis.

CRITERIA:

1. Clustering of all services, where proximity of institutions allow for cost effective use of it, shall be implemented.

2. Where 24-hour nursing coverage is not provided on-site, staff with basic first aid and cardio-pulmonary resuscitation (CPR) training will be on duty.

3. Nursing services shall be provided 24 hours per day in institutions where in-patients are cared for (Intermediate level).

STANDARD 204:
PRIMARY CARE

Primary mental health/general health services shall be provided on an ambulatory basis.

CRITERIA:

1. Clinic hours will not normally exceed 12 hours per day.

2. Assessments and prescribed treatment/tests shall be provided by appointment, during clinic hours.

3. Ambulatory Services, after clinic hours, shall be provided for first aid or minor emergency services.

4. Inmates may be self-referred, or referred by staff to the mental health team. Services provided shall include diagnosis, follow-up and emergency services (see Standard 208).

STANDARD 205:
INTERMEDIATE CARE

Arrangements shall exist within each region for the provision of an institutional based intermediate level of health care service. Offenders who are recuperating from surgery, suffering infectious disease or significant physical handicap require in-patient care which provides more nursing service than that available on an ambulatory basis. Chronically mentally ill offenders or those exhibiting some type of behavioral disorder may appropriately be treated in similar specialized units.

CRITERIA:

1. Dedicated program space and accommodation shall be provided for those offenders requiring intermediate level health services.

2. Where appropriate, general in-patient care shall be provided in the Health Care Centre (see Standard 203, Clustering arrangements).

3. Admissions shall be determined by health professionals based on medical need, not for administrative expediency.

4. Programs, designed specifically for the identified needs of the offender, shall exist.

5. Individual treatment plans shall exist for each offender in the unit.

STANDARD 206:
TERTIARY CARE

Offenders shall be transferred to health care facilities, when the condition warrant and as determined by the physician/psychiatrist/ psychologist.

STANDARD 207:
TERTIARY PSYCHIATRIC CARE

There shall be in-patient psychiatric beds providing an intensive level of service available in each region. Such a facility shall be designated under mental health legislation so that involuntary treatment may be provided, when necessary, with proper legal and ethical safeguards.

CRITERIA:

These facilities shall normally maintain accreditation status with the Canadian Council on Hospital Accreditation or other appropriate accrediting body.

STANDARD 208:
REFERRALS

Referrals to outside agencies for consultation, treatment and surgery shall be for essential services. Essential services can be categorized as emergency, urgent or non-urgent.

CRITERIA:

The categories shall be defined as:

1. Emergency: a case where delay will endanger the life of the offender;

2. Urgent: the condition is likely to deteriorate to an emergency or it is interfering with the offender's ability to carry out his or her activities of daily living; and

3. Non-urgent: the condition is not affecting the offender's activities of daily living now, but may in the future.

STANDARD 301:
ADMISSION ASSESSMENT

Assessment of all offenders' health status shall be completed on admission.

CRITERIA:

1. All offenders shall have their records reviewed by a nurse within 24 hours of admission to determine major health problems requiring immediate attention.

2. All new-to-CSC offenders shall receive an assessment by a nurse, to determine that they are free from obvious infection within two working days after admission.

3. A nursing history and physical/mental health assessment of all new-to-CSC offenders shall be carried out by a nurse within ten (10) days of admission. This assessment will provide a routine fitness for work evaluation.

4. An offender who may not be fit for work or who has chronic or current health problems shall be referred to the physician.

5. A medical examination, including medical history, examination of all body systems, and inmates' mental state shall be carried out by the physician within 14 days of admission.

STANDARD 302:
ADMISSION MENTAL HEALTH ASSESSMENT

All newly admitted offenders shall be assessed to identify the presence of a mental disorder. When such a concern is identified, the offender shall be referred to the health service. A comprehensive evaluation shall be conducted by a psychologist or psychiatrist within 14 days.

CRITERIA:

On admission, the offender shall be seen by a nurse and physician for the purpose of a history and physical/mental health assessment. The offender will also be interviewed by the Case Management officer, and other staff, as required.

STANDARD 303:
ROUTINE ASSESSMENT

While incarcerated, all inmates' health concerns shall be addressed.

CRITERIA:

1. Requests for services shall be reviewed and priorized by the nurse on receipt of same.

2. Assessment and screening shall be completed by the nurse within five (5) days of request submission.

3. Concerns which cannot be treated by the nurse shall be referred to the appropriate health professional.

4. These concerns shall be priorized and notification to the physician will be made in accordance with Standard 304.

STANDARD 304:
PHYSICIAN SERVICES

Access to physician services shall be provided.

CRITERIA:

1. Offenders shall be seen within seven (7) days of referral for non-urgent complaints.

2. Offenders shall be assessed on the same day of an urgent complaint.

3. Offenders shall be seen within three (3) hours for emergencies.

STANDARD 305:
DISCHARGE SCREENING

Pre-transfer and pre-release health screening shall be provided.

CRITERIA:

1. This health screening shall be carried out by the nurse.

2. Offenders with chronic illnesses or current health problems shall be referred to the physician/psychologist for examination.

PROGRAM COMPONENTS
400 Diagnostic and Treatment Services
INDEX

PROGRAM COMPONENTS
500 Physical Plant and Human Resources
INDEX

Standard 501 - Physical Plant
Standard 502 - Human Resources
Standard 503 - Staff Training

PART THREE: CANADIAN COUNCIL OF HEALTH FACILITIES ACCREDITATION

At the request of the Canadian Council for Health Facilities Accreditation, Dr. John Goodman (Chair, Professional Affairs) and Dr. Pierre Ritchie (CPA Executive Director) have recently submitted Canadian Psychological Association's (CPA's) response to the proposed Revised Standards for Psychology Services. The following are some general comments and policy issues which are emphasized in the submission to CCHFA:

> "We believe that it is always inappropriate for a psychologist to be clinically accountable to a member of another profession. We believe that it is important that accreditation standards reflect and respect this reality. Failure to do so risks inter-professional conflict which ultimately affects the quality of service."
>
> "We believe it is appropriate that the standards establish that the availability of psychological services is the norm, whether or not there is any structural entity for psychology within the facility.

The submission further proposes the requirements that psychologists providing services in a health facility be (a) licensed/registered in the jurisdiction of practice, and (b) listed in the Canadian Register of Health Service Providers in Psychology.

PART FOUR: MENTAL HEALTH NEEDS OF OFFENDERS IN C.S.C.

The Diagnostic Interview Survey (DIS) Study (1988-89) clearly documents a significant proportion of CSC offenders who have both serious and chronic psychotic, behavioral and personality disorders.

The Research Branch oversaw the completion of the study which involved interviews with a random sample of over 2,000 Federally sentenced male offenders across Canada. The Mental Health Survey represents the first major attempt by the Correctional Service of Canada to estimate the prevalence, nature, and severity of mental health problems among the adult male offender population by applying objective diagnostic criteria commonly used by mental health professionals. The survey relied on the administration of the Diagnostic Interview Schedule (DIS), a survey instrument by the World Health Organization. The DIS was designed for research on large numbers of the general population, both male and female, and has also been used to diagnose the incidence of mental and behavioral disorders among incarcerated populations. A diagnosis of mental disorder that flows from the DIS primarily involves meeting a set of stringent criteria derived from the American psychiatric Association's Diagnostic and Statistical Manual III. It is a highly structured interview with a set of probe patterns to reduce, as much as possible, interviewer discretion in coding.

The results of the survey revealed some remarkable facts about the lifetime prevalence of mental disorders in the Correctional Service of Canada offender population. Lifetime prevalence is defined as the percentage of the population that showed evidence of a particular disorder at least once in their lifetime. Please refer to a the discussion paper on Prevalence of Mental Disorder for further information on the results of the DIS Study.

PART FIVE: TYPES OF PSYCHOLOGICAL SERVICES REQUIRED WITHIN CSC

A. BY CD 800, CD 840 and CD 850

CD 840

#2. Psychological services for offenders shall be available at all operational units and shall include:

a. assessment;
b. counselling;
c. therapy;
d. program development, delivery and evaluation; and
e. crisis intervention and case consultation.

#3. These psychological services shall focus on the needs of the offender population and be available throughout their sentence, up to the warrant expiry date where feasible.

PAROLEES

CD 840
#4. Psychological services to parolees may be provided through community contract services.

AVAILABILITY FOR CONSULTATION

CD 840
#5. The psychologists shall be available to all levels of management, for consultation concerning behavioral science issues, applied psychological research projects, program implementation and evaluation and staff training.

REQUIREMENTS ON ADMISSION

CD 850
#2. As part of the medical examination on admission, an assessment of each offender's mental health shall be made.

CD 850
#4. Mental health services and programs for offenders shall include:

a. provision for continuity of care for those suffering from psychiatric, emotional, or behavioral problems at standards of professional quality consistent with those for the Canadian public;
b. individual assessment/diagnostic services;

c. programs for those suffering from acute, sub-acute or chronic mental illness;

d. identification of special categories of offenders; and

e. provisions to ensure that an offender who is acutely mentally ill and in urgent need of treatment is moved to an appropriate facility without delay.

REGIONAL PSYCHIATRIC SERVICES

CD 850
#6. Regional Psychiatric Centres and Regional Treatment Centres shall be responsible for the planning and implementation of psychiatric services for the institutions in their respective regions in collaboration with regional medical personnel and appropriate Regional Managers.

RESPONSIBILITIES

CD 850

#7. Health care staff shall provide guidance, as subject matter specialists, regarding the provision of mental health services and programs.

CD 800

#12. This examination shall screen for:

a. communicable conditions;

b. physical, mental or dental conditions;

c. conditions requiring continuing treatment;

d. activity limitations; and

e. signs of recent alcohol or substance abuse.

#13. The findings of this examination shall determine the requirement for treatment, hospitalization or special housing.

MEDICAL AND MENTAL ASSESSMENT

CD 800

#19. The health care staff shall indicate to the appropriate staff whether or not an offender is mentally and physically fit for normal institutional activities and determine his/her program capabilities.

ROUTINE AND EMERGENCY CARE

CD 800

#20. Regions and institutions shall develop instructions pertaining to the provision of medical and dental services.

#21. Procedures for medical and dental care in emergencies shall be in place in all institutions.

#22. Health Care Orders shall be established to outline the course of action to be taken by health care staff in both routine and emergency situations in the absence of a physician.

#23. The responsibility of health care staff for both visitors and staff shall be limited to emergency care until outside services are available.

B. BY TYPES OF PSYCHOLOGICAL SERVICES REQUIRED BY INSTITUTIONAL CRISIS MANAGEMENT MANUALS/PROCEDURE

Operation "H" or Operation "Assistance" contingency plans are incorporated into all CSC Institutional Crisis Management Manuals/Procedures. The Health Care Professionals (i.e. Institutional Psychologists) are responsible for crisis counselling/assistance to offenders, victims, CSC staff and family members of those involved in the incident. This psychological/mental health assistance is required during the incident; at the time of the post incident debriefings, and during longer term post incident to treat any post traumatic stress disorder symptomatology that may develop.

C. BY TYPES OF PSYCHOLOGICAL SERVICES REQUIRED BY THE INTEGRATED SENTENCE MANAGEMENT MODEL

I. A. Intake Mental Status Evaluation - to be completed by nurse/CMO/CO-2.

B. Comprehensive Intake Psychological Assessments - to be completed by psychologist (contract or institutional).

C. Screening Intake Psychological Assessment - to be completed by psychologist.

D. Treatment - to be completed by Registered Health Care Professionals (see section for definition).

E. Comprehensive Pre-Release Psychological Assessment - to be completed by psychologist (contract or institutional).

Subsequent Pre-Release Psychological Assessment

II. A. Post-Release Assessment - to be completed by psychologist or psychiatrist (contract or institutional).

B. Post-Release Treatment - to be completed by a psychologist or a psychiatrist (contract or institutional).

III. NPB Referrals for Assessment by Psychiatrist:

It is required that all Category I offenders receive an assessment completed by a psychologist or psychiatrist both on admittance and prior to their first review by the National Parole Board. It is noted that Lifers and Preventive Detention cases automatically require assessment by both a psychologist and a psychiatrist.

Further referrals may be made when:

a. requested by the National Parole Board; and

b. institutional staff perceive that a psychiatric assessment is needed. The psychologist shall then review the request and make referral if required.

Copies of all psychiatric reports will be provided to the referring psychologist to ensure follow-up and integration of treatment efforts.

IV. Referrals Outside of the Correctional Service of Canada

V. Quality Control of Psychological Assessment and Treatment:

To monitor and ensure quality psychological service delivery, each Region shall set up an advisory quality control "peer review" panel composed of three provincially registered psychologists; two from within CSC and one external contracted registered psychologist. The Quality Control Committee will consist of the Regional Senior Clinical Coordinating Psychologist (PS-4), a CSC indeterminate MA or PhD registered psychologist, and the above-noted registered contract psychologist who currently practices in that Region. As required, this panel will review the assessment and treatment competence of Correctional Service of Canada psychologists. The contract psychologist and institutional CSC psychologist members of the Quality Control Committee will be replaced every two years.

PART SIX: REQUIREMENTS FOR SPECIFIC PSYCHOLOGICAL SERVICES

A. REQUIREMENTS FOR SCREENING INTAKE PSYCHOLOGICAL ASSESSMENTS

Purpose:

a. To provide all offenders with a psychological review upon initial admittance to ensure that mental health status is assessed and any treatment needs identified;

b. To provide baseline mental health and intellectual functioning information on the offender for case management planning and correctional treatment plan development purposes; and

c. To detect offenders who, while not meeting the referral criteria for a comprehensive intake psychological assessment, required such an assessment.

Methodology:

a. Review of the Penitentiary Placement Report and the offender's criminal history;

b. Administration of a screening test battery including measures of intellectual functioning and personality assessment; and

c. Brief interview with the offender (including debriefing).

Report Content:

a. Identify why the report is being completed; and

b. Briefly address the following:

- intellectual functioning,
- any notable findings from the screening assessment or impressions from the interview,
- identification of treatment needs,
- suggestions regarding the content of the case management officer's correctional treatment plan, and
- requirement for psychiatric referral for assessment or treatment and, if required, the area of concern to be addressed.

B. REQUIREMENTS FOR COMPREHENSIVE INTAKE AND PRE-RELEASE PSYCHOLOGICAL ASSESSMENTS

Intake Assessment

Purpose:

a. To provide a detailed assessment of the offender's mental health needs which describes the severity of any identified problems;

b. To develop an understanding of and to describe the basic personality of the offender; and

c. To identify treatment needs and to develop a treatment/ intervention strategy which addresses these treatment needs in conjunction with the overall treatment plan being developed by the institutional case management officer.

Methodology:

a. A detailed file review, focusing on the criminal profile and the detailed analysis of the offense completed by the case management officer;

b. Psychometric testing;

c. Interviews with the offender (including debriefing); and

d. Consultation with case management, unit and health care staff as required.

Report Content:

a. Identify why the report is being completed; and

b. Address the following:

- intellectual functioning,
- personality structure,
- psychological/psychiatric/behavioral dysfunction,
- aggressive tendencies,
- sexual deviance (when appropriate),
- substance abuse,
- current mental status,
- motivation to change, and
- requirement for psychiatric referral for assessment or treatment and, if required, the area of concern to be addressed.

The report shall emphasize the intervention approaches which may reduce future criminal behaviour.

<u>Comprehensive Pre-Release Psychological Assessment:</u>

Purpose:

a. To address the factors which influence the degree of risk posed by the offender upon release in terms of the likelihood of re-offending.

Methodology:

a. Detailed review of file, including:

- details of police report and official version of offence,
- victim impact statement if available,
- previous medical, psychological, social and criminal history,
- institutional behavioral history,
- current and historical program participation, and
- release plan for the offender;

b. Consultation with case management officer, unit staff or health care, as required, focusing on identified special concerns regarding the actions, comments or behaviour of the offender;

c. Interviews with the offender (including debriefing);

d. Assessment of change from time of prior psychological assessment(s);

e. Review of progress made in treatment (or lack thereof); and

f. Psychometric testing.

Report Content:

a. The primary purpose of the pre-release comprehensive psychological assessment is to address those factors which reduce the likelihood of re-offending when the inmate is released, and to assess whether releasing the offender is a manageable risk; and

b. The assessment is based on and must address:

- an analysis of the offender's personality,
- an analysis of the criminal offence, including a statement of background information used, and major discrepancies found, focusing on the offender's version of the offence versus the official version of the role of the offender, acceptance of responsibility and the effect on the victim,
- profile of presenting problems, clinical history and relationship to his criminality,
- relationship of criminality, psychological profile and environmental and/or addiction factors at time or commission of the offence,
- the effectiveness of any treatment received and an assessment of what impact there may have been in relation to managing risk,
- analysis of the environmental factors in the community which would influence the risk of re-offending,
- identification of warning signs to look for in certain environmental situations in relationship to managing risk,
- clear statement of requirements for follow-up treatment, type of treatment, and on whether this treatment is best provided in an institutional or community setting, bearing in mind risk to the community,

- general recommendation regarding the appropriateness of the offender's release plans, and on the frequency of contact likely needed should the offender be release, and
- requirement for further assessment or treatment by a psychiatrist or at a Regional Psychiatric/Treatment Centre, and, if required, specification of area of concern to be addressed.

C. NATIONAL PAROLE BOARD REQUIREMENTS FOR PSYCHOLOGICAL/ PSYCHIATRIC ASSESSMENTS OF OFFENDERS

The National Parole Board is committed to the protected of society by making independent quality conditions release decisions that facilitate the timely reintegration of offenders as law-abiding citizens. Risk to society is the fundamental consideration in the conditional release decisions rendered by the Board. In the case of some offenders information based on psychological and psychiatric assessments is critically important in assisting Board members to effectively determine the risk of reoffending and to assess the potential of the offender to function as a law abiding citizen. Appropriate assessments, particularly those that address the question of risk, help ensure that fully informed, quality conditional release decisions are made in relation to these offenders. In addition, these reports may assist the Board in establishing special release conditions, or if release is not granted because of the risk posed as a result of an offender's mental health status, enable the Board to establish its expectations of the Correctional Service of Canada with respect to a treatment strategy that addresses the risk so the offender may be eligible for consideration for future release.

It is recognized that:

Board members may request psychological and/or psychiatric assessment reports, and assessments from independent external professionals, in addition to those specified below, in those cases where this additional information is deemed necessary for the determination of risk. It is stressed that requests for additional and/or outside assessments will be made on an exception basis and will be accompanied with a rationale as to their need.

Some regions may at present be experiencing problems in the availability of psychologists and psychiatrists to complete the assessments.

REQUIREMENTS

1. One psychological and one psychiatric assessment

   - lifers
   - preventive detention

2. One psychological assessment with a psychologist's recommendation regarding the need for a psychiatric referral (refer to Table of offense categories)

   - Category 1 (amended to include all offenses listed in the Schedule to the Parole Act). Such assessments are not required for robbery offenses except in cases of armed robbery or robbery with violence. In these cases, assessments may also be deemed unnecessary if the Correctional Service of Canada recommends they not be completed and the National Parole Board concurs.

   - Category 2 offenders incarcerated previously for an offence in Category 1 for which they have received a sentence of two years or more. Such assessments may be deemed unnecessary if the Correctional Service of Canada recommends they not be completed and the National Parole Board concurs.

   - any offender whose behaviour since sentencing indicates a need for such an assessment.

3. No assessments required

   - category 2 offenders except as stated in 2 above
   - robbery cases except as stated in 2 above

OFFENCE CATEGORIES

CATEGORY 1 OFFENSES:

Criminal Code Section		
Revised Statutes of Canada 1970	Revised Statutes of Canada 1985	
79	81	Using explosives
83	85	Use of Firearm During Commission of Offence
84	86	Pointing a Firearm
132	144	Prison Breach
203	220	Causing Death by Criminal
204	221	Causing Bodily Harm by Criminal Negligence
218	235	Punishment for Murder
219	236	Punishment for Manslaughter
220	237	Punishment for Infanticide
221	238	Killing Unborn Child in act of Birth
222	239	Attempt to Commit Murder
228	244	Causing Bodily Harm with Intent
229	245	Administering Noxious Thing
230	246	Overcoming Resistance to Commission of Offence
231	247	Traps Likely to Cause Bodily Harm
232	248	Interfering with Transportation Facilities
245.2	268	Aggravated Assault
245.4	269.1	Torture
246.1	271	Sexual Assault
246.2	272	Sexual Assault with a Weapon, Threats to a Third Party or Causing Bodily Harm
246.3	273	Aggravated Sexual Assault
247	279	Kidnapping
247.1	279.1	Hostage Taking
	465(1)(a)	Conspiracy to Commit Murder

OFFENSES AGAINST PERSON AND REPUTATION

245	266	Assault (former Common Assault - 245)
245.1	267	Assault with Weapon or Causing Bodily Harm
245.3	269	Unlawfully Causing Bodily Harm
246	270	Assaulting Peace Officer
303	344	Punishment for Robbery (offence 302)

ARSON AND OTHER

389	433	Arson
390	434	Setting Fire to Other Substance
392	436	Setting a Fire by Negligence

FORMER OFFENSES: (RCS 1953-54, C.51)

144	Rape
145	Attempt Rape
149, 156	Indecent Assault
245	Assault with Intent
	Dangerous Sexual Offenders
688	Dangerous Offenders

CATEGORY 2 OFFENSES

All other offenses

PART SEVEN: POLICY ISSUES

Inspection of the above noted requirements for psychiatric and psychological services raises a number of issues that need to be examined in terms of both the nature and quality of psychological/ psychiatric services and the impact of these services on offenders. In many cases, these issues will take further consultation with the affected individuals and agencies, i.e. National Parole Board, Psychologists, Case Management, and Parole Offices.

A. What is Treatment/What is a Program?

The Task Force reviewed the need for psychiatric/psychological services from two primary functional perspectives: assessment and treatment. The first of these functions, assessment, includes:

a. initial pen placement assessment,
b. assessment prior to a decision, and
c. brief clinical impression and consultation services for case managers.

Induction assessments and brief assessments for offender case management/program planning purposes should be routinely completed by C.S.C. psychologist employees. Comprehensive pre-release decision assessments can be effectively contracted out to private practice psychologists registered in the province where the inmate is currently being held.

The second function, treatment, includes the clinical treatment of mental illness including ongoing management of long term mental health patients.

Treatment, for this review, may be conceptualized as the dichotomy of the "mad" and the "bad". In the case of the former, "the mad" has a mental health focus, is driven by the D.I.S study, and is limited to the traditional role of mental health workers. The latter case, "the bad" is driven by the Integrated Sentence Management System including C.M.S. and the criminogenic factors, with programs focusing on cognitive restructuring (living skills), anger management and substance abuse program.

B. CSC Provides Treatment for the "Mad" and Programs for the "Bad"

The Task Force believes that for psychological and psychiatric assessments, a registered Health Care Practitioner (psychologist or psychiatrist) will be required, but for clinical treatment other treatment providers may be considered, i.e. psychiatric nurse, social worker, group specialist. The programs for the "bad", i.e. antisocial offenders, do not necessarily require a psychologist to provide the program; however some rehabilitative programs such as the sex offender program should be overseen by a registered psychologist. There are resource savings to be made if registered psychologists only used when necessary and less expensive options are used when "treating" or "programming" offenders. In addition, C.S.C. staff psychometrists (unregistered MA) can prepare assessment reports under the direct supervision of a registered psychologist.

Recommendation 1: The completion of full psychological assessments be limited to a contract registered psychologist, C.S.C registered indeterminate psychologist or C.S.C. psychometrist (MA unregistered) supervised by a senior registered institutional psychologist.

C. Service vs. Program Delivery

The difference between a service and a program needs to be made. Services tend to be open ended and user driven. Programs have parameters and are resource driven. When applying this notion to psychology, we should be looking for opportunities to develop programs with tight parameters, and integrity of operations, as we have done with the cognitive living skills and ABE programs. Other examples could include offering anger management or reality therapy group modules or programs. It is estimated that at least 50% to 60% of offenders could be managed in a group basis (National Resource Requirement Study on Psychology, 1989). This allows for extension of existing resources to provide more programs for offenders. Group treatment has been demonstrated effective for programming/changing addiction problems (alcoholism, drugs, weight loss, gambling, sexual deviation); anxiety related issues (stress management, phobias, grief and loss adjustment, parenting problems, chronic pain management); and behavioral inadequacies or excesses (life skills, living skills, temper control, anger management, assertiveness skills training, pre-release skills). In addition, more offenders can receive treatment services through a group treatment format as opposed to individual counselling.

Recommendation 2: Psychological treatment be delivered wherever possible as a defined program or module.

Recommendation 3: Group treatment be the preferred method of program delivery wherever possible.

D. One Assessment is Good, Two are Better?

The number of assessments per offender has to be examined if we are to maximize our resources. It is recognized that there are procedural requirements and in some difficult cases the need for second opinions.

Assessments have a shelf life of 24 months when there has been no extensive program involvement. The simple completion of a substance abuse program or Living Skills program should not in itself justify a new assessment in under 24 months. Further, getting another assessment because the offender or member of the C.M.T. didn't like the first, is a questionable practice.

Consultation with the National Parole Board and education of case management staff will be necessary. In addition, there needs to be improved screening for requests for psychological assessments.

Recommendation 4: Psychological assessments have a shelf life of 24 months unless significant program participation and/or treatment has occurred.

Recommendation 5: The need for a second psychological assessment should be re-examined to ensure value for the resources expended. Requests for psychological assessments be screened by a senior CSC psychologist to assess the necessity, priority and appropriate resource required.

E. Contract Psychological Assessment Requirements

Person years (PY's) are a valuable resource tightly controlled by Treasury Board. PY expenditures allow us to employ staff that develop an allegiance to the Service. The employee develops a keen understanding of the correctional milieu, however, they do not necessarily assess offenders any better than a contract forensic psychologist. To employ our own staff brings with it organizational obligations to train, provide leave and loss clinical services time to attend staff meetings, conferences, and travel time, and administrative matters.

When Integrated Sentence Management reports are routinely generated on all new admissions early in their sentence, the time required for a full psychological assessment will undoubtedly be reduced to one day, thereby allowing C.S.C. psychologists to cost efficiently complete assessments on a par with contract psychologists.

In addition, Induction/Reception Units in each Region will reduce the demand for the "old style" comprehensive psychological standard assessment. The leaner, more psychological and less social history oriented document outlined earlier in this report can likely be completed in a day by a CSC indeterminate or contract psychologist < (a) file review, (b) test interpretation, (c) interview inmate, (d) write report with interview impressions, test results and interpretation, summary and recommendations >.

Treatment programs designed to maximize offender change must operate within a supportive milieu. C.S.C. psychologists are more likely to be effective in this regard as their understanding of and ability to work within the correctional milieu is their edge over contract personnel. Their relationships with staff and offenders allow them to foster a climate supportive of treatment programs, i.e. sex offender or mental health program. They can be used to "supervise" other C.S.C. staff engaged in program activities.

Recommendation 6: Whenever practical and cost effective, contract resources ($) be used for comprehensive psychological assessment requirements and indeterminate PY psychology resources be used for treatment of offenders.

F. Functional Management of Mental Health Programs in the Five CSC Regions and at National Headquarters (NHQ)

The matter of some type of regional coordination/functional supervision of psychological services was examined. The Program Task Force proposed a Regional Psychologist position in each Region. It is clear from an examination of this issue there is a need to "manage" our mental health resources in a more effective fashion. Given the diversity in the provision of psychological services and the resources involved, region wide coordination is necessary. The current situation prevents introduction of efficiencies and produces unnecessary administrative costs.

Recommendation 7: A position for a registered Regional/Senior Clinical Psychologist (PS-04) be created in each RHQ to provide functional management to the Regional Mental Health program.

Recommendation 8: A position of Chief, Psychological Services (PS-05) be created at National Headquarters, Health Care Division, to provide functional direction, quality assurance, and management to the National Psychology Program. The incumbent of this position must be a registered psychologist in a province of Canada.

G. Psychological Services in Parole Districts

The Task Force on Programs has recommended that a PY be assigned to each parole district to provide case consultation, treatment services, and coordinate the work of contract psychologists.

The coordination of activities for contract psychologists in parole districts is now provided by District Directors, an Area Manager, a Community Development Parole Officer, and the proposed senior psychologist for the Region. This will allow parole districts to concentrate energies and resources on placing offenders in community treatment programs and facilitate the community psychologist's active treatment of offenders in the community.

The Task Force supports the need for consultation and psychological treatment services in parole districts. The provision of PY equivalent funds for these services are recommended in some districts and a PY in others. Parole Districts should also be given sufficient funds for a Community Sex Offender Program. This will allow maximum flexibility for District Directors to secure required treatment and consultation services.

Recommendation 9: Each Parole District Office receive a PY psychologist and sufficient O&M funds for special programming depending on a particular District Office's requirement for psychological/mental health services.

H. The Productive C.S.C. Psychologist

The standard of productivity for C.S.C. psychology staff has been extensively reviewed by previous NHQ reports. This review suggests (see Core Value 3 and psychology section) 50% of psychologists' time be allocated to assessment. Assessment productivity is expected to be on average ten (10) reports per month over eleven (11) months or one hundred and ten (110) per year.

In regards to treatment productivity, it is not unreasonable to expect that 5 1/4 hours should resource a group program of one weekly group therapy and at least one 3/4 hour of monthly individual follow-up for ten (10) offenders.

At least one-half (1/2) the psychologist's caseload should be in group treatment. Individual treatment should be for specific time frames for specific interventions. Brief ongoing supportive counselling sessions should, wherever possible, be carried out by case management and psychiatric nursing staff. Treatment intervention programs by psychologist should be target specific and time limited.

It is not unreasonable to expect staff psychologists to complete two (2) assessments per week, lead a treatment group program, provide consultation services and have an intensive individual treatment caseload (seen weekly 3/4 hour) of up to eight to twelve offenders. As these are very expensive resources, there is no room for under productive PYs. These productivity targets will require further consultation.

Recommendation 10: Performance appraisal objectives of mental health practitioners be written in measurable, achievable and meaningful terms to reflect productivity expectations.

I. Core Value 3 and Psychology

How to Effectively Manage a Valuable Resource

Psychologists provide specialty services to offenders within C.S.C. The psychological assessment function must be completed by either provincially registered contract professionals or C.S.C. indeterminate psychologists. Offender Treatment functions can be offered by many mental health professionals (nurses, social workers, psychiatrists, and psychologists) who have developed competence in specific treatment techniques.

To enable C.S.C. psychologists to maintain their enthusiasm, their effectiveness, and their productivity, the job requirements and the correctional environment must be conducive to professional growth. A narrow job description (i.e. 100% assessment duties) will lead to staff unproductivity and eventually staff turnover. A repressive, non-consultative work environment will lead to staff turnover.
However, with an adjustment to current practices, some of the clinical work carried out by the RPC Ambulatory Contract Professionals could be carried out by institutional psychologists - enriching their work environment, strengthening relationships between psychologists and the RPC and achieving greater benefit for monies spent.

The Integrated Sentence Management Model (ISM) highlights the important contribution that psychologists will make to the assessment and treatment of offenders. The ISM requirement for thorough risk management assessments and effective therapeutic agents for personality change of offenders requires psychologists to play a strong consultative and program delivery role within C.S.C. institutions. To enhance the job satisfaction of C.S.C. psychologists, it is recommended that:

Recommendation 11:

a) psychological assessment requirements are to be limited to 50% of the job description for non-reception centre psychology positions;
b) flexible staffing/hours of work be facilitated (e.g. 80% indeterminate positions and/or compressed work week schedules);
c) development of Ambulatory Services (out-patient services) type duties for institutional psychologists be explored;
d) a clearly defined training program for MA and PhD level psychologists in the Regions be developed;
e) in support of Core Value 3 and 4 efforts be made to facilitate university cross-appointment for PhD level CSC psychologists, and other mental health care professionals;
f) psychologists be an integral part of treatment delivery systems providing direction to programs where appropriate, e.g. sex offender treatment and substance abuse treatment;
g) research and program evaluation objectives be incorporated into each psychologists' position;
h) an annual professional development conference be held for the Correctional Service of Canada mental health staff, beginning in 1991, focusing on clinical issues and research.

J. Ambulatory Services

The Task Force briefly looked at the merits and cost/benefits of Ambulatory Services programs. This extension of the Regional Psychiatric Centres is provided by contracts with private psychiatrists/psychologists who are registered in the province of

practice. The RPCs and local universities should jointly sponsor doctoral level psychology residency programs. Recent PhD graduates or doctoral level students with all clinical psychology course work completed could be contracted for one year to provide clinical psychological assessment and treatment services to offenders under the clinical supervision of RPC registered psychologists and the RPC Ambulatory Team. Psychiatry residents would be a welcome addition to the health care team in each Region's Treatment Centre.

Residents deliver supervised clinical services to the RPC treatment programs and to offenders in the Regional Institutions.

Recommendation 12: That an 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.

PART EIGHT: THE STRUCTURE OF TRAINING IN APPLIED PSYCHOLOGY RATIONALE FOR DOCTORAL LEVEL ENTRY

The following is an abridged version of a brief article by B. Quarrington, PhD, prepared for the Ontario Board of Examiners in Psychology in January 1990.

Historically, psychology is a scientific discipline that emerged from philosophy. As the body of its scientific knowledge and theory developed, it became evident that there were applications of its methods and body of knowledge to matters of human concern in business, industry, education and in health. It was not until the second decade of the present century that significant numbers of individuals sought to prepare themselves as specialists in the application of psychological methods and knowledge. The preparation that they undertook was essentially an extension of the content of the graduate study programs which had evolved for training psychological scientists. Even today when psychologists are trained for work in different applied areas, this is the form that training takes. This is not just a matter of historical accident, but rather a response to a generally held conviction that, to produce a sound practitioner who will contribute to society and the profession, applied professional training in psychology must be balanced by thorough scientific training. For example, the most commonly employed educational model that universities in North America use in training clinical psychologists, known as the "scientist-practitioner model", seeks through its educational objectives and methods employed the instatement of complementary clinical and scientific knowledge and skills.

Applied psychology in North America has not sought to develop professional schools of psychology at the undergraduate level, nor has it sought to base professional training in graduate study at a degree level lower than the doctorate. Psychologists appear to hold generally three convictions which account for this and which will shortly be shown here to be supported by research evidence. These convictions are that:

a) The understanding and sound application of psychological knowledge requires a basic appreciation of man and society. This is usually acquired in undergraduate study which provides intellectual foundations in the humanities as well as in the social and biological sciences. (In large part this explains why undergraduate schools of professional psychology have not been develop.)

b) The sound application of psychological knowledge requires complex skills of analysis, decision-making, planning and ethical reasoning and judgment that can only be identified and developed in a number of closely supervised training contexts in which human problems, their identification and remediation, are the focus of concern. (This speaks to the question of why briefer non-doctoral graduate programs in applied psychology have not become significant terminal professional programs.)

c) The sound application of psychological knowledge requires much the same analytical and problem-solving skills, and a similar appreciation of research methodology and theoretical conceptualization as is required of the psychological scientist. (This conviction goes a long way in explaining why the doctoral degree is considered in North America to be the qualifying professional degree.)

UNDERGRADUATE AND MASTERS LEVEL INSTRUCTION

In psychology there is no undergraduate professional training school or program in North America. In this respect, psychology differs from occupational therapy, optometry, pharmacy, physiotherapy and some other health professions. Psychology is, of course, taught as an undergraduate subject to arts and to science students in Ontario universities. Such instruction, even when elected as an area of specialization, is concerned with the extremely broad scientific base upon which psychology as a science, and as an applied profession, is built. The amount of undergraduate instruction in applied psychology is so limited it may be said not to exist. Professional training in psychology really begins at the graduate level, and usually only after the Masters degree.

In Ontario universities the Masters program is usually conceptualized as either a one or two year program of study and as a preparatory program for the subsequent program which leads to a doctoral degree. Since graduate programs are training

individuals for academic as well as for a variety of careers in applied psychology, the content of a Masters program is usually common to all graduate students with some limited degree of specialization or personal choice. Understandably, the content of Masters program emphasizes training in statistics, research methodology and basic or general theoretical issues. There are very few Masters programs in Ontario which offer specialized applied training. There are several reasons for this. It is difficult to recruit high quality students and to attract faculty to teach in a program that will not prepare student for the highest professional qualification or permit access to doctoral programs. Most specialized Masters programs, explicitly or implicitly, recognize that the degree offered is a terminal degree permitting neither registration in Ontario, nor ready acceptance into doctoral programs.

GENERALITY OF THE DOCTORATE AS THE QUALIFYING DEGREE

It is a long-standing opinion of academic and applied psychologists that the level of knowledge and skills required for an applied practice of psychology in any area of specialization can only be attained through selection, training and evaluation procedures inherent in a doctoral level program. This conviction is manifest in many ways. Full membership in the fraternal organizations of the Canadian Psychology Association, or the Ontario Psychological Association, or the American Psychological Association requires a doctoral degree. The doctoral degree is required by 45 of the 50 states for the licensing of psychologists. In Canada, in all provinces west of Quebec the doctoral degree is required for licensing/certification, and will soon be required by Newfoundland.

That a doctoral degree is generally an admission standard for full membership in fraternal organizations, and as an entry requirement for professional registration, indicates that a doctoral degree is not an arbitrary criterion in any particular jurisdiction. This alone, however, does not prove that the doctoral degree is necessary to carry out the actual activities that are performed by members of the profession in independent or institutional practice. What would be required for proof would be information as to the actual activities performed by psychologists in their practices and, further, an analysis of these that would permit one to judge whether the training received in doctoral training was necessary for the execution of these activities. A study of this sort has been carried out.

JOB ANALYSIS OF PROFESSIONAL PRACTICES IN PSYCHOLOGY

The study in question was commissioned by the American Association of State Psychology Boards. The primary purpose of this study was to provide an empirical basis for the contraction of selection of test items in the written examination, which is one of the entry requirements for licensing/certification, but it has also provided detailed job analyses of the major areas of

specialization in applied psychology. The study was carried out by a team of psychologists in the Centre for Occupational and Professional Assessment within the Educational Testing Service, an established non-profit organization with an outstanding reputation for excellence in research and test development located in Princeton, New Jersey.

The study involved representative samples of licensed/certified psychologists in the United States (N=1,547) and Canada (N-506) who were employed or engaged in independent and institutional practices in the major areas of specialization, clinical, educational and school psychology ,.and industrial/organizational psychology. The design of this study was complex and the findings very extensive so that what is reported here oversimplifies, but it does not distort, the nature of the findings. Using a carefully developed questionnaire psychologists were asked to describe the responsibilities or activities involved in their practices and to supply information about the procedures, techniques and knowledge involved in these professional activities.

A powerful statistical procedure (factor analysis) was employed to the responsibility data for each of the major areas of specialization mentioned earlier and four factors or types of activity were found to be present in varying degrees in the various areas of specialization. The most appropriate terms for these factors appeared to be: Research and Measurement, Intervention, Assessment, and Organizational Applications. The practices of clinical psychologists were found to contain significant components of these four general categories or dimensions of activities with particularly strong representation from the Intervention and Assessment dimensions. The factor analytic techniques employed in this study permitted the investigators to study these general dimensions of activities or factors, to determine what specific activities were most characteristic or representative of the dimensions. When these most characteristic or salient activities had been identified, it was then possible to ask questions as to what sort of training experiences, or what level of training, would ordinarily be required to acquire the knowledge and skills involved in the performance of these activities.

The answers to these questions clearly imply that the nature and extent of training experiences required would typically only be attained with the successful completion of a doctoral program. A detailed examination of some of the findings of this study, presented in the table below, would be illustrative. The factor or activity dimension of Intervention is a major component of the practice of clinical psychology. The table shown is from the study under discussion, and shows in a declining order of salience the specific activities characterizing the Intervention factor. It is evident that activities of psychological intervention cannot be conceptualized adequately in terms of applying specific techniques or simply following the protocol for one or

two forms of psychotherapy. An examination of the listed activities reveals the multiplicity and complexity of the sorts of responsibilities involved in the management of treatment. The table shows that the most salient activities in the Intervention factor involve the selection and planning of treatment strategies in terms of the individual needs and characteristics of the client, and also in the light of their particular life circumstances. Also involved are the activities of evaluating the effectiveness of ongoing treatment and the revision of treatment when it is warranted. These are activities that depend importantly on having received instruction and supervised experience in several modalities of treatment, and on having studied diagnostic and assessment techniques as these relate to treatment planning and selection. The readings, course work and supervised experience underlying the knowledge and skills implied in the foregoing activities could only be attained in training extending to the doctoral level.

At the Masters level, the available time ordinarily permits little in the way of specialized training, but one could expect to expose a student to one or two forms of intervention that would yield specific technical skills. This, however, falls far short of the knowledge and skills required to decide what technique is likely to be fruitful with a particular client, or to evaluate the technique when applied in respect to its benefit or harm. These higher-order intervention skills provide the context within which specific technical skills of giving help yield benefits. Without these skills, which involve judgment, or without the benefit of supervision by someone with these skills, the potential for ineffective client management or harm is too great to be accepted by the profession.

An examination of the other activity dimensions or factors (Assessment, Research and Measurement, and Organizational Applications) also lead to the conclusion that while some clinical training offered at the Masters level might be expected to yield some specific skills of clinical value and some factual and theoretical knowledge of basic importance, it would not provide usually, the range of skill and knowledge required for clinical practice.

LOADING FOR RESPONSIBILITIES ON INTERVENTION FACTOR FOR CLINICAL PSYCHOLOGIST (from Rosenfeld, Shimberg, and Thornton, pp. E4-E5)

Dimension III: INTERVENTION. This dimension involves the setting of realistic goals for dealing with a problem, planning intervention strategies appropriate to the situation and discussing alternative courses of action with those concerned. Of high salience in this dimension are such functions as monitoring and evaluating the effectiveness of the intervention strategy and modifying or revising that strategy as necessary. On the basis of the initial assessment, the client or patient may be referred to another professional for help; or the services of other professionals with specialized skills, (i.e. remedial or

rehabilitation specialists, physicians, occupational training specialists) may be enlisted. In the latter case, the psychologist maintains liaison with agencies, organizations or other service providers who may be assisting the client or patient in dealing with the problem. Assuring the privacy and security of client records is also encompassed by this dimension.

Responsibility Number	Description	Factor Loading
35.	Modify or revise intervention strategy as necessary	.64
34.	Monitor and evaluate effectiveness of the intervention(s) in meeting specified needs	.63
24.	Set realistic goals and expectations with client and/or significant others taking into consideration such factors as time, resources available, and cost	.60
21.	Plan intervention strategies appropriate to the specific problem or situation	.55
23.	Discuss alternative courses of action with client/patient and significant others (i.e. relatives, teachers, employers, managers)	.53
20.	Based on assessment of the problem, refer client or patient to other professionals or organizations as appropriate	.51
33.	Maintain liaison with other agencies or service providers on behalf of clients, patients, or other individuals who may have been referred for assistance	.50
43.	Assure privacy and security of client's records in accordance with professional standards and guidelines	.50
32.	Recommend and/or arrange for services of other professionals (i.e. remedial or rehabilitation specialists, physicians, occupational training specialists) to help in dealing with problem(s) defined	.49

Responsibility Number	Description	Factor Loading
1.	Conduct interviews with client/patient, family members or others to gain an understanding of an individual's perceived problems	.49
25.	Obtain client's informed consent when treatment or procedure involved risks	.42
26.	Provide assistance to individuals regarding personal or organizational problems	.41
55.	Keep abreast of professional and scientific developments (i.e. reading literature, participating in continuing education programs, attending professional meetings)	.41
5.	Observe the behaviour of individuals who are the focus of concern	.40
6.	Organize the evaluate information and/ or observational data to determine what additional information may be needed	.38
2.	Take a personal history from client/ patient or relevant others to gain an understanding of an individual's perceived problem(s)	.38
17.	Discuss the preliminary interpretation(s) with the individual client/patient, and/ or concerned others (i.e. relatives, teachers, managers) before arriving at diagnosis or problem definition	.37
7.	Develop an approach or plan for the systematic collection of additional data needed for problem delineation	

CONCLUSIONS

The training and licensing/certification of clinical and other applied psychologists in North America has been based on the generally held opinion that the doctorate was the appropriate qualifying degree. Some of the assumptions or convictions underlying this conclusion appear to be reasonable when examined. When tested against the results of scientific study of the actual activities of psychologists in clinical and other applied practices, the requirement of successful doctoral training as the academic requirement for entry to the profession appears entirely justified.

Recommendation 13: C.S.C. develop a two level psychological service delivery system within C.S.C. institutions: registered psychologists 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. Current unregistered MA staff psychologists will need to be grandfathered as C.S.C. psychologists. All future staffing actions will require provincial registration for psychologist positions (PS-03); MA level psychometrists (PS-02) will be psychological associates.

PART NINE: PRACTICE GUIDELINES FOR PROVIDERS OF PSYCHOLOGICAL SERVICES (1989)

The Practice Guidelines are considered by the CPA Professional Affairs Committee to be of most interest and usefulness to psychologists who provide services directly to clients or who administer psychological service units and programs. The guidelines can be helpful in organizing services, and in evaluating their quality and appropriateness. The guidelines may also be of interest to regulatory bodies and training programs.

CPA has approved Practice Guidelines for Providers of Psychological Services (1989) to replace Standards for Providers of Psychological Services (CPA, 1978) just as APA approved General Guidelines for Providers of Psychological Services (1987) to replace Standards for Providers of Psychological Services (APA, 1977).

The CPA are:

1. The objectives are explicit, the most important being to define common expectations for organizations and psychologists, and to provide an external authority to support psychologists in maintaining practice standards in less than ideal work situations.

2. Four levels and types of providers are defined so that it is clear who carries responsibility for the various practices, and the employed psychologist provider cannot be held responsible for the responsibilities of the psychologist administrator or of the mandating agency.

3. The Practice Guidelines are cross referenced to the current Canadian Code of Ethics for Psychologists.

4. The emphasis in the Practice Guidelines is clearly on "Responsible Caring" in the provision of psychological services to clients. Three quarters of the standards content for "Responsible Caring" in the CPA Code of Ethics is included. One half of the standards content for "Respect for the Dignity of Others" is included, with somewhat less attention given to avoiding discrimination, informed consent, and vulnerable clients. The least well represented of the four major principles is "Responsibility to Society", which may be understandable inasmuch as "providers" may not emphasize either research or social advocacy. Placing the emphasis on the well-being of consumers seems more altruistic than on the well-being and recognition of the profession per se.

Following in its entirety are the Practice Guidelines for Providers of Psychological Services (CPA, 1989)

PRACTICE GUIDELINES FOR PROVIDERS OF PSYCHOLOGICAL SERVICES
This document replaced the CPA document, Standards for Providers of Psychological Services (1978)

Approved by the Board of Directors of the Canadian Psychological Association October 29, 1989.

Practice guidelines for psychologists who provide psychological services serve the important purpose of describing professional activities which demonstrate compliance with the profession's standards of ethical and competent behaviour. The Canadian Psychological Association provides this revision of its policy documents Standards for Providers of Psychological Services (1978) pursuant to the recent adoption of the new Canadian Code of Ethics for Psychologists (March, 1986). This revision of the guidelines is cross-referenced to current standards documents, including the Canadian Code of Ethics for Psychologists (1986).

The objectives of the guidelines for the providers of psychological services and for the users of such services include the following:

1. Practice guidelines define common expectations for organizations and psychologists who provide psychological services and for the user of the service. They provide both the provider and the user with a baseline or criteria for evaluating the quality and appropriateness of practice.

2. Practice guidelines provide an external authority for standards of ethical and competent practice for psychologists working in situations where others may be minimally knowledgeable and minimally supportive of these standards. Situations where such guidelines may be helpful may arise in working within organizational structures, or with third-party users.

3. Practice guidelines have significant influence on tomorrow's professionals through their incorporation into teaching models.

4. Practice guidelines may contribute toward legislative and regulatory requirement for the practice of psychology. Guidelines may assist in providing greater legislative uniformity across Canada with regard to standards of training qualifications and competence.

5. Practice guidelines may give specific content and structure to the profession's principles of ethical practice.

There are a number of features of the following practice guidelines for psychologists that warrant attention. First, guidelines identify standards of behaviour and approaches to service delivery which must be provided to at least a minimal level across the full range of psychological services. However, psychologists are expected to strive for excellence in the practice of their profession. Second, in order to assist psychologists in identifying the underlying principles, the practice guidelines are cross referenced to ethical principles and standards in the Canadian Code of Ethics for Psychologists. However, the practice guidelines are not seen as a substitute for the code of ethics. The practice guidelines are based on the code of ethics, and are not intended to provide comprehensive coverage of the code of ethics, nor of the professional ideals and models for ethical decision making contained within the code. Third, if these guidelines are used in the context of quality assurance mechanisms they may help to safeguard the public and provide a context within which service innovations may be safely made. These guidelines should not constrain psychologists from employing new methods of making flexible use of innovative procedures in serving the public and increasing the body of psychological knowledge. Fourth, it is believed that all Canadian psychologists in professional practice should be guided by a common code of ethics. While it is recognized that provincial regulatory bodies adopt their own enforceable standards documents, the Canadian Psychological Association's guidelines can provide leadership, information and inspiration in a manner which is designed to complement the work of provincial jurisdictions.

Standards evolve over time. The following sets of standards were reviewed in the preparation of this document:

- The Canadian Psychological Association Standards for Providers of Psychological Services (1978);

- The American Psychological Association Standards for Providers of Psychological Services (1977,1987);

- The Canadian Psychological Association Canadian Code of Ethics for Psychologists (1986); and

- Provincial minimum practice standards adopted since 1978.

The guidelines are divided into several sections, beginning with definitions of the terms to be used. Five general areas of standards follow, these being:

I. Provision of services;

II. Organization of services;

III. Client relationships;

IV. Training, qualifications and competence; and

V. Record keeping.

DEFINITIONS

Providers of psychological services refers to:

1. Professional psychologist practitioners who are registered/certified/licensed in a province/territory where psychology is regulated by statute and who may work independently or may be employed in a larger organization unit.

2. Any other persons who offer psychological services under the supervision of a professional psychologist.

3. Professional psychologist administrators who are responsible for organized psychological services units including agencies, departments, programs, teams, or other types of units.

4. A larger organization which mandates, funds, and/or employs staff to provide psychological services as part of its overall operations.

Psychological services refer to one or more of the following:

1. Evaluation, diagnosis and assessment of the functioning of individuals and/or groups in a variety of settings and activities.

2. Interventions to facilitate the functioning of individuals and groups.

3. Consultation relating to the assessment of the functioning of individuals or interventions to facilitate the functioning of individuals and groups.

4. Program development of services in the areas identified above.

5. Supervision of psychological services.

A psychological service unit is the functional unit through which psychological services are provided. This includes, but is not limited to, the following:

1. A unit which provides predominantly psychological services and is composed of one or more professional psychologists and supporting staff.

2. A psychological service unit which operates as a professional service or as a functional or geographic component of a larger governmental, educational, correctional, health-related, training, industrial or commercial organizational unit.

3. A psychologist providing professional services in a multi-occupational setting.

4. An individual or group of individuals in a private practice or a psychological consulting firm.

Clients or users of psychological services refers to all clients, irrespective of age or presenting problem and includes individuals, groups, families, organizations or whole ecologies of human beings and their institutions. (APA:SOS, 1984). Users/clients include, but are not limited to, the following:

1. Direct users or recipients of psychological services.

2. Public and private institutions, facilities or organizations receiving psychological services.

3. Third-party purchasers of psychological services. This includes purchasers who pay for delivery of services, but who may not be the recipients of those services.

I. PROVISION OF SERVICES

I. 1. Psychologists design the content and form of psychological services to meet the needs of users.

a. The psychologist administrators of service units systematically collect and analyze information on the needs of users in order to develop appropriate service programs. They identify which user interests are addressed by the program.

b. The psychologist practitioners assess individual user/client needs and assure that individual services are suited to these needs before the services are provided (CE II. 10-11; IV.9)

c. The psychologist practitioners recognize that when there is conflict between employer and third party user need and that of the direct recipient client need, that the latter takes priority. (CE I. Values Statement: 18)

I. 2. The psychologist administrators are responsible for assuring the psychologist practitioners are suitably trained in the skills and techniques necessary for providing the services offered.

a. The psychologist administrators of service units which offer a wide or diverse range of services assure that the psychologist practitioners concentrate on specific areas of practice or competence, and do not offer a range of services so broad as to reduce or dilute expertise. (CE II. 6,7)

b. The psychologist administrators of service units assure that psychologist practitioners have sufficient diversity of training and experience to meet diverse services needs. (CE II. 6,7)

c. The psychologist administrators assure that persons performing psychological service functions who do not meet standards for professional practice are supervised by professional psychologists with appropriate training and experience. (CD I. 36; II. 42, 43; III. 36; IV. 23)

I. 3. All levels of providers of psychological services are responsible for providing services efficiently and effectively.

a. Psychologist practitioners are responsible to only offer services for which they have established their competence, or to obtain adequate supervision when extending their areas of competence to new areas.

b. Agencies, psychologist administrators and practitioners work to ensure that users receive services in a timely fashion. Psychologists take action to avoid waiting periods or delays in the

provision of services by monitoring the volume of service requests, and the capability to meeting those demands. Options for avoiding unreasonable delays may include increasing the number of psychologists in a service unit, establishing hierarchy of user needs or directing users to alternate services. (CE II. 18, 27; IV. 2)

c. All levels of providers of psychological services monitor, review, or evaluate the effectiveness of services to ensure that user needs are met. Providers may alter or revise services to ensure effectiveness. They may adopt more effective new or alternate services as they become available. (CE II. 18; IV. 2)

d. Psychologists are to be accountable for the services which they provide to the users of the service, and may also be accountable where applicable to an employer, to an external accrediting body, and to their professional regulatory body. Psychologists actively participate in procedures established by the employer or the profession of psychology for the purpose of review and evaluation of psychological practice. Psychologists ensure that these procedures comply with the standards of the Code of Ethics. Professional standards and guidelines for psychological practice are used to evaluate the quality of service delivery, and provide a basis for corrective action when deficiencies are discovered. (CE II. 18)

II. ORGANIZATION OF SERVICE

II.1. Psychologists establish the rationale and philosophy of services through clear statements of service delivery objectives.

a. The psychologist administrators organize professional services to meet stated objective which identify the intended recipients and the general nature of the services to be provided. (CE II. 15)

b. Professional service program objectives are consistent with meeting the needs and well-being of users of psychology services. (CE II. 1)

c. Psychologist practitioners negotiate individual client objectives to meet the needs and well-being of individual users.

d. Psychologists communicate professional service objectives to staff, users, and other disciplines.

II.2. Psychologists develop clearly defined policies and procedures to structure the delivery of services.

a. Psychologists within psychological service units adopt written procedures and policies which are consistent with professional standards for competent and ethical practice.

b. Psychologists inform clients of the procedures and policies which govern the provision of service. (CE III. 12)

c. Psychologists develop procedures and policies which are consistent with codes of ethics and with standards established by professional regulatory bodies. (CE III. 32, 33)

II.3. Psychologists establish clear lines of professional responsibility and accountability.

a. Supervisory and professional roles and relationships within psychological service units are clearly defined. (CE II. 6; III.10)

b. A professional psychologist directs and administers a psychological service unit.

c. Supervisors must "accept a special responsibility to protect the interest of both users and providers of services in those situations where the persons providing the services do not have current professional creditation in psychology. (CE I. 36; II. 1, 3, 21, 42, 43)

d. Psychologists in a service unit provide regular, systematic evaluation of services at the organizational level.

e. Psychologists in a service unit monitor the adequacy of their staffing patterns to meet service demands and seek to redress staffing shortages which create barriers to service delivery.

III. CLIENT RELATIONSHIPS

III.1. Psychologists strive to make their client relationships clear and unambiguous. (CE I. 7, 12-18; III. 10)

a. Psychologists discuss with their clients the nature of their relationship; and clarify any factors that bear upon that relationship. They clarify limits of confidentiality of psychological records and if there

is a third-party payer for the services, they inform the client of the nature and extent of details that may be released to the third party (i.e. insurance companies, lawyers, courts). (CE I. 18, 32-43; III.10)

b. Psychologists avoid dual relationships with clients and/or relationships which might impair their professional judgement or increase the risk of client exploitation. Examples of dual relationships include treating employees, supervisors, close friends or relatives. Sexual relations with clients are prohibited. (CE I. 2,6; II. 10-31; III. 23; IV.6)

c. Psychologists faced with making difficult ethical decisions seek professional consultation and support. (CE III. 31, 34)

III.2. Psychologists use only those advertising or marketing strategies, and public statements which are consistent with the welfare of the client, of other psychologists, and of the profession of psychology.(CE I. 2, 6; II. 10-31; III. 3; IV.6)

a. To ensure that advertising and marketing strategies are targeted toward appropriate potential users, psychologists provide services to clients only if the service is based upon sound psychological principles or established research findings. (CE I. 17-18; II. 4-8, 10-31)

b. Psychologists use only those advertising and marketing approaches which are based upon sound business principles and which reflect well on the profession of psychology. Claims made by psychologists shall be based upon sound research findings, and may not employ testimonials, selective survey results, or misleading or false information. (CE III.1)

c. Psychologists who interpret the science and practice of psychology to the public enter into a relationship with the public users of that information. Psychologists base public statements upon fact and established information and do not make public statements in areas where they do not possess expertise. Psychologists clearly differentiate between statements which are supported by empirical evidence and those which are based on opinion. (CE III. 1-9)

III.3. Psychologists set reasonable fees for the services they render, inform the client of the fees that will apply to them, and collect fees in a manner which is considerate of the welfare of the client. Psychologists inform clients about fees and fee collection methods as early in the relationship as possible. (CE I. 17-18; II. 1; III. 10, 23)

IV. TRAINING, QUALIFICATIONS AND COMPETENCE

IV.1. Psychologists practice within the limits of their competence. Psychologists obtain training in the special areas of expertise where they will provide services. The training must meet the criteria for independent practice as required by the appropriate provincial/territorial regulatory body. Such training may include formal course work, research, individual study, applied training and/or supervision as deemed appropriate. (CE II. 6-8; III. 4)

IV.2. Psychologists who provide services maintain current knowledge of scientific and professional developments that are directly related to the services they render. (CE II. 8; IV. 3)

IV.3. Psychologists who wish to change their specialized area of practice, or with to expand their areas of competence, obtain such training as required by the provincial regulatory body. (CE II. 6; III. 4, 32, 33)

IV.4. Psychologists maintain knowledge of specialized standards and qualifications that are necessary in the areas in which they provide service. Where necessary and/or appropriate, psychologists obtain special training in the areas in which they provide service, and observe the standards for providers of those services. (CE II. 6, 8; III. 4, 32, 33; IV.3)

IV.5. Psychologists do not provide services when their ability to do so is impaired by alcohol, drugs, physical or psychological disturbance, or other dysfunction. (CE II. 6, 9, 24)

a. Providers who deem themselves, or are deemed to be, unable to provide services ensure that their clients are not adversely affected. Clients are informed of the inability to provide services, and where necessary and/or appropriate are referred to other service providers. (CE II. 24, 27)

V. RECORD KEEPING AND CONFIDENTIALITY

V.1. Psychologists maintain accurate and current records of services provided.

a. Psychologists maintain records with sufficient information for monitoring and evaluating the services provided. (CE II. 15, 18)

b. Psychologists respect clients' privacy by collecting and recording only that information necessary to respond to the needs of the client with appropriate services. When records are used for purposes not directly related to service provision, providers establish policies for protecting the rights of clients and their privacy, and for ensuring that information from records is not used in a manner that violates their rights and privacy. (CE I. 27-32, 34)

c. Psychologists respect clients' rights of access to their own records and they develop procedures to permit user access and user correction of errors. (CE III. 11; I.7)

V.2. All levels of providers work to establish and maintain a reliable method for safekeeping and control of records.

a. Psychologists control access to psychological service records regardless of the method of storage (i.e. physical, electronic, etc.). When records from a psychological service unit are made part of an organization-wide record-keeping system, psychologists develop procedural safeguards to ensure control over the part of the record collected by the provider of psychological service. (CE I. 30, 31)

b. All levels of providers ensure the physical safety of records from loss or damage. Information stored electronically is duplicated so that restoration after accidental loss or damage of an original version is possible. (CE I. 30, 31; II. 15)

V.3. All levels of providers establish unequivocal procedures for releasing records only with the fully informed consent of users.

a. Psychologists inform users of any limits to confidentiality of information concerning them, such as access to records or service information required by third-party users or courts. (CE I. 18, 33, 34; III 10)

b. Psychologists safeguard the confidentiality of information released to third parties, but providing suitable advice to recipients about the confidential nature of the information (CE I. 6; II. 5; IV. 6)

c. Psychologists avoid releasing information which requires professional training for interpretation or analysis to persons who lack that training. When this information must or should be released, providers advise recipients about the limits to the usefulness or meaningfulness of the information. (CE I. 6; II. 2-5; III. 6, 8; IV. 11)

d. Psychologists are cognizant of legal established limits on confidentiality which apply in the jurisdictions in which they deliver psychological services. These limits are addressed, whenever appropriate, within the informed consent procedure which is an integral component of a psychological service. (CE I. 34)

Recommendation 14: C.S.C. adopt the Practice Guidelines for Providers of Psychological Services (1989) for all C.S.C. psychologists (registered and grandfathered unregistered MA's).

TASK FORCE ON MENTAL HEALTH CARE

DISCUSSION PAPER

SUB-TASK # 16

THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

TASK FORCE ON MENTAL HEALTH

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.

submitted by: Jean-Guy Leger

APRIL 1990

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INTRODUCTION

The Correctional Service of Canada, through its powerful Mission Statement, recognizes that "staff constitute the major strength and resource in achieving its objectives". It has already provided strong direction with regards to professional standards through the recent publication of a document entitled "Standards for Health Care" in March 1989. It is committed to the achievement of community standards in the delivery of professional services, e.g. medicine, psychiatry, psychology, nursing, social work, occupational therapy, etc. Three of the 12 principles governing the delivery of health services by the CSC, more specifically principles 3, 8 and 10 attest to this professional commitment:

> Principle 3:
>
> The offender is entitled to reasonable access to the full range of health services, including prevention, treatment and rehabilitation, in accordance with generally accepted community standards.
>
> Principle 8:
>
> The health delivery system within CSC must meet the requirements of existing federal laws and applicable provincial legislation.
>
> Principle 10:
>
> The health services shall be provided by health professionals/practitioners currently registered/licensed (or eligible for registration/licensing) in Canada and preferably in the province of practice.

STANDARDS FOR QUALIFICATION

The standards for qualification and practice of professionals are generally set by provincial regulatory bodies established by provincial statutes.

All professional staff qualified through the Public Service Commission and employed in the Correctional Service of Canada are legally qualified to practice their profession within their terms of employment. For some professions, certification or licensure by provincial professional regulatory bodies, is a requirement for such employment e.g., College of Physicians and Surgeons and the provincial nursing associations. No such requirement exists for some other professions such as psychology, although a number of CSC psychologists are currently registered through provincial Board of Examiners in Psychology, Corporation des Psychologues, etc.

The qualification level set by the Public Service Commission may vary drastically from those set by some Provinces as is the case for psychologists practicing in Ontario. Some provinces register psychologists at the doctorate level only; others register them at the master's level; however, the clear trend and preference is for doctorate qualifications across Canada; usually, but not always, master's level personnel are supervised by a doctoral level, provincially registered psychologist.

Presently, the qualifications for employment as a mental health care professional are sometimes therefore lower in CSC than in the community where provincial certification/licensure is required for professional practice. In achieving community standards, CSC needs to recognize the complexities involved in the question of national standards for the provision of professional services. Staff needs and concerns must also be addressed.

The requirements of principle 10, previously enunciated, have been met by medicine, psychiatry and nursing. Social workers and occupational therapists can be certified through voluntary organizations and some provincial groups are attempting regulation by legislation. It is anticipated that the Government of Ontario will amend the Health Disciplines Act to establish a College of Occupational Therapy. The main challenge for achieving compliance with professional community standards lies in the psychology area. Currently, there is a significant expansion of psychological services in the CSC which brings with it new challenges and responsibilities. These relate to quality control and the training and supervision of inexperienced new recruits. The Correctional Service of Canada is in a position to take significant steps toward a healthy growth in psychological services, provided a number of important issues are addressed, i.e. professional community standards regarding qualification, structure for the delivery of psychological services and the varying role and authority of regulatory bodies governing the

practice of psychology in different provinces. The last three issues, namely professional ethics, recruitment and training do not only apply to psychology, but to other mental health professionals as well.

The minimum academic qualification established by the Public Service Commission for employment as a psychologist within the federal public service is described as follows:

> "Graduation with a master's degree from a recognized university with specialization in personnel psychology, psychometrics, industrial psychology, clinical psychology or some other specialty relevant to the position".

This standard can be altered at any time by CSC without consultation with the Public Service Commission; however, it can only be made more stringent,, i.e. Ph.D. as a minimum requirement.

As mentioned previously, psychologists meeting this PSC minimum standard are legally qualified psychologists in the federal public service. Some psychologists hired by CSC are also registered through provincial regulatory bodies, coincidentally without differential salary or professional recognition. In Ontario, for example, they are certified by the Ontario Board of Examiners in Psychology (OBEP) as registered under The Psychologist Registration Act (PRA) of Ontario (RSO 1980, Chapter 404). The PRA, and equivalent legislation in other provinces, recognizes the right of the Government of Canada to set its own qualifications for employment within the Government of Canada (Section 11(3) PRA). Therefore, a psychologist in CSC who has met the minimum standard established by the PSC is entitled to

practice as a psychologist and to use the title "psychologist" only in the course of his or her employment by the Government of Canada.

The psychologist registration bodies are attempting to prohibit this dispensation.

COMMUNITY STANDARDS: REGISTRATION AND PROFESSIONAL STANDARDS

The Correctional Service of Canada has to move towards the community standard of hiring as psychologist only those who are registered under the provincial legislation. It should be recognized, however, that this is an ambitious goal which may be difficult to meet initially. Therefore, there may be a need for the continued hiring of sub-doctoral level personnel, requiring revised position specifications and appropriate salary levels.

In order to meet professional community standards, the structure for the delivery of psychological services needs to be changed. CSC should ensure the creation of a Chief, Psychologist position in each major institution, the incumbent of which would be provincially registered and responsible for the monitoring of and adherence to professional and ethical standards.

All non-supervisory psychologist positions should remain at the PS3 level, but with a requirement for registration within the province of practice. If this requirement cannot be met in a timely manner, provisions should be made to classify only one such position downward (per institution) i.e. PS2 to permit

staffing. Ideally, such a candidate should possess the necessary potential to achieve registration. The hierarchy within the institution could be: MA entry level - PS2 (if required), registered psychologists - PS3 and registered psychologists in supervisory positions - PS4. It should be noted the above described structure could not be implemented without the re-negotiation of the 1973 Treasury Board Agreement which is both outdated, unrealistic and inadequate today. It basically stated that, should a Chief Psychologist position be established in an institution, the incumbent would be classified at the PS3 level and consequently, the supervised psychologist would have to be re-classified downward to the PS2 level.

The implementation of a new structure for the delivery of psychological services within the 1973 TB Agreement would have significant negative impact as the majority of CSC psychologists do not have PhD qualifications and furthermore, are not registered. Obviously, the implementation of a new structure would necessitate the "grandfathering" of current psychologists who are not registered provincially. The C.S.C.'s efforts to upgrade the qualifications of master's level psychologists through educational leave, highly supported in the Ontario Region, should continue.

The staffing of the newly established positions for District and Regional Psychologists is being approached in an inconsistent manner by the various regions with regards to process and professional qualifications. The incumbent of these positions should

be registered in the province of practice. It is felt the regional positions should possess at least equal qualifications to the proposed Chief in institutions and ideally be of higher classification.

The above mentioned suggested structure is considered to be mandatory in order to significantly enhance the professionalization of psychological services within C.S.C. and thereby, achieving community standards.

PROFESSIONAL ETHICS

The remaining three issues not only apply to psychology, but to the other C.S.C. mental health professional disciplines as well.

Professional ethics must be considered in the endorsement of professional community standards. Again, using psychology in Ontario as an example, OBEP has adopted three documents regulating the ethical conduct of psychology. Moreover, the Government of Ontario has issued a Regulation under the PRA which defines "professional misconduct". These standards are binding on registered psychologists. The Ontario Board of Examiners in Psychology maintains disciplinary control over the activities of registered psychologists similar to the College of Physicians and Surgeons with physicians. Psychologists who are not registered by OBEP and employed in C.S.C. are not subject to peer determined ethical and disciplinary review. The codes of ethical conduct issued by the Canadian Psychological Association and the Ontario

Psychological Association are only binding on members of those voluntary associations whose only sanction is withdrawal of membership. There is no requirement that psychologists in the CSC be members of the voluntary associations although it should be encouraged.

The CSC could insist upon adherence to professional ethical standards, whether or not the employees are registered by provincial certifying bodies or are members of a voluntary professional associations. A major step would be for C.S.C. to endorse the ethical standards of the professional associations and the provincial regulatory bodies for all professionals. If community standards are to be truly reflected in the practice of C.S.C. professional staff, then the role of these provincial regulatory organizations vis-a-vis C.S.C. needs to be clarified and well understood.

RECRUITMENT AND TRAINING

The professional staff selection criteria used for recruitment purposes are determined by the provincial standards decided upon and the competition process. The recruitment of professionals should reflect the specific demand of mental health services in a correctional setting. The selection criteria should, of course, address the specific knowledge, skills and personal suitability factors necessary to function, not only in a correctional facility generally, but equally in the specific position/work assignment considered for the applicant. It should

also recognize and emphasize the multidisciplinary team approach adopted by CSC in the delivery of mental health services as the ability to function effectively and efficiently within this process is an important factor for successfully professional practice within CSC.

Mental health services is currently in an expanding mode and past experience has shown that it is at times extremely difficult to staff mental health professional positions in a timely manner. It must be added, however, that we are partly responsible due to a lack of any organized and aggressive recruitment campaign. Due to our unique environment and type of clientele, advertisement in professional journals and newspapers and public service referrals are judged to be insufficient. A much more aggressive stance is needed and one option is to aim at the source of these professionals, i.e. universities, nursing schools, teaching hospitals, etc. through "an investment into the future."

One such investment is the development of paid psychology internship programs, nursing placement, fellowship program in psychiatry, etc. through the establishment of affiliation agreements with major universities, teaching hospitals, and other professional community mental health facilities. This process, while providing fairly inexpensive services, expose, train and familiarize a potential future employee with the correctional environment and its challenges. C.S.C. has been able to attract mental health professionals through this process; however, it needs major expansion.

The recruitment of certain professionals to C.S.C. has proven to be a rather difficult exercise, e.g. psychiatry and social work where salary differential alone is a major recruiting impediment; however other considerations, such as working conditions, are also very important. CSC corporate management needs to address the major discrepancies between federal public service levels of remuneration and outside public and private psychiatric practice. Furthermore, other incentives are also required, eg. joint appointments with universities, teaching possibilities and adequate time to conduct research. The other option, providing greater flexibility from a pecuniary point of view, is to provide these services through contractual agreements; however, it is at times been very difficult to avoid employer/employee relationships.

With regards to social work, social workers are currently only providing services in two of our Regional Psychiatric Centres. They provide valuable expertise to the multidisciplinary team and are responsible for the case management process; however, their salaries are much lower than our WP3. If we want to retain these professionals and futhermore hire new ones, this salary differential needs to be addressed.

Recruitment in general could be facilitated through improvement in the "self-image" of the professionals. The adoption of community standards will go a long way towards accomplishing this objective; however, much more is needed. Public education endeavors are required to present our mental health professionals as

they are, i.e., a caring group with specific professional expertise working in a unique environment with difficult clientele and who are highly motivated to effect positive changes in their clients. Public awareness and recruitment could be enhanced by the production of a video similar to the one on the nursing profession jointly sponsored and developed by New Brunswick Corrections and CSC, Atlantic Region. Furthermore, research efforts, publication of findings as well as presentations at outside professional conferences should not only be supported but highly encouraged in order to raise the profile of CSC mental health professionals.

SUMMARY

In summary, there are a number of powerful incentives which would assist to recruit and retain professional staff in the C.S.C., e.g., the physical working conditions and support system, levels of remunerations, continuing education, sabbaticals, career and promotions opportunity, joint appointments with universities, teaching and research opportunities, self-image of the C.S.C. professionals and attendance at relevant conferences and seminars.

Relevant training for professional staff is almost non-existent within C.S.C. Professional ethics suggest that professionals should not be asked to or allowed to carry out functions for which they are not trained. Since there are few

mental health professionals specifically trained to function in our unique correctional setting, it is C.S.C. responsibility to provide orientation training and supervised practice initially followed by future professional development and training. There should be a strong professional presence on Regional Training Committee to ensure the training needs of professional staff are both represented and addressed. Training packages could be developed, utilizing experienced C.S.C. professional staff as well as resources from universities and other professional community facilities.

RECOMMENDATIONS

The Task Force on Mental Health Care recommends the following:

1. Registration/licensure within province of practice be one of the conditions of employment for C.S.C. professional staff.

2. A Chief Psychologist position (PS4) be established in each major institution.

3. A psychometrist entry-level position (MA-PS2 level) be established in major institutions if the requirement for registered psychologists cannot be met in a timely manner.

4. All currently employed psychologists be "grandfathered" so as not to affect their present title, duties, classification and remuneration.

5. The Regional Psychologist position be at the PS4 level or higher.

6. The 1973 Treasury Board Agreement be re-negotiated in order to ensure that it does not interfere with the proposed structure for the delivery of psychological services.

7. The Regional Administrator, Health Care Services address the various provincial professional regulatory bodies with a view to clarify their role and authority vis-a-vis C.S.C. professionals.

8. Each region establish affiliation agreements with universities aimed at the recruitment and development of C.S.C. professional staff.

9. Recruitment tools such as information brochures, video tapes, etc. on the various professional groups be developed.

10. Professional staff be represented on Regional Training Committee to ensure the development and provision of relevant training.

11. CSC corporate management makes representation to Treasury Board regarding the inadequacy of current salary levels for psychiatrists and social workers.

TASK FORCE ON MENTAL HEALTH CARE

DISCUSSION PAPER

SUB-TASK # 17

THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

COMITE D'ETUDE SUR LA SANTE MENTALE

Clarification du rôle des professionnels et intervenants en santé mentale

soumis par: Lynne Bernier

AVRIL 1990

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INTRODUCTION

> "La santé mentale est la capacité de l'individu, du groupe et de l'environnement d'avoir des interactions qui contribuent au bien-être subjectif, au développement et à l'emploi optimaux des capacités mentales (cognitives, affectives et relationnelles), à la réalisation de buts individuels et collectifs justes et à la création de conditions d'égalité fondamentale"
>
> Santé et Bien-être Social Canada.

En adoptant une définition de la santé mentale qui va au-delà de l'absence de troubles mentaux et qui vise l'optimisation des relations qu'entretiennent les individus avec eux-mêmes, les autres et leur environnement, la santé mentale est devenue une réalité plus englobante. Elle dépasse ainsi le champ d'expertise de quelques professionnels pour s'apparenter de très près aux valeurs fondamentales 1 et 2 défendues par l'ensemble du personnel du S.C.C.

Valeur fondamentale 1

> Nous respectons la dignité des individus, les droits de tous les membres de la société et le potentiel de croissance personnelle et de développement des êtres humains.

Valeur fondamentale 2

> Nous reconnaissons que le délinquant a le potentiel de vivre en tant que citoyen respectueux des lois.

La promotion de la santé mentale, traditionnellement associée aux médecins, psychiatres, psychologues, infirmières et intervenants spécialisés, relève maintenant de toutes les

personnes oeuvrant au S.C.C., quelque soit leur statut, leur occupation et la division à laquelle elles appartiennent.

La planification, l'implantation, la coordination, la prestation ainsi que l'évaluation des services et programmes reliés à la santé mentale représentent en ce sens une responsabilité commune qui exige une collaboration interdisciplinaire.

Compte tenu du concept élargi de santé mentale que nous avons retenu et en accord avec la Mission, les normes de santé et le modèle de gestion par unité du S.C.C., le comité d'étude sur la santé mentale conçoit comme suit la nature de la contribution des différents professionnels, intervenants et groupes qui influencent directement la santé mentale des délinquants:

Le médecin

Le médecin identifie et tente de diminuer l'influence des problèmes médicaux sur la santé mentale du délinquant. Il évalue l'état de santé du délinquant et demande les consultations appropriées. Il détermine les besoins du délinquant en matière de traitements médicaux, d'hospitalisation et d'hébergement particulier. Il contribue activement à la promotion de la santé et éduque le délinquant en matière de prévention. Il coordonne et assure la responsabilité des actes médicaux dispensés au délinquant.

Le psychiatre

Le psychiatre identifie et tente de diminuer l'influence des troubles psychiatriques sur la santé mentale des délinquants. Il évalue l'état mental du délinquant et pose un diagnostic s'il y a lieu. Il prescrit la médication ou le traitement approprié. Il participe au traitement ainsi qu'à l'élaboration et l'évaluation de services et programmes. Il offre des services de consultation et d'encadrement au personnel traitant.

Le psychologue

Le psychologue institutionnel identifie et tente de diminuer l'influence des troubles psychologiques sur la santé mentale du délinquant. Il rend des services d'évaluation de diagnostic, de counselling, de thérapie ainsi que d'élaboration, de mise en oeuvre et d'évaluation de programmes. Il intervient auprès du délinquant lors de situation d'urgence. Il offre un service de consultation aux équipes de gestion des cas.

Le psychologue de district s'assure que des services et programmes spécialisés sont accessibles aux libérés qui ont des problèmes de santé mentale. Il repère et évalue les ressources en santé mentale déjà disponibles en communauté. Il participe à l'élaboration, la mise en oeuvre et l'évaluation de nouveaux services et programmes. Il joue un rôle de consultant auprès de l'agent de gestion des cas communautaires. Il intervient auprès du libéré lors de situations exceptionnelles ou d'urgence. Le

psychologue, institutionel et de district, offre des services de counselling à court terme et d'intervention en situation de crise aux employés victimes de stress relié au travail.

L'infirmière

L'infirmière constitue la principale alliée des médecins, psychiatres et psychologues en matière de santé. Elle contribue au diagnostic. Elle participe au traitement et à la réadaptation du délinquant en accord avec l'ordonnance médicale et le plan de traitement. Elle joue un rôle prédominant au niveau de la prévention, du dépistage et de l'évaluation des problèmes de santé physique et mentale. Conformément à la philosopie qui guide la pratique des soins infirmiers, elle encourage le délinquant à atteindre et à maintenir un niveau optimum de santé physique et mentale.

L'intervenant spécialisé (travailleur social, conseiller clinique, ergothérapeute, etc.)

L'expertise de l'intervenant spécialisé est sollicité pour répondre aux besoins spécifiques du délinquant. L'intervenant spécialisé assiste les professionnels au niveau de l'identification des besoins ainsi que de la prestation et de l'évaluation de certains services et programmes de réadaptation, de réhabilitation et de croissance personnelle.

L'agent de gestion des cas

L'agent de gestion des cas identifie et tente de diminuer l'influence des facteurs de risque de récidive chez le délinquant. Il identifie les besoins du délinquant à ce chapitre, en tient compte dans l'élaboration de son plan de traitement institutionnel, l'aiguillonne vers les ressources appropriées et assure le suivi de ses démarches. Il occupe une position privilégiée qui lui permet de dépister et d'évaluer l'influence des problèmes de santé mentale sur l'ensemble du fonctionnement du délinquant. Il est une personne-ressource clé pour le délinquant dont il favorise l'autonomie et renforce les acquis ainsi qu'un collaborateur important pour les autres professionnels, intervenants et groupes concernés par la santé mentale du délinquant. Il se situe au carrefour des informations et des interventions concernant le délinquant.

L'agent de correction

L'agent de correction accompagne le délinquant tout au long de sa sentence. Il fait des observations. Il centralise les informations concernant le délinquant. Il participe à l'évaluation de ses besoins ainsi qu'à l'élaboration de son plan de traitement. Il suit son cheminement, le soutient dans ses démarches, favorise son autonomie et consolide ses acquis. Lorsqu'il travaille dans une unité spéciale, l'agent de correction co-anime des activités spécifiques et offre du counselling

au délinquant, prenant ainsi activement part à la prestation de services de santé mentale.

Le personnel des programmes (instructeur, professeur, animateur socio-culturel, etc.).

Le personnel des programmes propose des moyens au délinquant et le stimule à se réaliser et à s'épanouir à la limite de ses capacités. Il crée des conditions et un milieu de vie favorables aux apprentissages. Il propose au délinquant des modèles et des valeurs qui s'apparentent aux principes d'une bonne santé mentale.

L'aumônier

En offrant un counselling spirituel au délinquant, l'aumônier le supporte dans sa recherche d'équilibre et le guide dans ses relations avec son entourage. Confident privilégié, l'aumônier contribue à rétablir chez le délinquant la dignité et le respect de lui-même et des autres.

Les groupes d'entre-aide de délinquants

Les groupes d'entre-aide de délinquants permettent à ces derniers de s'aider les uns les autres, de s'accorder un soutien moral, de partager des idées, des renseignements, des expériences, de définir leurs problèmes mutuels et de s'y attaquer en puisant dans leurs ressources respectives et en tirant profit d'occasions communes.

Les bénévoles de la communauté

Les bénévoles de la communauté contribuent à la santé mentale du délinquant en s'éveillant à ses besoins et en participant à des initiatives pour y répondre. Ils sensibilisent la population, militent en faveur des changements, promeuvent la tolérance et des modes de vie favorables à la santé mentale. Ils offrent un soutien pratique et émotionnel au délinquant et l'encouragent à transposer ses acquis dans la communauté.

CONCLUSION ET RECOMMANDATIONS

En s'attaquant à la prévention et à la résolution de problèmes physiques et psychiques chez le délinquant, les médecins, psychiatres, psychologues, infirmières et intervenants spécialisés participent de façon significative à l'amélioration de la santé mentale du délinquant.

Leur contribution à ce chapitre ne saurait cependant être suffisante si elle ne trouvait pas écho auprès des observations et des actions des autres intervenants et groupes du milieu et si les objectifs qu'ils poursuivent n'étaient pas intégrés dans un plan d'action collectif.

Par conséquent, le comité de santé mentale considère que:

- Le plan de traitement d'un délinquant ayant des problèmes de santé mentale, qu'il soit élaboré par un agent de gestion des cas ou par une équipe traitante spécialisée, doit tenir

compte de l'ensemble des besoins identifiés à ce chapitre et prévoir l'utilisation maximale des différents types de ressources disponibles.

- En contre-partie, chaque professionnel ou intervenant qui est appelé à interagir avec le délinquant ayant des problèmes de santé mentale doit s'assurer de le faire en conformité avec les besoins identifiés dans le plan de traitement.

- D'autre part, tous les professionnels, intervenants et groupes concernés par la santé mentale des délinquants doivent pouvoir disposer d'une tribune pour échanger et faire des recommandations sur les programmes et services de santé mentale.

En conséquence, le comité d'étude sur la santé mentale

recommande:

1. Qu'une couverture adéquate du dossier "gestion des cas, établissement et communauté" soit assurée par les professionnels et les intervenants qui donnent des services au délinquant ayant des problèmes de santé mentale (exemple: acheminer certaines informations contenues dans le dossier médical ou psychologique vers le dossier "gestion de cas"). Que le plan de traitement du délinquant soit accessible à ces professionnels et intervenants (exemple: classer une copie du plan de traitement institutionnel au dossier médical et psychologique). Des mécanismes et des mesures appropriés devront être développés et mis en oeuvre pour assurer la transmission de ces informations.

2. Que soient tenues périodiquement des conférences de cas présidées par l'agent de gestion de cas et réunissant autour du délinquant ayant des problèmes de santé mentale les principaux professionnels et intervenants qui lui donnent des services. Ces dissussions permettront d'assurer la coordination des interventions ainsi que le suivi du plan de traitement de chaque délinquant ayant des problèmes de santé mentale.

3. Que soit mis en place dans chaque établissement et chaque district un comité de programmes en santé mentale afin de discuter de l'orientation des priorités, des besoins et des exigences en matière de services et programmes. En établissement, ce comité se substituera au comité multi-disciplinaire de santé mentale. Il sera présidé par le psychologue senior et regroupera le Chef des soins de santé,

le Coordonateur clinique, le Directeur adjoint des programmes correctionels et un gérant d'unité. L'aumônier, un représentant du comité des citoyens ainsi qu'un représentant du comité de détenus pourront s'y joindre au besoin.

Le comité se rencontrera trimestriellement et soumettra ses recommendations au Directeur de l'établissement.

En communauté, le comité sera présidé par le psychologue de district et regroupera un Directeur de secteur, un Responsable du secteur, l'Agent de développement communautaire ainsi qu'un représentant d'un organisme de la communauté oeuvrant en santé mentale.

Le comité se rencontrera trimestriellement et soumettra ses recommendations au Directeur de district.

TASK FORCE ON MENTAL HEALTH CARE

DISCUSSION PAPER

SUB-TASK # 18

THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

MENTAL HEALTH TASK FORCE

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

submitted by: Bram Deurloo and
Caroline Cyr Haythornthwaite

APRIL 1990

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INTRODUCTION

The gathering and dissemination of information has troubled the Correctional Service of Canada for decades. This issue is becoming more and more complex with the many changes to the mental health care, legal, medical and correctional systems.

The past decade has seen a growing awareness of the rights of the individual, the rights of victims, and the right of public access to information. As a result, policies and practices regarding the sharing of information have changed dramatically: the Charter of Rights, the Privacy Act, the Access to Information Act, as well as a number of internal policies and standards within the correctional and mental health systems, have been implemented. Consequently, the number and complexity of issues surrounding the gathering and dissemination of information have made the enforcement of the myriad of standards difficult, at times conflicting with the case management and decision-making processes.

The Task Force on Mental Health Care was charged with the development of a strategy to gather and disseminate information in a systematic and efficient way and in keeping with the case management and decision-making processes, while satisfying the legal, professional and ethical standards. To do so, a number of issues need to be addressed: the civil rights of the offender, the legislative requirements, the results of public inquiries,

the issue of professionalism, the case management and decision making processes, the role of psychological and psychiatric assessments, and the rights and protection of third parties.

The aim of this discussion is to give direction in developing a systematic, efficient, and integrated strategy to gather and disseminate information within the correctional and mental health systems, which satisfy corporate, legal, professional and ethical standards.

HEALTH CARE STANDARDS WITHIN CORRECTIONS

The legal framework within which the Correctional Service of Canada operates is set out by the Constitution Act, including the Canadian Charter of Rights and Freedoms, the Criminal Code, and other relevant legislation. Because the special powers conferred on the Service by law impact on individual liberty and security of the person, CSC has an obligation to treat offenders humanely and fairly, bearing in mind that they retain their basic rights as members of society. It is, therefore, essential that the Service make every effort to respect the spirit of the Charter of Rights and Freedoms in its actions.

The Mission Statement of the Service, the essence of which is found in its Core Values and Strategic Objectives, recognizes

and respects the dignity and rights of offenders. The gathering and dissemination of information is, therefore, addressed as one of the focal points in the achievement of the Mission. The following Strategic Objectives offer guidance for the distribution of information within the correctional system:

1.1 To ensure that offenders are informed participants in the correctional process, we will establish and maintain mechanisms for discussion and cooperation.

1.2 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.

1.3 When making significant decisions affecting individual offenders, we will ensure that the offender, unless security considerations clearly make it impossible, is provided with all relevant information in a timely and meaningful manner and is given an opportunity to be heard.

A number of internal Health Care Standards also regulate the gathering and dissemination of information within the correctional system:

Standard 103: Health care records shall be confidential and access controlled by the appropriate senior health professional. The approval of the author of a report shall be obtained before disclosure, wherever possible. Where such approval cannot be obtained, the responsible senior health professional shall consult with a professional peer of the author.

Standard 104: Informed consent by the inmate is necessary before providing health record information to any third party, unless otherwise provided for by law. The offender shall be made aware

of the content of the report which is requested by a third party. A written consent shall be obtained from the offender before information is released.

Standard 105: Information judged necessary to the case management function shall be communicated by the appropriate health professional, preferably during a case conference. Information regarding conditions affecting correctional management and strategies to ensure consistency of approach shall be added to the case management record.

Standard 106: All information obtained in the course of treatment shall be confidential, with the only exceptions being the legal and ethical obligations to respond to a clear and present danger of grave injury to self or others, or with respect to a threat to the security of an institution. The health professional shall explain the limits of confidentiality. The exceptional disclosure of information shall be documented on a protected file.

Although these strategic objectives and standards give direction, a number of issues need to be dealt with before the Correctional Service of Canada can appropriately develop a strategy to gather and disseminate information in a systematic, efficient and integrated manner.

THE RIGHTS OF THE OFFENDER

The right of access, by the offender and legal representatives, to information used in the decision-making process, is the first of many factors complicating the gathering and distribution of information.

Fundamental justice requires that an offender applying for release (be it temporary absence, day parole or full parole), be made aware of the substance of the information the National Parole Board will be considering in the decision-making process, so that the offender may respond to it with argument and evidence. Section 17(1) of the Regulations states that the National Parole Board

> "shall, orally or in writing, provide an inmate whose case is to be reviewed, with the relevant information in its possession that is to be considered in the review of the case" (Section 17(1), Regulations, 1986)

However, the National Parole Board is not required to supply information that it feels should not be disclosed on grounds of public interest, including the disclosure of information that could potentially:

* threaten the safety of individuals;
* lead to the commission of a crime;
* be injurious to the security of penal institutions;
* be injurious to the physical or psychological health of the offender; or
* be injurious to the conduct of lawful investigations, or that would reveal the source of information obtained in confidence. (Section 17(5), Regulations, 1986)

If the decision-maker is in possession of information which cannot be disclosed, this must be disclose to the applicant.

As a safeguard, however, an extensive set of guidelines prepared by the Correctional Service of Canada and the National Parole Board, for staff, stipulates that only in rare circumstances can material be withheld (Information Sharing: A Guide for Staff, NPB, Policy and Procedure Manual).

THE LEGISLATIVE REQUIREMENTS

The enactment of the Access to Information Act and the Privacy Act bring forward a series of regulations which do not necessarily correspond to the internal policies of the Correctional Service of Canada, the National Parole Board, and the Case Management Process. The same can be said of the Charter of Rights and Freedom. Many policies and regulations relate to the gathering and dissemination of information. Consequently, these policies sometimes conflict: the parties involved - the Correctional Service of Canada, the National Parole Board, case managers, mental health professionals, correctional staff, offenders, lawyers, and the public - enter into disagreement on interpretation of internal policy. Due to this lack of concensus, agreement between the various parties on what information should be shared, with whom, when, and in what fashion, is often difficult to reach. The result is that the gathering and dissemination of information is not being conducted efficiently, and, in some cases, not at all.

PUBLIC INQUIRIES

The events surrounding the Ruygrok case served as an example of the problems inherent in the gathering and dissemination of relevant information. An inquiry into the events leading to this tragedy revealed that previous psychological/psychiatric testing completed on the offender in question indicated the potential for him to commit another violent offence. It also revealed that some twelve years earlier, the offender had brutally assaulted and killed another young woman. Unfortunately, this information was never shared with the staff at the halfway house.

The distribution of relevant information beyond the level of the National Parole Board and the institution in which the offender was held, is a great source of concern. Prospective parole supervisors, whether they work with the Correctional Service of Canada, provincial or private agencies, need to be well informed about the nature of the offender who is to be released in order that the appropriateness of the release plan be assessed, and a supervision strategy developed that will respond to the needs and risk the offender presents.

The results of recent Coroners' Inquests in Ontario highlight the need for better information gathering practices about offenders entering the system, as well as improvement in

the dissemination of information to those who deal with the offender following his/her release.

The following are some of the major recommendations pertaining to the gathering and dissemination of information, emerging from three recent inquests: the Pepino Inquiry, the Tema Conter Inquest, and the Ruygrok Inquest.

Pepino Inquiry:

Recommendation 15: In the immediate future, the Correctional Service of Canada Duty Officer shall have ready access to records which allow them to make proper decisions on cases involving violations of release conditions.

Recommendation 24: A system be implemented whereby the Review Committee is provided with reviews and comments on infraction reports, sensational incident reports, audits and other pertinent management information.

Recommendation 27: There must be no confidentiality among Correctional Service of Canada, Police and private agencies with respect to information involving an inmate on conditional release where any breach of conditions or any danger to the public or any individual is involved.

Tema Conter Inquest:

Recommendation 19: Upon the consent of the inmate, any and all reports from mental health professionals shall be shared with community agencies. No first conditional release decision shall be

effected until the direct parole supervisor has certified in writing to the institutional warden that he/she has read such reports.

Recommendation 26: That the National Parole Board and the Correctional Service of Canada should take steps to ensure that file materials, particularly criminal history, are shared between the two agencies.

Recommendation 30: A study group of psychologists / psychiatrists employed or contracted by Corrections Canada should develop user-guidelines for report standardization and comprehension.

Recommendation 34: Where there are contradicting recommendations between the case management team, psychology and/or assistant, a structured meeting between these parties should be held prior to the National Parole Board hearing to attempt coordination. If unable to come to unanimous agreement, it is the responsibility of each party to clarify its position to the National Parole Board.

Ruygrok Inquest:

Recommendation 1: A Case Preparation Department be instituted at the regional reception centers to collect, assemble, verify and update vital inmate non-confidential and confidential information for inclusion in separate master fils. The case preparation department must also ensure that all information is passed to the appropriate authorities.

Recommendation 2: In respect to all trials involving the sentence of a person to penitentiary the following reports be

prepared and forwarded immediately after the trial to the appropriate inmate regional reception centre:

a. a judge's report containing a summary of the trial evidence including a description of the offence, any issues raised such a insanity, provocation or drunkenness, and background information about the offender. The Criminal Code should be amended accordingly to indicate that such reports are compulsory.

Recommendation 3: In addition to recommendation # 2, the Crown shall forward all psychiatric and psychological reports dealing with the offender to the case preparation department at the reception centre.

Recommendation 10:

a. In formulating the release plan, consultation must take place with persons in the community who will be supporting the parolee such as girlfriends and wives. They must be given all relevant information about the offence and be fully aware of their role in the release plan.

b. The release plan must include all psychiatric and psychological information and must give clear guidelines to parole supervisors and CRC staff as to how to deal with the parolee. There must be an identification of any danger signals to watch for and action to be taken if problems are encountered.

Recommendation 12: Parole supervision must take place in accordance with the Release Plan and there must be a full sharing of information between the various agencies working towards the same purpose.

Recommendation 12: d. There must be no confidentiality with respect to any information involving a parolee where any danger to the public or any individual is involved. This principle must be clearly understood and communicated to everyone.

Recommendation 21: There be a clear definition of the roles and responsibilities of the CRC and CSC to ensure a complete exchange of information regarding the residents and their parole release plan.

The direction given by these inquests becomes another complicating factor. These recommendations become policy, sometimes conflicting with existing standards and regulations.

PROFESSIONALISM

The psychological and psychiatric associations have expressed a growing concern for the need to respect professional ethics and standards, in the gathering and dissemination of information. As the issue of professionalism is reaffirmed, this concern becomes more acute and complex, since psychologists and psychiatrists are bound by professional ethics.

The integration of psychology and psychiatry within the correctional mental health care system demands that the issue of medical confidentiality be taken into consideration and respected. However, the specific requirements of the case management

and decision-making processes sometimes render this difficult, if not unethical. As a result, correctional staff at all levels, be it the case manager, Parole Board member, or mental health professional, are often faced with weighing the conflicting demands of professional ethics and internal policy. While the decision whether to respect the rights of the individual or the rights of the public will always be a question of good judgment, there is a need to develop protocol and policy to help staff make the most appropriate decision.

CASE MANAGEMENT

The arm's length relationship between Case Management and psychologists/psychiatrists that has developed in recent years has meant that the sharing of information relies almost entirely on written rather than face to face communication. This further complicates this issue, as the policies regulating the sharing of written information are often more stringent than that of verbal dissemination. Access to information, especially sensitive psychological data, often requires that the health care professional share with the offender or case manager the "gist" of the information. This is not possible without personal interaction.

One of the primary users of the information gathered by mental health professionals are the Case Management Officers, who are called upon to make recommendations regarding a wide variety of decisions, only one of which is conditional release. Case Managers should, therefore, have current mental health information in order that they may make appropriate recommendations about transfers, work placements, treatment programs, unescorted temporary absences, and conditional release. The National Parole Board expects that in the preparation of their reports, synthesizing factors that support a recommendation, case managers will have availed themselves of all relevant information, including information about the status of an offender's mental health.

This process requires a functioning case management team, in which all parties involved in the "treatment" of offenders work towards a common goal. Concerns felt by the psychologist, for instance, which should be shared among all decision-makers, might not appear in the written records or, if they do, these files may be restricted. In a system that does not function on a team approach, this information may not be communicated.

The Role of Psychological/psychiatric Assessments

Psychiatrists and psychologists, both within the system and contracted[1] services, are presently routinely asked to make

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[1] The increase use of external contracted agencies and resources for the purpose of assessments means that the sharing of information is governed by their respective

assessments about an offender's mental health. They are also asked to render judgments that predict the risk associated with future behaviour: i.e. the probability the offender will recidivate, and the risk to the community that might accompany such behaviour.

Literature suggests that this should be an area of extreme caution. Consequently, the Service needs to address several issues: what is the express purpose of these assessments, to whom are these disseminated, and how can their use by the decision-makers be regulated?

THE RIGHTS AND PROTECTION OF THIRD PARTIES

The rights and protection of third parties - families, spouses, victims - need to be considered in the dissemination of information.

Section 17(5) of the Regulations (1986) states that the National Parole Board is not required to supply information that it feels should not be disclosed because such information could reasonably be expected to threaten the safety of individuals.

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standards.

The question becomes as to how the Correctional Service of Canada, and the National Parole Board can strike a balance between the policies regulating the dissemination of information, and the protection and rights of third parties?

Their is a need to establish a protocol which balances the rights of third parties within the context of legal, ethical and professional standards, which would provide a basis on which staff could render judgments on individual cases.

CONCLUSIONS AND RECOMMENDATIONS

There is no lack of standards and regulations governing the gathering and sharing of information. To the contrary: it seems that the substantial number of policies and regulations is, in itself, a source of conflict. What is lacking is a systematic, efficient and integrated strategy to gather and disseminate information to all sectors of the correctional system, while meeting legal, ethical and professional standards.

The Task Force believes that the Correctional Service of Canada, the National Parole Board, the legal profession, mental health professionals and representatives from the Privacy Act and Access to Information Act, need to develop such a strategy to answer some fundamental questions:

* what information is required by the case management and decision making processes?;

* when should this information be gathered and disseminated?;

* who is responsible to create, collate and disseminate the required information;

* with whom should/can this information be shared?;

* how will the access to this information be controlled, and by whom?;

* what are the legal, ethical, and professional limitiations to gather, access and disseminate the information?;

* what mechanisms are available to resolve conflicts in the interpretation of policies and standards?;

It should be noted that the issue of the gathering and dissemination of information is not exclusive to mental health care: although it is one important component of corrections, these issues cannot be resolved independently.

The Task Force on Mental Health Care recommends that the following action be taken:

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

2. 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, and Privacy branches, to develop policies and standards regulating the gathering and dissemination of information, regarding the mental health care of offenders.

3. A protocol should 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.

4. The case management team approach should 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.

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

6. 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.

7. 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.

8. 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.

TASK FORCE ON MENTAL HEALTH CARE

DISCUSSION PAPER

SUB-TASK # 19

THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

TASK FORCE ON MENTAL HEALTH CARE

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.

submitted by: Bram Deurloo and
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INTRODUCTION

The Correctional Service of Canada has the objective to provide offenders with a timely and adequate continuum of mental health-related services, from date of admission to warrant expiry. To achieve this aim, it is imperative that the Correctional Service of Canada develop agreements with the provincial governments and the academic facilities to improve the quantity and quality of mental health programs and services offered to the offenders, promote research, and attract qualified mental health professionals.

The primary goal of the Service, as stated in its Mission Statement and Corporate Objectives for 1990-1993, is to reduce recidivism, encourage and assist the offender to become law-abiding, and facilitate the safe reintegration in the community. This task rests largely on the abilities of staff (psychologists, psychiatrists, nurses, case management officers, and correctional officers) to develop and deliver the most effective programs available in terms of both treatment outcome and cost. This will require expanded research endeavour, as well as the recruitment of mental health care professionals with special training in the field of forensic/correctional practice. Mutual cooperation between the Correctional Service of Canada, the Provinces and universities will facilitate the achievement of these aims.

During mid-1970's, the Ministry of the Solicitor General undertook to negotiate forensic custody agreements with all of the provinces. This following discussion, while presenting some of the existing agreements between the provinces, the academic facilities and the Correctional Service of Canada, pertaining to mental health, will underline the importance of such agreements for the development and effective delivery of mental health services and programs to offenders.

RECIPROCITY OF AN AGREEMENT

To expand collaborative research efforts and increase the training and recruitment of mental health professionals has reciprocal benefits for the Correctional Service of Canada, the universities, and the Provinces. Often lacking in previous attempts to establish mutually beneficial agreements, the importance of reciprocity cannot be over stated. While goodwill is a necessary ingredient in any joint initiative, it is not sufficient in itself to sustain long-term endeavors; there must be tangible benefits for both parties. The Correctional Service of Canada benefits from expanded delivery of services and programs, and the recruitment and training of well-qualified, experienced graduates. It also profits from research projects in the forensic field. Universities, on their part, benefit from research opportunities in the growing field of forensic/corrections. They also profit from the opportunity to increase sources

of funding, and develop particular expertise and internationally-recognized programs of education and research, through the establishment of forensic centres of excellence.

This liaison between academic institutions, provincial governments, and the Correctional Service of Canada is of particular importance for Regional Psychiatric/Treatment Centres across Canada: affiliation agreements ensure qualified staff are recruited and trained through an agreement with the academic facilities, and help to meet accreditation standards. The Regional Psychiatric Centre (Prairies), for example, is a unique mental health facility established through a tripartite, cooperative effort, and administered

> "within a framework of an Affiliation Agreement between the University of Saskatchewan and the Government of Canada and a second agreement between the Government of Canada and Saskatchewan. Correctional institutions within the Prairie Region (Alberta, Saskatchewan and Manitoba) of CSC and the National Parole Board are the primary users of Centre services. Access to assessment and treatment services is also provided, under the terms of the Canada/Saskatchewan agreement, to inmates of Saskatchewan correctional institutions, individuals held by virtue of a warrant of the Lieutenant Governor of Saskatchewan, and referrals are also accepted from Saskatchewan Courts. This agreement guarantees that up to 32 beds within the 106 bed facility will be made available for patients referred by the Province." (Regional Psychiatric Centre, Master Plan, Draft, June 1989).

The main objectives of the agreement are to provide clinical assessment and treatment services for mentally disordered inmates; to provide learning opportunities for students; to facilitate, promote and conduct research aimed at achieving a

better understanding and treatment of such offenders; and to maintain accreditation as a psychiatric hospital from the Canadian Council on Health Facilities Accreditation. For a psychiatric hospital to be accredited, its professionals need to be registered/licensed (or be eligible for such). This is consistent with Health Care Standard 107, pertaining to professional qualifications, which states that health professionals shall be appropriately registered/licensed (or be eligible for such) with a Canadian provincial authority, preferably in the province of practice.

Agreements between provincial governments, universities and the Correctional Service of Canada are of mutual and reciprocal benefit. These partnerships establish an excellent model of collaboration and lead to the establishment of internationally-recognized programs that combine education, research, and clinical services to offenders. This synergy of knowledge, resources and services is not only cost-efficient, but is often the means by which the Correctional Service of Canada can offer more efficient, effective programming to the offender population.

RESEARCH AND RECRUITMENT

There is a substantial need for additional research relating to mental health and the offender. The expansion of research is in keeping with Core Value 4 of the Mission of the Service which

states that the sharing of ideas, knowledge, values and experience, nationally and internationally, is essential to the achievement of the Mission. It is also compatible with the guiding principle that the Service will actively encourage the gathering, creation, application and dissemination of new knowledge. It is consistent with the strategic objective that sets out to encourage and support research and evaluation which will contribute to the continued development of knowledge. Finally, it is in keeping with the Corporate Objectives of the Service for 1990-1993, which set as the first long-term objective to actively pursue research and program strategies aimed at reducing recidivism, and to increase research and development activities in support of correctional programs and management.

Research is indispensable to the education of future mental health professionals, and to the enhancement of the capacity of correctional staff to provide offenders with improved levels and quality of mental health programs and services aimed at reducing recidivism. It is, therefore, seen as one of the principle goals of any bilateral agreement between the Correctional Service of Canada and academic institutions. This provides mental health practitioners, academics, and students with the opportunity and support to conduct research and contribute to the long-term objectives of the Correctional Service of Canada.

In addition to the necessity of expanded research, there is a great need to attract, train and recruit qualified personnel. This includes psychiatrists, psychologists and nurses, with educational backgrounds that focus on forensic/corrections work. The need for mental health care personnel who have an understanding of and experience in the special needs of corrections is compelling. The objective to increase the number and quality of mental health professionals is consistent with Core Value 3, which states that staff are the strength and major resource in achieving the objectives of the Service. It is also necessary in order to remain competitive in the labour markets, given the relatively short supply of qualified mental health professionals and the growing demand for their services. The establishment of agreements will enhance the Service's ability to compete for these scarce resources, and facilitate the achievement of Health Care Standard 405: each major institutions shall have a multi-disciplinary team, comprised of the psychiatrist, psychologist, nurse, case management officer, and ad hoc members as appropriate. This team serves as a vital coordinating body for services to those inmates in need of mental health services. These agreements are consistent with Corporate Objectives set by the Service for 1990-1993, which state that there is a need to develop staff training, develop programs adapted to the needs of staff engaged in correctional intervention, and establish a

personnel management framework which included recruitment, training, developmental opportunities and programs which will provide competent and motivated staff.

CURRENT AGREEMENTS

Certain offenders are defined as behaviourally disordered rather than psychiatrically ill, manifested by substance abuse, assaultive behaviour, etc. A second category is the chronically mentally disordered offender who does not function well in the general population and presents, consequently, a greater challenge. In the provincial system, these offenders are not transferred to mental health facilities. In the federal correctional system, they have access to the Regional Psychiatric/Treatment Centres which have specialized programs such as sex offender and anger management treatment. Currently, however, the Correctional Service of Canada addresses the majority of these needs at the intermediate level of care, through programs established by general population institutions. (CSC, 1990)

The following is a broad overview of some of the major components of the agreements currently in place with the Provinces and universities. It should be noted that Exchange Services Agreements exists between all the Provinces and Territories, and the Correctional Service of Canada. These agreements provide for reciprocal and mutual benefits: the

Service has the accessibility to a certain number of beds within provincial facilities while the provinces have the opportunity to send offenders to federal institutions. These agreements are not, however, specifically directed to mental health services and programs.

Pacific Region:

The Correctional Service of Canada operates a Psychiatric Centre near Abbotsford, for federally sentenced offenders. Included is the provision of ambulatory care to area institutions and the community for former patients of the Regional Psychiatric Centre, under an agreement with Simon Fraser University.

Other bilateral discussions include negotiations with the British Columbia Institute of Technology regarding curriculum development for nurses in corrections, and federal/provincial cooperation on Lieutenant Governor's warrants, psychological assessments, and the development of educational programs for health care staff.

A proposal submitted in 1986 between the Regional Psychiatric Centre and the Schizophrenia Service at the University of British Columbia's Health Sciences Centre Hospital, offered the University access to a group of individuals to teach and conduct research, while providing the Regional Psychiatric Centre access to special expertise in the area of schizophrenia.

Prairie Region:

The Regional Psychiatric Centre (Prairies), located in Saskatoon, Sask., was established in 1978 as a result of tripartite negotiations with the Governments of Canada and Saskatchewan, and the University of Saskatchewan. The Affiliation Agreement between the Correctional Service of Canada and the University of Saskatchewan requires the CSC to operate a hospital for the assessment and treatment of mentally disabled clients of the Criminal Justice System. The Agreement authorizes a unique Board of Governors structure which provides for University and community representation on the Board. The Agreement also requires the Centre to maintain accreditation status with the Canadian Council on Health Facilities Accreditation. The Agreement provides for the University appointment of senior staff, and commits the Centre to provide learning opportunities for students, and to foster research in forensic mental health issues. The Centre has a separate agreement with the Province of Saskatchewan to provide mental health services in a secure, in-patient facility for provincial cases including:

a) inmates serving provincial sentences;

b) individuals remanded by the courts for psychiatric evaluation, and

c) individuals subject to warrants of the Lieutenant Governor of Saskatchewan (those found unfit to stand trial or not guilty by reason of insanity).

The Centre also has agreements with other educational facilitites including:

a) University of Regina - provides for the joint appointment of the Chief of Social Work, and for social work student placements;

b) University of Manitoba and University of Alberta - provides for field placements of Occupational Therapy students;

c) Saskatchewan Institute of Applied Arts, Science and Technology, Wascana Campus - provides for training placements for students in psychiatric nursing.

An agreement has recently been reached with the Department of Psychiatry, University of Manitoba, for the establishment of a forensic psychological post-doctoral training program at Stony Mountain Institution. Anticipated cost for this agreement is 40 thousand dollars for the fiscal year 1990/1991, rising to 80 thousand dollars by 1991/1992. Through a contract with the Correctional Service of Canada, and in cooperation with Manitoba Forensic Services, the University of Manitoba offers a one year post-doctoral fellowship in forensic psychology. From the perspective of the Correctional Service of Canada, this program demonstrates the following attractive features:

1. Ongoing liaison with the University of Manitoba's department of psychiatry, through the behavioral science section. Through this program, the post-doctoral fellow gains a working knowledge of the federal corrections and an understanding of the roles psychologists can play in the pursuit of the CSC's objectives. Furthermore, the opportunities for university affiliation, clinical

supervision and research which accompany the establishment of a training program serves to attract psychologists who would not otherwise consider employment with the CSC.

2. Service delivery is provided in accordance with the 1989 Standards for Health Care, including the current professional standards for the practice of psychology. The post-doctoral fellow gains a sense of the responsibility inherent in the work of the forensic psychologist and of the appropriate level of professional qualification necessary for this work.

3. Service delivery takes place at a variety of clinical sites, from the pretrial stage, through institutional programming and management, to parole and community based treatment. As a result, a continuity in service delivery is provided, whenever possible, for offenders receiving treatment.

4. Research and program evaluation are natural adjuncts to a post-doctoral training program. Institution-based research represents a source of knowledge of particular value for the Correctional Service of Canada, consistent with Core Value 4 of the Mission Statement: the sharing of ideas, knowledge, values and experience, nationally and

internationally, is essential to the achievement of the Mission.

In April 1986, an accommodation agreement was signed between the province of Alberta and the Correctional Service of Canada. Under this agreement, federal offenders are eligible for all mental health services available to provincial adult offenders under the jurisdiction of the Federal/provincial Exchange of Services Agreement. The Correctional Service of Canada is guaranteed one hundred beds within the provincial facilities, and in return, the province can send their offenders to federal institutions. A potential area for future cooperation with the Province of Alberta is the proposed Forensic Treatment Centre, planned to be built in Calgary.

Because the Prairie Region is spread over three provinces, there is a necessity to maintain a good liaison with all provinces for the exchange of services and use of facilities. To this end, preliminary negotiations were held, in 1986-1987, with Alberta and Manitoba about the provision of forensic services as a joint venture. No agreement has yet been reached between the two provinces.

In November 1989, the Task Force Report on Forensic Services in the province of Saskatchewan revealed that, of all provincial offenders, 63 % of young offenders were assessed to fit into one

of four diagnostic categories by which offenders with mental health needs were classified. Thirty-three percent of all adult corrections clients also fit into these categories. A review of level of program need and current level of service identified that, with one exception, in every forensic program, the number of clients whose needs were not being addressed exceeded the number of clients receiving service. Some of the needs identified were:

* Treatment of the acutely mentally ill
* Treatment for sex offenders
* Alcohol/drug treatment
* Long-term supervised care
* Anger management programming.

The Task Force on Forensic Services identified the potential for agreements with the Correctional Service of Canada, and recommended: "The establishment of an 'Interdepartment Forensic Service Advisory Committee' composed of senior managers representing the senior managers of the Departments of Health, Social Services, Young Offenders Branch and Justice, Corrections Branch and additionally, a representative from the Correctional Service of Canada." (Forensic Service Task Force Report, November 1989:3) This committee would assist the province as well as the Service in meeting the identified need for forensic services for offenders in Saskatchewan.

Ontario Region:

Negotiations are in progress with Queen's University and the Correctional Service of Canada, with the aim of establishing a

broadbased umbrella agreement for forensic/correctional services. The initial step toward this goal was an agreement to provide Sex Offender assessment and treatment services at Warkworth Institution. Under the terms of the contract, up to sixty offenders are assessed and treated per annum. This contract is estimated at an approximate cost of a quarter of a million dollars per year. The provision of forensic psychiatric services, internships, residencies, and the establishment of a Forensic Chair in the Department of Psychiatry are among the issues being considered to expand this agreement.

The potential for a tripartite agreement involving Queen's University, the Correctional Service of Canada and the provincial Government in the areas of services, research and education is presently being examined. It appears that the time is right to work jointly towards the development of a Centre of Excellence in Forensic/Correctional psychiatry/psychology, as well as other professional disciplines.

Queen's University is presently proposing "the joint development of a program combining research and the education of forensic/corrections psychiatrists and psychologists with the concurrent provision of clinical service to offender/patients in institutions within the Ontario Region of the CSC." (Draft proposal) The shared goals to be achieved are to:

1) provide offenders with a full range of exemplary psychiatric and psychological services;

2) improve the supply and qualifications of Canadian-trained psychiatrists and psychologists in the forensic/corrections field; and

3) conduct research to enhance both future education and service provided in the fields of forensic/corrections psychiatry and psychology.

Substantial, reciprocal benefit is to be gained from the development and implementation of this agreement. The Correctional Service of Canada would benefit from improved services, increased recruitment of mental health professionals, enhanced staff training, and availability of pertinent research results. The University would benefit from research opportunities, seize the chance to be nationally/internationally recognized in the field of forensic/correction work, and increase its source of funding. This agreement would meet the need for increased, targeted research and the education of students in forensic/corrections.

Agreements exists with the Clarke Institute of Psychiatry for the provision of psychiatric assessment services for offenders. Under the terms of the contract, psychiatrists from the Clarke Institute conduct pre-release psychiatric assessm*ents for consideration by the National Parole Board.

In July, 1988, the Solicitor General of Canada entered into an Exchange of Services Agreement with the province of Ontario. The Correctional Service of Canada and the Province of Ontario

consider this agreement mutually desirable in order to serve the public interest more effectively.

As a result of this agreement, the Correctional Service of Canada and the province of Ontario agreed to jointly fund and utilize adult treatment centre in Northern Ontario: the Northern Treatment Centre. The Centre is staffed and programmed for offenders with treatable psychiatric and behavioral disorders. The operation of this facility is administered by the province of Ontario, and linked to the University of Ottawa. Under this mutual agreement, the Correctional Service of Canada agreed to confine provincial offenders in a institution under its direction or supervision, on request by the province of Ontario. On the other hand, the province of Ontario agreed to confine federal offenders, under the same terms. The agreement also provides for the supervision by the Province of inmates released from a penitentiary, a sharing of programs and facilities for native offenders, and a sharing of resources and facilities to improve opportunities for staff training and development for staff. Through this agreement, Ontario agrees to provide and guarantee to the Correctional Service of Canada 48 beds at the Northern Treatment Centre, for the purpose of treatment of psychiatric disorders or behavioral problems. Special emphasis is given to the program and treatment needs of native inmates.

Liaison with the Province is particularly important in view of the significant use, by the Correctional Service of Canada, of psychiatric hospitals such as Penetanguishene, St. Thomas, Brockville, Kingston Psychiatric Centre, and local general hospitals. Provincial negotiations are also necessary for the designation of the Treatment Centre under the Mental Health Act.

Quebec Region:

In 1977, the Province of Quebec signed an agreement to provide psychiatric assessment and treatment services to federal offenders at l'Institut Philippe Pinel de Montréal. Each year, the terms are reviewed in order to adjust the requirements and cost estimates. The agreement specifies the maximum number of bed-days to be utilized and the per diem rate. During 1987-1988, the ceiling rate was set at 25,500 bed-days.

Atlantic Region:

Plans are currently proceeding to establish a Regional Treatment Centre at Dorchester, New Brunswick. Negotiations will be held with both the Atlantic provinces and universities for the provision of assessment, treatment, community follow-up, research and staff training services. An affiliation agreement with the universities on psychological and psychiatric services is being considered. As currently conceived, the Centre will provide assessment and treatment services for acute and chronically mentally disordered offenders. Because the Atlantic Region

covers four provinces, communication with various health and corrections agencies is imperative.

CONCLUSIONS

In anticipation of strengthening ties with educational facilities and provincial mental health services, various types of services could benefit from joint initiatives:

* forensic/professional services to Regional Psychiatric Centres / Regional Treatment Centres' in psychology and psychiatry;
* treatment services for specialized offender groups (sex-offenders, violent offenders, etc.);
* psychiatric/psychological assessments for intake and pre-release;
* referral and treatment services for psychotic patients (eg. St Thomas, Clarke Institute, Penetanguishene, Pinel, etc.);
* joint research projects and evaluation of present programs;
* residency programs, internships, student placements;
* joint appointments, conferences, and clinics; and
* joint staff training and recruitment.

The primary reason for the success of agreements already established is the creation of a reciprocal relationship, in which both parties benefit without compromising their respective roles and focus. In the case of universities, there should be an equitable exchange: the Correctional Service of Canada receives the delivery of assessment and treatment services to offenders,

staff training, and research; whereas the university receives academic opportunities and stable funding. Areas of mutual benefit include joint research and the achievement of excellence in forensic services. Similar mutual benefits flow from the establishment of agreements with provincial ministries for jointly operated mental health programs and facilities. As with the Northern Treatment Centre, agreements with the provinces could potentially give the opportunity to both the Correctional Service of Canada, and the provinces, to develop and implement services aimed at specific targeted offender groups (such as natives, female offenders, etc.).

Agreements between the Correctional Service of Canada, the Provinces and the universities help to provide offenders with a full range of mental health services; improve the qualifications and supply of Canadian-trained mental health professionals in the field of forensic/corrections; and facilitate research efforts that could enhance both future education and service provided in this field. Mutual partnership in education and research into mental health-related services to offenders aids in the provision of a level of care to offenders in keeping with prevailing community and professional standards.

With improved services and more timely assessments and therapy, a higher proportion of offenders will be discharged from institutions and returned to communities at the earliest oppor-

tunity, with the necessary skills to cope with the stresses of daily life. Agreements should be seen as an investment producing research, programs, education, increasing supplies of mental health professionals in the forensic/corrections field, and efficient and effective service delivery, with potential savings flowing from the need to maintain fewer offenders in correctional and psychiatric institutions.

The real benefits, however, are measured in the successful reintegration of offenders in the community, and the reduction of recidivism. The greatest benefits will be for offenders faced with mental health problems who require adequate assessment, informed diagnosis, and effective therapies. Mutual, collaborative agreements between the Service, Provinces and universities will, ultimately, contribute towards the achievement of this Mission. While there are some exemplary, mutually beneficial affiliation agreements with provincial governments and academic facilities, throughout the Service, there are areas of the country where much more could be done to enhance these mutual, reciprocal relationships. To achieve the level of cooperation envisioned requires a long-term, coordinated strategy, consistent with corporate goals and geared to meet regional needs. It also requires the establishment of a network of communication with the professional associations (Canadian Psychological Association, Canadian Psychiatric Association, Canadian Nurses' Association) and an infra-structure by which to identify areas of mutual need,

plan for the delivery of appropriate services, implement same, and evaluate their effectiveness.

RECOMMENDATIONS

The Task Force on Mental Health Care recommends:

1. 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.

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

3. 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.

4. That Affiliation Agreements 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, and maintain accreditation standards.

5. 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.

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TASK FORCE ON MENTAL HEALTH CARE

DISCUSSION PAPER

SUB-TASK # 20

THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

TASK FORCE ON MENTAL HEALTH CARE

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

submitted by: Bram Deurloo and
Caroline Cyr Haythornthwaite

APRIL 1990

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INTRODUCTION

The definition on Mental Health Care stresses the need to strive towards fostering healthy interactive processes and to ensure that the relationship between the offender, the Service and the community is positive. To be effective, this definition must attest certain values: human equality, justice, freedom of choice, and social responsibility. Various factors can either enhance or weaken mental health: mental health can only be improved when the social and legal environments advocate human rights.

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

ETHICO-LEGAL ISSUES

As part of the Task Force on Mental Health Care, a number of issues were identified regarding the ethics and legal parameters of the assessment and treatment of offenders. In response, a sub-task was created to analyze a number of ethico-legal issues, including the following:

> Confidentiality and disclosure: There are a number of issues surrounding these topics. Among them are the limits of medical confidentiality in a correctional setting; the disclosure of information to non-professionals (clients, lawyers, the Police, victims, the National Parole Board, etc.); the use of information by lay decision makers; and the release and use of information not intended for the purpose utilized.

A series of Health Care Standards addressing these ethico-legal issues form the basis on which to ensure that confidentiality and disclosure are respected. Standard 103 states that health care records shall be confidential and access controlled by the appropriate senior health professional; Standard 104 states that informed consent by the inmate is necessary before providing health record information to any third party, unless otherwise provided for by law; Standard 105 states that information judged necessary to the case management function

shall be communicated by the appropriate health professional, preferably during a case conference; and Standard 106 states that all information obtained in the course of treatment shall be confidential, with the only exceptions being the legal and ethical obligations to respond to a clear and present danger of grave injury to self or others, or with respect to a threat to the security of an institution.

Due process: Issues surrounding this topic include the right to in-person hearings and rules of evidence; the right to challenge and call expert witnesses; and the right to solicit alternative opinions.

Consent to treatment: Professionals as well as offenders have raised a number of concerns regarding consent: some feel that treatment within a correctional setting is coercive per se; others challenge the right of the releasing authorities to impose conditions which stipulate treatment.

The entire notion of contingent treatment and release may be brought into question. By contingent treatment is meant the right to refuse to treat an offender unless some pre-conditions are met. With sex offenders, for example, treatment may not commence until the offender successfully meets the criteria of admission of guilt: it is deemed necessary that the offender deal with the

issue of denial, minimization and rationalization before treatment is offered, by accepting responsibility for the criminal actions. By contingent release is meant the insistence upon the successful completion of treatment prior to consideration of conditional release and/or the stipulation that continued therapy is a condition of the release plan. Offenders often feel this side steps the consent issue.

Two Health Care Standard addressing this ethico-legal issue are at the basis: Standard 101 states that informed consent of a mentally competent offender shall be obtained before commencing a treatment program and such an offender shall have the right to refuse treatment; and Standard 102 states that involuntary treatment shall be governed by legislative requirements of the provincial health legislation under which the health facility is designated.

> Access to treatment: This concern is a corollary of the consent issue: offenders are challenging the Service regarding their perceived right to treatment when indicated, especially if this is a pre-condition for release and such treatment is either delayed or unavailable.

Professionalism: Practicians often question their right to refuse service when there is an apparent conflict between the needs of the organization and the respective ethical-legal requirements of their professions. Another issue raised is the legal status of psychologists practising within the Correctional Service of Canada who are not registered under the provincial professional licensing bodies.

Health Care Standard 107 states that health professionals shall be appropriately registered/licensed or be eligible for registration/ licensing with a Canadian provincial authority, preferably in the province of practice. This issue is further discussed in another chapter, pertaining to the respective roles of mental health professionals.

Violence and risk assessment: A number of concerns have been raised about the ability to predict risk and the use of this information by lay decision makers. This has become a serious issue, since the detention of offenders often hinges on the assessment of risk and prediction of future violence.

Victims: The potential role of victims in the decision making and the reconciliation processes has not yet been well defined.

Patient advocacy: Issues surrounding this topic include the determination of mental competence and consent to treatment, and the broader issue of a "democratic" treatment approach in which patients play an active role in determining and evaluating treatment modalities.

FORUM ON MENTAL HEALTH AND LAW

These issues are very complex and require the input of correctional, medical and legal practitioners. The Task Force, therefore, recommends that a forum of international experts in corrections, law and mental health be assembled to guide policy in these areas.

The XVI International Congress on Law and Mental Health provides an opportunity to profit from their deliberations by actively participating in their forthcoming conference, scheduled for June 20-24, 1990, in Toronto.

The International Academy of Law and Mental Health provides a multidisciplinary forum for the exchange of information and ideas among professional concerned with the broad range of issues in the relationship between mental health and law.

The correctional area is emphasized and a side effect is that various governments, for example the Ministry of Justice in Holland, have consulted at a high level with experts on particular topics pertaining to issues such as release procedures in prisons and hospitals for the criminally insane, legislative reform and regulations under review, and specific policies.

Participation in the Congress is in keeping with Mission and Core Values of the Correctional Service, especially Core Value 4 which states that the sharing of ideas, knowledge, values and experience, nationally and internationally, is essential to the achievement of the Mission.

This international congress attracts leading figures working in research, theory and practice in the legal and medical fields, including policy makers, academics, and practitioners form all parts of the world. With an expected selection of over 200 papers being presented in parallel sessions, this Congress allows the Correctional Service to tailor the program to suit its own needs, and provides the opportunity to interact with international experts. The proceedings of the Congress will be published, thus providing a high quality record of the deliberations. These stimulate further discussion and provide an international forum for future research.

As foreseen, the Congress would allow the Correctional Service to devote one entire day to issues pertaining to the delivery of mental health services within Canadian federal corrections, to be followed by a one-day seminar to discuss policy implications for the Correctional Service of Canada.

RECOMMENDATIONS

The Task Force on Mental Health Care recommends the following:

1. That representation from the Correctional Service, the National Parole Board, the Ministry Secretariat, mental health professionals and legal experts, meet together annually to develop on-going ethico-legal issues related to mental health care within corrections.

TASK FORCE ON MENTAL HEALTH CARE

DISCUSSION PAPER

SUB-TASK # 21

THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

TASK FORCE ON MENTAL HEALTH CARE

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

submitted by: Larry Motiuk

APRIL 1990

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RESEARCH AND DEVELOPMENT IN CSC:

NHQ Research Branch

The role and function of the CSC Research Branch has been evolving since 1988 and should be regarded as essential to the development and coordination of an applied program of research that flows from the Service's Mission Document. The Research Branch at NHQ is organized and managed in order to coordinate Regional and National efforts in the development of new research knowledge; encourage active collaboration with the academic research community; and balance the conduct of research with the effective communication and dissemination of findings.

The Executive Committee has endorsed a National Research Plan (1989-1991) prepared by the Research Branch which attempts to strike a balance between research that is needed for immediate practical applications, (i.e., to support important operational or program initiatives), and research that is required for more strategic reasons, (i.e., to develop a base of knowledge on which future initiatives can be built upon to realize the Service's Mission). Some of the most significant research themes and projects in the National Research Plan (1989-1991) include:

1) **Case Management and Development of New Correctional Assessment Technology**

   . Custody Classification
   . Risk/Needs Assessment for Community Supervision
   . Case Management Strategies

- Lifestyle Assessment for Substance Abuse
- Sex Offender Risk Assessment
- Assessment of Native Offenders

2) Understanding Violence

- Cross-jurisdictional Review of Levels of Prison Violence
- Antecedents of Violent Recidivism

3) Staff Motivation

4) Offender Motivation

- Inmate Perceptions of "Reinforcers" and "Punishers"
- Motivation for Treatment
- Living Skills Evaluation

5) Impact of Programming on Community Adjustment

- Educational/vocational and Occupational Development Programming
- Substance Abuse

6) Other Ongoing Research Related to Mental Health Issues

- Follow-up of Offender Mental Health Survey
- Female Offender Mental Health Survey
- Psychopathy and Release Outcome
- Assessment of Family Violence

Regional Research Initiatives

While the Research Branch at NHQ has been mandated to ensure that CSC utilizes research resources in an effective and coordinated fashion, there has been and will continue to be support for research activity at the regional level. Currently, all regions have active regional research committees.

Notwithstanding the traditional lead role that the Regional Psychiatric Centres and Regional Treatment Centres have taken in this regard, a variety of mental health-related research projects have been initiated at other settings.

RESEARCH ON MENTAL HEALTH:

Much that is presently known about the mental health of Federally sentenced offenders derives from the Mental Health Survey that was conducted by CSC in 1988. To date, it seems likely that inmates in our institutions have experienced much more mental disorder than was understood before.

While there is clearly a need for a well-developed mental health assessment technology in CSC, the quantity and quality of services required by offenders identified as mentally disordered remain as important health and management concerns. These concerns have been fostered, in part, by the continued growth in the number of Federally sentenced offenders over the years.

Mental Health Assessment

An important component of organizing for effective mental health intervention within CSC is the identification of mental health problems that may be particularly prevalent among our offender population. In order to accomplish this task, a concerted effort is required to develop a systematic method of assessing and reassessing the mental health status of offenders throughout the Service. In keeping with this requirement, there is an urgent need to put into practice a reliable and valid instrument that provides the following:

1. Incidence of mental disorder;
2. Age of onset;
3. Recency and level of severity;

4. Comorbidity;
5. Previous involvement with mental health care; and
6. Indicators of response to intervention.

It is expected that empirical data gathered from a systematic approach to mental health assessment will enable the Service to better understand the nature and scope of the mental health problems confronting offenders and the public at large.

The question of how mental health assessment data will impact on an orientation for mental health service delivery obviously requires some detailed consideration. To date, CSC has focused on assessing the extent of the problem of mental disorder in our offender population and, more recently, on prevalence estimates for specific categories of disorders across the country. While such information is necessary to develop a clear direction for delivery of mental health services, CSC also needs to address to the issue of "needs definition" and "priority setting" before making any recommendations for specific categories of disorders.

Mental Health Services

There is a recognized need for continued development of mental health programs and the need for systematic knowledge in this area. With respect to mental health service delivery there is a need to investigate:

- theoretical orientations
- implementation and maintenance
- program monitoring
- conditions that ensure therapeutic integrity

- interactions between type of service and structural variation among offenders
- receptivity to innovation
- effective evaluation protocols

Coordination of Research on Mental Health Issues

Under the coordination of the research Branch at NHQ, it is recommended that:

1) 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 (i.e., for a two-year period and which is updated annually).

2) each Regional Psychiatric Centre/Regional Treatment Centre develop a Research Plan that focuses on forensic mental health issues.

3) research efforts among Regional Psychiatric Centre/ Regional Treatment Centre's be coordinated to

    a) establish research priorities;
    b) test efficacy of alternative treatment modalities; and
    c) provide a basis for comparative outcome analysis on the efficacy of treatment.

4) regions develop a mental health strategy based on the prevalence of mental disorder among their respective offender populations by targeting specific offender groups, planning and delivering interventions, and evaluating results.

5) mental disorder prevalence data be updated on an ongoing basis (i.e., three year cycles) to establish a demographic data base.

6) the Diagnostic Interview Schedule (DIS) be assessed to determine its practical utility as a diagnostic instrument at reception.

TASK FORCE ON MENTAL HEALTH CARE

REVIEW OF LITERATURE

THE CORRECTIONAL SERVICE OF CANADA

HEALTH CARE SERVICES

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STAFFING ISSUES, NURSING

PREVALENCE OF MENTAL ILLNESS, NEEDS

EVALUATION ASSESSMENT, EVALUATION STUDIES

GENERAL ISSUES PERTAINING TO MENTAL HEALTH WITHIN CSC

PREAMBLE

PREAMBLE

This document outlines some of the more pertinent findings, conclusions and recommendations put forth by various working groups, task forces, assessment and evaluation studies, etc., over the last two decades, in the field of mental health care.

The purpose of this document is to provide some background information on the previous enquiries and studies conducted since the early 1970's, in the field of mental health care in general, and more particularly of mental health care for the offender. As such, this document serves a dual purpose: to provide information on what has been recommended to improve the mental health system within the Correctional Service of Canada, and a comparison with what has been achieved.

The first segment will briefly summarize some of the major reports that were commissioned by the government, dating back as far as the Archambault Report, in 1938. Following these historical perspectives, the findings and recommendations of more recent studies will be presented, divided into six different subject sub-groups:

Management, organization, policy, programming
Staffing issues, nursing
Prevalence of mental illness, needs
Evaluation assessment, evaluation studies
General issues pertaining to mental health within CSC
Other issues pertaining to community

HISTORICAL PERSPECTIVES

Correctional Services Canada: Appendices and Bibliography, Correctional Services Canada, Ernst & Whinney (Consultants), October 1982,

HISTORICAL PERSPECTIVES

The Canadian Penitentiary System has experienced revolutionary changes in the past 125 years. According to historical records as late as 1855 dungeons characterized prison life of psychiatric inmates consisting of small windowless, airless cubicles, in the subterranean part of the building. The inhumane and "barbaric" treatment eventaully led to public outcry and government was forced to improve penitentiary conditions.

As a result of continuing pressure throughout the years prison life for these wretched people changed from the dungeon era to the current phase where psychiatric inmates are treated lake any other citizens except for the incarceration.

A more extensive review of the various reports that were commissioned is included in the following pages:

1. Archambault Report 1938
2. Fauteux Report 1956
3. Ouimet Report 1969
4. Report of Advisory Board of Psychiatric Consultants 1972
5. The Swackhammer Report 1972
6. The Federal and Provincial Ministerial Conference 1973
7. The Vantour Report 1975
8. The Farris Report 1976
9. The Law Reform Commission 1977
10. The Federal Correction Agency Task Force Report 1977
11. The Sub-Committee on the Penitentiary System 1977

The Report of the Advisory Board of Psychiatric Consultants (commonly known as the Chalke Report) has outlined the historical perspective of psychiatric services beginning in the 19th centruy and extending to the late 1960's.

Part 1: Pre-psychiatric Period - 19th century and the first half of 20th century

1. Mentally afflicted and the criminally insane were kept in newly built isntitutions known as "lunatic asylums". Since the number of "lunatics" exceeded the facilities available in the new asylums, many of them were kept in common jails regardless of whether or not there had been a criminal conviction.

   In the penitentiary at Kingston, they were in a "dungeon" which consisted of small windowless, airless cubicles, in the subterranean part of the building, which were occasionally flooded at high tide.

2. Period 1850-1867

   Public criticism of the inhumane treatment led to the Commission of Inquiry into what had been described as "barbarous" conditions at the penitentiary. An act was promulgated in 1852 aimed at improving the administration of the penitentiary, and building a Criminal Lunatic Asylum at Rockwood for "lunatic convicts" separated from the general population.

   Rockwood Asylum opened in 1855 and "lunatics" from common jails were transferred there, for humanitarian reasons. Within a few years overcrowding took place, and lunatic convicts continued to languish in the dungeon.

In 1865 the Medical Superintendent of Rockwood expressed very advanced views regarding the needs of mental patients. He advocated the classification of patients into distinctive categories, their segregation through diversified institutions and the establishment of two distinct classes of asylums, one for the curable patients, and the other for the incurably insane.

3. Period 1867 - 1880

"Lunatic Asylum" operated under provincial jurisdiction. Rockwood Asylum was an exception as it was part of the Kingston penitentiary. Rockwood was confronted with problems involving jurisdiction and control of admissions. In the 1868 Annual Report the director of penitentiaries observed that other asylums could select and admit suitable cases for successful treatment, whereas Rockwood was obliged to admit indiscriminately all who were sent.

After considerable public criticism, the Province of Ontario took over Rockwood Asylum, and transferrred the criminally convicted back to the institutional hospital at Kingston penitentiary.

4. Period 1881 - 1916

A facility for the insane called "Asylum for Insane Criminals" completed by 1881, was housed within the walls of Kingston penitentiary. The administration was pleased with the new facility, and proudly pointed to the increased size of the dungeon cells, their airiness and extra strength. Medical opinion, however, was very critical of the facility's admission of convicts of the idiotic and imbecile types. It was argued that these convicts should be admitted to other asylums where they would receive proper care and treatment, rather than to a penitentiary.

In the 1899 annual report of the Inspector of Penitentiaries, Surgeon of Kingston stated, "The more enlightened view which obtain now concerning the nature of insanity, assure us that it is a disease like any other disease, and can be treated on well know principles which must be fulfilled. . . An amount of personal liberty to the insane, commensurate with their own and their attendant's safety is necessary for treating insanity under its modern conception".

In 1891 there was a campaign for the removal of "insane criminals" from the penitentiary, and to accommodate them in a separate building.

In the years following, the successive wardens of Kingston Penitentiary pleaded for better deal for these inmates. In 1908 the Warden wrote as follows? "To this miserable abode, the most antiquated of our prison structure, are consigned the irresponsible unfortunates whose crimes led to insanity or whose insanity led to crimes. The cells remain as they were originally constructed (8 1/2 by 2 1/2 by 6) while every other cell-block has been demolished and rebuilt with compartments twice the size of the old cells and equipped according to modern ideas of sanitation and comfort. . . Stone walls in any direction they may look unless they look upward to the sky. In winter and during inclement weather the few hours they are released from their cells they spend in one large dingy, unsanitary room where they mingle promiscuously, with no entertainment except reading and playing checkers. They have prison police who lock and unlock the doors and follow them into the yard and back again to their cells in endless monotonous routine. . ."

5. In 1913 a Royal Commission investigating the management of Kingston penitentiary, reported "The building in which the insane are at presently housed is, in my opinion, entirely unsuited to the purpose for which it is used. It is defective in structural arrangements, lacking in nursing and medical facilities and devoid of means of providing occupation. The physical condition of the patients shows the effect of improper diet, insufficient exercise and being deprived of fresh air. . .Each patient is locked in his cell, without proper conveniences, from 4 p.m. to 7 a.m.; the door of each cell is simply a grating, and there is no provision for the isolation and care of the noisy and filthy patients. . .

There is no provision for the proper classification of patients all of whom are gathered together in a large day room, the acute with the chronic, the old and helpless with the impulsive and violent, the lucid with the demented. . ." The Commission also considered the problem of the relationship between mental deficiency and criminal recividism and the fact that ther were no provisions for the detection and treatment of defectives. Arising out to the 1913 Royal Commission, the Insane Ward at Kingston was disbanded in 1916, and the patients were transferred to provincial custody.

6. Period 1916 - 1946

In 1921 a Commission of Inquiry stated, "The existing provisions on the subject of insane prisoners are not satisfactory and indicate an obsolete and unscientific view of mental diseases". They suggested that there be control of admissions to penitentiaries of mentally afflicted offenders and their disposition following, completion of sentence, and provision to facilitate care and treatment.

The following year 1922, the newly appointed Superintendent of Penitentiaries recommended the opening of a penitentiary mental hospital, as there was some difficulty in the admission of patients to the mental hospitals. In some cases, very troublesome patients, although hopelessly insane were returned to the penitentiary.

For a number of years Superintendent Hughes advocated the reopening of the "Penitentiary Mental Disease Hospital" without success. Finally in 1938 after a considerable period of stagnation and neglect in penitentiary administration a Royal Commission investigated and reported its findings in the Archambault Report.

7. The Archambault Report stated, "nothing should be omitted which might improve the character of the prisoner. . . Proper treatment should follow in an effort to remove the causes of his criminal tendencies. Quite apart from the humanitarian consideration, the question of greater national economy is involved here, because. . . the cost of maintaining a prisoner in the penitentiary is high and if he can be cured, he ceases to be a charge on he state, and becomes instead an asset.

From any point of view it is necessary that a full-time physician and a full-time psychiatrist should be provided for the larger institutions. . . and part-time physician and part-time psychiatrist for the smaller ones. . ."

It also expressed concern that "insane prisoners should be confined in penitentiaries, caged like wild beasts, where there is neither means for proper treatment nor personnel with experience to deal with them."

With intervention of World War II, energies were directed elsewhere and penal reform was delayed.

Part 2 Period of Psychiatric Services 1946 - 1970

8. Period 1946 - 1960

Major General Gibson who was appointed Commissioner of Penitentiaries in 1946 played an important role in the birth and expansion of psychiatric services with the Penitentiary Serivice.

The central psychiatric facility with a psychiatric ward of 9 cells at Kingston, was opened in 1948 and expanded to 42 beds within a decade. In 1955 Kingston obtained its first full-time psychiatrist, while part-time psychiatrists were added to the staffs of various maximum security penitentiaries.

Annual reports during 1950 and 1960 pointed to the developing psychiatric services, the methods of treatment that were available, and the evaluation of different methods and techniques.

9. Fauteux Report and Royal Commission on Sexual Psychopaths

Both reports stressed the need for special facilities for the care and treatment of different offenders, including alcoholics, drug addicts, sex offenders and psychopaths. They also pointed out that there was no provision for the treatment of pschopathic sex offenders as required by the criminal code.

10. Period 1960-1970

In 1963 a "Ten Year Plan" of constructing new penitentiaries was developed and commenced. The plan which also included the construction of Regional Medical Centres, with psychiatric facilities, still awaits implementation.

The 1963 Report of the Commissioner of Penitentiaries continued to stress;the shortage of psychiatrists and psychologists and consequently needs of most institutions were not adequately met.

11. The Ouimet Report dealt with the matter of providing psychiatric services to criminal courts concerning mentally disorderd persons facing criminal charges. It also concerned itself with the issue resulting from detention of mentally disordered offenders. Basically the report stressed that if a 'just society' is to fulfill its obligations to all handicapped offenders, vastly improved psychiatric facilities will be required.

The report suggested that there was a need to prepare a new legal definition of dangerous offenders and that clinical assessment of the degree of dangerousness should be utilized by the courts.

12. The Swackhammer Report 1972 investigated the causes of disturbances at Kingston penitentiary and Millhaven Penitentiary, and found that authorities overstressed custody while understressing rehabilitation. They referred to the 'communication gap' between custodial and non custodial staff, resulting in staff polarization and "destruction of the programme, and deterioration in the life of the institution".

To overcome the risks posed by custody and security, the need for an aggressive rehabilitation programme with "each of equal authority and importance" was recommended.

To achieve this the authority and jurisdiction of the Director and his departments were to be more precisely defined, a reallignment of staff function was to be undertaken so that professional staff obtain intensive, full-time training programmes to provide an understanding of prison psychology and to equip them in the techniques of group counselling and staff inmate interactions.

Thus, a better trained staff, and programmes stressing work, study, training and recreation could be rehabilitative and so reduce the "tension which idleness, a sense of hoplessness and the dehumanizing characteristics of life at Kingston penitentiary frequently imposed".

It is to be noted that the Swackhamer Report endorsed the rehabilitative proposals of earlier proposals which unfortuantely failed to be implemented.

13. In 1973 a Federal-provincial ministerial conference concerning the criminal in Canadian Society was held in Ottawa. The perspective which echoed the Ouiment Report declared, "The criminal justice system has one basic aim; to protect individuals and members of society by reducing the level and effects of crime and delinquency." The paper stresses "the importance of the social and human value of the individual who comes into conflict with the laws of our society and the need to protect him, and society as a whole by keeping him from falling into a life of crime. What this means is essentially that the first and most important function of the criminal justice system is to prevent individuals from entering into criminal activity. Second is the diversion of offenders from criminal careers prior to sentencing, third, is the reduction in the level and seriousness of recurrent criminal activity:. It further stated, "Correctional activity cannot be looked at in isolation from the total criminal justice system, of which it is an integral part".

It drew attention to the fact that correctional authorities must deal "in large measure with offenders in their committment to criminal activity" and that this criminal justice system must do the rehabilitation job that society failed to do.

Furthermore, it emphasized the importance of prevention and diversion, and the need for constraint on the power of criminal justice. "Only the most serious act should be codified as criminal, interference with freedom must be kept to the minimum necessary, discretion should be exercised at every stage, and the system must reflect prevailing concepts of fairness and justice to commend the respect and the support of the public". It stated further that "The court must take into consideration the need to punish the offender to establish a deterrent that will discourage similar crimes; the need to protect society from the criminal through incarceration; the need to return a corrected individual to society; and the possibility of restitution to the victim".

It questioned the purposes of sentencing and the appropriateness of incarceration. If there is to be a reduction in crime, correctional authorities must show an ongoing committment in the "areas of necessary control, humane treatment, sound correctional programmes, and a strongly coordinated effort".

Although it considered control and rehabilitation as being complementary, it gave custody a higher ranking. It stated, "the correctional process must in large measure be directed towards getting the offender back into society as a responsible citizen, while complying with society's demands for protection, and ensuring that the offender is dealt with humanely".

It saw offenders as "damaged" who are not miraculously remedied by techniques and programmes. Since they have "personal deficiencies which make it difficult for them to function as responsible members of society".

Institutional programmes must therefore be tailored to correct personal deficiencies and to anticipate the pressures in the individual, and enforce him against them? This is achieved through counselling, vocational training, alcohol and drug rehabilitation, psychological treatment, academic upgrading, work programmes and so on. In addition to these, "new correctional programmes have... challenged institutional management. In the last five years, revolutionary concepts such as living units, therepeutic groups and separate psychiatric units have been introduced."

Basically, the report outlined the role of correction within the criminal justice system. Attention is drawn to the interrelatedness of the elements of the system, and the need to increased cooperation within the fragmented correctional system and across jurisdictional boundaries.

While stressing the importance of improved rehabilitation programmes, it also stresses that the high expectations of earlier reports may have been unrealistic.

14. Vantour Report (1975) examined the question of dissociation, and found "lack of substantive rehabilitative or therapeutic value in the concept of segregation. While supporting the rehabilitative process in the dissociation sub-system, they recommended a gradual re-introduction of the dissociated inmate into the general prison population, just as prison inmates should be gradually re-integrated into "outside" society before outright release".

Essentially, the report stressed rehabilitation and treatment, concern for the rights of the inmate, and the importance of well trained, specialized staff.

15. Farris Report (1976) was a specific inquiry to investigate a British Columbia Penitentiary incident involving hostage taking. It concluded "With these conditions, namely a grossly inadequate physical plant, a largely untrained staff with excessive turnover, a lack of communication and cooperation between the security people and the classification people, an inmate population containing 80 to 90 extremely dangerous men, an inhumane way of controlling such dangerous offenders, it is inevitable that there will be incidents of a like nature to those under investigation".

It referred to the "almost impossible" task of training staff because of the astronomical turnover rate. Esentially, the classification officers remained an untrained force. Furthermore, conflict between correctional and classification staff tended to lower the effectiveness of both groups.

In summary, it challanged the optimistic assumption of earlier reports and pointed out the difficulties of realizing their objectives.

17. The Law Reform Commission (1976) Unlike Archambault, Fauteaux and Ouimet, their predecessors, for whom the goal of the prison system was the "protection of society by way of deterrance, segregation and rehabilitation," The law Reform Commission felt that the only justification for a sentence of incarceration were separation, denunciation or refusal to comply. There was no reference to rehabilitatin as a goal, since they were not convinced of its effectiveness.

While stressing restraint, they emphasized the need for finding solutions other than inprisonment.

18. Federal Corrections Agency Task Force Report (1977) Undertook "to develop and implement an integrated Canadian Penitentiary Service which would include the Canadian Penitentiary Service and the National Parole Service". It attempts to come to grips with the vexing problems which confronted the Perspectives Paper of 1973 and the Law Reform Commission.

This Report perceived "four major trends in society which already have and will continue to have an impact on corrections across Canada:

a) Growing public concern about crime and criminal justice.

b) Increasing public awareness about crime and criminal justice.

c) The growth of the crime rate.

d) Changes in society's views of crime."

It noted "clear signs that major segments of society are moving towards a renewal of emphasis on individual responsibilities and on the rewards obtainable through self-discipline and adherence to the work ethic"

In view of past difficulties encountered in stressing treatment, they emphasize the need for a radical shift in focus. While asserting societies need for protection and of returning the offender to the community in no worse condition than when he was taken into the system, a new perception was needed. They point out that the 'medical' or 'coerced cure' model which states that "criminal behaviour is an expression of some underlying personality disturbance which requires extensive therapy and treatment before the criminal behaviour ceases, is an unsuitable assumption.

Instead they propose that "Federal Corrections must provide correctional opportunities designed to assist the offender in the development of daily living skills, confidence to cope with his personal problems and social environment and the capacity to adopt more acceptable conduct norms. The concept is based on the assumption that the "offender is ultimately responsible for his behaviour."

This new model provides a basis for making the offender responsible for changing his own behaviour, for providing Federal Corrections with a realistic goal of changing the offender's behaviour, and suggesting that the Federal Corrections cannot solve the problem of crime.

In light of a restructured role of corrections, the following basic principles and objective for Federal Corrections were identified by the Federal Corrections Agency Task Report.

Principles

a) The offender is ultimately responsible for his criminal behaviour.

b) The sentence of the court constitutes the punishment.

c) The community is a responsible participant in the correctional process.

d) Federal Corrections is responsible for the provision of an environment with appropriate measures of security conducive to active participation in programme opportunities.

e) Federal Corrections is responsible for the provision of adequate procedural safeguards designed to protect the rights of the offender.

f) The offender is responsible for earning and maintaining his privileges.

Objectives

a) To manage and administer the sentence imposed by the court.

b) To confine and control the offender for that period of time designated by the court.

c) To provide programme opportunities designed to assist the offender in developing and adopting; more acceptable conduct norms.

e) To manage and control the reintegration of the offender into the community.

f) To promote public awareness, understanding and acceptance of programmes and activities within Federal Corrections.

g) To promote and contribute to the development of an effective criminal justice system in Canada.

If the organization and management of the correction system is to become effective, the system must be more and better integrated. To accomplish this, the emphasis must be on:

i human resources management

ii a sound base of information, relying on sophisticated computer technology

iii a structure which clearly designates roles, authority and responsibility

iv a management philosophy or style which includes diversity and innovation, yet where necessary (e.g. security) stresses disciplined control.

There must be a sensitive balance between essential court imposed restrictions of freedom and the need to protect the public, while making programme opportunities accessible to the offender. Furthermore, Federal Corrections has the responsibility "to override opportunities which will allow the offender to demonstrate increasing responsibility through exercising his ability to choose".

The community has an improtant role to play, and must share with the institution a common purpose.

From the very outset staff and offender must share in the planning of how the sentence will be served, and a "package" approach is recommended, including, work, training, education, privileges, community release and measures of control. This "shared responsibility" makes the offender accountable while making Federal Corrections accountable for the provision of necessary resources for the plan.

The shift from "counselling" to "management" is similar to the shift from "treatment" to "opportunities".

Trained living unit officers are responsible for the actual case work, monitor total performance. They must also develop community resources and communicate with police, courts and the various sectors of the community.

In summary, the Federal Corrections Agency Task was to resolve the dilemma posed by Ouimet and the Law Reform Commission and to integrate the experience of the past 30 years with "treatment" and rehabilitation programmes.

The report stresses that the new "programme opportunities" model is not an admission of failure on the part of Federal Corrections, but rather a statement that "we have bitten off more than we could chew". The focus then is to be on a more realistic, but more modest objective for Federal Corrections.

Pepino Inquiry

1. Release recommendations and psychiatric or psychological assessments must address risk to the community.

5. The Correctional Service of Canada should undertake an initiative to develop an exchange of service agreement with all provinces to resolve the problem of health care payments for conditional releases.

30. The Board recommends that the Government of Canada initiate a comprehensive evaluation of the effectiveness of all present sexual offender treatment programs. If such evaluation indicates that there are no effective programs at present, further consideration should be given to ending ineffective programs, and concentrating funds and human resources in those areas where some promise is shown.

Ruygrok Inquest

4. All new inmates arriving at a reception centre be subjected to in-depth psychiatric/psychological testing to facilitate the development of a rehabilitation program.

6. The inmate undergo periodic counselling and psychiatric/psychological treatment during the course of his program and a final assessment be made prior to Parole Board consideration. In the case of offenders who have committed crimes of violence, a thorough independent psychiatric evaluation must take place at an outside psychiatric facility.

10(e) Where psychiatric problems were identified as being present at the time of the offence, the parole release plan must include a special condition that the parolee will attend professional counselling, psychiatric treatment and monitoring while on parole. In these cases, there should be periodic administration of psychological tests.

27. The CRC must have access to all appropriate psychological and medical services. All residents shall be provided with an O.H.I.P. number to ensure their access to appropriate medical care.

Tema Conter Inquest

6. The federal government should complete an agreement to pay for health insurance premiums for all inmates in the federal institutions located in that province. This will facilitate outside psychiatric treatment when indicated (eg. Clarke Institute)

9. A Chief Psychologist should be appointed at each federal institution. Duties would include: staffing, orientation and training of psychological staff, development and administration of a separate budget for the psychology department.

30. A study group of psychologist/psychiatrists employed or contracted by Corrections Canada should develop user guidelines for report standardization and comprehension.

MANAGEMENT, ORGANIZATION, POLICY, PROGRAMMING

MANAGEMENT, ORGANIZATION, POLICY, PROGRAMMING

Programming in Federal Corrections, Solicitor General Canada, Prepared by the Task Force on Integration of C.P.S. - N.P.S., 1976.

Objective:

It has long been recognized in the field of corrections that there is a need for a uniform and effective approach to programming. The purpose of the programming team was three-fold. First, the members created an inventory of all programs currently operant within the spheres of the Canadian Penitentiary and National Parole Services. Second, the members conducted in-depth studies of eight programs operated in Canada by both government and private agencies. Third, on the basis of an analysis of the data generated by these eight studies, the members developed and proposed a standard programming process, which is contained within this report.

Recommendations:

The Federal Corrections Agency should utilize the expertise of external consultants at all organizational levels to facilitate programming.

Programming in the Federal Corrections Agency should include consultation with or the direct participation of representatives of private agencies and other external organizations that are expected to be involved in or affected by the program.

The Federal Corrections Agency should adopt a programming policy requiring wide consultation with staff at all levels, who may be affected by implementation of the program, in order to facilitate communication, planning and encourage support for the programs.

The Federal Corrections Agency should directly involve or consult with clients in all programming that affects them in order to plan more effectively and prepare the clients for new programs.

The Federal Corrections Agency should utilize both the individual and team planning approaches where appropriate, with as much involvement of staff, inmates and others affected by the program as possible, to carry out at all levels the programming process recommended in this report.

The Federal Corrections Agency should clearly delineate the responsibilities and authority of persons to initiate and plan programs.

The Federal Corrections Agency should develop a program planning body or bodies whose function would include the analysis of the influence of internal organizational pressures and dynamics, social trends, political issues, correctional philosophies, public reactions, and other factors in the programming process.

Staff training and development should be emphasized to prepare staff at all levels for the new roles and functions required by new programs.

The Federal Corrections Agency should utilize methods to create commitment to programs. For example, utilize the staff and inmates who will work in the program to plan it. Secondly, involve staff in the program who have philosophies or vested interests that are compatible with the objectives of the program.

The programming process should include a clear definition of the anticipated roles and functions of clients, which is developed in consultation with and understood by clients.

Clients should be provided with orientation and training to prepare for new roles and functions that differ substantially from traditional roles.

The programming process should consider the attitudes of clients towards the program and, if possible, be implemented with the support of clients. This may be facilitated by involvement of clients in planning and attempting to structure the program to accommodate their concerns.

The Federal Corrections Agency should develop guidelines and principles outlining its relationship to other component organizations within the Criminal Justice System and the Government of Canada. This should be done with a view to reducing fragmentation and ensuring coordination within the systems.

The Federal Corrections Agency should establish an organizational structure that would include a body or bodies responsible for the programming process.

The Federal Corrections Agency should clearly define staff roles at all levels, including responsibilities and authority in the initiation, implementation, evaluation, and modification of programs.

The needs that are not presently fulfilled by existing programs should be clearly identified, verified, and stated before the search for programs begins. Clients and "front line" field staff, who are closest to the operations should be involved in the identification and verification of needs.

A systematic evaluation of the program is required to determine whether or not the program meets the stated objectives. The results of the evaluation should be shared with all people involved in the program, as well as those responsible for planning and implementing the program.

Program Proposal:

In view of the importance of the completeness and quality of the proposal, the following format is recommended:

A concise description of the proposed program and the activities involved.

An explanation of the relationship between the proposed program and the purposes of the organization.

A clear statement of quantifiable objectives the program intends to accomplish.

A statement of client-related considerations (roles, functions, attitudes, etc.).

A statement of the anticipated roles, functions and acceptance of other organizations, agencies and individuals who will be involved in or affected by the proposed program.

A statement of staff-related considerations (roles, functions, attitudes, etc.).

A statement of proposed evaluation, monitoring and feedback systems to indicate the extent to which the program meets original stated organization purposes; the degree of success in meeting original stated quantifiable objectives; statistical description and evaluation of the program; and methods of consultation with individuals, agencies and organizations involved in or affected by the program.

Implementation planning should include details of quantifiable objectives of the program, procedures and policy, administrative structure, job descriptions and expectations of the staff, staff training content and schedules, conditions and regulations affecting clients, budget allocation, the liaison and coordination with external individuals and organizations that will be involved or affected by the program, time frame for implementation, feedback, monitoring and evaluation, and expected roles and functions of the individual, board, team or committee responsible for coordination and guidance for the implementation process.

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A Program Planning System For The Canadian Corrections Services, Solicitor General Canada, Management Consulting Service, Project # 92, July 1977.

Executive Summary:

The purpose of this study was to extend the scope of the study report "Programming in Federal Corrections" to assist with its implementation in the Canadian Corrections Service (CCS). In particular, this study was concerned with the definition of "program" as it applies to the CCS planning function, organizational considerations, refinements to the programming model, and the development of a standard format for program proposals.

Summary of Principles and Recommendations:

Defining a Program:

A structured process to define program objectives should be adopted.

Program initiation and planning activities should be limited to those program objectives approved by the top management team evolving from their strategic planning decisions on organization objectives, policy issues and problems and opportunities to be acted upon.

A problem identification phase which fully describes the dimensions and implications of outstanding policy issues should be completed prior to the consideration of program alternatives. Top management consensus that the problems have been adequately defined should be a prerequisite prior to program initiation being authorized.

The program definition process should include the delineation of issues clarifying regional operational planning and national program planning.

Planning Coordination - Organizational Consideration

Strategic planning is a top management responsibility. Any supporting organization group and the planning system should provide no more than the designed process which organizes, coordinates, and supports the activities of top managers who do the planning.

A planning coordination component should be established for the CCS organization and its role should be based on the organization, integration, and coordination of planning system activities in support of the Commissioner and the top management team.

Program Evaluation

The CCS evaluation function should include provisions for qualitative program assessments as an important part of the procedure. This subjective evaluation should stem from the managers responsible for the program in the operational unit.

Environmental Analysis

Further study should be undertaken to determine the best methodology for coordinating the organization's response to environmental factors and integrating it in the planning process.

Search for Alternatives

For each objective authorized for program initiation, a comprehensive systematic search should be undertaken to locate and develop program alternatives to meet the stated needs.

Program Proposal Documentation

The proposal framework should be based on the following evaluation criteria and information:

Description: an explanation of what is to be achieved, how it relates to operational requirements, its scope and time frame in terms relevant to senior management.

Purpose/objectives: a statement of program objectives and how they relate to the purpose and goals of the CCS. To the extent possible, indicators by which results will be evaluated should also be postulated.

Internal Consistency: an explanation of how the proposed program will interact with the existing organization and operational processes with attention to client-related considerations, staff-related considerations, and the extent to which the current organizational infrastructure is affected.

Environmental Consistency: an assessment of how the proposal relates to what is going on outside, including the political climate, community attitudes, and trends in the criminal justice system.

Cost/Resource Estimates: a detailed statement of anticipated budget requirements and source of funds.

Alternatives Considered: a concise summary of alternatives considered and reasons for rejection.

Appropriateness/Constraints: a summary of risk factors and constraints the program is likely to face.

Feasibility study: an analysis of cost/effectiveness factors.

Project/Plan: an outline of how the program would be brought to implementation including resourcing and scheduling needs.

Evaluation Plan: a statement of the proposed evaluation, monitoring and feedback information by which results can be assessed.

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Medical and Health Care Services Branch, Information System Report: Phase I, Correctional Service of Canada, September 1984.

Executive Summary:

The Medical and Health Care Services (MHCS) Branch chose to examine its existing information system as a first step toward the development of a health care information system which would enable the Branch to manage and evaluate its ongoing service and to plan rationally for future service needs. Phase I also intended to identify the information requirements of users, both health personnel and non-health users.

The data systems within MHCS Branch was an out growth of the professionalization of the service and they compare favorably with those found in health services in the community. However, because of the dual set of objectives that health services must meet within the CSC, objectives of a health care information system was formulated for each functional level: institutional, regional and national. Although there is a need for a sequential flow of data to provide the information necessary for management at the three levels, there is a distinctly different series of activities involved.

Major definitional problems were identified. One, that of "inmate visit", is a case of different interpretation of what constitutes a visit. This can be rectified to produce reliable data. The second, that of a classification system of the mentally ill, is of greater complexity. This definitional problem is a long standing one and is not confined to health care in CSC. However, within CSC, there is a greater need to address behavioral problems which may or may not have a psychiatric basis. The existing data bank provides prevalence data by

psychiatric, diagnostic categories and hospital utilization, similar to that collected by other psychiatric facilities. The need now is to generate operational data by the various programs being mounted.

A comprehensive health care information system to meet operational, planning and evaluation needs, as that envisioned by the Branch does not currently exist in the Canadian nor the American health care system, much less within the correctional systems. The Branch does not have professional staff in institutions across the country who are willing to accept the challenge, provided the development of such an information system has clear operational relevance and benefits. With functional objectives and effective communication, all the ingredients are present within the Branch for the development of a health care information system that will break new ground, not only in the correctional field, but in the health field.

Recommendations:

That NHQ continually monitor the development of the health care information systems to ensure that the service is paramount and the information system, operationally valid, timely and useful.

Although the Branch has responded to growing perceived mental health needs, even in the absence of hard data, it is now recommended that Branch

* conduct an empirical study to determine number of inmates exhibiting behaviour requiring acute, subacute and chronic care services;
* demonstrate the effectiveness of existing programs, identifying those factors contributing to its success or failure;
* collaborate with other disciplines for the acceptance of a working nomenclature of presenting mental health problems;
* coordinate the implementation of the mental health team concept, expanding the limited mental health resources;
* encourage the development of unique and innovative programs within RPCs and the RTC; and
* raise questions of the judicial sentencing turnstile of what is expected of CSC along with incarceration, where the offender is mentally handicapped.

Within the medical community, it is recommended that the Branch

* work towards increasing professional awareness of the expanding mental health role now being demanded of the correctional health care service;
* initiate discussion of alternate placement and programs for the mentally disturbed and retarded inmates;

* seek their participation in developing the working nomenclature of presenting mental health problems which would be compatible for their diagnostic needs but sufficiently broad for administration, classification and program needs.

Within the community, the Branch is recommended to

* expand the network of voluntary community organizations to strengthen support programs for the mentally disabled and retarded, and
* increase the awareness of citizens to the effects on the correctional system of de-institutionalization in the mental health field, without concomitant tax resource transfer.

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Operational and Resource Management Review: Review no 11, Review of Mental Health Services, November 1985.

Executive Summary:

This report describes present mental health services within the Correctional Service of Canada (CSC) and posits a number of mechanisms likely to increase the effectiveness with which offenders' mental health needs are met.

Findings and recommendations:

* measures should be taken to ensure that CSC managers and other users of the financial system are sufficiently familiar with it. Specifically, the recommendations call for validation of useful data items, concise serviceable formats and service/program oriented reporting.

* mental health services for community after-care was presented as an identified need across the country. Policy decisions on the extent of CSC involvement in parole activities related to mental health services must precede resource allocation decisions.

* the therapeutic community concept was identified as desirable by all regions but with varying degrees of reservation. Additional resources are required to establish units or ranges using this concept but above all, a committed leader must be present.

* the growing demands for, and expectations of, psychological services call for a review of its role, priorities, organization, resources and accountability. The current state

of diffused services cannot persist if the expertise is to be most effectively utilized.

* several region specific recommendations were made. An ongoing assessment of the ambulatory mental health team in the Pacific Region was recommended. In the Ontario Region, it was recommended that a similar team be initiated with a full time coordinator and clerical assistance based in the RTC, using existing resources.

* the attributed benefits of the multidisciplinary mental health unit at Saskatchewan Penitentiary led to the recommendation that the feasibility of such a unit be examined for each institution in the Prairie Region based on a reallocation of existing resources.

* despite the expressed satisfaction with mental health services in the Quebec Region, the rising cost of the arrangement between CSC and L'Institut Philippe Pinel warrants a re-examination of the agreement.

* the paucity of mental health services in the Atlantic Region, which has been identified and reiterated over the years, led the task force to recommend an increase of its basic resource allocations.

* the larger proportion of the disturbed inmates within CSC are behaviorally disordered, rather than mentally ill.

* there is an increasing number of chronically mentally ill among the CSC inmate population, in all regions.

* of the array of existing services, although laudable, many require re-examination in relation to identified needs, precise objectives, measurable indicators (qualitative or quantative) and financial accountability.

* that the proposed objectives for mental health services be adopted as representing the ideal aim, with program specific objectives to be developed by the program manager; and with the Regional Deputy Commissioner ensuring that measurable goals are congruent with the overall objectives.

* that Wardens in every institution consider the establishment of a multidisciplinary team or teams to determine required mental health services and their resources and to obtain commitment to the service or program.

* that Psychological Services prepare functional definitions of integrated core programming for progressive behavioural change. That mental health core programs be included in consideration of services which will be recommended for all

institutions by the Report on Offender Support Services. That Psychological Services include in its review, the structure and the resources required to implement this recommendation.

* that regional consensus be obtained by the Regional Deputy Commissioner to identify those institutions where a TC unit could be mounted most cost effectively, with institutional support and the least amount of additional cost and where a committed individual is available to lead the program.

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The Diagnostic Interview Schedule

This document presents the history and scope of the Diagnostic Interview Schedule (DIS). It also illustrates how to use this instrument in aiding the professionals diagnose their clients.

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STAFFING ISSUES, NURSING

STAFFING ISSUES, NURSING

An Analysis of Staffing Problems for Registered Nursing Personnel Within the Regional Psychiatric Centres and Institutional Health Care Centres, Correctional Services Canada, Special Project 119C, August 1980.

Objectives:

The objectives of this paper are to provide a brief historical overview of the evolution of medical health care services within CSC, detailing the different classifications of nursing, and nursing support staff employed; to examine the issues and problem areas relative to nursing personnel employed by CSC with respect to salary scales, classification, conditions of employment and professional relativity; and to make recommendations to provide short term relief and to suggest policy options that could be taken to move towards long term problem resolution.

Recommendations:

* Treasury Board again be approached and made aware of the unique circumstances which apply to CSC registered nursing staff.

* CSC continue to actively recruit R.N.s with the ultimate aim of being able to provide all facets of medical health services.

* CSC must ensure that a working milieu exists within the HCC's and RPC's wherein the professional nurse is recognized and respected by all staff members as an essential element of the health care services team.

* The Director of Nursing Operations, as the chief functional advisor for all matters related to CSC nursing staff, should be advised and consulted about all matters pertinent to nursing operations.

The problem analysis, discussion, alternative proposals, and as reflected in the recommendations, indicate that the most advantageous long term course to follow is that of health care services professionalization. Other alternatives are short term in nature, and do not address the real problem. Unless a policy decision is taken to change the goals of CSC health care services, the accreditation program, and the professionalization of the service, employment conditions must be improved to a degree where CSC becomes at least an employment option for R.N.s.

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Review of Contract Nursing Services at the Atlantic and Donnacona Institutions, Correctional Service of Canada, Project #4-6961, October 1987.

Executive Summary:

The review of the privatization of nursing services at the Donnacona and Atlantic Institutions revealed some problems with the implementation of the concept. The major problems observed are as follows:

* the contract process (the institution had little input into the drawing up of the contract; there is confusion over roles and responsibilities, etc.)
* administration of the contract (the use of unit managers to administer the contract has created a lack of control over the contractor, etc.)

The evaluation assessment reports the following findings:

* no savings are apparent
* inmates are now basically satisfied with the interpersonal contacts and level of access to health care.
* there are problems, some of which may be personal, some due to institutional start-up, but some seem related to privatization itself.
* there is considerable complaint from security staff that the private sector staff don't understand the institutional milieu and procedures.

Recommendations:

The CSC should consider the possibility of acquiring all medical and health services under the terms of one contract. This would provide a more integrated and better coordinated general service. It would also appear that the contractor could more effectively utilize his resources in terms of service to be provided.

CSC should design and implement an internal information and communication program that addresses all aspects of the policies, programs and procedures for nursing services in a penitentiary environment. This program should include regular meetings with managers, nursing staff, and security officers so that common problems may be discussed, possible agreements reached and an atmosphere conducive to co-operation created.

CSC should reconsider its decision to reduce functional support for health care management at the regional level. The differences in penitentiary environments, sites, and health care operating methods appear to require functional professional support both for management and planning and control of health care as

well as to ensure health care services enjoy a professional status on a par with security services.

CSC should specify and effectively communicate to all parties concerned the formal roles and responsibilities regarding health care management that must be respected at the national, regional and institutional level.

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PREVALENCE OF MENTAL ILLNESS, NEEDS

PREVALENCE OF MENTAL ILLNESS, NEEDS

Steering Committee on Mentally and Behaviorally Disordered Inmates, Correctional Service of Canada, April 1980.

Terms of Reference:

The CSC Steering Committee was formed with two basic objectives: (1) to clearly identify the nature and scope of problems related to mentally and behaviorally disordered inmates within CSC and to establish direction for the development of new policies, programs and plans to resolve these problems within our jurisdiction; (2) to prepare a CSC position paper (in fact, this paper) clearly describing the problems and proposed solutions to be incorporated in a Solicitor General paper for presentation to the Interdepartmental Committee previously described.

Recommendations:

* There should be in all institutions a uniform procedure which should ensure that, whenever an offender is recommended for psychiatric assessment or has been observed by any CSC employee exhibiting a behaviour pattern deemed unusual, that offender (a) will be referred for evaluation by competent authority, (b) the results of the evaluations will be recorded in his medical file, as well as (c) a description of the treatment prescribed, and finally, (d) where applicable, the person having made the original observation will be informed of the disposition of the case.

* In regards to staff training, this can be effected on both a formal and informal basis. The formal process should be delivered as part of the induction training for CSC employees and later reinforced in the institution by the psychiatrist and psychologist using as much as possible the institution's own case histories to illustrate the types of comportment associated with mental and behaviour disorder and to suggest the appropriate intervention in each case. An additional and informal aid to training in the identification of disordered cases will be the feedback process as proposed earlier, whereby the person having reported an offender for unusual behaviour will be informed later as to the accuracy of his observation.

* A constant difficulty experienced during the survey concerned the lack of information pertinent to the activities and needs of the mentally and behaviorally disordered. Some examples of the type of need involved are as follows:

    1. an inventory of dangerous offenders is maintained by Preventive Security and it is important to

establish a link between this inventory and the list of mentally and behaviorally disordered cases.

2. to record the costs of incidents involving the mentally and behaviorally disordered.
3. to provide information for the NPB, community release programs and ultimately the police.
4. to provide data for research.
5. to evaluate the effectiveness of special programs e.g. programs aimed at personality/character disorders.

* The Offender Programs Branch develop and direct implementation of a detailed five-year operational plan related to that category of inmate defined as a sexual deviant but not suffering some other form of mental illness requiring medical/psychiatric attention.

* The Offender Programs Branch intensify efforts to more precisely identify, through psychological and IQ testing; the numbers and types of mentally retarded within CSC.

* The Medical and Health Care Branch develop and direct implementation of detailed five-year operational plans for the development of pilot programs for certain inmates suffering personality disorders. This plan should build upon the already started RPC Pacific Pilot Project. If successful, the Offender Programs Branch should prepare plans for expansion or transfer of these programs to other institutions.

* The Offender Programs Branch take immediate steps, in conjunction with the Medical and Health Care Branch, to tighten up the referral process for psychiatric assessment in order to permit reduction of the over 25% of perceived problem cases which have not been diagnosed.

* The CSC adhere to the principle of voluntary treatment for inmates in the RPCs. IF it is necessary for the protection of the inmate or others, consequent upon behaviour arising because of possible mental disorder, and if the inmate is unwilling to enter the RPC, or another psychiatric facility, then the procedure for involuntary admission recognized by the provincial government of the province in which the receiving institution is situated, must be completed.

* The Offender Programs Branch examine the viability of increased use of reduced security incarceration following successful RPC treatment to prevent return of symptoms caused by return to normal maximum or medium security environment.

* The Personnel Branch develop and implement a component in all induction and refresher training programs designed to permit staff to more easily recognize behavioral signs of mental or behavioral disorder and take appropriate steps to manage the resulting situations. These components should also communicate CSC policy in the implementation of medical and case management programs for mentally and behaviorally disordered offenders.

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Le comportement criminel et institutionnel des psychopathes, Solliciteur général Canada, 1984.

Synopsis:

This study is based on a random sampling regrouping 15 % of the inmate population of the Correctional Service of Canada, in the Prairie Region. A psychopathy control list (established by Hare and Frazelle in 1980) was used to determine the groups of individuals who are considered slight, average (medium) and high (strong) psychopaths.

Fifteen to thirty percent of the subjects in the sample were found to be psychopaths. Maximum security penitentiaries proportionally held more psychopaths than other institutions. The group of high psychopaths had more past and serious criminal behaviour than the part of the group defined as slight psychopaths. They also breached the conditions of their parole more often, and generally speaking had a higher incidence rate of offenses. Finally, contrary to common belief, their criminal behaviour persisted until the end of their thirties.

The goal of this study was to systematically examine the relationship between the degree of psychopathy (slight, average or high) of federal inmates, and their criminal and institutional behaviours.

The data indicates that almost 20% of the CSC population can be considered as being psychopaths. This percentage increases considerably (30%) in maximum security institutions, and decreases in minimum security institutions (15%). Psychopaths lack respect for discipline, and usually in a more violent and threatening manner. This study confirms previous studies that submitted that psychopaths, as a group, committed more offenses per year of freedom, assumed their criminal lifestyles at a younger age, and

consequently spent more time in jail. It does not to appear that any significant link exists between race and the fact of being assessed as a psychopath. Psychopaths and non-psychopaths do not differ in the order in which they were born (within the family), nor by the number of brothers and sisters they have. In general, psychopaths were not the victims of negative (bad) treatment in their childhood. On the other hand, more often than the non-psychopaths, they were raised by someone that was not their biological parent. They experienced behavioral problems at an early age, and usually committed a criminal offence before the age of 15. They left the parental home at an earlier age as well. In general, psychopaths breach the conditions of their parole, and for more serious reasons, than non-psychopaths. Nevertheless, it would appear that it is not any more difficult for psychopaths to be granted parole, than for non-psychopaths (they might be more manipulative and convincing in front of the NPB). As these results are based on a random sample, it is felt that these conclusions can be applied to other similar populations.

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Mental Disorder in the Criminal Justice System, Solicitor General of Canada, 1985-14.

Executive Summary: Findings and Recommendations

A fundamental review of criminal law in "an evolving Canada" and a "changing world" is underway. One portion of this review focuses on mental disorder in the criminal justice system. This paper presents a comprehensive schematic overview of the mentally disordered offender and how he is processed in Canada. The objectives of this section are to assist in a comprehensive identification of the issues and put each component in its criminal justice and mental health context. The exercise should also facilitate the resolution of definitional criteria, disposition, and jurisdiction issues along the path of criminal, civil, and correctional processing.

Any such analysis, however, must incorporate a thorough review of the social context if it is to be contemporary and relevant. Too often, these background factors are not adequately addressed. For example, public sentiment, mental health certification, jurisdiction and costs, accommodation and treatment, client consent, and dangerousness constitute just some of the important but problematic social issues with which an effective system must contend.

A pivotal component of any such exercise is the provision of legal definitions with good operational criteria and appropriate terminology that are in the spirit of the underlying fundamentals. There, a logical sequence is to begin by reviewing the

fundamental principles of our mental disorder legislation. With terms defined in a manner consistent with these fundamentals, the basis "building blocks" are established, and the remainder of the exercise becomes somewhat simplified. Only by undertaking a complete analysis at this stage can one expect the subsequent legislative, policy and treatment components of remand, fitness, and insanity to assume their place in a logical and systematic manner.

Once these legislative issues are resolved, the problems of disposition, jurisdiction, treatment, and identification of other mental disorders can be addressed in a rational and effective manner. This kind of sequence will contribute to our knowledge as to what type of offender, as defined legally and psychiatrically, requires or is best suited to, what kind of disposition (management or treatment) and by what jurisdiction (legal, mental health, or corrections) this ought to be accomplished.

This process analysis leads to the following observations and projections. A community perspective will produce greater accomplishments in the prevention of mentally disordered crime and in the use of mental health diversion. Psychopaths and other mentally disordered offenders, who are neither certifiable nor "insane", will continue to populate our prisons. Current mental health and correctional systems are either equipped or incapable of accommodating and treating them. Mental health post-release programs are inadequate. Client volition and treatment ineffectiveness continue to be major problems. Prediction difficulties notwithstanding, the assessment of dangerousness will continue to be a major factor in most processing decisions of the mentally disordered offender.

The mentally disordered are being caught up in the criminal justice system. This is occurring because of the deinstitutionalization with mentally ill, the police practices in handling the mentally ill, and the inaccessibility to treatment on the part of many disordered individuals who are at risk for criminal offenses. Considering that correctional facilities are not typically designed for a psychiatric clientele, it stands to reason that there will be a burgeoning number of untreated psychiatric clients if de- and noninstitutionalization continues.

The fact that the criminalization of the insane is taking place can be considered a comment on the failure of the community health movement. In reality, ill-prepared dischargees were left to fend for themselves, and eventually became the wards of an alternative service system. However, another perspective is to simply view the criminalization phenomenon as a reflection of changes in the relative use of two methods for dealing with the socially aberrant. In the end, society finances both systems, and it may even be less expensive to detain persons in jail.

However, to the extent that society subscribes to a rehabilitative model, the mentally ill must be accommodated in facilities commensurate with their need for care. The principle of universal access to health care must be maintained even for incarcerated offenders.

The mentally disordered sentenced offender has been largely ignored in the mental health and legal literature in spite of its prevalence and the problems he creates in the inmate population. The group has been overlooked partly because of the preoccupation with the forensic issues of fitness and insanity and because, at least theoretically, serious cases should be filtered out of the correctional system by legal proceedings. The best estimates suggest rates of 5% and 15-20% for serious and less serious forms of mental illness, respectively. For a variety of reasons, few cases are referred to provincial mental health facilities.

Less severe forms of mental disorder include some particularly troublesome types of offenders. For example, the psychopath may be very difficult to mange or treat and is quite prevalent in prison. The most cautious surveys indicate rates of 20%a and 30% in Canadian penitentiaries.

One model that has been reported to be very successful, at least subjectively, is the State of Washington's treatment of sexual offenders. Although sexual offenders are not necessarily mentally disordered, they do present similar management and treatment problems. Therefore, Washington's "Sexual Psychopath" legislation provides an interesting model as to how the court, mental health system, offender, and community can all be involved in a systematic, long-term treatment program that maintains continuity over the duration.

Finally, one must acknowledge the difficulty in treating the mentally disordered incarcerated offender. Most are not, nor could they be, certified under provincial mental health legislation which means that treatment must be voluntary. Aside from those who outrightly decline participation, others, although superficially cooperative, are resistant to treatment efforts, the effectiveness of which remains at issue in correctional and mental health circles.

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Traitement des troubles psychiques: Evaluation des besoins, Evaluation des projets spéciaux, Mai 1985.

Terms of Reference:

The purpose of this study is to assess the number of inmates in the institutions of the Correctional Service of Canada (CSC) suffering from serious psychological and/or behavioral disorders.

It is imperative to conduct a detailed study of the incidence and nature of psychological and/or behavioral disorders found within the population of the CSC. This data would allow us to more effectively plan programs and allocate resources.

Findings:

* approximately 30.1 % of the incarcerated population of CSC suffer from serious psychological and/or behavioral disorders.

alcoholism/toxicomania	18.6 % et 23.4 % of inmates
violent behaviour	9.9 % et 12.4 % of inmates
sexual deviance	7.8 % et 9.8 % of inmates
mental/mental immaturity	4.4 % et 5.5 % of inmates
thought disorders	3.3 % et 4.2 % of inmates
depressive states	2.8 % et 3.5 % of inmates
suicidal tendencies	2.4 % et 3.0 % of inmates.

(first group is the total of inmates (12 060), the second group is the study group (9 578)).

* Psychiatric centres and regional treatment centres only treat an insignificant number of cases found in the incarcerated population of the CSC.

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The Prevalence of Mental Disorder in Michigan Prisons, July 1987.

Executive Summary:

The Michigan Department of Corrections has been mandated to make certain improvements in the delivery of services to prisoners with serious mental health disorders. As part of that process, the Department submitted two mental health plans, the Comprehensive Psychiatric Services Plan and the Comprehensive Plan for Mental Health Services. These plans differed in their theoretical models of mental health and estimates of mental health needs. While both plans made many positive recommendations, neither provided an adequate epidemiologic data base which could be used for planning purposes. Despite employment of different methodologies and mental health models, the two comprehensive services plan were in complete agreement that the Michigan Department of Corrections needed a more accurate estimate of the prevalence of mental disorder in the prison population. Thus, the major purpose of this study was to conduct a psychiatric epidemiologic study of the Michigan prison system (to determine the prevalence of serious mental disorder and associated treatment needs).

This study represents the most comprehensive and methodologically sophisticated psychiatric epidemiologic study ever conducted on a prison population.

The study demonstrates that mentally ill prisoners require a broad range of diagnostic, treatment and rehabilitative services. The setting in which these services occur may vary throughout the prison system (comprehensive, in-patient, transitional and out-patient settings). These settings may also be different from those found in the community.

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A Survey of Case Management Officer's Perceptions Concerning the Prevalence of Mental Disorders: Identification, Needs, and Resources in Minimum Security Institutions and on Conditional Release, Offender Policy And Program Development Sector, Correctional Service of Canada, November 1988.

Executive Summary:

This survey, completed in all minimum security institutions, community correctional centres, and parole offices, had three goals: to identify the number of offenders who were suffering from psychological/behavioural disorders; to assess the current level of resources available; and to determine whether or not the resources are adequate to meet the identified needs.

Findings:

A total of 887 offenders (8.9%) of the population surveyed were identified as having a serious mental/behavioural disorder, other than substance abuse. If serious substance abuse is included then the total disordered increases to 1 186 (11.8%).

Substance abuse was the major primary disorder. In addition it was also a secondary disorder strongly associated with all other disorder types.

On the survey date, there was intervention occurring in the cases of 62.6% of offenders with identified problems.

Case managers across the country identified gaps in available programs. The following is a list of the programs (in descending order of importance) seen as desirable but unavailable in many locations:

1. psychological services
2. alcohol/drug treatment
3. sex treatment

4. anger management
5. life skills
6. psychiatric services.

Recommendations:

From the results of this survey, the following recommendations are seen as being logical and necessary to the achievement of the Correctional Service of Canada's goal of meeting the needs of offenders, maintaining them in the community, and returning them to the community as law-abiding citizens after sentence completion:

* Further consideration should be given to increasing mental health services in minimum security institutions. The survey team recommends that each minimum security institution be provided with psychological services to the same ratio as the major institutions.

* The CSC should encourage and support regional and local initiatives to increase access to public mental health resources.

* CSC regions should examine ways of expanding sex offenders treatment programs in minimum security institutions and in parole districts.

* Major parole offices, or clusters of offices in close proximity should have a full time psychologist to coordinate/liaise with community mental health resources, to run specific programs to address local needs, to provide assistance to community residential facilities and consultation services for CSC staff.

* Each region should examine ways of increasing accommodation in community residential facilities for borderlines and post-psychiatric cases.

* There is a need for more programs in the community such as life skills, anger management, stress management, vocational programs, and various support groups. Each region should consider implementing or securing new programs into the community wherever possible.

* Case management officers, in both institutions and parole field operations should receive training in drug/alcohol counselling.

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EVALUATION ASSESSMENT, EVALUATION STUDIES

EVALUATION ASSESSMENT, EVALUATION STUDIES

The First Report of the National Health Services Advisory Committee to the Commissioner of The Canadian Penitentiary Service, Solicitor General Canada, July 1974.

Terms of reference:

To review and to recommend to the Commissioner of Penitentiaries, and for cause to the Solicitor General, changes in the policies, organization and administration of the Health Services in the federal correctional field.

To inquire into the existing system of health records, and to make recommendations for the development of an appropriate records system.

To help establish liaison with appropriate professional bodies and Colleges.

To inquire into coordination of resources available in the Ministry of the Solicitor General and other departments and agencies.

To advise and recommend with regard to achieving uniformly high quality of health services in all five regions.

To create sub-committees, if required, to deal with specific matters.

To explore the integration of penitentiary Health Services with the medicare programs of each province.

To explore the context of remuneration and working conditions for health service personnel in order to reflect the special problems of the Penitentiary Service.

Recommendations:

1. The National Health Services Advisory Committee recommends that a humane health service, including medical, psychiatric, dental, nursing and allied health services, be provided by provincially registered professionals in good standing to serve patient-inmates in the correctional institutions. This service will contribute directly and indirectly to the efforts of inmates to rehabilitate themselves.

2. It is recommended that the Penitentiary Act be amended by the addition of a separate section: Medical and Health Care Services.

i. There shall be a Medical and Health Care Services Branch in the Canadian Penitentiary Service.
ii. Inmates, men and women, shall have, under the Penitentiary Act, access and entitlement to medical and health care services provided by professionals legally qualified in accordance with the laws of the province in which they are practicing.
iii. All reasonable efforts shall be made to raise the standard of health of the inmates who come into the federal correctional system.

4. It is recommended that arrangements be made for educational leave to existing health care officers, registered and licensed nurses and psychiatric nurses.

9. It is recommended that the Director General, Medical and Health Care Services, must be provided with a group of consultants representing at the outset general medical care, psychiatry, dentistry and nursing, on the basis of approximately five half-day sessions per week.

10. It is recommended that the phrase "total medical and health care services" include psychiatric care as well as medical, dental, surgical, nursing and allied health services.

18. It is recommended that the Penitentiary Service Regulation 2.13 be amended by adding a new sub-section as follows:

> Medical and Health Care Services records of inmates shall be confidential and, without permission of the Director General, Medical and Health Care Services, disclosed only to health care professional personnel, as defined by the Director General, Medical Health Care Services. Only those general conclusions and recommendations which are relevant to general Ministry institutional treatment and management should be communicated to the responsible Ministry staff.

21. It is recommended that there should be one comprehensive medical-dental-psychiatric health services record.

23. It is recommended that the concern for the Canadian Penitentiary Service for the total health of the individual patient be reflected in the unification of all medical and health care services and the removal of the present administrative dichotomy between psychiatry, and other medical and health care services.

25. It is recommended that the health care facilities of the Canadian Penitentiary Service remain available to parolees and that liaison with community health care resources be actively encouraged.

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Study Goals, Issues, Audiences and Approach: Evaluation of Psychiatric Services, Medical and Health Care Services Branch, Correctional Service of Canada, Solicitor General Canada, October 1981.

Terms of Reference:

The purpose of this document is to convey to the reader why a study of psychiatric services within CSC is being undertaken at this time and to indicate what its primary focus will be. It will describe the process adopted by EHE to ascertain the critical issues and study audiences. In addition, this report will outline the proposed study methodology, work program and products. Furthermore, the respective roles and expected interaction between CSC and EHE during the course of the study will be delineated.

The primary purpose of the evaluation would be to provide information which would facilitate the optimization of the organization and delivery of psychiatric services, rather than the assessment of the quality of care being provided.

An overall, system-wide evaluation of the management, organization and distribution of psychiatric services would be the first priority for the evaluation team (EHE).

This document describes the various tasks it wants to address, the methods they plan to use, and the products they anticipate generating. It does not actually provide the reader, in this document, with any of the findings and/or recommendations.

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Evaluation Assessment: Medical and Health Care Services Program, Correctional Service of Canada, Solicitor General Canada, February 1982.

Overview:

The purpose of this document is to report on the findings of the Education Health Environment (EHE) Evaluation Team with respect to the evaluation assessment of the Medical and Health Care Services Programs of CSC (psychiatric services has been excluded from the evaluation because an evaluation assessment of this component was recently completed). The purpose of this document is to report on the results of the evaluation assessment and to recommend an evaluation strategy for the proposed evaluation of the medical and health care services provided to federal inmates.

Major Findings and Conclusions:

* due to interaction of the prison environment and the prisoners, and the personal characteristics of the inmates, a higher-than-average demand on health care services can be expected.

* the type and scope of health services delivery are comparable to those outside the penal environment with the exception of the accommodations made to meet the special needs required in a penal institution. In general, a broad range of services is being offered.

* the program goals are essentially the same in terms of both definition and development as those set by the medical community at large, with the exception of the specific goal relating to the correctional rehabilitation of the inmates.

* health care staff strive to achieve a level of quality of care delivery comparable to that provided by "outside" communities.

* nurses were found to take a greater role in the delivery of health care that their counterparts in the "outside" community.

* see Evaluation Assessment (report 2), October 1982, for results.

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Evaluation Assessment of Psychological Services, Correctional Service Canada, June 1982.

Executive Summary:

As a first in the process of understanding an evaluation of the Psychological Services component, the evaluation assessment is intended to review the component's objectives, identify issues that would be addressed in the evaluation, devise appropriate methodologies for conducting the evaluation and propose alternative options for evaluation. These requirements were set out in the study's term of reference: To prepare an evaluation assessment report on Psychological Services in CPS/NPS in order to comment on the clarity of the program objectives, clarity and adequacy of the program design, to identify issues that merit evaluation and propose alternative methodologies of evaluation.

The structure and objectives of Psychological Services were assessed and a judgment was made regarding the problem which these could cause in an evaluation. Several non-programs were found to exist in the current component. Firstly, the objectives

of Psychological Services are articulated as activities, making their evaluation essentially tautological. The objectives are activity-oriented or service-oriented rather than goal-oriented and are neither set in a temporal planning framework nor in a priority ranking. A further problem relates to the fact that psychological services are delivered in a varied discretionary manner. There are idiosyncrasies in the activities of the component among regions, institutions and psychologists.

The purpose of this document is to perform an evaluation assessment of the Psychological Services program within CSC. An evaluation assessment is the planning phase leading up to an evaluation; it is designed to address the pertinent issues as well as the approaches to be used for answering them.

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A Program Evaluation for Psychiatric Services in Correctional Services Canada, Ernst & Whinney, October 1982.

Executive Summary: Major findings and recommendations

Our study was conducted with the aim of ensuring the delivery of psychiatric services in an up-to-date and humane manner. The program evaluation process is a two stage process composed of the evaluation assessment study and an evaluation study.

The specific issues identified by the Evaluation Assessment Report, and discussed in this document, are as follows:

* What can psychiatry be reasonably expected to contribute towards meeting the needs of behaviourally and mentally disordered federal inmates?
* What are the real (or perceived) mental health needs, that concerns CSC internally and externally?
* Clientele - an analysis of that segment of the prison population in need of psychiatric services.
* A critical analysis of what programmes are required to satisfy the needs identified.
* What facilities would be most suitable to ensure programme delivery?
* A broad analysis of management and organizational structure, particularly for identified problem areas.
* Based on client needs, programme content and facilities available, what professional staff requirements exist to ensure adequate provision of psychiatric services?
* An analysis of the benefits and costs associated with the various CSC affiliations.
* Comparison - How does the service delivery at the existing RPCs compare to that currently available at Pinel, Clarke, Butner or other comparable institutions?

* Alternatives - Based on client needs and programme definition, alternative options for delivery could be provided.
* Psychiatrists - Should psychiatric capabilities be internalized, or should dependence upon external resources be emphasized?
* The identification of medical, legal and other related issues which will require further study to fully assess implications.

An efficient information system and data base must be in place to identify the characteristics of the population being served, including its demography and the case mix by diagnosis. The system must also have some predictive capabilities and must be updated regularly.

A systematic planning methodology is needed. This should be designed to service the entire system. It should be well documented, readily understandable and revised regularly in accordance with the feedback from users. It should allow for an appropriate evaluation and revision, involving users of the data.

While a general and systematic planning methodology should be in place, there should be sufficient flexibility to allow local input and issues to modify the overall general planning system where unique local circumstances warrant.

The system must have an ability to examine the likely effects of alternatives to existing health care delivery systems. Ideally, there should be a capability to predict the likely effects, in terms of both treatment outcomes and costs, prior to the introduction of the alternative. Realistically, this may require the development of pilot projects, with appropriate evaluation of the outcome before major changes are introduced.

Differentiation among facilities and programs, on the basis of pre-determined levels of care (primary, secondary, tertiary), may assist in planning for the delivery of service.

The psychiatric programme must address the following system needs (system needs are best characterized by the phrase which refers to the maintenance of the good order of the institution):

> Provide assistance in the treatment/management of behavioural problems in the institution through removal of the inmate of intervention.
>
> Provide a realistic understanding to all staff of the benefits and limitations of psychiatric intervention.
>
> Prevent the dumping of non-mentally ill inmates into psychiatric programs.

There is a need for psychiatric treatment within the institutions.

Psychiatric parole assessments must be handled outside the psychiatric treatment programmes.

There should be formal agreements with external resources to minimize the reliance on informal networks.

The institution is also a patient; treatment in the institutional setting requires an understanding of the dynamics of CSC and the institution.

The programmes must emphasize the use of non-psychiatric mental health professionals.

CSC has identified the need for 30 tertiary psychiatric beds in the Atlantic Region.

The psychiatric programme must address the following client needs (client needs will be the primary focus of medical and service professionals including psychiatrist, physician, psychologist, nurse, etc. The perspective is more client oriented and treatment oriented than that held by those charged with the administration of the institutions):

Treat inmates who are mentally ill in a humane and professionally accepted way.

Provide for the treatment of patients not motivated or unwilling, to give consent where there is a mental health problem.

There should be programmes available for the total range of mental illness.

Continuity of care should be emphasized in programs developed internally and, when possible, arranged externally.

The psychiatric services for female inmates must be developed to the same level as for male inmates.

Medical records must accompany patients through different level of care.

Psychiatric treatment should not be limited because inmates are perceived as too violent or dangerous.

There should be programmes developed for inmates in protective custody, special handling units and segregation.

The psychiatric programme must address the following community needs (community needs or expectations are expressed in the belief that an individual who is sentenced to penitentiary with an identified or suspected mental disorder, will receive treatment and be at least improved, upon release from imprisonment. There is an expectation, or at least an assumption, that psychiatrists and the services they provide will reduce recidivism and significantly lower crime rates):

> Psychiatry must provide service to treat sexual offenders, violent offenders and others whose crimes are related to mental illness.
>
> Psychiatry must help prevent the release of inmates who are potentially dangerous.
>
> Follow-up care must be arranged for those patients who will have difficulty coping in society.
>
> Psychiatry must provide the judiciary with a relative understanding of and expectations of psychiatric treatment in CSC.

Having drawn attention to the absence of certain basic data we concluded that CSC should conduct an "accommodation study" of its population. This study should be designed to compile information relating to such things as the level of care required and the ideal location for such care.

In the planning process, under ideal conditions, specific data should be available to determine patient needs and demand for services.

We have recommended that a pilot study of the institutional mental health team be conducted to provide data on the impact of formalized institutional psychiatric care. This document has developed programme descriptions (patient load, staffing, facilities, delivery methods, follow-up requirements, etc.) for the following major diagnostic groups: psychotic, neurotic, personality disorders, sexual offenders, violent offenders, drug and alcohol, and mental retardation.

The treatment of mentally disordered offenders require two separate sites for delivery: facilities within the institution and regional referral centres. Within the institution, the programmes call for ambulatory and short-term in-patient services (primary and secondary). The regional referral centre (tertiary) must be designed for long term in-patient care for both acute and chronic patients and for special programmes.

Our investigation led us to conclude that most provinces are willing to accept some federal inmates subject to the availability of staff, resources, facilities and the level of security required for the inmates. Sharing services, especially in the Atlantic Region, is a concept which should be continued and expanded in the future. Since CSC has limited jurisdiction over people released on MS or warrant expiry, it is equally important that suitable services are available at the provincial level for released inmates. The provinces tend to have very limited resources available to treat these individuals. Shared services could assist with this aspect of the problem, particularly in smaller provinces.

In recent times, a number of major health care firms in Canada have been marketing their skills in "contract management" of individual hospital. They would contract to manage the complete operation. In doing so, they assume responsibility for providing staff and ensuring that the quality of care is maintained - or enhanced when appropriate. This type of service should be considered by CSC.

It is recommended that the objective for psychiatric services within CSC be reworked to (1) allow for quantifiable measures of programme compliance with the objectives; (2) maintain the integrity of the objectives as they now exist; (3) be keyed to service levels experienced or expected by patients with similar pathologies in the provincial psychiatric settings.

It is recommended that CSC use the following ranked list of services in any review of existing psychiatric programmes or in the development of any new psychiatric programmes:

* recognition and treatment of the severely mentally ill (psychotic, demented, psychotically depressed or suicidal inmate)
* recognition and treatment of less severely ill (the anxious and non-psychotically depressed inmates) and the recognition and consultation in the treatment of marginals (mentally retarded, chronic psychotics and organic brain damaged)
* development of pilot projects in the RPC for the provision of service and the possible export to the institutions of special programmes, such as violent offenders, sexual offenders and personality disorders
* direct control during the initial implementation phase, and consultation role to offender programmes for the on-going operation of these expired programmes in the institutions
* advisory role to institutional management

* provision of psychiatric reports and recommendation for classification, program assignments, temporary absences, release on parole, etc.
* research and education.

It is recommended that CSC establish a mental health team in each institution, to be responsible for the assessment of inmates, the development of treatment recommendations and the coordination of treatment. It is recommended that the team be composed of the consulting psychiatrist, the G.P., a nurse, an institutional psychologist, and the case manager.

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Evaluation Assessment (Report 2): Medical and Health Care Services Program, Correctional Service Canada, October 1982.

Terms of reference:

In February, 1982, EHE submitted to Correctional Services of Canada their report of the Evaluation Assessment of the Medical and Health Care Services Program. On July 7, 1982, EHE was recommissioned to prepare another report on the Evaluation Assessment of medical services (leading to this present document) focusing the material of the first report specifically for the readership of senior management. This report identifies and describes the central evaluation issues and ranks them in order of priority; examines the options available for evaluating the CSC medical and health care program and highlights the advantages and disadvantages of each; and recommends the evaluable option which would be most appropriate for the CSC medical and health care program at this time.

Findings and conclusions:

Five issues central to the CSC medical and health care program were identified through a consultative process with key individuals at CSC and ranked in order of priority as follows:

* characterization of the program
* quality of care
* funding of the program
* organizational structure
* professional development

Emanating from these five issues, three global objectives for the evaluation were formulated by the Evaluation Team:

* to assess whether the quality of the CSC health care program is consistent with currently accepted Canadian practices and standards.

* to determine if the present program is being delivered in the most efficacious and efficient manner.
* to assess whether the current custodial model of health care is most appropriate to achieving overall organizational effectiveness.

The results revealed that the program could be evaluated but the options for undertaking this evaluation were limited by the non-specificity of program goals and the lack of required information Eight activities were identified and described which, when collectively completed, could provide information on the comparability of the CSC health care program to that of the Canadian system at large, on the quality of care provided, and on program performance in terms of efficacy and efficiency:

1) Determination of the health requirements of the target population
2) Examination of accessibility factors (availability, accessibility, acceptability, bias, coverage)
3) Evaluation of the health care delivery structure, i.e. facilities and personnel.
4) Description of the health care delivery process
5) Evaluation of the health care delivery process
6) Review of untoward outcomes during the delivery of health care
7) Sample survey of inmate satisfaction with the delivery of health care
8) Position paper on the organization structure and program delivery model

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Evaluation Assessment: Executive Summary, Medical and Health Care Services Program, Correctional Service of Canada, Solicitor General Canada, November 1982.

Overview:

This executive summary has been prepared for the readership of senior management and was based on evaluation assessment. This report therefore highlights the main findings and recommendations of the earlier report, in particular concentrates on the recommended strategy for the proposed evaluation (the mandate for the evaluation assessment and the evaluation excluded psychiatric services).

Issues that need to be addressed:

1. The first issue which emerged from EHE's study and which is central to all other issues concerns how the section of the Penitentiary Act (hereafter called the Act) which describes health care services is interpreted and subsequently translated into the goals and

objectives of the health service programs in penitentiaries. EHE, among others, has observed that there appears to be conflict between the Act and the program objectives. While we observed this conflict, we were unable to ascertain within our present study the precise extent to which it exists. General interpretation of the act is that it specifies that inmates within the penitentiary system shall be entitled to receive **essential** health services. Program objectives, on the other hand, imply that inmates shall be entitled to **equivalent** services. It is in the interpretation of the two words, essential and equivalent, that the conflict appears to arise.

2. Issue 2 concentrates more on assessing the appropriateness of the program objectives themselves. Essentially the desirability, validity, attainability and applicability of program goals and objectives must be explored.

3. The issue is whether the current data being collected by CSC is sufficient in detail, clarity and uniqueness to be used to assess the effectiveness and efficiency of the Program. An expansion of the core issue, questions as to whether data collection mechanism should be put in place only for the Program Evaluation Study (one time) or whether CSC looks at improving upon the current data collection activities and expand the information collected on the program, thus providing management with a permanent tool to monitor the ongoing operation of the program.

4. Is the program doing what it is intended to do? If yes, can it be done better? If not, how can it be modified?

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Preparatory Report for a Program Evaluation and System Review of Psychological Services, Correctional Services of Canada, 1983.

Synopsis:

Psychological services have been provided to inmates in Canadian Penitentiaries for 35 years and psychologists currently are on staff in approximately 35 federal correctional institutions. These psychologists are mandated to provide the following: (1) psychological assessment; (2) psychological counselling and therapy; (3) consultation regarding inmates; (4) consultation regarding management issues; (5) program development/evaluation; (6) staff training and staff professional development.

This document, following two previous reports (Evaluation Assessment of Psychological Services, and Report on Psychological Services CSC 1982) agrees that specific issues and concerns should be addressed by CSC staff before initiating an evaluation study. But before hand, CSC staff feels that the preparatory work should be more clearly articulated, the management issues addressed and then evaluation issues and questions posed in preparation for a programme evaluation which would commence early in the fiscal year 1984-85.

The following summarizes the issues to be addressed prior to commencement of a system review and programme evaluation:

* rationale for Psychological Services CSC to be developed.
* statement of priorities to be developed.
* list of activities to be completed
* target groups to be described
* programme plans and report formats to be developed for psychologists, institutions, regions, national programme.
* evaluation questions and issues to be decided.
* evaluation questionnaires to be developed.
* follow-up measures to be developed.
* National Director of Psychological Services to be assigned responsibility for all Psychologists doing psychological work.
* role of Regional Coordinators to be clarified.

GENERAL ISSUES PERTAINING TO MENTAL HEALTH WITHIN CSC

GENERAL ISSUES PERTAINING TO MENTAL HEALTH WITHIN CSC

The General Program for the Development of Psychiatric Services in Federal Correctional Services in Canada, Solicitor General Canada, 1972.

Terms of Reference:

To determine the need for psychiatric services in each region to provide total treatment for mentally ill inmates.

To determine the program required to meet the needs for each category of mental illness, whether in the institutions themselves, or by hospitalization in a psychiatric centre and the staffing requirements in each case.

To determine the location of psychiatric centres where required.

To determine the desirability and possibility of establishing training fellowships for psychiatrists and other means to provide the required professional staff on a continual basis.

To advise regarding affiliation with universities, and regarding the suitability of any existing facilities as psychiatric centres.

To provide general comments, where relevant, on the architectural design for any new psychiatric centre.

Summary:

The report reviews the objectives of psychiatric services in any correctional system, and it gives the historical background of psychiatric services in the Canadian Penitentiary Service. It formulates requirements for providing adequate psychiatric services in the specifically Canadian setting; wherein various alternatives are considered and numerous recommendations are made as to how such services might be effected. Finally, the report deals with the problem of evaluating the effectiveness of psychiatric services in terms of cost benefits; this matter will also be the subject of a complementary report rendered by consulting economists appointed by the Solicitor General to collaborate with the Advisory Board of Psychiatric Consultants.

Recommendations:

* That there be five Regional Psychiatric Centres in the Canadian Penitentiary Service.

* That there should be diversity of arrangements in the planning of penitentiary psychiatric centres and the provision of psychiatric services in different regions, recognizing the variety of needs, programs and facilities that are operative in the five main regions of Canada.

* That a unified psychiatric service be established in each region under the professional direction of a regional psychiatrist who would assign the professional staff to provide the range of services required on a priority basis. This would provide better professional liaison, collaboration and consultation; opportunities for diversity of practice; continuing care throughout all phases of illness, and coverage of separate institutions during vacation, illness, absences at medical meetings, etc.

* That a formal approach be made as soon as possible to those Universities with which it is hoped the Regional Psychiatric Centres might be affiliated.

* That in order to attract and keep professional staff and to facilitate university affiliation the centre must be located within convenient distances of large urban and/or university centres.

* That the operating cost of psychiatric care provided in the Canadian Penitentiary Service should be commensurate with those costs that reflect an adequate and contemporary standard of psychiatric care.

* That the functions of research and teaching within the penitentiary psychiatric centres are essential to successful operation of these centres and that budgetary provision for these centres be adequate for this purpose.

* That there should be early joint planning and consensual agreement on treatment goals and requirements to be fulfilled, established between the psychiatric staff and National Parole Service Officers in order that release will ensue at a meaningful time, if the conditions of parole are met.

* That the need for a study of the provision of adequate psychiatric services on release be recognized, and that this study be undertaken immediately by the Advisory Board in conjunction with the NPB.

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Issues Bearing on Correctional Law vis a vis the Mentally/Behaviourally Disordered Inmate in Canada, Hogan, Timothy, 1985.

Executive Summary:

This Issues Paper focuses on matters concerning the mentally/behaviourally disordered inmate in the context of the Correctional Law Review and the Canadian Charter of Rights and Freedoms. Seven major issues were identified, related questions posed and problems specified for each issue followed by a discussion of that issue. The issues and problems are identified in the Executive Summary, followed by the recommendations that resulted from this study.

Issue 1: The definition and identification of the mentally/behaviourally disordered inmate.
Issue 2: Availability and accessibility to programs designed to assist the mentally/behaviourally disordered inmates
Issue 3: The mentally/behaviourally disordered inmate dealing with the discipline, authority and management requirements of a Federal Correctional Institution.
Issue 4: The transfer of mentally/behaviourally disordered inmates to suitable treatment facilities.
Issue 5: Jurisdictional responsibilities and the mentally/behaviourally disordered inmate.
Issue 6: The mentally/behaviourally disordered inmate and parole, mandatory supervision and warrant expiry.
Issue 7: The Canadian Charter of Rights and Freedoms, the Correctional Law and the mentally/behaviourally disordered inmate.

Recommendations:

1. Definitions for mental disability, mental/behavioural disorder and its various subcategories should be developed so as to provide reference points in legislation.

2. The law should be modified to allow sentencing judges who have established beyond a reasonable doubt that a person has a disorder and can benefit from treatment to sentence the person to a place where that treatment can be provided.

3. Ample resources should be made available for the rehabilitation of inmates who are motivated and able to benefit from treatment.

4. There should be a suitable codification of the Correctional Law and consolidation of statues.

5. There should be a review of the Commissioner's Directives, Regional and Divisional Instructions and Institutions' Orders so as to effect more uniformity where possible and desirable.

   (Recommendations 4 & 5 should be implemented with the special requirements of the mentally/behaviourally disordered inmate in mind).

6. The Gilbert Sharpe recommendation regarding a tribunal should be implemented - that is

   > "It is recommended that a mechanism be established under the Penitentiary Act to provide for the consideration of ongoing problems of mentally ill convicts and to arrange for appropriate care and treatment and that act provide for detention authority in the receiving mental health facility."

7. Consideration should be given to the reorganization of the Canadian Penal System (a. the possibility of there being one national system; or b. the possibility of there being 12 provincial/territorial systems). In considering option (b) the federal role may be limited to: (1) distribution of funds; (2) development of standards; (3) program evaluation and audit; and (4) incarceration of special groups such as dangerous offenders serving life sentences.

8. A complete review of "Charter decisions" should be undertaken, especially those that have a bearing on the definition, assessment, management, punishment, treatment and placement of mentally/behaviourally disordered inmates.

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OTHER ISSUES PERTAINING TO COMMUNITY

OTHER ISSUES PERTAINING TO COMMUNITY

Building Community Support For People: A Plan for Mental Health in Ontario, The Provincial Community Mental Health Committee, July 28, 1988.

Terms of Reference:

To define what constitutes a comprehensive community mental health care delivery system.

To develop guidelines and standards for various program models, for example, housing program standards or what constitutes a vocational rehabilitation program.

To develop service delivery models for use in urban centres, rural settings, and remote areas.

To advise the Minister on the initiatives required to meet the needs of special target populations including women, youth, the elderly, ethnic and Native groups.

Findings:

Some problems continue to exist: a lack of clear policy regarding who is to be served and how services are to be provided; a lack of a systems approach; a lack of a multiyear plan; little coordination; disparities in the availability of services across the province; and gaps in service.

This report is a directional paper for mental health. It presents a plan for the development of a comprehensive mental health care system. It outlines strategies for action at both the provincial and local levels that will move us closer to attaining the goal of a mental health care system that ensures that all residents of Ontario have equal access to the mental health services they need in their own community, and that is consistent with the following principles:

- joint participation of individuals, organizations and government

  a concept of health that includes the totality of an individual's well being and addresses the determinants of quality of life as well as quality of care

  an integrated government policy for health, and

  a balance of province wide and local perspectives which provides for flexibility, pluralism and innovation.

It is the conclusion of this Committee that mental health care must be focused in the community. Ontario's mental health care system should provide a comprehensive range of services and support to people as close to their homes as possible. Such a system must be able to address a broad range of mental health needs.

Recommendations:

That the Ministry of Health adopt the following goals for a comprehensive mental health care system as provincial policy.

a) Ontario develop a mental health system to deliver comprehensive services that:

ensure all residents of Ontario access to mental health services in, or as close to, their own communities as possible;

place priority on providing support to individuals and their families who experience serious or prolonged mental illness or impairment;

recognize the multi-dimensional nature of the origin and management of mental illness;

ensure a balance between institutional and community sectors of the mental health system by providing an adequate supply of a range of formal and informal supports and treatment in order to reduce the need for institutionalization, in response to geographic and population needs;

enhance quality of life as well as quality of care by maintaining people in the community and close to their natural environment and;
provide access to adequate incomes through work or social assistance.

b) Ontario's mental health system provides for:

a partnership between consumers, their families, service providers and government in the planning, development, and delivery of services;

improved communication and cooperation between Ministries and other levels of government;

a balance between province-wide perspectives and local priorities that encourages flexibility and community innovation; and

the integration of services provided by health professionals, community agencies, general hospitals and provincial psychiatric hospitals.

That by 1995, mental health services provided by community agencies, general hospitals, psychiatric hospitals and other professionals reflect the following principles in order to qualify for funding:

Focused in the community: care is provided in such a way as to enable individuals to obtain needed support and encourage them to make use of family, friends, and other naturally occurring helping relationships. A broad cross-section of the community, including consumers and their families, should have direct input into planning, development, ongoing operation and evaluation of services.

Mandated: communities and government share the responsibility to ensure that a full range of services is provided.

Comprehensive: a range of services will be available to meet diverse needs and provide for consumer choice about how needs are met.

Individualized: Care is particular and appropriate, planned with and for the individual and his family and directed toward enhancing individual participation in community life.

Flexible: Services should be adaptable and responsive to the special needs of identified individuals, groups and communities, and to changing needs over time.

Accessible: Services should be provided in such a way so as to ensure that they are available to those most in need and that individuals will not experience significant difficulties in using them.

Coordinated: The service system must provide for the continuity of care and ensure that integration takes place at the client, program and system levels.

Accountable: Supports and services should be monitored, evaluated and adjusted in order to remain appropriate and responsive to changing client needs.

Culturally and geographically relevant: The dimensions of a service system must reflect the unique characteristics of specific communities and target populations within them.

Functionally equivalent: Services are developed with the recognition that a variety of service interventions can meet the same need.

Use of natural and informal supports: Self-help approaches and natural support systems (family, etc) are essential to the maintenance of mental health and to the treatment of mental illness.

Effective: The mental health plan will encompass more than the narrow range of traditional services. Services will be evaluated in relation to their effects on quality of life as well as outcome measures.

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Solicitor General Annual Report 1986-1987, Solicitor General Canada, 1988.

Synopsis:

In this report, each of the five major components of the Ministry reviews in some details its legislative and policy initiatives and its operational activities for fiscal year 1986-1987.

Initiatives and results (within Health Care Division):

* a total of 28 health care centres, located in maximum and medium security institutions, provide service to 41 institutions. Health care centres provide ambulatory and out-patient services, including medical, dental, optometric and nursing services. A limited number of infirmary beds are available to provide primarily short-term care. Health care centres coordinate inmate access to community medical services for diagnosis, treatment and rehabilitation for more complex health problems.

* psychiatric services are provided to inmates on an in-patient and out-patient basis. Short-term or minor problems may be treated in institutions by consultant psychiatrists and health care centre staff or by professional staff from regional psychiatric centres providing an out-patient service. Patients who require hospitalization, or those who may benefit from longer term treatment are transferred to one of three CSC regional psychiatric treatment centres located in the Pacific, Prairie and Ontario regions or to provincial mental health facilities. Quebec region's psychiatric services are provided exclusively by l'Institut Philippe Pinel under a Federal-Provincial agreement.

* to implement program changes to provide effective multidisciplinary mental health services more cost effectively. This included examining the cost effectiveness and client satisfaction of the Pacific Region ambulatory mental health team with a view to possible implementation in the Ontario Region. Client and institution satisfaction with the ambulatory mental health team in the Pacific has been evaluated and found to be high. It has been demonstrated that some offenders who previously would have required admission to a psychiatric centre can be maintained at their institution with regular treatment by the ambulatory team. Follow-up of offenders returned to an institution after treatment at a regional psychiatric centre is often effective in preventing relapse. In Ontario Region, mental health committees have been set up in each institution to coordinate service to mentally disordered offenders. Membership includes representation from health care, psychology, and case management. The Regional Treatment Centre has established a position for a coordinator of ambulatory services. The coordinator's primary responsibility will be for follow-up of patients returned to the institutions after treatment, as well as for establishing priorities for elective admissions.

* to implement program changes to provide effective multidisciplinary mental health services more cost effectively. This included assisting the Quebec Region to examine the costs and benefits of the Pinel agreement with a view to identifying alternate methods of psychiatric service delivery for the region. It was decided that CSC would gain flexibility in meeting the needs of mentally ill and mentally disordered inmates by contracting with Pinel institutions for professional service to federal mentally disordered inmates. The contract took effect April 1, 1987.

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