CORRECTIONAL SERVICE CANADA

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Evaluation Report

EVALUATION OF CORRECTIONAL SERVICE CANADA'S ENGAGEMENT AND INTERVENTION MODEL

JUNE 2021

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Signatures

Evaluation of Correctional Service Canada's Engagement and Intervention Model

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Acronyms/Abbreviations

AID	Assessment/Intervention/Debrief
AIM	Ability, Intent, Means
CCRA	Corrections and Conditional Release Act
CCRR	Corrections and Conditional Release Regulations
CD	Commissioner's Directive
CISM	Critical Incident Stress Management
CSC	Correctional Service Canada
CXCD	Correctional Officer Continuous Development
DRF	Departmental Results Framework
EIM	Engagement and Intervention Model
GBA+	Gender Based Analysis Plus
HRMS	Human Resources Management System
ICCPR	International Covenant on Civil and Political Rights
IIB	Incident Investigations Branch
LGTBQ2+	Lesbian, Gay, Bisexual, Transgender, Queer, and Two-Spirited
MHNS	Mental Health Needs Scale
NHQ	National Headquarters
NTS	National Training Standard
OC	Oleoresin Capsicum
OCI	Office of the Correctional Investigator
OMS	Offender Management System
PMMR	Performance Measurement and Management Reports
RTC	Regional Treatment Centre
SIU	Structured Intervention Unit
SMEAC	Situation, Mission, Execution, Administration, and Communications
SMM	Situational Management Model
STG	Security Threat Group
UoF	Use of Force
WOC	Warrant of Committal

Executive Summary

This report presents the evaluation of the Engagement and Intervention Model (EIM), which is a risk-based model designed to assist Correctional Service Canada (CSC) staff working in both security and health activities in responding to, and resolving institutional incidents, using the most reasonable interventions. To have and maintain safe operations of institutional environments, the EIM was introduced in January 2018, and replaces the previous institutional incident management model, the Situational Management Model (SMM), in its entirety.

The EIM differs from the SMM in four primary respects. First, it emphasizes a balanced approach to risk assessment using a person-centered perspective and intervention strategies to prioritize an offender's well-being. Second, engagement and intervention strategies include those focused on mental and physical health, in addition to those that are security focused. Third, the use of non-security partners, such as Health Professionals, is urged. Fourth, there is a focus on reducing the risk of physical harm through non-use of force responses.

Key sources of information used to examine the relevancy, design and delivery, and effectiveness of the EIM included internal and external documents and literature, data from the Human Resources Management System (HRMS), interviews with 15 key informants, and online survey data from 237 staff members. Data from the Offender Management System (OMS) were also used to compare institutional incident and use of force indicators between incidents managed under the SMM, the previous incident management model, and the EIM.

Relevance

There is evidence of a continued need for the EIM to prevent, respond to, and resolve situations within federal institutions that could potentially disrupt the safety and security of inmates or staff. This need is further reinforced through the requirement to consider unique characteristics and situational factors of inmates when responding to institutional incidents.

Alignment with Governmental Priorities

EIM aligns with, and supports, the federal government's priority of providing a safe and secure environment for Canadians, in general, and inmates, in particular.

Consistency with Departmental Roles and Responsibilities

The EIM priority of guiding both security and health services staff to use the most reasonable intervention strategies is aligned with the roles and responsibilities of the CSC.

Design and Delivery

Training and Identified Best Practices

The data (where available) suggest that most CSC staff had received the EIM training prior to its implementation, with the exception of National Headquarters (NHQ) employees. However, key informants articulated a need for refresher training and scenario-based training for non-security staff (e.g., health services). The effectiveness of training could also be enhanced by involving multiple disciplines in completing training together, particularly in scenario-based

training. There is also a need to incorporate more content related to women inmates and inmates with cognitive impairments when educating staff about de-escalation strategies. This need may also extend to other sub-populations as many survey respondents did not know if they possessed enough knowledge to de-escalate incidents among various sub-populations of inmates.

Use of Physical Interventions

It should be noted that the EIM emphasizes that the appropriate intervention strategies will be chosen following the initial and ongoing assessment of the individual(s), the situational factors, and the associated level of risk, and the interventions may or may not include use of force options.

Considering all institutions together, there has not been a decrease in use of force during institutional incidents since the implementation of the EIM. This is also true when comparing use of force incidents within inmate security levels. The percentage of use of force review packages where the amount of force used was deemed necessary and proportionate is high. Overall, while there is evidence of some positive changes, particular attention needs to be paid to the more frequent use of force with younger, ethnocultural, and Indigenous inmates.

Considering all institutions together, there was a decrease in force used during behaviour-related incidents. Examining regional treatment centres (RTCs) specifically, there was also a decrease in force used during behaviour-related incidents. Overall, there is evidence of some positive changes.

Considering all institutions together, there was a decrease in the discharge of inflammatory or chemical agents during use of force incidents. Examining RTCs specifically, there was also a decrease in the discharge of chemical or inflammatory agents. Overall, there is evidence of some positive changes.

Considering all institutions together, findings show a decrease in inmate injury during use of force incidents. Overall, there is evidence of some positive changes. Identified areas for concern in use of force practices among older inmates are mental health, physical disability, and physical health. There is also a need for more guidance and training on how to manage older inmates when force is required.

Considering all institutions together, there has been an increase in planned uses of force and a decrease in spontaneous uses of force under the EIM when compared to the SMM. This is evidence of some positive changes.

Institutional Incidents Involving Physical or Mental Health Distress

Considering all institutions together, during the EIM period, there have been two positive changes regarding incidents involving an inmate with mental health concerns. There has been a decrease in use of force during incidents involving an inmate with a suicide alert and among those occupying a mental health bed. Overall, this is evidence of some positive changes. Examining RTCs specifically, there has been a decrease in use of force during incidents involving an inmate with an active suicide alert as well. Effect sizes indicate this change is small, which is promising.

Overall, there has been a decrease in the percentage of incidents in which first aid was required, including in RTCs. While there is evidence of a positive change, the effect sizes indicate the observed changes are negligible.

Overall, there has been a decrease in the percentage of interventions conducted in accordance with the Guidelines for Health Service Responsibilities, including in RTCs.

Effectiveness

Implementation of the EIM when Responding to Incidents

Staff are engaging in key components of the EIM philosophy, as most reported that they are taking a person-centered approach and placing mental and physical well-being at the center of engagement and intervention strategies. Most are also able to identify cues of distress or altered levels of consciousness when dealing with inmates, to continuously reassess situational factors as the incident unfolds and to categorize the level of risk, and to employ de-escalation strategies when responding to incidents. Where staff may not fare as well is in their ability to select appropriate force options, and in their ability to get help to safely manage incidents of mental and physical distress when dealing with inmates.

While for the most part key elements of the EIM have been implemented as intended, the model does not appear as intuitive and easy to apply, especially when it is compared to the SMM. It is also perceived that the EIM has not resulted in a decrease in the use of force. There is a lack of clarity of roles and expectations of staff during an incident, a lack of teamwork among staff in responding to incidents, and a lack of readily accessible staff to effectively manage incidents during off-peak hours. Although, for the most part, roles and responsibilities of the Sector Coordinator are being implemented appropriately, survey responses suggested that the implementation of roles and responsibilities could be improved. Moreover, there may be a need to have more clarity in who is in charge during the course of an incident. Additionally, Sector Coordinators are finding it difficult to transition from the first Officer on the Scene to their role as Sector Coordinator.

While the culture of some institutions allows the EIM to be successfully implemented, CSC's culture at the organizational level may present challenges to the implementation of the EIM. This may be due to a perception that there is a strong focus on security rather than the use of interventions, and a culture that is resistant to change. The EIM has not had a positive influence on the culture of some institutions.

With respect to managing incidents in the SIUs, findings show that the EIM philosophy has not had a positive influence on the outcomes of incidents managed within these units.

Implementation of Key Activities

While Correctional Officers/Primary Workers and Correctional Managers were most often identified as being involved in the planning and application of intervention strategies, Sector Coordinators were not as involved as would be expected. Sector Coordinators and Health Professionals appear to be more involved in the application of intervention strategies at RTCs than overall in institutions. Staff perceptions suggest there has been an increase in interdisciplinary teamwork since the implementation of the EIM as Correctional Managers, Sector Coordinators, Health Professionals, and individuals who have a good rapport with the inmate were slightly more involved in the application of intervention strategies than they were under the SMM. Despite this, there still remain some obstacles to collaboration, for example, the extent of integration and interaction between correctional and clinical staff, and a lack of access to non-security staff during off-peak hours.

While two-thirds of staff understood the intent of the AIM tool and viewed it as useful for assessing risk, only about half of staff survey respondents found it feasible to use the AIM tool during an active incident.

There appears to be frequent use of non-physical interventions as response options during an active incident, with

tactical maneuvering being least commonly used. Moreover, the frequency of use of these response options does not appear to have changed between the SMM and EIM periods.

Use of Quality Improvement Activities

While many of the management roles and responsibilities are being fulfilled under the EIM, some issues were raised, including the lack of dissemination of trends and deficiencies in how the EIM is operating, and a need for more follow-up from management in the instance of violations of law or policy. When model periods are compared, overall, there has been a decrease of required post-incident care (e.g., post-incident decontamination shower), particularly with respect to care where an inflammatory or chemical agent has been deployed.

Overall, with respect to documentation of incidents, including RTCs, there has been a decrease in both the percentage of inmates being given the option to report their version of events and in video recording issues. There has been no significant change in the percentage of forms that have not been completed. It was also noted that there were issues with performance monitoring and reporting, particularly when it came to data quality, data accessibility, and to a balanced approach to reporting on how well the EIM is performing.

Although there is value to conducting debrief sessions, a lack of adequate staff, operational constraints, and time constraints are identified as barriers to conducting them. These barriers may have an impact on the quality of debriefs.

While the majority of respondents believed that current policy provided adequate guidance for conducting use of force reviews, there were some inefficiencies with regard to the policy and process identified, namely that at times the policy is over-prescriptive and that the process itself can be cumbersome. During the EIM period, there has also been an observed increase in the proportion of institutional and regional reviews not being completed on time. For RTCs, there has been an observed increase in reviews not being completed on time at the regional level.

When the EIM period is compared with the SMM period, there has been an increase in use of force packages for which there has been a finding of violations of law or policy. This finding also applies to RTCs, where the effect size of the observed change is medium. When it comes to disciplinary measures for excessive uses of force, there may be reason to believe that there is under-reporting or inaction to correct this behaviour as many key informants spoke to a need for more follow-up subsequent to violations of law or policy.

As a whole, the EIM is contributing to CSC's mission as, in principle, it emphasizes the use of the most reasonable, safe, secure, and humane approaches to managing inmates during incidents. Moreover, the model addresses five of the six corporate priorities as indicated in the Relevancy Section of this report. However, the areas for improvement described above demonstrate that there is still work to be done in order for the EIM to realize its true potential.

Summary of Recommendations

Five recommendations were formulated to action improvements on the performance of EIM, as well as on program expansion.

Recommendation 1- Training

The Evaluation Division recommends that Correctional Service Canada (CSC) reassess the EIM training, including refresher training, to ensure more clearly, well-defined, and effective: (a) scenario-based modules that incorporate the diverse sub-population of inmates (e.g., offenders with mental health needs); and (b) roles and responsibilities of all parties (e.g., the Sector Coordinator, as well as staff including non-security staff) during an incident.

Recommendation 2- Incidents involving mental health and physical distress

The Evaluation Division recommends that CSC devise options to increase capacity to respond to incidents involving mental health and physical distress, particularly those occurring during evenings and weekends.

Recommendation 3- Policy review

The Evaluation Division recommends that CSC review and revise, as necessary, Commissioner's Directive 567 - *Management of Incidents* and 567-1 - *Use of Force*, in consultation with operational staff, to ensure the proposed guidance, including prescribed timelines, are relevant in an operational environment.

Recommendation 4- Corrective actions

The Evaluation Division recommends that CSC review the guidance on corrective actions to ensure it provides more appropriate direction on breaches of law and/or policy.

Recommendation 5- Information collection

The Evaluation Division recommends that CSC develop a national protocol for reporting information found in Statement/Observation Reports in an accessible manner.

Introduction

The Engagement and Intervention Model (EIM) is a risk-based model designed to assist Correctional Service Canada (CSC) staff working in both security and health activities in responding to, and resolving institutional incidents, using the most reasonable interventions. To have and maintain safe operations of institutional environments, the EIM was introduced in January 2018, and replaces the previous institutional incident management model, the Situational Management Model (SMM), in its entirety. The EIM was given authority through the promulgation of *Commissioner's Directive (CD) 567 - Management of Incidents*, by which all interventions used to manage incidents are to be consistent with law and policy in the application of the EIM.[i] This directive helps to maintain the safe operations of institutional environments, as well as respectful environments that promote dynamic security and interactions between staff and inmates.

The EIM integrates a strong focus on the guiding principles of life preservation, interdisciplinary teamwork, CSC Mission & Values, necessary and proportionate response, and leadership. To implement this model nationally, there was a requirement for new training to be developed and for revisions to be made to the existing training.[ii] The EIM differs from the SMM on four primary respects:

1) There is an emphasis on a balanced approach to risk assessment, in which assessments are person-centered rather than solely behaviour-centered. Thus, all intervention strategies prioritise an offender's well-being;
2) Engagement and intervention strategies are broadened to not only include those which are security focused, but also those which are focused on mental and physical health;
3) The use of non-security partners such as Health Professionals (e.g., Psychiatrists, Psychologists, Nurses, etc.), as well as Chaplains, and Elders in responding to security incidents is highlighted; and
4) There is a greater focus on reducing the risk of physical harm through non-use of force responses in responding to security incidents, such as de-escalation and controlled non-intervention approaches.

To ensure that appropriate leadership and health considerations are integrated, a Sector Coordinator role was added to the EIM.[iii] The main responsibility of the Sector Coordinator is to ensure intervention options are appropriate, and to continuously reassess their appropriateness, including the monitoring of both the physical and mental health of the inmate.[iv]

The EIM therefore builds on the SMM by adding more response options and post-intervention accountability. It also provides greater clarity for these elements, and expands on the use of partners during a response, particularly CSC health services. With the goal of eliminating some of the limitations identified from the SMM, the EIM's main objectives include, but are not limited to the:

- Increase in the use of non-security partners to assist with verbal intervention and de-escalation options;
- Introduction and implementation of the Sector Coordinator role to ensure on-scene leadership, with specific responsibilities to ensure health considerations are integrated into the intervention;
- Increased focus on the use of non-physical interventions where there is a low-risk of imminent harm to the offender or others; and

- Increase in the use of health-partners to respond to incidents involving mental or physical distress.[v]

Context

International standards, federal legislation, and CSC's internal policies and directives prohibit torture and other cruel, inhumane or degrading treatment of prison inmates. The first principle of the *United Nations' Body of Principles for the Protection of Detained or Imprisoned Persons* states that "All persons under any form of detention or imprisonment shall be treated in a humane manner and with respect for the inherent dignity of the human person."[vi] Section 26 of the *Criminal Code of Canada* also declares that, "Everyone who is authorized by law to use force is criminally responsible for any excess thereof according to the nature and quality of the act that constitutes the excess."[vii] Staff behaviour and decision-making in managing incidents in institutions are guided by CSC's core values of respect, fairness, professionalism, inclusion, and accountability.[viii] Any engagement or intervention strategy selected by frontline officers should therefore be necessary and proportionate to the level of risk;[ix] surpassing this threshold could result in criminal and/or civil liability.

The SMM was intended to ensure that incidents occurring in federal correctional institutions were managed in a way that supported a safe and secure environment for both inmates and staff. However, over the years, deficiencies in its operational application emerged. The death of an inmate, Matthew Ryan Hines, during an institutional incident in 2015 led to an investigation by the Office of the Correctional Investigator (OCI) into the circumstances surrounding his death. The OCI identified failures in the timeliness and appropriateness of the response of CSC staff to medical emergencies and/or acute mental health distress of inmates.[x] The OCI also identified inadequacies in the appropriate and safe use of chemical and inflammatory agents, including the application of accountability and oversight for their use.[xi] Further, an investigation by the OCI and the Canadian Human Rights Commission into the experiences of older individuals in federal custody also identified a need to incorporate best practices and lessons learned regarding the use of force on older inmates.[xii]

In August of 2017, CSC's Security Branch released a report summarizing their analysis of use of force incidents at CSC institutions. The report identified various areas for improvement, including a need for CSC to:

1) Introduce a modified SMM that emphasized situational analysis, de-escalation, and non-physical responses to institutional incidents;
2) Add data fields to the Offender Management System (OMS) and implement an automated Statement/Observation Report that would enhance the efficacy, quality, and breadth of analysis as well as monitoring that could be conducted in relation to use of force incidents;
3) Provide front-line staff more guidance and improved training on incident response options that emphasize better de-escalation tactics and/or planned interventions;
4) Review policy to strengthen the alignment of the Sector Coordinator position with Correctional Manager roles and responsibilities, and enhance the Sector Coordinator's ability to coordinate layered responses to the specific circumstances and situational factors involved in an institutional incident;
5) Conduct a review of Oleoresin Capsicum spray (OC spray) to ensure the continued safety of its use and as well to examine alternative non-lethal use of force tools;

6) Review use of force trends and analysis on an ongoing basis and improve communication with management groups at the local, regional, and national levels; and
7) Examine the potential use of body cameras in the video documentation of use of force incidents.[xiii]

In addition, the Internal Audit Sector of CSC completed an *Audit of the Framework and Implementation of Situation Management at CSC* in 2018.[xiv] Results concluded that management needed to address a number of issues to improve the manner in which CSC staff manage institutional incidents. In particular, the audit results indicated that:

1) There was no clear prescription and assignment of who was in charge of controlling and leading a response to an institutional incident when multiple staff members were responding to an incident;
2) Training on the use of force module was not consistently provided to staff;
3) There was a lack of guidance material regarding how to perform a use of force review, including the nature of corrective action required for different types of non-compliance;
4) There was insufficient performance monitoring and reporting at the local, regional, and national levels;
5) Intervention plans were not always documented as required; and
6) First aid and physical assessments were not always completed following a use of force incident.[xv]

Findings from the OCI investigations into the use of force in federal institutions, Security Branch's review and report on use of force within CSC, and CSC's internal audit of situation management all confirmed that a shift in responding to and managing institutional incidents within CSC institutions was necessary. The EIM was developed and introduced to improve how CSC staff assess and intervene during an institutional incident.

Program Description

The EIM can be described by summarizing the model according to the following three core components: the philosophy behind the model, how the model works, and management post-institutional incident (a detailed description and visual depiction of the model is included in Appendix A).

The EIM is aligned with the core responsibility of Care and Custody within the Departmental Results Framework (DRF), and within the program area of Institutional Management and Support (P1). For a detailed description of the EIM logic model refer to Appendix B.

About the Evaluation

CSC's Departmental Evaluation Plan (2019-2024) includes a commitment to conduct an evaluation on the impact of the EIM on managing security incidents. The 2017-2018 Annual Report of the OCI[xvi] also recommended that CSC conduct an evaluation of the EIM to provide stakeholders with an enhanced understanding of its performance in key areas since its implementation. The results may be used to provide CSC with necessary information to make strategic policy, operations, and resource allocation decisions as they relate to the EIM.

In accordance with the *Treasury Board of Canada Policy on Results*[xvii] (2016), the evaluation focused on the

relevance and effectiveness[2] of the EIM in the management of institutional incidents. As such, the current evaluation focuses on two core evaluation objectives:

1) Relevancy of the EIM, such as its alignment with government priorities and consistency with federal roles and responsibilities (e.g., does the EIM address a demonstrable need within federal corrections?); and
2) Effectiveness of the EIM (e.g., are there any barriers to quality improvements in the way that the EIM is currently functioning?).

In addition to these two core evaluation objectives, the current evaluation also focuses on the design and delivery of the EIM to examine the alignment of the EIM implementation with identified outcomes.

Methodology

The following describes the methodology employed for this evaluation in a brief format to help with understanding the results presented in this report.

Evaluation findings are presented across three main areas: relevancy, design and delivery, and effectiveness. To evaluate relevancy, a review of government literature, grey literature, and internal documents, such as CSC policies, legislation, evaluation reports, research reports, and operational documents, was conducted.

To evaluate the design and delivery of the EIM, a number of key sources of information were used.

1) Offender Management System (OMS) data were extracted and used to identify institutional incidents and use of force review package indicators for both the SMM and the EIM time periods (for comparison purposes). Specifically, incident reports and use of force review packages for incidents that occurred on or after April 1, 2016, as well as those that had been either submitted or reviewed on or before December 31, 2017 (21 months), were retained and analyzed as incidents that were managed under the SMM. Incident reports and use of force review packages for incidents that occurred on or after January 1, 2018, as well as those that had either been submitted or reviewed on or before September 30, 2019 (21 months), were retained and analyzed as incidents that were managed under the EIM.
    i. All results indicating that there were changes between the EIM and the SMM periods are statistically significant. Further, reference is made to the effect size when reporting statistics, which is a statistical concept measuring the strength of a relationship. A detailed description of the results for design and delivery is included in Appendix C, including the results of significance testing and effect sizes.[3]

[2] At the time of this evaluation, no financial resource indicators for the EIM existed, nor are there specific resources dedicated to it. As a result, an examination of efficiency has been excluded from the evaluation.

[3] In this chapter, the following guidelines for effect size interpretation were used: .1 to .29 = small effect, .3 to .49 = medium effect and ≥.5 = large effect. These are equivalent to Cohen's (1988) rules of thumb for *r*. A detailed description of the analysis can be found in the Methodology and in Appendix D. The EIM period in these analyses, unless specified otherwise, is January 1, 2018, to September 30, 2019, and April 1, 2016, to December 31, 2017, for the SMM.

2) Compliance reports from CSC's Human Resources Management System (HRMS) for EIM-specific training were also analyzed, and the number and percentage of staff who were deemed EIM training compliant were reported.
3) Key informant interviews were conducted with stakeholders who were directly or indirectly involved in, or familiar with the EIM (e.g., Project Officers, Chiefs of Mental Health, and Assistant Wardens of Operations). In all, 15 key informants were individually interviewed, using an interview guide of approximately 20 open-ended questions.
4) Online staff survey data from 237 respondents were analyzed, representing a 12.2% response rate. Notably, any responses that were missing were excluded from analyses (frequency counts and percentages). Additionally, *I don't know* responses are presented as part of the findings when a large proportion of respondents selected this response option, however, frequency counts and percentages are not discussed as they are excluded from the survey analyses presented herein. This resulted in the total number of responses changing across items. Finally, given that the majority of survey items were rated on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*), responses were reported in an aggregated fashion (i.e., *strongly agree* and *somewhat agree* responses were aggregated for each item and are reported as *agree*; *strongly disagree* and *somewhat disagree* responses were aggregated for each item and are reported as *disagree*).

Finally, to evaluate effectiveness, key informant interviews and staff survey data were used. Additionally, HRMS data on disciplinary actions taken for excessive use of force by staff were examined. These data were provided for two time periods - between April 1, 2016, and December 31, 2017 (SMM), and between January 1, 2018, and September 30, 2019 (EIM).

Where possible, findings specific to the Regional Treatment Centers (RTCs) were reported separately. Additionally, where possible, findings pertaining to diverse sub-populations of inmates were reported (as defined by gender based analysis plus (GBA+), including female, younger, older, Indigenous, and ethnocultural inmates). Refer to Appendix D for the evaluation questions and matrix, and Appendix E for a detailed explanation of the methodology.

Limitations, Impact and Mitigation Strategies

The evaluation team encountered certain limitations while conducting the evaluation and put in place strategies to mitigate their impacts on the findings and recommendations (see Table 1 below).

Table 1. Limitations, Impact, and Mitigation Strategies

Limitation	Mitigation Strategy
Sample size/response rate too small to conduct meaningful analyses and/or draw definitive conclusions.	Any OMS and staff survey findings with a sample size of less than five ($n < 5$) were not reported.
Unable to evaluate the reliability of the data flag indicating whether a physical, mental, or cognitive impairment was present.	Only sufficient and reliable data that were available were examined for diverse sub-populations of inmates.[4]
No OMS data on LGBT2Q+[5] inmates	Only sufficient and reliable data that were available were examined for diverse sub-populations of inmates.
Inability to access Statement/Observation Reports (SORs) due to Coronavirus Disease (COVID-19) causing the prohibition to do site visits to collect data from SORs.	OMS data were used as a standalone data source without additional context from SORs. Questions were included in the staff survey and key informant interviews to gain perspectives around non-use of force intervention practices.
Due to the onset of COVID-19 the, timelines for the evaluation were extended by six months.	The final report will receive Commissioner approval by June 2021.

[4] Where possible, data were analyzed among diverse subpopulations of inmates which (as defined by gender based analysis plus) includes females, younger, older, Indigenous, and ethnocultural inmates, as well as inmates with a cognitive impairment, physical, or mental health concern. That is, only data that were available on a large enough sample of these diverse subpopulation and that was deemed reliable were examined.

[5] LGBTQ2+ is an acronym standing for the categories of lesbian, gay, bisexual, transgender, intersex, queer, and two-spirit. The plus-sign signifies a number of other identities, and is included to keep the abbreviation brief when written out. It is important to note that the acronym LGBTQ2+ is used throughout the report because at the time of developing the data collection tools for this evaluation, it was the appropriate acronym.

Findings: Relevance

This section of the evaluation summarizes the evaluation findings related to the relevance of the EIM. It examines the demonstrable need for the model, its alignment with Government of Canada priorities, and its consistency with federal roles and responsibilities. The section further examines how the EIM was intended to address the limitations of the SMM.

Continued Need for the Model

Findings: There is evidence of a continued need for the EIM to prevent, respond to, and resolve situations within federal institutions that could potentially disrupt the safety and security of inmates or staff. This need is further reinforced through the requirement to consider unique characteristics and situational factors of inmates when responding to institutional incidents.

There is a demonstrable need for the EIM to prevent, respond to, and resolve situations within federal institutions that could potentially disrupt the safety and security of inmates or staff. Between April 2016 and December 2017 (the period wherein the SMM was employed), 37,226 incident events were recorded. Out of these incident events, 7% (*n* = 2,469) were use of force cases.[xviii] Given the consistent frequency at which institutional incidents occur, there is a continued need for an approach or model to provide guidance to institutional staff to manage these incidents.

Given the diversity of the inmate population, a key element of an appropriate approach in responding to institutional incidents is to consider an inmate's personal characteristics as well as situational factors. The EIM addresses this need as it takes a person-centered approach in which the inmate is placed at the center of the model to ensure all strategies utilized will consider the inmate's well-being as a priority. In this regard, the EIM allows for consideration to be given to the diversity of the inmate population and specific individual factors in assessing/reassessing the situation and determining an appropriate response. These may include sex, age, mental and physical health, ethnicity, etc. Table 2 provides some key relevant profile information regarding the current inmate population as of February 2020.

Table 2. Total Inmate Population Demographics

Demographics		Number (*n*)	Percent (%)
Category	Characteristic		
Sex[1]	Male	13,251	95.0
	Female	690	4.9
Ethnicity	Indigenous	4,213	30.2
	White	6,844	49.1
	Asian[2]	741	5.3
	Black	1,227	8.8
	Other/Unknown[3]	919	6.6
Age	25 years or younger	1,573	11.3
	26-49	8,906	63.9
	50 years or older	3,465	24.8

Source: *Performance Direct, Performance Measurement and Management Reports, CSC,* Total inmate population = 13,944.

[1] **Sex:** Three (3) people indicated that they were neither male nor female.

[2] **Asian:** Inmates who are Arab, Arab/West Asian, Asian-East and Southeast, Asian-South, Asian West, Asiatic, Chinese, East Indian, Filipino, Japanese, Korean, South Asian, and South East Asian.

[3] **Other/Unknown:** Inmates who are Hispanic, Latin American, European French, European-Eastern, European-Northern, European-Southern, European-Western, Multiracial/Ethnic, Oceania, British Isles, Caribbean, Sub-Sahara African, inmates unable to identify to one race, other and unknown. Hispanic and Latin American are included in Other/Unknown due to low prevalence in the population (<1%).

Security Threat Group (STG)[6] affiliation activities are directly linked to security-related incidents within prison institutions. Several authors such as Griffin and Hepburn (2006),[xix] Cunningham and Sorensen (2007),[xx] and Dininny (2009)[xxi] have reported a direct relationship between STG affiliation activities (prison gang activities) and prison violence. Dininny (2009), for instance, found that even though STG affiliates constituted only 18% of the inmate population, they accounted for 43% of prison violence. The percentage of inmates with STG affiliation within CSC institutions increased from 11.9% in 2017/2018 to 12.4% in 2018/2019. In the same time period, recorded institutional incidents increased by 11% from 23,360 to 25,904, respectively.[xxii]

In addition, research on the prevalence of health needs among inmates highlights the importance of considering the

[6] STG affiliation is any formal or informal ongoing inmate group, gang, organization or association consisting of three or more members.

physical and mental health of inmates when managing incidents. For instance, CSC's research on mental disorders among inmates identified that 79% of women[xxiii] and 70% of men admitted to federal custody[xxiv] have a mental health diagnosis. When alcohol and substance use disorders and antisocial personality disorder were excluded, 67% of women and 40% of men had a current mental disorder. More recent data[7] indicate that approximately 15.4% (*n* = 535) of new warrant of committal (WOC) admissions to federal custody in 2019 had an identified mental health need according to the Mental Health Need Scale.[8] Research by CSC found that inmates with mental health needs have significantly more institutional charges and more transfers to voluntary and involuntary segregation.[xxv] (Notably, segregation is no longer used in federal corrections.)[9] Therefore, the EIM's incorporation of health professionals in its intervention strategies seeks to address the mental health needs of inmates.

Based on the aforementioned reports and documents, there is evidence to support that the current context under which CSC operates necessitates a health and security focused approach to incident management such as the EIM. Further, there is evidence for a continued need for the EIM given the characteristics of the current inmate population.

Alignment with Governmental Priorities

Findings: EIM aligns with, and supports, the federal government's priority of providing a safe and secure environment for Canadians, in general, and inmates, in particular.

The EIM closely aligns with, and supports, the federal government's priority of providing a safe and secure environment for all Canadians as captured in the Prime Minister's 2019 Mandate Letter[xxvi] to the Minister of Public Safety and Emergency Preparedness. In this letter, the Minister is directed to "lead the Government's work in ensuring that Canadians are kept safe from a range of threats, while safeguarding the rights and freedoms of Canadians."

The conduct of all Correctional Officers is mandated by the *Criminal Code of Canada*[xxvii] section 25, which authorizes them, if they act "on reasonable grounds," to use "as much force as is necessary" to carry out their authorized duties. In particular, the Corrections and Conditional Release Act (CCRA),[10] limits the type of measures that CSC may use in carrying out its mandate so that it "uses measures that are consistent with the protection of society, staff members and inmates and that are limited to only what is necessary and proportionate to attain the purposes of this Act."[xxviii] To achieve this, the EIM provides a guide to staff in security and health services on how to prevent, respond to, and

[7] Performance Measurement and Management Reports Data Warehouse, CSC.

[8] The Mental Health Needs Scale is a way of organizing findings and documenting the results of an assessment process. The Mental Health Need Scale is completed by a licensed mental health professional, or mental health staff under the supervision of a licensed mental health professional. The Scale is required to be completed as part of the triage process when an offender is first assessed by a mental health professional.

[9] In contrast to segregation, Structured Intervention Units (SIUs) have been implemented in CSC since November 30, 2019. In comparison to segregation, inmates in an SIU receive structured interventions, enhanced mental health care, and programming to address their specific needs.

[10] https://laws-lois.justice.gc.ca/eng/acts/C-44.6/page-10.html#h-106202

resolve incidents.

Another equally important federal priority is facilitating reasonable access to health services to all residents of Canada.[xxix] As outlined in the CCRA (CCRA [86]), "[t]he Service shall provide every inmate with (a) essential health care; and (b) reasonable access to non-essential health care" and "[t]he provision of health care under subsection (1) shall conform to professionally accepted standards." Unlike the SMM, which did not provide guidance regarding the quality, timeliness, and adequacy of a health care response,[xxx] the EIM is designed to address these gaps in relation to medical emergencies and mental health needs of inmates within the context of institutional incidents.

Finally, the EIM also aligns with the federal government's international commitments and responsibilities. Article 10 of the International Covenant on Civil and Political Rights (ICCPR), to which the government of Canada is a party, establishes that "all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person."[xxxi]

Based on a review of the federal government's priorities, there is evidence to support that the key activities and intended outcomes of the EIM are aligned with federal government priorities, legislation and policy, roles and responsibilities.

Consistency with Departmental Roles and Responsibilities

Findings: The EIM priority of guiding both security and health services staff to use the most reasonable intervention strategies is aligned with the roles and responsibilities of the CSC.

The priorities of the EIM are aligned with CSC's corporate priorities, roles, and responsibilities. For example, the mission of the CSC, as part of the criminal justice system and respecting the rule of law, is to contribute to public safety by actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure and humane control.

The EIM is also aligned with the Minister of Public Safety and Emergency Preparedness' Mandate Letter to the Commissioner of CSC. The letter mandates the Commissioner, among others, to ensure that inmates receive their programming, interventions, and treatments in a safe, secure and humane environment, and to ensure "that use of force incidents are fully investigated, and lessons learned implemented."[xxxii] In the same regard, the EIM has greater emphasis on reducing the risk of physical harm through the use of appropriate response options during incidents.

The EIM also provides a guide to staff in both security and health services on preventing, responding to, and resolving incidents, using the most reasonable interventions (CD 567).[xxxiii] This intention is linked directly to five of CSC's corporate priorities, as outlined below:

1) The EIM supports the priority of "Safety and security of the public, victims, staff and offenders in institutions and in the community." The EIM prioritizes the safety and security of everyone involved directly or indirectly in incidents, by using a person-based approach to ensure that the offenders in CSC institutions and under supervision are managed in a humane manner. Thus, the model ensures that the processes and manner in

which response/force is used are appropriate and in line with CSC policy and applicable legislation. Furthermore, all incident participants (i.e., both inmates and staff) receive the care and support they need following incidents.

2) The EIM contributes to "Effective and timely intervention in addressing mental health needs of offenders" by introducing the duality (combination) of a security and health (mental and physical) approach to guide assessment of risk for appropriate intervention strategies. As part of the assess/reassess component of the model, the EIM includes emphasis on the need to use appropriate response protocols for institutional incidents involving physical or mental health distress.
3) The EIM also supports "Efficient and effective management practices that reflect values-based leadership in a changing environment." By introducing a Sector Coordinator role, the EIM seeks to ensure on-scene leadership, with responsibilities of ensuring that health considerations are integrated into the intervention strategy. In addition, following the occurrence of an incident and the submission of the required documents, a Correctional Manager, in conjunction with the Chief of Health Services, where applicable, conducts an operational debrief with the staff directly involved in the situation. This debrief process provides an opportunity for the participants to assess the strengths and weaknesses of their response and what lessons can be learned and implemented to improve responses in the immediate future. These practices allow for quality improvements to occur, thereby facilitating an increase in the efficiency and effectiveness of the implementation of the model in federal institutions.
4) The EIM contributes to the "Safe management of eligible offenders during their transition from the institution to the community, and while on supervision" (CSC, 2018a, p. 3). The model uses a person-based approach to ensure that the offenders in CSC institutions and under supervision are managed in a humane manner. Thus, the model ensures that the processes and manner in which response/force is used are appropriate and in line with CSC policy and applicable legislation. The use of force is therefore guided by the principle of life preservation.
5) The EIM contributes to "Productive relationships with diverse partners, stakeholders, victims' groups and others involved in support of public safety" by using partners outside of the security department, such as Health Professionals, Chaplains, Elders, Parole Officers, Crisis Negotiators, and Emergency Response Teams, to assist with various intervention strategies/options. This interdisciplinary team approach to interventions not only facilitates the safe return of offenders to communities but also maintains the well-being of offenders and the general Canadian population.

The EIM is also supported by other CDs. The most relevant include:

- CD 001 – *Mission, Values and Ethics Framework of the Correctional Service of Canada ;*
- CD 003 – *Peace Officer Designation;*
- CD 253 – *Employee Assistance Program;*
- CD 560 – *Dynamic Security and Supervision;*
- CD 567-1 – *Use of Force;*
- CD 567-2 – *Use of and Responding to Alarms*;
- CD 567-3 – *Use of Restraint Equipment for Security Purposes*;

- CD 567-4 – *Use of Chemical and Inflammatory Agents;*
- CD 567-5 – *Use of Firearms*;
- CD 568-1 – *Recording and Reporting of Security Incidents;*
- CD 600 – *Management of Emergencies in Operational Units;*
- CD 800 – *Health Services;* and
- CD 843 – *Interventions to Preserve Life and Prevent Serious Bodily Harm.*

Furthermore, the EIM is implicated with the corporate theme of Population Management[11] and also contributes to the mitigation of the following corporate risks:[xxxiv]

There is a risk that CSC will not be able to maintain required levels of operational safety and security in institutions and in the community. Specific risk sources that the EIM and EIM training may mitigate include riots and hostage-takings requiring emergency measures and intervention; challenges to ensuring the safety and security of staff working in institutions and in the community, offenders, victims and members of the public involved in CSC operations or programs; and lack of knowledge or ability in de-escalating potential volatile situations. EIM is also a tool for staff to review and enhance their skills. In this regard, the risk mitigation strategy being undertaken is the provision of training and tools to de-escalate potentially volatile situations and inmates. All security-related training for staff is now driven by the EIM. The EIM training features a scenario-based component, and a module on dynamic security has been added to the Correctional Officer Continuous Development (CXCD) training.

There is a risk that CSC will not be able to respond to the complex and diverse profile of the offender population. If this risk area is not sufficiently addressed, one potential impact is an increase in security and emergency incidents contributing to disruptions of institutional routines. By using an appropriate response to institutional incidents that takes into consideration the complex and diverse needs of offenders, the EIM has the potential to mitigate this risk.

There is a risk that CSC will not be able to maintain a safe, secure and healthy working environment as established by its legal and policy obligations, mission, and values statement. Given that difficult work environments may be a source of risk by negatively affecting the mental health of employees, and a lack of knowledge or ability in de-escalating potentially volatile situations may also put the safety of the work environment at risk, the EIM and the appropriate training on this model may be important tools to mitigate these sources of risk.

Based on the review of five of CSC's corporate priorities, as well as three of its corporate risks, there is evidence to support that the key activities and aims of the EIM are aligned with the organization's priorities, legislation and policy, roles and responsibilities.

[11] Population Management, at CSC's local level, refers to an ongoing analysis of offender profiles, security intelligence and offender movements (i.e., internally between units or ranges, and transfers between institutions). The management of criminal gang affiliations/disaffiliations and management of incompatibles are also critical elements.

Findings: Design and Delivery

The following section addresses the alignment of the EIM implementation with identified outcomes. In particular, to evaluate the design and delivery of the EIM, a number of key areas were examined, including:

- Whether the EIM is being delivered in a manner that is identified with best practices;
- The extent to which there have been changes in the use of physical interventions and/or in the use of de-escalation strategies under the EIM;
- Whether there has been changes in response protocols; and
- Whether there has been a focus on diverse sub-populations of inmates

Data obtained from a variety of sources were assessed, including compliance reports from CSC's HRMS, Use of Force Module OMS data, responses from staff surveys, and key informant interviews (see Appendix E for more details on the Evaluation Methodology, Appendix F for more details on the staff survey, and Appendix G for more information on the key informant interview protocols).

Training and Identified Best Practices

Findings: The data (where available) suggest that most CSC staff had received the EIM training prior to its implementation, with the exception of National Headquarters (NHQ) employees. However, key informants articulated a need for refresher training and scenario-based training for non-security staff (e.g., health services). The effectiveness of training could also be enhanced by involving multiple disciplines in completing training together, particularly in scenario-based training. There is also a need to incorporate more content related to women inmates and inmates with cognitive impairments when educating staff about de-escalation strategies. This need may also extend to other sub-populations as many survey respondents did not know if they possessed enough knowledge to de-escalate incidents among various sub-populations of inmates.

The literature on use of force training programs suggests that training prior to the implementation of new use of force and incident management protocols may equip personnel with an enhanced ability to exercise their new skills by increasing their confidence, preparation, and the ability to assess safety risks and to respond to high-risk situations.[xxxv] In order to facilitate the implementation of the EIM at the national level, new training courses were either developed or revised and added to existing courses.[xxxvi,12]

[12] The following training offerings were developed: Introduction to the Engagement and Intervention Model (Online); EIM Train the Trainer: Scenario Based Training (In-class); Safety for All: Manager Training (In-class); Safety for All: All Staff Briefings (In-class); Engagement and Intervention Model Scenario Based Training (In-class); and WebEx Sessions for trainers not included in the EIM Train the Trainer: Scenario Based Training. In addition to this training, an EIM refresher training online course is mandated every three years. However, as of April 1, 2018,

According to the EIM training implementation plan, the variety of training courses offered, as well as various targeted completion dates, ensured that:

- Staff had many opportunities to learn about the new EIM through various formats;
- There was an online strategy whereby staff received training promptly, in order to get acquainted with the model;
- The all-staff briefings course allowed staff to receive information as a member of an institutional team, in order to generate discussion and increase understanding of everyone's roles, responsibilities, and contributions during an incident;
- Train the trainer sessions and manager training allowed staff to receive specific training linked to their leadership role in ensuring that the new EIM was well understood and promoted at their worksite; and
- Correctional Officers, Correctional Managers, Nurses, all other licensed Health Care Professionals (includes including terms and casuals) with direct interaction with inmates (Psychologists, Social Workers, Occupational Therapists), and any other health professional designated by the Chief of Health Services or the Chief of Mental Health, received a more in-depth scenario-based training on how to apply the model with an interdisciplinary team approach. [xxxvii]

Introduction to the Engagement and Intervention Model[13]

The Introduction to the EIM online training has been designated as mandatory training for all new term (with a contract longer than six months) and indeterminate CSC employees. This course consists of a one-hour online training module that introduces all staff to the EIM by defining and describing the model's concepts and components.[xxxviii] The course was developed as a means of managing the transition from the SMM to the EIM, and was a prerequisite for other EIM staff training.[xxxix]

As of September 30, 2019, the vast majority of CSC staff (92.4%, *n* = 15,320) had completed this introductory training. However, from a regional perspective, only 66% (*n* = 853) of NHQ staff had completed this training at that point in time, which may be due to the limited interactions that NHQ staff have with inmates (Table C 1).

According to 2017/2018's National Training Standards (NTS) for CSC, the scenario-based training was mandatory for all CX-01, CX-02, CX-04, Nurses and all other licensed Health Care Professionals (including terms and casuals) with direct interaction with inmates (i.e., Psychologists, Social Workers, Occupational Therapists), and any other health professional designated by the Chief of Health Services or the Chief of Mental Health.[xl] This course was built on the EIM introduction course content. It consisted of a trainer-led group practical application of the model, a video scenario, exercises, technical inflammatory agents application, and scenario-based training with the new Debrief Process.[xli] Moreover, participants were given the opportunity to practice developing responses, which took into

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the only EIM training that remained available was the online Introduction to the EIM, and the EIM refresher, given that the other in-class and WebEx training sessions had reached their targeted completion dates, as per established timelines.

[13] Refresher training compliance rates are not examined because refresher training would not yet have been available to staff at the time of data collection for this evaluation.

account both security and health considerations through the development of interdisciplinary team approach intervention strategies.[xlii] Correctional Learning and Development Centres began providing this training October 1, 2017, and all staff in the target-training group were to have completed this training by March 31, 2018. The course content was later incorporated into the CXCD Chemical and Inflammatory Agents training.[xliii] According to the data, by the time this course had met its sunset date, most targeted staff had completed this training (92.6%, *n* = 7,301). Regional data yielded similar results (Table C 2).

Overall, key informants reported that they felt the content of the initial, in-person training for the EIM adequately presented the model and that the information was clear. Key informants provided suggestions regarding training, including the importance of regular refresher training for staff. Correctional Officers are exposed to content related to the EIM during their continuous development training, whereas other staff have not received refresher training on the EIM. While the Correctional Officers reportedly continue to have the opportunity to practice putting the EIM into effect during scenario-based training, key informants suggested that other staff members, such as Health Care Professionals, would benefit from similar practice. This practice would help with understanding and recalling the content and build confidence in their application of it. Some key informants also spoke of the importance of having staff from across disciplines, including health and operational staff, complete the training together so that they would develop an understanding of each other's roles and perspectives, particularly in combination with scenario-based training where they apply the EIM.

Safety for All – All Staff Briefings

The Safety for All – All Staff Briefings information sessions were comprised of multiple group briefings at sites, led by the institution's Warden or the District Director. This training was intended for all institutional and community corrections staff. These information sessions were approximately one hour and their objective was to deliver key messages for all staff regarding the roles and responsibilities of every employee in creating a safe environment at their sites. It also included an overview and discussion of the EIM in relation to its key principles, implementation, and relevant related policy. These information sessions also afforded staff an opportunity to "ask questions and discuss the new model's application within their unique sites."[xliv] The delivery of these sessions began in September 2017 and were to have been completed by December 31, 2017.[14]

Training for Managing Incidents with Sub-populations

Staff survey respondents were asked about the extent to which they had received the necessary training to effectively de-escalate an incident when dealing with diverse sub-populations of inmates. A large proportion of staff indicated that they *disagreed* that they possessed the necessary training to deal with inmates with cognitive impairments (40.3%, *n* = 81/201) and women inmates (37.7%, *n* = 51/135). Among those who *agreed* to this question, having knowledge about older inmates (42.6%, *n* = 84/197) ranked the highest, followed by Indigenous inmates (41.8%, *n* = 84/201), younger inmates (40.8%, *n* = 80/196), inmates with mental health issues (39.9%, *n* = 81/203), and ethnocultural inmates (38.4%, *n* = 76/198). Interestingly, a large proportion of respondents *did not know*, or *neither*

[14] This training was not tracked for compliance.

agreed nor disagreed that they had received the necessary training to effectively de-escalate an incident when dealing with specific sub-populations of inmates.

Key informants described a number of best practices for working with diverse sub-populations of inmates. First, they suggested increasing the knowledge and skills of staff. For example, staff with knowledge of a particular sub-population could coach and provide additional information and support to those with less knowledge. Mental health was identified as one area in which staff could benefit from knowledge and training, specifically, learning strategies for managing inmates with mental health needs.[15] Key informants also suggested incorporating mental health and other sub-population considerations into the EIM training. Training examples for the EIM could involve inmates from different sub-populations and discuss how to respond in a way that considers these characteristics. Further knowledge about dementia and older adults was also an area of interest.

The evidence above suggests that the EIM aligns with the best practice of delivering training prior to the implementation of new use of force and incident management protocols as most staff received training when CSC transitioned from the SMM to the EIM. However, the evidence also suggests that there are other best practices which could be adopted in relation to training such as offering enhanced scenario-based training to all staff and teaching strategies for managing inmates with health and mental health needs.

Use of Physical Interventions

One of the main goals of the EIM is to reduce physical harm by decreasing physical interventions and increasing de-escalation and controlled non-intervention. It should be noted that the EIM emphasizes that the appropriate intervention strategies will be chosen following the initial and ongoing assessment of the individual(s), the situational factors, and the associated level of risk, and the interventions may or may not include use of force options. The following section examines whether there have been changes in use of force between the SMM and EIM periods.

Overall Use of Force

Findings: Considering all institutions together, there has not been a decrease in use of force during institutional incidents since the implementation of the EIM. This is also true when comparing use of force incidents within inmate security levels. The percentage of use of force review packages where the amount of force used was deemed necessary and proportionate is high. Overall, while there is evidence of some positive changes, particular attention needs to be paid to the more frequent use of force with younger, ethnocultural, and Indigenous inmates.

Analyses of OMS data showed that when expressed as a percentage of incidents where use of force occurred, comparing across all institutions, there has been no change in use of force between the SMM (6.5%, *n* =

[15] It should be noted that institutional staff are provided with a NTS training of Fundamentals of Mental Health to help support their interaction with sub-populations who have mental health conditions.

2,375/36,737) and the EIM (6.3%, *n* = 2,646/42,097) periods (Table 3 and Table C 3). Further, the rate of use of force[16] has increased from 166.1 use of force incidents per 1,000 inmates during the SMM period, to 188.0 use of force incidents per 1,000 inmates during the EIM period.[17] When examining RTCs separately (Table 3 and Table C 3), there was no change in use of force (SMM period: 11.5%, *n* = 474/4,117; EIM period: 10.6%, *n* = 389/3,670).

The Use of Force Review Module in OMS contains data with a flag to indicate where the use of force was deemed necessary and where the use of force was deemed proportionate. It must be noted however, that although data are presented for both time periods, comparisons cannot be made between the SMM and the EIM due to the changes in how data were collected.

In April 2018 use of force review modules were updated to include an answer to the question "was the use of force necessary?" based on the reviews at the institutional and regional level. While the date of introduction precludes comparisons between the SMM and the EIM period, analyses show that from April 1, 2018 until September 30, 2019 94.9% (*n* = 2,258/2,380) of package reviews resulted in force being deemed necessary at the institutional level and 87.2% (*n* = 893/1024) of reviews at the regional level.

As of April 1, 2018 use of force review modules were also updated to include an answer the question "was the amount of force used proportionate to the situation?" based on the reviews at the institutional and regional level. Analyses show that between April 1, 2018 and September 30, 2019, 94.4% (*n* = 2,246/2,380) of uses of force reviewed were deemed proportionate at the institutional level and 84.9% (*n* = 869/1,024) at the regional level. Similar percentages were also reported at RTCs (see Table C 4 for more information).

Prior to April 1, 2018 the use of force review module captured both whether the use of force was necessary and proportionate under one field. While comparisons cannot be made between the SMM and EIM due to changes in definitions, during the SMM period 97.1% (*n* = 2,313/2,382) of package reviews deemed the use of force both necessary and proportionate at the institutional level and 88.0% (*n* = 1,042/1,184) at the regional level of review. For RTCs during the SMM period, 99.4% (*n* = 474/477) of package reviews deemed the use of force both necessary and proportionate at the institutional level of review and 92.9% (*n* = 442/476) at the regional level (Table C 5).

[16] Notably, given the population under examination (inmates in federal institutional settings), it is expected that there will be situations that occur requiring use of force. That is, it is important to keep in mind when reviewing these findings that use of force within the context of federal corrections will never be eradicated in its entirety.

[17] This is due to an increase in the total number of incidents over time (both use of force and non-use of force), while the population of offenders has remained mostly stable, and does not reflect a relative increase in use of force incidents. Because incident count is increasing in general, percentages of total incidents resulting in use of force, rather than raw counts or rates of use of force, are used to compare changes between the SMM and EIM periods.

Use of Force and Sub-populations

Analyses of OMS data showed that the rate of use of force among all diverse sub-populations of inmates, with the exception of older inmates, was higher than the rate for that of the total inmate population[18], particularly for younger inmates (Table C 6). Specifically, the rate of use of force was almost three times that of the total population[19] (188.0 per 1,000 inmates) among younger inmates (542.8 per 1,000 inmates), more than double among female inmates (384.9 per 1,000 inmates), and almost double among ethnocultural (330.5 per 1,000 inmates) and Indigenous inmates (323.7 per 1,000 inmates; Table C 6). The rate of use of force demonstrated among younger inmates is in line with the OCI's findings regarding the disproportionate rate of force against younger inmates in federal institutions.[xlv] Findings from the OCI also point to the need to account for intersectionality among diverse sub-populations of inmates, as the OCI further found a disproportionate rate of use of force particularly among younger Indigenous inmates.[xlvi]

Staff survey respondents were asked to assess the extent to which they agreed that there is a need to decrease the use of physical force towards diverse sub-populations of inmates. The largest proportion of staff indicated that they *agreed* that there was a need to decrease the use of physical force among inmates with physical disabilities (44.0%, *n* = 69/157), inmates with cognitive impairments (41.9%, *n* = 69/165), and inmates with mental health issues (40.0%, *n* = 66/165). Some respondents also *agreed* with the need to reduce the use of physical force among women inmates (30.0%, *n* = 30/100) and older inmates (31.0%, *n* = 46/148). Interestingly, few respondents *agreed* that this need applied to younger inmates (14.5%, *n* = 22/151), ethnocultural inmates (17.0%, *n* = 27/159), and Indigenous inmates (20.8%, *n* = 34/164). Few respondents also *agreed* that there was a need to decrease the use of physical force among inmates who identify as LGBTQ2+ (14.4%, *n* = 22/153). It is important to note that across all diverse sub-populations that were in question, a relatively large proportion of respondents *did not know* or *neither agreed nor disagreed* with whether there was a need to decrease the use of physical force against these groups (see Appendix F for more details on staff survey responses).

According to key informants, staff consider the unique needs of older inmates, such as health and mobility. Consistent with the responses of staff and the actual rates of use of force reported above, key informants had also observed that uses of force were less common with older inmates, and older inmates were reportedly less likely to be involved in security incidents.

Key informants described how staff should best work with diverse subpopulations of inmates. They highlighted a person-centered approach as important in working with sub-populations of inmates, which is consistent with the EIM. With a person-centered approach, staff members take into account the characteristics of the inmate when choosing a response option, make accommodations to meet their needs, and treat them respectfully and humanely. Several key informants spoke of the importance of being aware of the needs and characteristics of inmates with mental health

[18] Significance testing was not conducted for rate comparisons because rates were provided in aggregate format thereby making it unfeasible to do.

[19] Due to an inability to group the data as required (i.e., we were not able to identify inmates who fall under multiple categories), rate of use of force per 1,000 offenders could not be calculated for the general inmate and diverse sub-populations of inmate categories.

issues, and applying the EIM in a way that responds to those needs. Key informants also indicated that staff should consider the ability of the inmate to understand the situation in selecting an intervention. For instance, staff should ensure that an individualized protocol that outlines the preferences of a transgender inmate regarding searches is developed and followed. With Indigenous inmates, staff should ensure that there is follow-up from a cultural perspective after an incident.[20] Key informants stated that access to resources with specialized training in working with mental health, such as Psychiatrists and Psychiatric Nurses, who can assist with assessment and managing situations, was helpful. Access to health resources 24 hours a day was described as a good practice.

Use of Force and Security Level Rating

Analyses of OMS data showed that the majority of use of force incidents occurred during incidents involving inmates with a maximum security level rating. There was no difference in the percentage of incidents where use of force occurred within minimum, medium, or maximum security levels when comparing the SMM to the EIM[21] (Table C 7).

Table 3. Summary of Changes in Percentage of Overall Use of Force (UoF) for the EIM, compared to the SMM

Institution Types	% UoF Incidents	% of UoF Incidents Minimum Security Level	% of UoF Incidents Medium Security Level	% of UoF Incidents Maximum Security Level
All institutions	=	=	=	=
RTC	=	·	·	·

Note. ↑↓ negligible effect (φ < .1), ↑↓ small effect (φ > .1), ↑↓ medium effect (φ > .3), ↑↓ large effect (φ > .5), = no significant effect (p > .05), · statistical comparisons not possible.

Use of Force for Assault and Behaviour-Related Incidents[22]

Findings: Considering all institutions together, there was a decrease in force used during behaviour-related incidents. Examining RTCs specifically, there was also a decrease in force used during behaviour-related incidents. Overall, there is evidence of some positive changes.

OMS analyses showed that among assault-related incidents, 26.7% (n = 988/3,699) resulted in a use of force during the EIM period compared to 27.1% (n = 826/3,050) during the SMM period. Among behaviour-related incidents, 8.9%

[20] The provision of an Indigenous intervention should be documented in a Statement/Observation Report or Casework Record.

[21] While breaking down findings related to use of force by institution type further is outside of the scope of this evaluation, the finding that there were no differences between the SMM and EIM for % of use of force incidents in offenders within each security level provides some reassurances for the validity of examining results at an overall CSC level.

[22] These were chosen as they are the two most common incident subtypes.

(*n* = 1,115/12,570) involved a use of force during the EIM period compared to 11.0% during the SMM period (*n* = 1,168/10,595). Although the effect size is negligible the findings are considered a significant improvement (Table 4 and Table C 8).[23]

Similar to the overall results, analyses of OMS data show no significant change in assault-related incidents at RTCs under the EIM compared to the SMM, but there was a decrease in use of force in behaviour-related incidents in RTCs during the EIM period (8.5%, *n* = 122/1,429) compared to the SMM period (11.3%, *n* = 197/1,737; Table 4 and Table C 8).[24]

Table 4. Summary of Changes in Use of Force by Incident Type for the EIM, compared to the SMM

Institution Types	Assault	Behaviour-related
All institutions	=	↓
RTC	=	↓

Note. ↑↓ negligible effect (φ < .1), ↑↓ small effect (φ > .1), ↑↓ medium effect (φ > .3), ↑↓ large effect (φ > .5), = no significant effect (*p* > .05), · statistical comparisons not possible.

Type of Force Used[25]

Findings: Considering all institutions together, there was a decrease in the discharge of inflammatory or chemical agents during use of force incidents. Examining RTCs specifically, there was also a decrease in the discharge of chemical or inflammatory agents. Overall, there is evidence of some positive changes.

OMS analyses showed that physical handling is the most frequently reported use of force type, occurring in 56.7% (n = 1,347/2,375) of the SMM and 57.0% (n = 1,508/2,646) of the EIM use of force incidents, respectively. There was no statistically significant change in physical handling between model periods (Table 5 and Table C 9). Following physical handling, the discharge of a chemical or inflammatory agent is the second most frequently used type of force in both models. However, there was a decrease under EIM with 43.5% (n = 1,151/2,646) of use of force incidents resulting in chemical or inflammatory agents being discharged compared to 47.6% under the SMM (n = 1,130/2,375). There was also a decrease in the non-routine use of restraints, the third most frequently used force type in both models, with 28.0% (n = 742/2,646) of use of force incidents under the EIM involving non-routine use of restraints, compared to 32.3% under the SMM (n = 767/2,375). Although the effect sizes of the decreases are negligible the findings are considered a significant improvement between the SMM and the EIM (Table 5).

[23] It should be noted that the percentage of use of force incidents has increased for all other incident types (e.g., self-injurious behaviour, property related, escape related/Unlawfully at Large, miscellaneous) when the EIM is compared to the SMM.

[24] With the exception of escape related/Unlawfully at Large, the percentage of use of force incidents has increased for all other incident types at RTCs when the EIM is compared to the SMM.

[25] Physical handing, discharge of a chemical or inflammatory agent, and non-routine use of restraints are reported here as they are three most commonly used types of force

Similar to the overall results for use of force incidents, in RTCs, there was a decrease in the percentage of chemical or inflammatory agents discharged under EIM (28.3%, *n* = 110/389) compared to under the SMM (34.4%, *n* = 163/474). There were no changes in physical handling or non-routine use of restraints in RTCs (Table 5 and Table C 9).

Table 5. Summary of Changes in Use of Force by Force Type for the EIM, compared to the SMM

Institution Types	Physical Handling	Discharge I/C Agents	Restraints
All institutions	=	↓	↓
RTC	=	↓	=

Note. I/C = inflammatory or chemical. ↑↓ negligible effect (φ < .1), ↑↓ small effect (φ > .1), ↑↓ medium effect (φ > .3), ↑↓ large effect (φ > .5), = no significant effect (*p* > .05), · statistical comparisons not possible

Inmate Injury[26]

Findings: Considering all institutions together, findings show a decrease in inmate injury during use of force incidents. Overall, there is evidence of some positive changes. Identified areas for concern in use of force practices among older inmates are mental health, physical disability, and physical health. There is also a need for more guidance and training on how to manage older inmates when force is required.

Analyses of OMS data show that compared to the SMM, use of force incidents with an inmate injury have decreased under the EIM (SMM period: 7.2%, *n* = 172/2,375; EIM period: 3.2%, *n* = 85/2,646). Although the effect size is negligible, this finding is considered a significant improvement (the severity of injury to inmates as a result of use of force is compared across the two time periods in Table 6 and Table C 10). Inmate major injury, staff injury, and staff major injury[27] occurred so infrequently in both periods that they are not presented in the report. The number of inmate injuries in RTCs was too small to report (Table C 10).

Inmate Injury and Sub-populations

Overall, OMS results show very few use of force incidents resulted in an injury (3.2%, *n* = 85/2,646). However, results from OMS analyses indicate that a larger proportion of injuries occurred for the general inmate population (5.4%, *n* = 29/538) than for those diverse sub-populations of inmates (2.7%, *n* = 56/2,108) as a whole (Table C 11). When diverse sub-populations of inmates are examined, a similar percentage of injuries occurred among older inmates (5.1%, *n* = 11/217) when compared to the general inmate population (5.4%, *n* = 29/538), whereas Indigenous

[26] Data for staff injury are underreported, therefore we do not include them in this evaluation.

[27] Major injuries are those defined as death, major, or serious bodily injury in OMS. Non-major are those defined as minor or non-serious bodily injury in OMS.

inmates (2.0%, *n* = 26/1,311), younger inmates (2.5%, *n* = 23/907), and ethnocultural inmates (2.9%, *n* = 21/735) show a relatively lower occurrence of injuries when compared to the general inmate population (5.4%, *n* = 29/538) (Table C 11).

Table 6. Summary of Changes in Use of Force Resulting in Inmate Injury

Institution Types	Inmate Injury
All institutions	↓
RTC	·

Note. ↑↓ negligible effect (φ < .1), ↑↓ small effect (φ > .1), ↑↓ medium effect (φ > .3), ↑↓ large effect (φ > .5), = no significant effect (*p* > .05), · statistical comparisons not possible

Of the issues identified as areas of concern for older inmates related to the current use of force practices, the largest proportion of staff survey respondents *agreed* that mental health was an area of concern (64.9%, *n* = 124/191). Many respondents also *agreed* that physical disability (61.1%, *n* = 118/193) and physical health (58.0%, *n* = 112/193) were areas of concern. A small amount of respondents did not know if the identified areas were of concern for older inmates.

Staff survey respondents were provided an opportunity within the survey to comment about the current use of force practices and older inmates. Comments indicated that when an incident occurs, the response options should be similar regardless of the inmate's age. According to the respondents, attending to the situation promptly to address the inmate's behaviour using the appropriate level of force is the primary consideration, and staff should use the least amount of force necessary for any inmate. When dealing with inmates during an incident or a use of force, some individual factors should be taken into consideration (e.g., mental health, cognition), however respondents maintained that age should not be one such consideration. Additionally, there is no specific training or guidance on how to manage older inmates when use of force is needed. Thus, there is a lack of knowledge on how to adapt use of force with older inmates, which may increase the risk of use of force occurring. A few staff noted that older inmates are not frequently involved in conflicts with other inmates or staff members, or assaults on other inmates or staff members.

Planned and Spontaneous Uses of Force[28]

Findings: Considering all institutions together, there has been an increase in planned uses of force and a decrease in spontaneous uses of force under the EIM when compared to the SMM. This is evidence of some positive changes.

[28] Since use of force review packages can include multiple incident events, packages can reflect both spontaneous and planned use of force incident events.

There is a distinction between planned and spontaneous uses of force per CD 567-1.[xlvii] A planned use of force is a situation where time and circumstances allow a Correctional Manager or Crisis Manager to authorize an intervention plan that may involve use of force to resolve an incident safely, whereas a spontaneous use of force is a situation that requires immediate intervention of staff based on an assessment of risk. In a spontaneous use of force, it is assessed that at least one use of force measure is required to prevent imminent harm to oneself or others.

While most uses of force are spontaneous, when examining OMS data, it was found that among all use of force incidents, planned use of force has increased under the EIM (14.3%, *n* = 389/2,721) compared to the SMM (10.6% *n* = 252/2,382). There has also been a decrease in spontaneous use of force under the EIM (87.1% *n* = 2,371/2,721) compared to the SMM (90.6%, *n* = 2,157/2,382; Table C 12). Although the effect sizes are negligible, the findings are considered a significant change between the SMM and the EIM (Table 7). There were no changes in the percentage of use of force incidents that were planned or spontaneous in RTCs (Table C 12 and Table 7).

Table 7. Summary of Changes in Planned and Spontaneous Uses of Force for the EIM, compared to the SMM

Institution Types	Planned	Spontaneous
All institutions	↑	↓
RTC	=	=

Note. ↑↓ negligible effect (φ < .1), ↑↓ small effect (φ > .1), ↑↓ medium effect (φ > .3), ↑↓ large effect (φ > .5), = no significant effect (*p* > .05), · statistical comparisons not possible

Taken as a whole, the evidence suggests that the implementation of EIM has not been associated with a lower rate or decline in the number or percentage of physical interventions. Further, the rate of use of force has increased overall and has remained the same at RTCs. There has also been no change in the percentage of incidents where use of force occurred across all three security level ratings. Moreover, rates of use of force are particularly high for younger, Indigenous, and ethnocultural inmates when compared with the general population. It is not feasible to comment on the extent to which there has been a change in the use of de-escalation strategies using OMS data, as these data were not readily available.

Institutional Incidents Involving Physical or Mental Health Distress

The EIM differs from the SMM as engagement and intervention strategies have been broadened to not only include those which are security focused, but also those which are focused on mental and physical health. The following section explores the extent to which there has been an observable change in the proportion of institutional incidents involving physical or mental health distress. It also examines the extent to which appropriate response protocols for incidents involving physical or mental distress have been implemented.

Incidents Involving Mental Health Distress

Findings: Considering all institutions together, during the EIM period, there have been two positive changes regarding incidents involving an inmate with mental health concerns. There has been a decrease in use of force during incidents involving an inmate with a suicide alert and among those occupying a mental health bed. Overall, this is evidence of some positive changes. Examining RTCs specifically, there has been a decrease in use of force during incidents involving an inmate with an active suicide alert as well. Effect sizes indicate this change is small, which is promising.

When comparing OMS data related to use of force interventions during incidents that potentially involved mental health distress across all institutions, there has been no change in the percentage of use of force during self-injurious behaviour-related incidents[29] between the EIM (11.9%, *n* = 345/2,889) and the SMM (11.6%, *n* = 260/2,232) periods (Table 13). Additionally, there were no differences in self-injurious behaviour-related incidents in which chemical or inflammatory agents were discharged under the EIM (6.3%, *n* = 181/2,889), compared to under the SMM (6.0%, *n* = 135/2,232). Further, there was no statistically significant change between the EIM (16.7%, *n* = 454/2,721) and the SMM (14.7%, *n* = 350/2,382) in the percentage of incidents in which use of force was deemed to be prompted by self-injurious behaviour, as assessed in the use of force review module (Table C 14).

However, as displayed in Table 8 and Table C 14, use of force during an incident involving an inmate with an active suicide alert[30] has decreased under the EIM (20.4%, *n* = 555/2,721) compared to under the SMM (25.9%, *n* = 616/2,382). Although the effect size is negligible, this finding is considered a significant improvement between the SMM and the EIM. Use of force during an incident involving an inmate who occupies a mental health bed has also decreased under the EIM (21.0%, *n* = 572/2,721) compared to the SMM (23.8%, *n* = 566/2,382). Although the effect size is negligible, this finding is also considered a significant change (Table 8 and Table C 14).

Looking specifically at RTCs, OMS analyses show there were no statistically significant changes in the percentage of self-injurious behaviour incidents resulting in a use of force, self-injurious behaviour-related incidents resulting in the discharge of chemical or inflammatory agents, nor in incidents in which the use of force was deemed to be prompted by self-injurious behaviour in the use of force review module. However, use of force during an incident involving an inmate with an active suicide alert has decreased under EIM (37.4%, *n* = 154/412), compared to under the SMM (59.7%, *n* = 285/477) in RTCs. The effect size indicates the magnitude of this decrease is small (Table 8). Most incidents occurring in RTCs involved an inmate who occupies a mental health bed in both the EIM (98.5%, *n* = 406/412) and the SMM periods (96.6%, *n* = 461/477), and there has been no significant change over time.

[29] Self-injurious behaviour related incidents include self-inflicted injuries, hunger strikes, overdose interrupted, suspected overdose interrupted, and attempted suicide.

[30] At least one offender involved in the use of force incident had an active "Current risk of suicide/self-injury" alert on the date of the incident. No criterion specified the role of the offender.

Table 8. Summary of Use of Force Data (UoF) for Mental Health Related Outcomes

Institution Types	Any UoF in Self Injurious Behaviour Incident	Discharged I/C Agent In Self-Injurious Behaviour Incident	UoF Prompted by Self-Injurious Behaviour	UoF in incident with Inmate with an Active Suicide Alert	UoF involving Inmate who Occupies a Mental Health Bed
All institutions	=	=	=	↓	↓
RTC	=	=	=	↓	=

Note. I/C = inflammatory or chemical. ↑↓ negligible effect (φ < .1), ↑↓ small effect (φ > .1), ↑↓ medium effect (φ > .3),↑↓ large effect (φ > .5), = no significant effect (p > .05), · statistical comparisons not possible

Incidents Involving Physical Health Distress

Findings: Overall, there has been a decrease in the percentage of incidents in which first aid was required, including in RTCs.

To assess use of force during incidents related to physical health distress, use of force during the need for medical treatment was examined. Guideline 800-2[xlviii] stipulates that the use of physical restraints for medical purposes within the parameters of the treatment plan and ordered by the Physician/Psychiatrist, regardless of who assists the Nurse in the application, is not a reportable incident and is therefore not reportable as a "use of force." Additionally, assisting an inmate to walk, when no resistance is provided by the inmate, is not a use of force. However, the use of medical restraints becomes a reportable incident and/or reportable use of force if the application of the restraints progressed beyond the parameters of the treatment plan and any level of force, security restraint equipment and/or physical handling was used. It is important to note that Health Care Professionals are responsible to report when interventions are beyond the parameters of the treatment plan, and Correctional Officers must report when a level of force has been used.

With these considerations in mind, analysis of the OMS data show there has been no change in the number of use of force incidents for medical treatment (i.e., force used beyond the parameters of the treatment plan) between the EIM (2.4%, n = 64/2,721) and SMM (2.9%, n = 68/2,382) periods (Table 9 and Table C 14).

The percentage of incidents in which first aid was required has decreased under the EIM (5.4%, n = 2,286/42,097), compared to the SMM (6.6%, n = 2,428/36,737). Although the effect size is negligible, this finding is considered a significant change between the SMM and the EIM (Table 9). Under both models, the vast majority of people requiring first aid during an incident received it (EIM: 98.6%, n = 2,255/2,286; SMM = 98.3%, n = 2,386/2,428; Table C 15). It is important to note that there was no information available about who required first aid, therefore it could have been an inmate, staff member, visitor, etc.

There was also a decrease in the percent of incidents requiring first aid in RTCs, with 2.9% (n = 105/3,670) of

incidents requiring first aid under the EIM compared to 5.5% (*n* = 228/4,117) under the SMM. There were no differences in use of force incidents for medical treatment (Table 9 and Table C 15).

Table 9. Summary of Incident Data for Physical Health Related Outcomes

Institution Types	Use of Force for Medical Treatment	First Aid Required During Incident	First Aid Provided when Required
All institutions	=	↓	=
RTC	=	↓	=

Note. ↑↓ negligible effect (φ < .1), ↑↓ small effect (φ > .1), ↑↓ medium effect (φ > .3),↑↓ large effect (φ > .5), = no significant effect (*p* > .05), statistical comparisons not possible

Appropriate Response Protocols for Incidents Involving Physical or Mental Distress

Findings: Overall, there has been a decrease in the percentage of interventions conducted in accordance with the Guidelines for Health Service Responsibilities, including in RTCs.

As part of use of force package review module, there is an assessment of whether interventions were conducted in accordance with the Guidelines for Health Service Responsibilities related to use of force Incidents and nursing standards[31] as part of the Institutional Review/Health Services Review. Analyses of OMS data show that there has been a decrease in the number of incidents which met the health standards criteria under the EIM (61.0%, *n* = 1,655/2,711), compared to the SMM (71.8%, *n* = 1,711/2,382). However, in 21.3% (*n* = 580/2,711) of cases during the EIM period, it was noted that while health guidelines were not met, the issues have been addressed. Further, in 17.5% (*n* = 476/2,711) of EIM incidents, it was indicated that while health guidelines were not met, the identified issues would be addressed. Effect sizes indicate that the decrease in meeting health guidelines under the EIM is small (Table 10 and Table C 16).

Looking at specific response protocols examined during the Institutional Review/Health Services Review, there has been a decrease in the percentage of planned[32] use of force incidents under the EIM (29.6%, *n* = 86/291) in which Health Services were consulted during plan development compared to the SMM (43.5%, *n* = 73/168). The effect size indicates that this change is small (Table 10 and Table C 16).

There has been no change in the percentage of planned use of force incidents developed through a Situation, Mission, Execution, Administration, and Communications (SMEAC) plan in which health services were consulted.

[31] The Guidelines for Health Services Responsibilities Related to Use of Force Incidents ensures that all medical components of a use of force are reported and reviewed according to established procedures within this document and as per CD 567-1.

[32] Refers to an Intervention Plan as per CD 567-1, para. 9[a], 19[c]

There was a decrease in the percentage of spontaneous use of force incidents in which health services were briefed after the intervention under the EIM (86.3%, *n* = 2,014/2,334) compared to under the SMM (88.4%, *n* = 1,854/2,098). Although the effect size is negligible, this finding is considered a significant change between the SMM and the EIM (Table 10 and Table C 16).

Examining RTCs separately, similar to the overall results, there has also been a decrease in the number of incidents which met the health standards criteria (54.0%, *n* = 220/411), compared to under the SMM (68.6%, *n* = 327/477). Effect sizes indicate that the decrease in meeting health guidelines under the EIM in RTCs is small (Table 10 and Table C 16). There were no other changes in appropriate response protocols in RTCs.

Table 10. Summary of Appropriate Response Protocols for Use of Force Packages

Institution Types	Health Guidelines Met	Health Services Consulted Planned UoF	Health Services Consulted SMEAC for Planned UoF	Health Services Briefed Spontaneous UoF
All institutions	↓	↓	=	↓
RTC	↓	=	=	=

Note. ↑↓ negligible effect (φ < .1), ↑↓ small effect (φ > .1), ↑↓ medium effect (φ > .3),↑↓ large effect (φ > .5), = no significant effect (*p* > .05), · statistical comparisons not possible

Overall, there are some positive trends in outcomes for inmates with mental health and physical health considerations, such as fewer uses of force with inmates with an active suicide alert at RTCs. However, the evidence also suggests there has been a decrease in the use of appropriate response protocols for institutional incidents involving physical or mental health distress. There was a decrease in the frequency with which staff met health guidelines, consulted health services for planned uses of force, and briefed health services on spontaneous uses of force as compared with the SMM.

Findings: Effectiveness

To evaluate the effectiveness of the EIM, a number of key areas were examined, including:

- The extent to which there are barriers or challenges to the effective implementation of the EIM when responding to incidents.
- The extent to which the key activities that have been emphasized as a result of the issues identified under the SMM are being implemented under the EIM.
- The extent to which quality improvement activities under the EIM are being implemented.

Data obtained from a variety of sources were assessed, including responses from staff surveys, key informant interviews, and Use of Force Module OMS data (see Appendix E for more details on the Evaluation Methodology).

Implementation of the EIM when Responding to Incidents

To identify the extent to which there are barriers or challenges to effectively implementing the EIM when responding to incidents, interviews with key informants were conducted and staff surveys were administered. Questions addressed:

- The implementation of the philosophy of the EIM, including consideration of the mental and physical well-being of inmates and use of available response options to incidents.
- Experiences with the implementation of the EIM and institutional culture.

Additionally, given the recent implementation of SIUs, questions were posed in relation to managing incidents in SIUs.

Engagement in the EIM Philosophy

Findings: Staff are engaging in key components of the EIM philosophy, as most reported that they are taking a person-centered approach and placing mental and physical well-being at the center of engagement and intervention strategies. Most are also able to identify cues of distress or altered levels of consciousness when dealing with inmates, to continuously reassess situational factors as the incident unfolds and to categorize the level of risk, and to employ de-escalation strategies when responding to incidents. Where staff may not fare as well is in their ability to select appropriate force options, and in their ability to get help to safely manage incidents of mental and physical distress when dealing with inmates.

One of the key concepts of the EIM is the consideration of inmates' mental and/or physical health conditions in the management of incidents. The inmate is placed at the center of the model to represent a person-based approach to engagement and intervention. As such, staff survey respondents were asked questions pertaining to taking a person-centered approach, responses to incidents, and support from other personnel.

Based on staff survey respondents'[33] experience with the EIM, most indicated that they engage in key components of the EIM philosophy. For example, most respondents *agreed* that they consider an inmate's physical well-being (89.7%, *n* = 192/214) and mental well-being (84.7%, *n* = 183/216) when responding to an incident, and are able to identify cues of distress or altered levels of consciousness when dealing with inmates (89.9%, *n* = 196/218). As seen in Table 11, RTC staff also indicated that they consider inmates' physical well-being (100%, *n* = 13/13) and mental well-being (92.3%, *n* = 12/13) when responding to incidents.[34]

Use of Force and Response to Incidents

With respect to use of force and responding to incidents, most staff *agreed* that they are able to continuously re-assess situational factors as an incident unfolds and categorize level of risk (87.0%, *n* = 188/216), are able to determine the most appropriate intervention strategy (81.6%, *n* = 177/217), and are able to employ de-escalation strategies when responding to incidents (81.0%, *n* = 170/210). Many staff also *agreed* that they are able to select the appropriate force options when deemed necessary (71.1%, *n* = 128/180). In comparison, all RTC staff respondents *agreed* that they are able to determine the most appropriate intervention strategy, are able to select appropriate force options when deemed necessary, and are able to employ de-escalation strategies when responding to incidents (see Table 11).

Other Personnel

Most staff *agreed* that they consider the safety of other personnel when responding to incidents (93.5%, *n* = 201/215) and many *agreed* that they are able to get the help needed to safely manage incidents of mental and physical distress situations when dealing with inmates (71.8%, *n* = 158/220). These findings were similar to the RTC staff survey findings (see Table 11).

Overall, staff reported to be adopting and engaging in the model philosophy. Key elements of the EIM that differ from the SMM are being implemented, such as taking a person-centered approach to engaging and intervening, the prioritization of physical and mental well-being, and a balanced approach to risk assessment. Staff also indicated that they employ de-escalation strategies, which are emphasized with the EIM. Fewer staff reported that they were able to select appropriate force options and to safely manage incidents of mental and physical distress when dealing with inmates, which has also been emphasized with the EIM.

[33] "Staff survey respondents" are herein referred to as "staff" and "RTC staff."

[34] It is important to note that caution is warranted when comparing percentages between all staff and RTC staff due to the discrepancy in sample size. Specifically, it is difficult to compare percentages when one group is large (all staff: $n > 200$) and one group is very small (RTC staff: $n \leq 13$).

Table 11. Engagement in the EIM Philosophy

Staff Survey Responses	All Institutions		RTC	
	n / N	%	*n / N*	%
I take a person-centered approach to engaging with the inmate when responding to an incident	182/214	85.0	11/12	91.7
I consider the inmate's physical well-being when responding to incidents	192/214	89.7	13/13	100
I consider the inmate's mental well-being when responding to incidents	183/216	84.7	12/13	92.3
I consider the safety of other personnel when responding to incidents	201/215	93.5	13/13	100
I am able to identify cues of distress or altered levels of consciousness when dealing with inmates	196/218	89.9	12/13	92.3
I am able to get the help needed to safely manage incidents of mental and physical distress situations when dealing with inmates	158/220	71.8	11/14	78.6
I am able to continuously re-assess situational factors as the incident unfolds and categorize the level of risk	188/216	87.0	12/13	92.3
I am able to determine the most appropriate intervention strategy	177/217	81.6	13/13	100
I am able to select appropriate force options when deemed necessary	128/180	71.1	7/7	100
I am able to employ de-escalation strategies when responding to incidents	170/210	81.0	12/12	100

Note. Reflects staff survey respondents who *somewhat* or *strongly* agreed. All Institutions = All staff survey responses. RTC = Regional Treatment Centre. Number of missing and *I don't know* responses fluctuate per response item; Missing and *I don't know* responses were excluded from analyses.

Implementation

Findings: While for the most part key elements of the EIM have been implemented as intended, the model does not appear as intuitive and easy to apply, especially when it is compared to the SMM. It is also perceived that the EIM has not resulted in a decrease in the use of force. There is a lack of clarity of roles and expectations of staff during an incident, a lack of teamwork among staff in responding to incidents, and a lack of readily accessible staff to effectively manage incidents during off-peak hours. Although, for the most part, roles and responsibilities of the Sector Coordinator are being implemented appropriately, survey responses suggested that the implementation of roles and responsibilities could be improved. Moreover, there may be a need to have more clarity in who is in charge during the course of an incident. Additionally, Sector Coordinators are finding it difficult to transition from

the first Officer on the Scene to their role as Sector Coordinator.

The largest proportion of staff indicated they *agreed* that the EIM had been implemented as intended (41.5%, *n* = 78/188). Specifically, many staff *agreed* that the EIM has an interdisciplinary approach (61.9%, *n* = 133/215), and about half of staff *agreed* that the EIM promotes staff self-awareness (50.7%, *n* = 107/211). However, there does appear to be some opacity when considering the application of the EIM as only about half of the staff surveyed reported that it was intuitive/easy to apply (48.9%, *n* = 106/217). Key informants also articulated that there were challenges with the model in that it is not as linear, intuitive, or as clear as the SMM.

Half of staff *agreed* that the EIM resolves situations with inmates at the most appropriate level of intervention (50.5%, *n* = 108/214). As seen in Table 12, about half of staff also reported that they *agreed* that the EIM has clearly defined roles as prescribed by CSC (as per CD 567) (47.8%, *n* = 102/213).

Respondents were also asked about the extent to which the EIM has resulted in a decrease in use of force. The largest proportion of staff indicated that they *disagreed* that the EIM has resulted in a decrease in use of force (39.8%, *n* = 67/168), which is in line with OMS data presented earlier showing the rate of use of force has increased with the implementation of the EIM.

Based on their experience with the EIM, most RTC staff *agreed* that the EIM results in resolving situations with inmates at the most appropriate level of intervention (78.6%, *n* = 11/14). As seen in Table 12, many RTC staff also *agreed* that the EIM is intuitive/easy to apply (64.3%, *n* = 9/14), has an interdisciplinary approach (64.3%, *n* = 9/14), promotes staff self-awareness (64.3%, *n* = 9/14), is implemented as intended (64.3%, *n* = 9/14), and has clearly defined roles as prescribed by CSC (per CD 567) (57.1%, *n* = 8/14). Notably, half of RTC staff reported that they did not know if the EIM resulted in a decrease in use of force[35].

Several key informants described the philosophy of the EIM as being applied within institutions, with consideration of situational and person-centered factors and emphasis on engagement and intervention response options. For example, key informants believed that with the application of a non-use of force intervention, such as negotiation, there could be a positive impact on incidents with reductions in use of force and de-escalation of situations. Key informants also noted that staff acceptance of the EIM took time, ongoing education, and reinforcement. Staff had to become more familiar with the approach, the reasons for its adoption, and understand how to apply it. About half of the key informants spoke of situations in which the EIM was not applied, and had observed inconsistencies in its use between institutions and regions.

Key informants identified a number of factors that they believed negatively impacted implementation. Key informants expressed that a lack of clarity about the roles and expectations among some staff during an incident was a barrier to the implementation of the EIM. They also cited that at times there is disconnect between the training on the model or the model itself and the operational reality. There is also a lack of teamwork that impedes the EIM from being

[35] *I don't know* responses have not been included in the frequency counts.

implemented as it should be. In addition, a lack of resources presents challenges to implementation, for example, a lack of accessible Health Care Professionals and other non-security partners during off peak hours. Operational constraints, such as the need to react quickly in response to an escalating incident was also identified as a barrier to the appropriate application of the EIM. Key informants also felt that a lack of experience working in an institution could be a hindrance to the implementation of the EIM. Additionally, key informants expressed some challenges with the EIM policy and processes as barriers to the implementation of the EIM. For example, challenges with video recordings and ensuring staff include a date, time, and the name of presiding staff at the beginning and end of every video recording during an incident. Key informants also reported that the implementation of the EIM has been less effective in institutions with more inmates who engage in problematic behaviour, larger institutions, as well as institutions that do not deal with many uses of force.

Table 12. Experience with the Implementation of the EIM

Staff Survey Responses	All Institutions		RTC	
	n / N	%	*n / N*	%
EIM Is intuitive/easy to apply	106/217	48.9	9/14	64.3
EIM has an interdisciplinary approach	133/215	61.9	9/14	64.3
EIM promotes staff self-awareness	107/211	50.7	9/14	64.3
EIM allows for constant situational re-assessment	150/215	69.8	11/14	78.6
EIM has clearly defined roles as prescribed by CSC (as per Commissioner's Directive 567)	102/213	47.8	8/14	57.1
EIM results in resolving situations with inmates at the most appropriate level of intervention	108/214	50.5	11/14	78.6
EIM has resulted in a decrease in use of force	48/168	28.6	--	--
EIM is implemented as intended	78/188	41.5	9/14	64.3

Note. Reflects staff survey respondents who *somewhat* or *strongly* agreed. All Institutions = All staff survey responses. RTC = Regional Treatment Centre. Number of missing and *I don't know* responses fluctuate per response item; Missing and *I don't know* responses were excluded from analyses. Items with less than 5 responses were not reported (--).

Role of the Sector Coordinator

To ensure appropriate leadership and health considerations are integrated, a Sector Coordinator role was added to the EIM. The main responsibility of the Sector Coordinator is to ensure intervention options are appropriate, and to continuously reassess their appropriateness, including the monitoring of both the physical and mental health of the inmate.

Almost one-fifth of staff identified as having been a Sector Coordinator (19.1%, *n* = 45/235). Of those who stated they had been a Sector Coordinator, more than two-thirds felt that they had *often* or *always* implemented the role appropriately (as per CD 567) (68.3%, *n* = 28/41). Conversely, from the perspective of staff who were *not* in the role of the Sector Coordinator, only some staff felt that Sector Coordinators had *often* or *always* implemented the role

appropriately (40.2%, *n* = 39/97).

In line with the above findings about the implementation of the Sector Coordinator role, most of the Sector Coordinators also indicated that they *often* or *always*: ensured that inmates' mental and physical health were considered during interventions (86.4%, *n* = 38/44); used ongoing risk assessments to determine the appropriate response option (84.4%, *n* = 38/45); and provided guidance and direction to staff on scene (81.4%, *n* = 35/43) (see Appendix F for more details on staff survey responses). Comparatively, from the perspective of staff who were *not* in the role of the Sector Coordinator, a large proportion reported that the Sector Coordinator *often* or *always* employed the roles and responsibilities described above (e.g., 58.7%, *n* = 61/104, reported the Sector Coordinator *often* or *always* ensured that inmates' mental and physical health were considered during interventions), however, markedly smaller proportions reported so when compared to Sector Coordinator responses (see Appendix F for more details on staff survey responses).

Key informants reported that there were some challenges with the implementation of the Sector Coordinator role, such as:

- Correctional Managers not assigning a Correctional Officer to the Sector Coordinator role during a shift;
- Challenges with transitioning from first Officer on the Scene to the role of the Sector Coordinator;
- A lack of clarity on the roles and expectations of a Sector Coordinator;
- A lack of communication of who is the Sector Coordinator during an incident;
- A lack of leadership from a Sector Coordinator during an incident; and,
- Variations in how the role is applied from site to site.

The largest proportion of staff who had identified as having been a Sector Coordinator *disagreed* that it was easy to transition from first Officer on the Scene to the role of the Sector Coordinator (45.2%, *n* = 19/42). Some also *agreed* that the Sector Coordinator's roles and responsibilities complement those of the Correctional Manager (44.2%, *n* = 19/43).

Due to a small proportion of Correctional Managers (Operations Desk) who completed the survey, their specific experiences with the EIM's implementation could not be assessed.

Institutional Culture

Findings: While the culture of some institutions allows the EIM to be successfully implemented, CSC's culture at the organizational level may present challenges to the implementation of the EIM. This may be due to a perception that there is a strong focus on security rather than the use of interventions, and a culture that is resistant to change. The EIM has not had a positive influence on the culture of some institutions.

Institutional culture generally refers to the values, assumptions, and beliefs people hold that drive the way the institution functions and the way people think and behave. Based on their experience with the EIM, 44.9% (*n* = 96/214) of staff indicated that they *agreed* that the culture at the institution they work in allows for the EIM to be successfully implemented as designed, compared with 35.5% (*n* = 76/214) who *disagreed*. As seen in Table 13, a

higher proportion of RTC staff indicated that they *agreed* that the culture at their institution allows the EIM to be successfully implemented as designed (64.3%, *n* = 9/14).

When focusing on CSC's culture at the organizational level, 29.6% (*n* = 63/213) of staff *agreed* that it is conducive to the successful implementation of the EIM, compared with 45.1% (*n* = 96/213) of staff who *disagreed* with this statement. Although a small proportion of staff indicated that CSC's culture is conducive to successful EIM implementation, the proportion of RTC staff who agreed was 57.1% (*n* = 8/14). See Table 13 for all staff and RTC staff responses.

As further described in Table 13, some staff *agreed* that the EIM has had a positive influence on the culture of their institution (30.2%, *n* = 64/212), compared with 43.9% (*n* = 93/212) who *disagreed.* Half of RTC staff indicated that the EIM has had a positive influence on the culture of their institution (50%, *n* = 7/14).

Staff were provided an opportunity within the survey to comment about the institutional culture at CSC, or within their institution, and the implementation of the EIM. Staff from a few institutions agreed that the approaches emphasized in the EIM, such as dynamic security, are consistent with those used at their institutions. However, other staff described challenges with institutional culture in applying the EIM, such as a strong focus on security rather than interventions. They described a continued reliance on approaches to incident management based on the SMM on the part of some staff, as well as their reluctance to adopt and adapt to the principles of the EIM. Staff also described a lack of interdisciplinary teamwork between security and health services, and that partners are not always involved in incident management. Several staff stated that the EIM does not take into account the operational reality of institutions, particularly maximum security institutions or units. They expressed concern that the model reduced the ability of Correctional Officers to respond to incidents, affecting the operations of the institutions and potentially risking the safety and security of staff.

Table 13. Staff Perceptions on Institutional Culture

Staff Survey Responses	All Institutions		RTC	
	n / *N*	%	*n* / *N*	%
The culture at my current institution allows for the EIM to be successfully implemented as designed	96/214	44.9	9/14	64.3
The EIM has had a positive influence on the culture at my current institution	64/212	30.2	7/14	50.0
CSC's culture in general is conducive to the successful implementation of the EIM	63/213	29.6	8/14	57.1

Note. Reflects staff survey respondents who *somewhat* or *strongly* agreed. All Institutions = All staff survey responses. RTC = Regional Treatment Centre. Number of missing and *I don't know* responses fluctuate per response item; Missing and *I don't know* responses were excluded from analyses.

Key informants also spoke to challenges with institutional culture and a lack of staff buy-in in implementing the model as a barrier. For example, key informants spoke of some staff being resistant to change and wanting to maintain the status quo (i.e., the SMM), with an "us" versus "them" mentality when dealing with inmates, and indifference towards the model as challenges with the institutional culture. It was also expressed that there is a need for staff to feel accountable for their actions under the EIM and for senior management to support the EIM's implementation culturally.

Managing Incidents in the Structured Intervention Units

Findings: With respect to managing incidents in the SIUs, findings show that the EIM philosophy has not had a positive influence on the outcomes of incidents managed within these units.

Nearly half of staff (47.7%, *n* = 112/235) have interacted with inmates while they have been housed in a SIU, of whom 45.0% (*n* = 45/100) *disagreed* that the EIM philosophy assists with effectively managing inmates who are in SIUs. Just over half of staff (52.0%, *n* = 51/98) *disagreed* that the EIM philosophy assists staff in effectively managing incidents in the SIU (see Appendix F for more details on staff survey responses). However, given that inmates housed in SIUs may be quite different from the general inmate population (e.g., in terms of risks and needs, etc.), this may be one possible explanation for the challenges in managing inmates and incidents in the SIUs under the EIM reported by staff. Given that 85.7% (*n* = 12/14) of RTC staff have not interacted with inmates housed in SIUs, additional questions pertaining to SIUs could not be examined.

Based on the above findings regarding the implementation of the EIM in correctional institutions, there is some evidence to suggest that staff are engaging in key components of the EIM philosophy, including taking a person-centered approach. However, evidence also suggests that there are barriers to the effective implementation of the EIM when responding to incidents. These barriers include challenges with the implementation of the Sector Coordinator role, the availability of appropriate staff during non-peak hours in all institutions other than RTCs, the culture within institutions and the broader organization, and managing incidents in SIUs.

Implementation of Key Activities

The EIM has a number of goals and key activities that stem from limitations identified under the SMM, including an emphasis on the use of an interdisciplinary team when responding to security incidents, including non-security partners such as Psychiatrists, Psychologists, Nurses, Chaplains, and Elders. There is an emphasis on a balanced approach to risk assessment, in which assessments are person-centered rather than solely behaviour-centered. Finally, the EIM stresses the use of alternative response options to reduce the risk of physical harm, such as de-escalation and controlled non-intervention approaches. The following section examines the extent to which these key activities are being implemented under the EIM. Specifically, effectiveness around implementation of the use of interdisciplinary teams, assessment of risk, and response options will be examined.

Use of Interdisciplinary Teams

Findings: While Correctional Officers/Primary Workers and Correctional Managers were most often identified as being involved in the planning and application of intervention strategies, Sector Coordinators were not as involved as would be expected. Sector Coordinators and Health Professionals appear to be more involved in the application of intervention strategies at RTCs than overall in institutions. Staff perceptions suggest there has been an increase in interdisciplinary teamwork since the implementation of the EIM as Correctional Managers, Sector Coordinators, Health Professionals, and individuals who have a good rapport with the inmate were slightly more involved in the application of intervention strategies than they were under the SMM. Despite this, there still remain some obstacles to collaboration, for example, the extent of integration and interaction between correctional and clinical staff, and a lack of access to non-security staff during off-peak hours.

The EIM encourages collaboration between different staff in order to respond appropriately to the situation at hand. Among staff, 43.8% (*n* = 103/235) indicated that, in their current role, they have direct, on-scene involvement in incident management, whereas 19.2% (*n* = 45/235) indicated that they have indirect involvement in incident management which includes intervention planning or approvals. A small number of staff indicated that they were involved in incident oversight, which includes compiling reports and monitoring trends (11.8%, *n* = 28/235). In terms of RTC staff, 57.1% (*n* = 8/14) indicated that they have direct involvement in incident management, in comparison to 35.7% (*n* = 5/14) of RTC staff who are either involved in incident oversight or have indirect involvement in incident management. Due to small numbers, follow-up questions pertaining to indirect involvement in incident management could not be examined.

Planning of Intervention Strategies

The 45 staff who had indirect involvement in incident management identified several staff or contractors who they perceived were *often* or *always* involved in the planning of intervention strategies. In particular, 80.0% (*n* = 36/45) identified Correctional Managers, 75.6% (*n* = 34/45) identified Correctional Officers/Primary Workers, 68.9% (*n* = 31/45) identified Institutional Managers, and 55.6% (*n* = 25/45) identified Health Professionals as being *often* or *always* involved in the planning of intervention strategies. As previously mentioned, RTC staff responses were not analyzed due to the limited number of respondents who indicated having indirect involvement in incident management.

Application of Intervention Strategies

Correctional Officers/Primary Workers (89.2%, *n* = 166/186), Correctional Managers (80.4% *n* = 148/184) Sector Coordinators (66.9%, *n* = 97/145), and Health Professionals (52.7%, *n* = 97/184) were identified as *often* or *always* being involved in the application of intervention strategies (see Table 14). Notably, a substantial number of *I don't know* responses were excluded from the analysis (ranging from 46 to 118 respondents per question).

All 14 RTC staff indicated that Correctional Officers/Primary Workers were *often* or *always* involved in the application of intervention strategies. Most RTC staff indicated that the following staff/contractors were *often* or *always* involved in the application of intervention strategies: Correctional Managers (84.6%, *n* = 11/13), Sector Coordinators (87.5%, *n* = 7/8), and Health Professionals (84.6%, *n* = 11/13) (see Table 14).

Table 14. Staff/Contractors Often or Always Involved in the Application of Intervention Strategies

	All Institutions		RTC	
Staff/Contractors	*n / N*	%	*n / N*	%
Correctional Managers	148/184	80.4	11/13	84.6
Correctional Officers/Primary Workers	166/186	89.2	14/14	100
Sector Coordinators	97/145	66.9	7/8	87.5
Emergency Response Team	29/167	17.4	--	--
Crisis Negotiators	30/168	17.9	--	--
Health Professionals	97/184	52.7	11/13	84.6
Elders	36/174	20.7	--	--
Chaplains	26/170	15.3	--	--
Institutional Parole Officers	49/177	27.7	--	--
Institutional Managers	68/169	40.2	--	--
Any person who has a good rapport with the inmate	54/178	30.3	--	--

Note. Reflects staff/contractors who are *often* or *always* involved in the application of intervention strategies, based on staff survey respondents. All Institutions = All staff survey responses. RTC = Regional Treatment Centre. Number of missing and *I don't know* responses fluctuate per response item; Missing and *I don't know* responses were excluded from analyses. Items with less than 5 responses are not reported (--).

Comparison of the SMM and the EIM: Application of Intervention Strategies

Of all staff, 41.7% (*n* = 98/235) indicated that they were involved in the application of intervention strategies under the SMM. When comparing the application of intervention strategies under the EIM to that of the SMM, it was reported that Correctional Managers, Sector Coordinators, Health Professionals, and individuals who have good rapport with the inmate were found to be slightly more involved under the EIM. Notably, only 42.9% (*n* = 6/14) of RTC staff were involved in the application of intervention strategies under the SMM. As such, follow-up questions pertaining to the application of intervention strategies under the SMM were not examined due to the limited number of respondents.

Key informants perceived the inclusion of a health-focused approach within the model and the emphasis on collaboration as positive. About half of the key informants agreed that there has been an increase in interdisciplinary teamwork to address incidents since the implementation of the EIM, with an increased role for partners, including Health Professionals, Parole Officers, and Elders. They may be called upon to work with a particular inmate with whom they have good rapport. Correctional Officers may also reach out to them for assistance when appropriate. The use of these partners provides more response options. The EIM approach is supported in some institutions by ongoing communication across sectors. Some sites have access to health services 24-hours a day, such as the RTCs, which allow health staff to support incident management no matter the time of day. It should be noted that women's institutions and the RTCs were also described as having multi-disciplinary, collaborative approaches to

incident management prior to the EIM.

About half of the key informants reported that interdisciplinary teamwork did not always occur. Some staff were reported to be less open to working with other disciplines, and at some institutions, there was reportedly less integration and interaction between the security and clinical staff. In those instances, key informants thought that an increased role for health staff would be beneficial. However, within many sites, there are no Mental Health/Health Professionals, Parole Officers, or Elders available outside of daytime hours. As such, Correctional Officers do not have access to partners to work with during incidents that occur at night or on weekends.

Use of the AIM Tool to Assess Risk

Findings: While two-thirds of staff understood the intent of the AIM tool and viewed it as useful for assessing risk, only about half of staff survey respondents found it feasible to use the AIM tool during an active incident.

In the EIM, staff evaluate each situation to determine the level of risk of harm relative to the threat by using the Ability, Intent, Means (AIM) tool. Ability refers to the physical and mental capacity and opportunity to carry out the threat. Intent refers to showing intent to behave or act in a specific manner (verbal/non-verbal) to carry out the threat. Finally, Means refers to the inmate having the means to carry out specific action or behaviour associated with the threat.

Almost two-thirds of staff indicated that they *agreed* that the intent of the AIM tool is clear (64.3%, *n* = 128/199) and useful for assessing risk (64.0%, *n* = 126/197). In comparison, a higher proportion of RTC staff respondents *agreed* that the intent of the AIM tool is clear (85.7%, *n* = 12/14) and that the AIM is a useful tool for assessing risk (85.7%, *n* = 12/14). Although about half of staff indicated that it is feasible to assess level of risk using the AIM tool during an active incident (54.9%, *n* = 106/193), the proportion of RTC staff who *agreed* was higher (76.9%, *n* = 10/13). About half of staff reported that their assessment of risk does not change when considering events post-incident (52.7%, *n* = 88/167), whereas two-thirds of RTC staff agreed (66.7%, *n* = 6/9). Notably, a large proportion of staff indicated that they did not know whether the AIM tool was clear, useful during an active incident, or whether their assessment of risk changed post-incident, and these responses were not included in the analyses (see Table 15 for all staff and RTC staff responses, and see Appendix F for more details on staff survey responses).

Some key informants described the EIM as placing an increased emphasis on assessment of risk and greater consideration of person-centered factors such as health, rather than just focusing on inmate behaviour, as may have occurred with the SMM. Key informants described Correctional Officers as assessing whether an incident is a medical or security situation, which influences their response. Ongoing assessment influences responses throughout an incident.

Table 15. Usefulness of AIM for Assessing Risk

Staff Survey Responses	All Institutions		RTC	
	n / N	%	*n / N*	%
The intent of the AIM tool is clear	128/199	64.3	12/14	85.7
The AIM tool is a useful tool for assessing risk	126/197	64.0	12/14	85.7
It is feasible to assess the level of risk using the AIM tool during an active incident	106/193	54.9	10/13	76.9
Considering the events post-incident, my assessment of risk does not change	88/167	52.7	6/9	66.7

Note. Reflects staff survey respondents who *somewhat* or *strongly* agreed. AIM = Ability, Intent, Means. All Institutions = All staff survey responses. RTC = Regional Treatment Centre. Number of missing and *I don't know* responses fluctuate per response item; Missing and *I don't know* responses were excluded from analyses.

Use of Engagement and Intervention Response Options

Findings: There appears to be frequent use of non-physical interventions as response options during an active incident, with tactical maneuvering being least commonly used. Moreover, the frequency of use of these response options does not appear to have changed between the SMM and EIM periods.

Under the EIM, once the level of risk has been determined and the goal is identified, a number of intervention strategies are available at the staff members' disposal. Staff were asked about the types of engagement and intervention response options carried out at their institution as a reaction to incidents. As seen in Table 16, staff indicated that the following response options were *often* or *always* carried out at their institution: staff presence (92.9%, *n* = 183/197), dynamic security (89.2%, *n* = 173/194), communication (85.4%, *n* = 170/199), observation and monitoring (82.4%, *n* = 159/193), verbal orders (80.1%, *n* = 153/191), de-escalation (79.5%, *n* = 151/190), and isolate, contain, and control (77.7%, *n* = 146/188).

Most RTC staff indicated that the following engagement and intervention response options were *often* or *always* carried out: staff presence (92.9%, *n* = 13/14), observation and monitoring (92.9%, *n* = 13/14), dynamic security (85.7%, *n* = 12/14), health care interventions (78.6%, *n* = 11/14), negotiation (76.9%, *n* = 10/13), and isolation, contain, and control (76.9%, *n* = 10/13). Additionally, all RTC staff indicated that de-escalation and verbal orders are *often* or *always* carried out in response to incidents at their institution (100.0%, *n* = 13/13). Finally, 71.4% (*n* = 10/14) of RTC staff reported that communication is used in response to incidents whereas 50% (*n* = 6/12) reported that tactical manoeuvring is used (Table 16).

Table 16. Engagement and Intervention Response Options to Incidents that are Often or Always Carried Out

Engagement and Intervention Response Options	All Institutions		RTC	
	n / N	%	*n / N*	%
Dynamic security	173/194	89.2	12/14	85.7
Staff Presence	183/197	92.9	13/14	92.9
Communication	170/199	85.4	10/14	71.4
Negotiation	106/176	60.2	10/13	76.9
De-escalation	151/190	79.5	13/13	100
Isolate, Contain, and Control	146/188	77.7	10/13	76.9
Observation and Monitoring	159/193	82.4	13/14	92.9
Verbal Orders	153/191	80.1	13/13	100
Health Care Interventions	116/187	62.0	11/14	78.6
Tactical Maneuvering	64/164	39.0	6/12	50.0

Note. Reflects response options that are *often* or *always* carried out in response to incidents, based on staff survey respondents. All Institutions = All staff survey responses. RTC = Regional Treatment Centre. Number of missing and *I don't know* responses fluctuate per response item; Missing and *I don't know* responses were excluded from analyses.

Among all surveyed staff, 45.1% (*n* = 105/233) indicated that they were familiar with the response options carried out when incidents occurred during the period that the SMM was being used. Of those 105 staff with familiarity of the SMM response options, the largest proportion did not see an increase in engagement and intervention responses under the EIM model in comparison to the SMM model. For example, 41.7% (*n* = 43/103) of those surveyed *disagreed* that dynamic security is used more often under the EIM compared to the SMM, and 50.0% (*n* = 51/102) *disagreed* that isolate, contain, and control is used more often under the EIM compared to the SMM. Notably, for the majority of engagement and intervention responses, about one-third of staff indicated that they *neither agreed nor disagreed* that these responses increased under the EIM compared to the SMM (see Appendix F for more details on staff survey responses). Given that only 35.7% (*n* = 5/14) of surveyed RTC staff were familiar with the response options to incidents at their institution during the SMM period, follow-up questions pertaining to the SMM period were not examined.

Several key informants agreed that the EIM has provided an emphasis on using the least restrictive measures and engagement and intervention response options, including negotiation, de-escalation, verbal communication, mediation, conflict resolution, and dynamic security. They reported that they believed Correctional Officers used a greater range of response options, describing situations where officers spoke with inmates to address situations, de-escalating the situation and avoiding use of force. Key informants spoke of the flexibility of the model in terms of returning to a lower level of intervention, when appropriate. They felt response options are calibrated to the assessment of risk and inmate factors, like physical and mental health. Key informants reported that in their

experience, staff have recognized the benefit of the response options highlighted in the EIM and adopted these lower level response options as first steps, with the level and type of intervention being re-evaluated throughout the interaction. A response might also involve different partners, who can address a health issue, or who have good rapport with the inmate.

Key informants also described situations that resulted in uses of force that could potentially have been dealt with at a lower level or with less force, and a few had not observed a decrease in use of force incidents. About half of key informants stated that in their experience, staff do not always apply the EIM as intended. It was suggested that staff may be responding quickly to manage a situation. A few key informants were concerned about the use of negotiation with specific inmates, which they reported was clinically contraindicated in certain cases, as the negotiation was perceived to reinforce problematic behaviour on the part of the inmates.

Overall, the evidence suggests that many of the goals and objectives of the EIM are being implemented/ administered in ways that address the issues identified from the SMM. One such issue was the need for an interdisciplinary approach to engaging and intervening with inmates, and another was the emphasis on the use of de-escalation strategies before responding with physical interventions. Nonetheless, there are areas for improvement, including the need for further interaction and integration between correctional and non-correctional staff, the need to ensure the effective implementation of the AIM tool, as well as the need to increase the use of de-escalation strategies.

Use of Quality Improvement Activities

Under the EIM, there are a number of quality improvement activities that are intended to enhance the EIM's effectiveness in its implementation. These activities include the completion of documentation, including those required for reporting and monitoring purposes, a video recording of the incident in the case of use of force, debrief sessions with all staff involved in the incident, and the timely completion of appropriate reviews. The following section examines the extent to which these key activities are being implemented under the EIM, specifically, effectiveness around implementation of the new roles and responsibilities for management under the EIM, documentation, debrief sessions, use of force reviews, and disciplinary measures and corrective actions.

Management Roles and Responsibilities

Findings: While many of the management roles and responsibilities are being fulfilled under the EIM, some issues were raised, including a need for the dissemination of trends and deficiencies in how the EIM is operating, and a need for increased follow-up from management in the instance of violations of law or policy. When model periods are compared, overall, there has been a decrease of required post-incident care (e.g., post-incident decontamination shower), particularly with respect to care where an inflammatory or chemical agent has been deployed.

Under the EIM, additional responsibilities and oversight functions were allocated to senior levels of management. These new functions include the Assistant Warden of Operations or the Manager of Operations who are responsible for providing oversight related to the application of the EIM, providing Correctional Managers support and guidance in

relation to their role in managing incidents, and identifying trends related to incident management, reinforcing the appropriate application of the EIM, and identifying any deficiencies. The responsibilities of the Chief of Mental Health Services and the Chief of Health Services include: providing general oversight of health care professionals regarding the application of the EIM; identifying trends related to the provision of health services prior, during, and post incidents; conducting post-use of force medical assessments; and providing treatment, if required.

Key informants were divided with respect to whether or not management roles and responsibilities were being met. Many believed that there was leadership in providing support and guidance to staff in relation to their role in managing incidents and, concerning use of force reviews, there is also some liaising occurring at both the national and regional levels. Key informants questioned whether there was always sufficient follow-up with disciplinary measures and corrective actions for violations of policy or law. There is also a view that management has insufficiently disseminated identified deficiencies and trends to staff working in institutions, particularly to those working in lower ranking positions.

Post-incident care and assessments

Examining OMS data across all institutions shows there has been a decrease in the percentage of inmates who were given a post-incident decontamination shower between the EIM (37.6%, *n* = 1,023) and the SMM (41.4%, *n* = 986) periods (Table 17 and Table C 17). There has also been a decrease in the percentage of inmates who were given a post-incident change of clothes between the EIM (36.6%, *n* = 996) and the SMM (42.2%, *n* = 1,005) periods. Although the effect sizes of these decreases are negligible, the findings are considered a significant change between the SMM and the EIM. There has been no statistically significant change in the percentage of inmates who, when unintentionally exposed to an chemical or inflammatory agent, had the opportunity to see a health care practitioner (EIM: 8.7%, *n* = 238; SMM: 9.1%, *n* = 216), nor who were offered a decontamination shower (EIM: 8.7%, *n* = 237; SMM: 9.4%, *n* = 224) between the EIM and the SMM periods. Table 17 presents a summary of results concerning post-incident follow-up procedures for use of force incidents where an inflammatory or chemical agent was deployed.

Using OMS data to examine RTCs specifically shows there was no statistically significant change in the percentage of inmates who were given a post-incident decontamination shower, between the EIM and the SMM periods, nor in the percentage of inmates who, when unintentionally exposed to an chemical or inflammatory agent, had the opportunity to see a health care practitioner or were offered a decontamination shower. There has however, been a decrease in the percentage of inmates in RTCs who were given a post-incident change of clothes between the EIM (22.1%, *n* = 91) and the SMM (28.7%, *n* = 137) periods. Although the effect size is negligible, this finding is considered a significant change between the SMM and the EIM.

Examining OMS data across all institutions shows there has been a decrease in the percentage of inmates who were offered an initial health services examination between the EIM (87.7%, *n* = 2,386) and the SMM (89.8%, *n* = 2,138) periods (Table 18 and Table C 18). Although the effect size is negligible, this finding is considered a significant change between the SMM and the EIM. There has also been a decrease in the percentage of staff who were offered a physical assessment post use of force incident between the EIM (73.0%, *n* = 227) and the SMM (91.1%, *n* = 438) periods when the offer was deemed to be applicable. Effect sizes indicate that this change is small in magnitude. Table 18 presents a summary of results concerning the offering of health and physical assessments after a use of

force.

Table 17. Summary of Changes in Follow-up Procedures after the Deployment of a Chemical or Inflammatory Agent for the EIM, compared to the SMM

Institution Types	Decontamination Shower	Change of Clothes	Opportunity to See Health care Practitioner (UE)	Decontamination Shower (UE)
All institutions	↓	↓	=	=
RTC	=	↓	=	=

Note. UE = Unintentionally Exposed. ↑↓ negligible effect (φ < .1), ↑↓ small effect (φ > .1), ↑↓ medium effect (φ > .3), ↑↓ large effect (φ > .5), = no significant effect (p > .05), · statistical comparisons not possible.

Using OMS data to examine RTCs specifically shows there has been a decrease in the percentage of inmates who were offered an initial health services examination between the EIM (86.2%, n = 355) and the SMM (96.2%, n = 459) periods (Table 18 and Table C 18). Effect sizes indicate that this change is small in magnitude. There has been no statistically significant change in the percentage of staff who were offered a physical assessment post use of force incident between the EIM (87.0%, n = 20) and the SMM (84.4%, n = 27) periods.

Table 18. Summary of Changes in Offering of Health/Physical Assessments Post Use of Force for the EIM, compared to the SMM

Institution Types	Inmate Offered Initial Health Services Examination	Staff Offered Physical Assessment
All institutions	↓	↓
RTC	↓	=

Note. ↑↓ negligible effect (φ < .1), ↑↓ small effect (φ > .1), ↑↓ medium effect (φ > .3), ↑↓ large effect (φ > .5), = no significant effect (p > .05), · statistical comparisons not possible.

Critical Incident Stress Management (CISM) Program

One of the aims of the Critical Incident Stress Management (CISM) program is to provide support, help and follow-up services following an incident in order to lessen the acute response associated with a potentially traumatic event. When examining whether this program is routinely offered to staff involved in a use of force incident, there was only information in 3.6% (n = 179) of use of force incidents across both the EIM and SMM periods. Under the EIM, staff were offered CISM in 1.4% (n = 34) of incidents compared to in 3.3% (n = 88) of incidents under the SMM. Further, under the EIM, staff were not offered CISM in 1.8% (n = 47) of incidents, compared to 0.4% (n = 10) under the SMM. Based on the amount of missing data, no conclusions regarding the actual use of this program under either model period can be drawn.

Documentation

Findings: Overall, with respect to documentation of incidents, including RTCs, there has been a decrease in both the percentage of inmates being given the option to report their version of events and in video recording issues. There has been no significant change in the percentage of forms that have not been completed. It was also noted that there were issues with performance monitoring and reporting, particularly when it came to data quality, data accessibility, and to a balanced approach to reporting on how well the EIM is performing.

One of the critical tasks in informing use of force reviews is the completion and acquisition of key pieces of documentation in relation to an incident. OMS analyses show that for all institutions, there has been a decrease in the percentage of inmates who were offered the two options for reporting their version of events between the EIM (85.3%, *n* = 2,321) and the SMM (90.6%, *n* = 2,157) periods (Table 19, Table C 19). Although the effect size is negligible, this finding is considered a significant change between the SMM and the EIM. There has also been a decrease in video recording issues[36] during the EIM (9.6%, *n* = 260) period compared to the SMM (13.1%, *n* = 313) period. Although the effect size is negligible, this finding is considered a significant improvement. There has been no significant change in the percentage of forms that have not been completed appropriately. Table 19 presents a summary of results for completed documentation after a use of force.

Using OMS data to examine RTCs specifically shows there has been a decrease in the percentage of inmates who were offered the opportunity to report their version of events between the EIM (85.4%, *n* = 352) and the SMM (96.9%, *n* = 462) periods (Table 19). There has also been a decrease in video recording issues during the EIM (7.8%, *n* = 32) period compared to the SMM (16.8%, *n* = 80) period. Effect sizes indicate that these decreases are small in magnitude. There has been no significant change in the percentage of forms that have not been completed appropriately (Table 19; Table C 19).

Table 19. Summary of Changes in Documentation Post Use of Force for the EIM, compared to the SMM

Institution Types	Inmate Offered Opportunity to Report Their Version of Events	Forms Not Completed Appropriately	Video recording Issues Present
All institutions	↓	=	↓
RTC	↓	=	↓

Note. ↑↓ negligible effect (φ < .1), ↑↓ small effect (φ > .1), ↑↓ medium effect (φ > .3), ↑↓ large effect (φ > .5), = no significant effect (*p* > .05), · statistical comparisons not possible.

While some key informants stated that there was sufficient monitoring and reporting at both the national and regional levels, particularly for use of force incidents, others expressed that it was not sufficient due to regional variations in

[36] The most common video recording issue during the EIM period was not recording ASAP (2.4%), followed by breaks in recording (2.2%) and not recording at all (2.0%).

how performance monitoring and reporting are managed. Key informants also noted other issues with monitoring and reporting. It was suggested that it may be worthwhile to monitor positive trends or outcomes in the application of the EIM as opposed to only the negative incidents that typically come under scrutiny. It was believed that doing so would provide a more accurate picture of how well the EIM is performing. Key informants also noted some data quality issues that have emerged. These include:

- Incident events where there was a use of force but no related records in the Use of Force Review Module;
- Instances where segregation information was flagged in the Use of Force Review Module, but not in the Incident Module or vice versa;
- Incidents where the flag for if the use of force was prompted by self-injurious behaviour is set to 'yes' but there is no related incident type of self-injurious behaviour in the Use of Force Review Module;
- Inconsistencies in the reporting of the role of the inmate as either the victim or the instigator in an incident; and,
- The likelihood of the underreporting of certain events such as self-injurious behaviour and staff injuries.

Key informants also alluded to the need to have readily accessible information regarding the application of the EIM, for example, through electronic Statement/Observation Reports. Although it was acknowledged that there are time constraints, key informants also described a need to have more detailed analytical reporting in regards to the application of the EIM.

Debrief Sessions

Findings: Although there is value to conducting debrief sessions, a lack of adequate staff, operational constraints, and time constraints are identified as barriers to conducting them. These barriers may have an impact on the quality of debriefs.

As per CD 567, when an incident occurs, the Correctional Manager, in conjunction with the Chief of Health Services (when there is a health care intervention), is required to conduct an operational debriefing prior to the end of shift, where operationally practicable, with the individuals (based on staff availability) directly involved in the intervention, including the Health Care Professionals. The debrief process provides an opportunity for the participants to assess the strengths and weaknesses of their response and the lessons that can be immediately learned and implemented going forward.

Operational Debrief Attendance

About half of all staff reported that they have been involved in an operational debrief (55.1%, *n* = 130/236). Based on the 130 staff that reported having had been involved in an operational debrief, more than half stated that the debrief session had *often* or *always* been conducted by a Correctional Manager and/or Chief of Health Services (62.0%, *n* = 75/121). A relatively large proportion of respondents also indicated that they did not know if the debrief session had been conducted by someone other than the Correctional Manager and/or Chief of Health Services. About half of staff who reported having been involved in an operational debrief indicated that the operational debrief was *often* or

always attended by all directly involved staff (51.3%, *n* = 60/117).

In contrast, of all RTC staff, 71.4% (*n* = 10/14) have been involved in an operational debrief. Slightly higher proportions of RTC staff, in comparison to all staff, indicated that debriefs following incidents have *often* or *always* been conducted by a Correctional Manager and/or Chief of Health Services (70.0%, *n* = 7/10) and been attended by all directly involved staff (60.0%, *n* = 6/10).

Operational Debrief Process

With respect to the debrief process, about half of staff that had been involved in an operational debrief conveyed that the debrief session *often* or *always* provided an opportunity for staff to: assess the strength of the response (51.7%, *n* = 61/118), assess what could have been done differently during the response (50.4%, *n* = 60/119), and identify lessons learned that could be implemented going forward (48.4%, *n* = 58/120). In comparison, 70.0% (*n* = 7/10) of RTC staff indicated that the debrief session *often* or *always* provides an opportunity to assess the strength of the response and what could have been done differently during the response (see Table 18).

Many staff also *agreed* that they were encouraged to give feedback about the incident(s) during the debrief process (65.0%, *n* = 76/117). Most staff *agreed* that debriefs are a useful part of the EIM process (82.7%, *n* = 100/121), however, only less than half *agreed* that they were satisfied with the quality of debriefs at their institution (46.6%, *n* = 55/118). This might be partly explained by the limited resources to conduct quality debrief sessions as many staff voiced that they *disagreed* that there is adequate time to conduct debriefs (59.7%, *n* = 71/119) and about half said that they *disagreed* that there are adequate staff resources to conduct debriefs with at least the main participants (51.3%, *n* = 60/117).

Of the 10 RTC staff who have been involved in an operational debrief, 90.0% (*n* = 9/10) *agreed* that debriefs are a useful part of the EIM process, 80.0% (*n* = 8/10) *agreed* that they are encouraged to give feedback about the incident(s) during the debrief process, and 60.0% (*n* = 6/10) *agreed* that there is adequate time to conduct debriefs.

While key informants indicated that debrief sessions are occurring, there were some obstacles to conducting them. Obstacles included challenges with having the resources/staff available and time to conduct them, institutional culture, inadequate training or guidance on how to conduct them, challenges with the process or policy around debrief sessions, a disconnect between the policy or training and the operational reality, and a lack of communication during debriefs.

With respect to challenges with the process or policy around debrief sessions, while policy dictates that a debrief session should occur subsequent to an incident, key informants reported that not all incidents warrant one, such as those that solely involve the use of restraints or pointing OC spray. It was also believed that, at times, debriefs were more of a formality with no real value to conducting them. In relation to there being a disconnect between the policy or training and the operational reality, although Correctional Managers were provided with training on debrief sessions and there is direction from CD 567 to conduct them, the reality of the operational context (e.g., needing to tend to a lock down) doesn't always allow for them to occur as they were intended. With respect to a lack of communication, it was felt that there were missed opportunities for quality enhancements to improve how the EIM is functioning in institutions as many of the debrief sessions that do occur do not result in the valuable discussions that

they were intended to produce. Questions such as “What did we do well? What can we do differently? How did that work? How are you feeling?” are not always being addressed. In discussing challenges with institutional culture, key informants flagged a lack of support from management, as well as staff, as an impediment to the conducting of debrief sessions.

Use of Force Reviews

Findings: While the majority of respondents believed that current policy provided adequate guidance for conducting use of force reviews, there were some inefficiencies with regard to the policy and process identified, namely that at times the policy is over-prescriptive and that the process itself can be cumbersome. During the EIM period, there has also been an observed increase in the proportion of institutional and regional reviews not being completed on time. For RTCs, there has been an observed increase in reviews not being completed on time at the regional level.

Under the EIM, all uses of force must be reviewed to ensure that the amount of force used is limited to only what is necessary and proportionate to manage the incident. The number of reviews to be completed and the level (i.e., institutional, regional, national) are prescribed in CD 567-1 – *Use of Force*.[xlix]

Of the 42 staff (18.4%, *n* = 42/228) from the staff survey who were involved in use of force reviews, 61.0% (*n* = 25/41) *agreed* that overall, there is sufficient guidance for how to conduct use of force reviews. Fewer than 5 RTC staff indicated that they were involved in use of force reviews. As such, follow-up questions pertaining to use of force could not be examined for this group.

While it was clear that use of force reviews were occurring as per CD 567-1 guidelines, key informants did express that there were challenges with the process and policy surrounding use of force reviews. These challenges included lags in the identification of uses of force, inconsistencies in how the EIM and uses of force are interpreted, over prescriptive policy that does not allow for discretion, a cumbersome review process, and the review process at times not being as comprehensive as it should be. Key informants also vocalized that there was inadequate training and guidance for use of force reviews. There are also issues with resources, namely that staff are not using those that are available to them such as the Use of Force Reviewer’s guide.

Review Timeframes

There are prescribed timeframes for which use of force reviews must be completed at the institutional, regional, and national levels. For institutional reviews, it is within 20 working days of the incident. For regional reviews, it is within 25 working days after completion of the institutional review. For national reviews, it is within 30 working days of notification of the use of force review completion at the regional level. The same timeframes applied under the SMM.

Examining OMS data shows that the percentage of use of force packages in which reviews were not completed within the specified timeframe increased at the institutional review (EIM: 68.8%, *n* = 1,843; SMM: 65.6%, *n* = 1,562) and regional review (EIM: 60.7%, *n* = 572; SMM: 46.2%, *n* = 810) levels under the EIM. Although the effect size at the institutional level was negligible and at the regional level was small, these increases are considered a significant change between the SMM and the EIM. There were no statistically significant differences at the national review level

(see Table 20 and Table C 20).

Looking only at RTCs, the percentage of use of force packages in which reviews were not completed within the specified timeframe decreased at the institutional review level under the EIM (66.2%, *n* = 270) compared to under SMM (81.6%, *n* = 389) but increased at the regional review level (EIM: 84.1%, *n* = 175; SMM: 58.7%, *n* = 277). Effect sizes indicate that the magnitudes of both of these changes are small.

Table 20. Summary of Changes in the Percentage of Use of Force Package Reviews Not Met Within the Timeframe for the EIM, compared to the SMM

Institution Types	Institutional Review	Regional Review	National Review
All institutions	↑	↑	=
RTC	↓	↑	=

Note. UE = Unintentionally Exposed. ↑↓ negligible effect (φ < .1), ↑↓ small effect (φ > .1), ↑↓ medium effect (φ > .3), ↑↓ large effect (φ > .5), = no significant effect (*p* > .05), · statistical comparisons not possible.

Disciplinary Measures and Corrective Actions

Findings: When the EIM period is compared with the SMM period, there has been an increase in use of force packages for which there has been a finding of violations of law or policy. This finding also applies to RTCs, where the effect size of the observed change is medium. Concerning disciplinary measures for excessive uses of force, many key informants spoke to a need for additional follow-up subsequent to violations of law or policy.

Following the completion of a use of force review, all identified areas of improvement and disciplinary measures and corrective actions are to be addressed as soon as practicable and documented as prescribed in CD 567.

Examining OMS data shows that the percentage of use of force packages in which there was a violation of law or policy flag at the institutional review level has increased under the EIM (93.3%, *n* = 2,540) compared to under the SMM (78.8%, *n* = 1877). This finding is considered a significant change between the SMM and the EIM. The effect size indicates that this change is small. Examining RTCs separately, there has also been an increase in violation of law flags at the institutional level under the EIM (86.7%, *n* = 357) compared to under the SMM (60.2%, *n* = 287), however the effect size indicates that this change is medium in magnitude (see Table 21 and Table C 21).

With respect to the types of disciplinary measures taken for excessive uses of force, the OMS data show that there have been slightly more oral reprimands, suspensions without pay, financial penalties, and terminations given under the EIM when compared to the SMM period. In contrast, there have been fewer written reprimands under the EIM when compared to the SMM (see Table C 22 for more details). It should be noted that given the volume of violations of law or policy recorded for both periods, there may be an underreporting or a lack of disciplinary measures that

have been taken under both model periods.

Table 21. Summary of Changes in Violation of Law or Policy Flags for the EIM, compared to the SMM

Institution Types	Violation of Law or Policy Flag at Institutional Review Level
All institutions	↑
RTC	↑

Note. UE = Unintentionally Exposed. ↑↓ negligible effect (φ < .1), ↑↓ small effect (φ > .1), ↑↓ medium effect (φ > .3), ↑↓ large effect (φ > .5), = no significant effect (p > .05), · statistical comparisons not possible.

About half of staff who were involved in use of force reviews articulated that they *agreed* that there is sufficient guidance for corrective actions required for different types of non-compliance with use of force guidelines (46.4%, n = 19/41) and for monitoring whether the necessary corrective actions have occurred (52.5%, n = 21/40). Only some of these staff *agreed* that the disciplinary measures for non-compliance are effective (38.9%, n = 14/36).

Although about half of key informants believed that disciplinary measures and corrective actions were occurring, many also reported that additional measures and actions should be taken. For example, the use of an e-mail as follow-up was viewed as inadequate, especially for staff who have repeatedly failed to adhere to policy. Key informants also spoke to the challenges with the process surrounding disciplinary measures and corrective action. Challenges with the process included the inability to monitor and track measures and actions that have taken place. Key informants also identified a lack of communication with parties who have violated policies or law as an issue. Institutional culture was also viewed as a barrier to the administration of disciplinary measures and corrective measures.

Overall, many of the intended quality improvement activities, such as debrief sessions and use of force reviews, are occurring. However, the evidence suggests that there remain barriers to quality improvements in the way that the EIM is currently functioning. These include challenges such as deficiencies in performance and monitoring, operational obstacles to conducting debriefs, the timely completion of use of force reviews, and limitations in the reporting and monitoring of corrective actions.

Conclusions and Recommendations

Conclusions

As indicated at the outset of this report, there were a number of goals with the introduction of the EIM as related to improvements from the SMM. This evaluation has shown that some of the EIM objectives have been achieved. In particular, there has been an increase in the use of non-security partners to resolve incidents, which was identified as an area for improvement from the SMM. Similarly, there is also evidence to suggest that there has been an increase in the use of health partners to respond to incidents involving mental or physical distress. Though not a direct objective of the model, the evidence also suggests that there has been a reduction in the use of OC spray as demonstrated by a decrease in the use of chemical or inflammatory agents for behaviour-related incidents.

While there are some promising findings for the EIM, other evidence presented shows that there is still progress required regarding the achievement of EIM's main objectives. Regarding the objective related to an increased focus on the use of non-physical interventions, this evaluation found there has been no change in the percentage of incidents involving a use of force. It should be noted however, that the assessment of situational factors play a role in determining whether use of force is necessary, and therefore success of the EIM cannot be weighted only on whether there is a decrease in physical interventions. In addition, the extent to which the role of the Sector Coordinator has been effectively implemented is unclear. This role was introduced with the EIM to ensure on-scene leadership, with specific responsibilities to ensure health considerations are integrated into interventions.

At this stage of implementation, it appears that the EIM is performing well on many fronts, however, due to its relative infancy there is a need to allow more time before definitive evidence and conclusions can be made about the model, and how effective it is at managing institutional incidents. In particular, additional data are needed to examine whether the application of the EIM is associated with an increase in non-physical response options. When examining data on non-physical response options, it would be important to be aware that the selection of an intervention is based on contextual factors, and use of force might be deemed necessary in a given situation instead of a non-physical response option.

Relevance

There is evidence of a continued need for the EIM to prevent, respond to, and resolve situations within federal institutions that could potentially disrupt the safety and security of inmates or staff. Further, the EIM supports the federal government's, as well as CSC's, corporate priority of providing a safe and secure environment for Canadians, in general, and prison inmates, in particular. Finally, the EIM priority of guiding staff to use the most reasonable intervention strategies is aligned with federal roles and responsibilities.

Expected Results/Achievement of Outcomes

Design and Delivery

There is evidence that the EIM is being delivered in a manner consistent with best practices, as most CSC staff received EIM training prior to its implementation. However, there are still some training needs, particularly pertaining to refresher and scenario-based training for non-correctional staff. Moreover, there is a need to better equip all staff with the knowledge required to engage and intervene with inmates from diverse sub-populations, including those who are experiencing mental health issues.

Overall, the evaluation findings did not provide strong evidence that there has been a decrease in use of force during institutional incidents since the implementation of the EIM, when examined across all institutions (including RTCs), as well as across inmate security levels. As previously mentioned, there are a number of situational factors that are considered in the decision-making process when determining if force is required to safely manage an incident. Nonetheless, there has been a decrease in force used during behaviour-related incidents, a decrease in the discharge of chemical or inflammatory agents, and a decrease in inmate injury during use of force incidents. Also, a majority of uses of force are being deemed necessary and proportionate. Further, regarding improvements for the use of appropriate response protocols for institutional incidents involving physical or mental health distress, there have been two positive changes regarding incidents involving an inmate with mental health concerns. First, there has been a decrease in use of force during incidents involving an inmate with a suicide alert, and second, there has also been a decrease in use of force during incidents involving those occupying a mental health bed. There were no changes in use of force in incidents related to medical treatment. Further, there has also been a decrease in the percentage of interventions conducted in accordance with the Guidelines for Health Service Responsibilities. The evaluation findings also suggest that particular attention needs to be paid to the more frequent use of force towards diverse sub-populations of inmates.

Extent Goals and Objectives of the EIM are Implemented

To a certain extent, there is evidence to suggest that the key activities that have been emphasized as a result of the issues identified under the SMM are being implemented under the EIM. For example, staff report to be taking a person-centered approach, prioritizing mental and physical well-being, and are better able to identify altered levels of consciousness when dealing with inmates. There also appears to be more of an interdisciplinary team approach to resolving incidents and greater emphasis on the use of non-physical response options, yet, the findings still suggested the need for further improvement. Where the EIM appears to be lagging, is in the involvement of Sector Coordinators and Health Professionals in the planning and application of intervention strategies. There appears to be a need to cultivate more integration and interaction between correctional and non-correctional staff. The AIM tool's utility as a balanced approach to risk assessment is appreciated by staff, but the extent to which it is being appropriately implemented in practice and the practicality of using this tool during an incident is unclear.

Challenges with the Effective Implementation of the EIM

There are barriers to the effective implementation of the EIM. While the model philosophy and de-escalation strategies seem to be applied by staff when responding to incidents, staff report difficulty in selecting appropriate

response options and in their ability to get the help they need to safely manage incidents of mental and physical distress when dealing with inmates. Moreover, staff working in SIUs are experiencing challenges with aligning the model philosophy with the realities of working within these units. While key elements of the EIM are being implemented, challenges do exist with executing the roles and responsibilities of the Sector Coordinator, and there is a lack of teamwork and clarity in the roles and expectations of staff during an incident. Obstacles to the availability of non-correctional staff to manage incidents during off-peak hours also exist. CSC's organizational culture also presents some challenges with the implementation of the EIM in some institutions.

Quality Improvement Activities

Although quality improvement activities are occurring under the EIM, there are areas for improvement in this domain. While many management roles and responsibilities are being fulfilled, one issue that was raised was a need for additional follow-up from management in the instance of violations of law or policy. There was a decrease in the provision of post incident care. With respect to documentation, there has been a decrease in the percentage of inmates being given the option to report their version of events, and there were noted issues with performance monitoring and reporting. While debrief sessions are occurring and staff do see their value, there were resource and operational constraints, which may have an impact on the quality of debriefs that do occur. Use of force reviews are also occurring, however, policy requirements may have an impact on the timely completion of reviews at the institutional and regional levels. While there is evidence to suggest that disciplinary measures and corrective actions are occurring, violations of law or policy have increased since the implementation of the EIM, particularly in RTCs. Moreover, there is reason to surmise that there may be a need for additional follow-up subsequent to violations of law or policy.

As a whole, the EIM is contributing to CSC's mission as, in principle, it emphasizes the use of the most reasonable, safe, secure, and humane approaches to managing inmates during incidents. Moreover, the model addresses five of the six corporate priorities as indicated in the Relevancy Section of this report. However, the areas for improvement described above demonstrate that there is still work to be done in order for the EIM to realize its true potential.

Recommendations

Following analyses of data from the OMS, staff survey, and key informant interviews, five recommendations were formulated to suggest actions to help improve the EIM performance, as well as suggestions on program expansion.

Recommendation 1- Training

The Evaluation Division recommends that CSC reassess the EIM training, including refresher training, to ensure clear, well-defined, and effective: (a) scenario-based modules that incorporate the diverse sub-population of inmates (e.g., offenders with mental health needs); and (b) roles and responsibilities of all parties (e.g., the Sector Coordinator, as well as staff including non-correctional staff) during an incident.

The evaluation has shown that many staff report that they do not have the training to de-escalate incidents with diverse sub-populations of inmates (e.g., women inmates, inmates with cognitive impairments, and inmates with mental health needs). Further, staff indicated they did not feel they could get the help they needed to safely manage incidents of mental and physical distress situations when dealing with inmates.

The evaluation has also underscored findings that show a lack of understanding in the role of the Sector Coordinator, as well as the roles and responsibilities in EIM implementation for other staff. Additionally, there was concern that non-security partners were among those least likely to be involved in the application of intervention strategies, and that they had limited opportunities to practice responding to incidents in a learning environment. It would be beneficial to highlight interventions that are used for the diverse sub-population of offenders during training to increase staff competency in dealing with offenders in general. Other data also show that the use of interdisciplinary teamwork (i.e., collaboration between different partners) could be strengthened.

Recommendation 2- Incidents involving mental health and physical distress

The Evaluation Division recommends that CSC devise options to increase capacity to respond to incidents involving mental health and physical distress, particularly those occurring during evenings and weekends.

The evaluation highlighted the need for correctional staff to further their knowledge in managing offenders with mental health needs, particularly due to the lack of clinical staff on-site after hours in many institutions. Access to health resources was described as a good practice and one that should be available in all institutions, not only within RTCs.

Similarly, the results of this evaluation also demonstrated that staff did not feel they could get the help needed to safely manage incidents of mental and physical distress situations when dealing with inmates. Notably, a large proportion of staff indicated there was a need to decrease the use of physical force among inmates with mental health issues, which was also an issue identified for older inmates related to the current use of force practices.

Recommendation 3- Policy review

The Evaluation Division recommends that CSC review and revise, as necessary, Commissioner's Directive 567 - *Management of Incidents* and 567-1 - *Use of Force*, in consultation with operational staff to ensure the proposed guidance, including prescribed timelines, are relevant in an operational environment.

The evaluation underscored challenges when conducting debrief sessions given operational realities such as shift changes or need to fulfill other responsibilities. It also raised concerns related to the efficacy of policy when it comes to use of force reviews. Results also showed there is inadequate time and staff resources to conduct debriefs. Further, OMS analyses showed that many use of force packages are not completed within the timeframes as specified in CD 567-1.

Recommendation 4- Corrective actions

The Evaluation Division recommends that CSC review the guidance on corrective actions to ensure it provides more appropriate direction on breaches of law and/or policy.

The evaluation highlighted that, among those involved in use of force reviews, many disagreed that there is sufficient guidance for corrective actions and that the disciplinary measures for non-compliance are effective. Challenges were also identified with the process surrounding disciplinary measures and corrective actions, including the inability to monitor and track measures and actions that have taken place, as well as a lack of communication with parties who have violated policies or law as an issue.

Recommendation 5- Information collection

The Evaluation Division recommends that CSC develop a national protocol for reporting information found in Statement/Observation Reports in an accessible manner.

During the process of the evaluation, there was a lack of readily accessible data to report on, particularly those related to incidents managed through non-uses of force. By improving access to these data, a better understanding of the changes between the EIM and the SMM can be attained. Further, the implementation of an automated Statement/Observation Report would assist in having this information readily available and would also enhance the efficacy and breadth of analyses that could be conducted in relation to use of force incidents. This data surveillance should be utilized to improve the EIM and associated practices as needed.

Appendix A: Program Description

The Engagement and Intervention Model (EIM) is described by its three core principles: the philosophy behind the model, how the model works, and management post-institutional incidents.

The Philosophy behind the Model:

Guiding Principles

The EIM incorporates a strong focus on five guiding principles at the core of the model: the preservation of life, interdisciplinary teamwork, CSC's mission and values statements, necessary and proportionate interventions, and leadership.[l]

Person-centred

Within the EIM, the inmate is placed at the centre of the model to represent a person-based approach to engagement and intervention, where all strategies ensure the inmate's well-being is a priority. [li] Intervention strategies are not only based on inmate behaviour but also inmate's physical and psychological conditions.

How the Model Works:

Sector Coordinator

Correctional Officers or Primary Workers are assigned the role of Sector Coordinator. Sector Coordinators are responsible for coordinating security incident responses under the supervision and direction of the Correctional Manager. The Correctional Manager is also responsible for coordinating all security operations within a specified sector. The Sector Coordinator has the primary responsibility of ensuring that selected intervention options are the safest and most reasonable, and are continuously reassessed for their appropriateness. Based on the complexity of the incident, this responsibility may be assigned to other staff members as the incident unfolds. The Correctional Manager's role supersedes the Sector Coordinator in the overall management of the incident response.[lii]

Interdisciplinary Team Work

The EIM encourages collaboration between different staff to respond appropriately to incidents and situations. The model identifies security, health services, and all staff as possible interveners.[liii]

Staff or contractors involved in the planning and/or application of the intervention strategies may include, but are not limited to, the Institutional Head, the Correctional Manager, front-line staff, health professionals, Indigenous Elders/Spiritual Advisors, Chaplains, Parole Officers, Crisis Negotiators, Emergency Response Teams and/or any person who has a good rapport with the inmate.[liv] All staff involved in the situation are encouraged to remain self-aware and perceptive as the situation develops.[lv]

Assess/Reassess

The EIM requires intervening staff to assess all situational factors as the incident unfolds. Situational factors include: level of compliance and associated actions of the inmate, altered levels of consciousness/cues of distress, and other factors such as the presence of weapons or available staff. At transition periods (e.g., changes in level of compliance, behaviours, level of risk, or response to intervention strategy), reassessments are required.[lvi]

Risk

In the EIM, staff evaluate each situation to determine the level of risk of harm relative to the threat by using the AIM (Ability, Intent, Means) tool. *Ability* speaks to whether an inmate has the physical and mental capacity and opportunity to carry out a threat. *Intent* refers to whether an inmate shows intent to behave or act in a specific manner (verbal/non-verbal). *Means* signifies whether the inmate has the means to carry out specific actions or behaviour associated with the threat. After the application of the AIM tool, staff determine a level of low, moderate, or high risk that is based on the probability of harm occurring and the severity of the harm.[lvii]

Once the level of risk has been determined, there are a variety of engagement and intervention strategies at a staff member's disposal, including:

1) dynamic security and staff presence (which can function as a preventative measure);
2) communication;
3) isolate, contain, and control;
4) first aid/health assessment;
5) health care intervention;
6) controlled non-intervention;
7) tactical manoeuvring and/or intervention;
8) interdisciplinary team and any person with a good rapport with the inmate.[lviii]

Any engagement or intervention strategy selected should be necessary and proportionate to the level of risk.[lix]

Response

Engagement and intervention response options are visually depicted in the EIM; levels of risk are indicated with the colours green, orange, and red (Appendix A1). It is important to note that all engagement and intervention options remain available regardless of the assessed level of risk.[lx] Green denotes responses to low risk situations where all options are always available to all staff. As the level of risk increases, the responses under the orange area of the model become available to certain staff only (i.e., security or health services). Orange denotes a moderate level of risk. The red portion of the visual depiction of the model denotes responses to extremely high-risk situations and may require the use of any and all interventions to manage the situation in the safest most reasonable manner. As with the orange level, interventions under the red level are limited to certain staff (i.e., security or health services).

When formulating a response, staff will take into account tactical considerations such as past behaviour, size of inmate, skills of the officer, and availability of support from additional officers. Responses to the situation should be reformulated to reflect any significant changes and the risk the new situation represents. Every situation should be

managed using the safest and most reasonable response, and should be limited to only what is necessary and proportionate to respond to the situation. When necessary and possible, staff members should consider isolating, containing, withdrawing, reassessing, and re-planning their response option so that the most appropriate response is implemented.

Post-Institutional Incident:

Provision of Care

All incident participants (i.e., both inmates and staff) must receive the care and support they need following the incident. This includes the provision of physical assessments and medical assistance post-use of force for inmates, and access to support services such as the Critical Incident Stress Management (CISM) Program for staff.

Quality Improvements

Subsequent to the occurrence of an incident in an institution, staff must submit various forms of documentation that provide details surrounding the incident. This includes a video recording of the incident in the case of use of force, an Institutional Incident Report (CSC/SCC 1083), and a Statement/Observation Report (CSC/SCC 0875).[lxi] Once all required documentation has been completed following the incident, a Correctional Manager, in conjunction with the Chief of Health Services (where applicable) will conduct an operational debrief with the staff directly involved in the situation.[lxii] The debrief process provides an opportunity for the participants to assess the strengths and weaknesses of their response and the lessons that can be immediately learned and implemented.[lxiii] It must be noted, however, that the debrief process often occurs at a point in time where video evidence and much of the documentation from the incident have not been reviewed. Although all use of force responses must be reviewed, the number of reviews to be completed and the level (i.e., local, regional, national) are prescribed in CD 567-1–Use of Force.[lxiv] There are other types of reviews that may also occur in response to an institutional incident, such as those conducted by the Incident Investigations Branch or when a grievance or complaint has been lodged and must be investigated.

Description of Engagement and Intervention Model Components

<table>
<tr><th>Assess Situation</th><th>Self-Awareness & Perception</th></tr>
<tr><td>Identify Threat/Risk/Problem/Health Status

• Level of Compliance and Associated Actions
  ○ Cooperative
  ○ Verbal resistance
  ○ Passive resistance
  ○ Active resistance
  ○ Assaultive
  ○ Grievous bodily harm or death
  ○ Escaping
• Altered Level of Consciousness/Cues of Distress
• Appearance
  ○ Dishevelled - in part or change from normal
  ○ Blank stare/daze look
  ○ Red face/pale complexion
  ○ Signs of blood or trauma
• Speech
  ○ Slurred speech
  ○ Unusually fast/slow speech
  ○ Delayed response to questions/directions
  ○ Repetitive/non-sensible statements</td><td>• Staff's role is essentially defensive (not aggressive or passive)
• An incident is an emotional and physical event
• Self control is key - mind and body are one
• Indicators of hostility, fear and/or aggression:
  ○ Kinesics (body language)
  ○ Proxemics (body space)
  ○ Paraverbal communication (pitch, tone, volume)

Engagement & Intervention Strategies

• Dynamic security and staff presence
• Communication
• Isolate, contain and control
• Controlled non-intervention
• First aid/health assessment
• Health care intervention
• Tactical intervention and manoeuvring
• Interdisciplinary team and any person who has a good rapport with the offender</td></tr>
</table>

<table>
<tr>
<td>

Speaking incoherently

Behaviour

Swaying/staggering/unable to sit straight
Overly animated/crying
Drowsiness/disoriented/unresponsive
Excessive perspiration

Other Situational Factors

Available staff
Level of containment
Self-injurious or suicidal behaviour (or history of)
Offender’s mental state and ability to comprehend direction
Offender’s institutional behaviour
Offender’s characteristics
Location
Presence of weapons
Number of offenders

OMS - Flags, alerts, needs
OSCAR

</td>
<td>
Response to Cues of Distress

Treat all persons who present with Cues of Distress as a medical emergency and call for medical assistance; either institutional Health Services or 9-1-1
Stay calm and help the person remain calm
Try to keep the person conscious, ask them questions to encourage them to keep talking, ask the person to keep their eyes open
Monitor, assess and stay with the person until help arrives
Do not ignore the person’s complaints or calls for help even if the signs and symptoms are not obvious

Reassess

Reassess interventions
Reassess situational factors
Reassess the person
Has the level of risk changed?

</td>
</tr>
<tr>
<td>Risk Evaluation</td>
<td>Debrief, Report & Quality Improvement</td>
</tr>
<tr>
<td>

AIM

Ability: physical and mental capacity and opportunity to carry out a threat
Intent: shows intent to behave or act in a specific manner (verbal/non-verbal)

</td>
<td>

Debrief Process

Assessment/Intervention/Debrief (AID)
Why now
Legal, moral, ethical
Necessary and proportionate

</td>
</tr>
</table>

○ Means: has the means to carry out specific action or behaviour associated with the threat • Need for immediate response? • Reasonable perception • Risk - low, moderate, high ○ Low: no imminent harm ○ Moderate: potential for harm ○ High: imminent severe harm	• Report Writing ○ Most appropriate report(s) ○ Clear, concise, accurate ○ Articulate decisions made

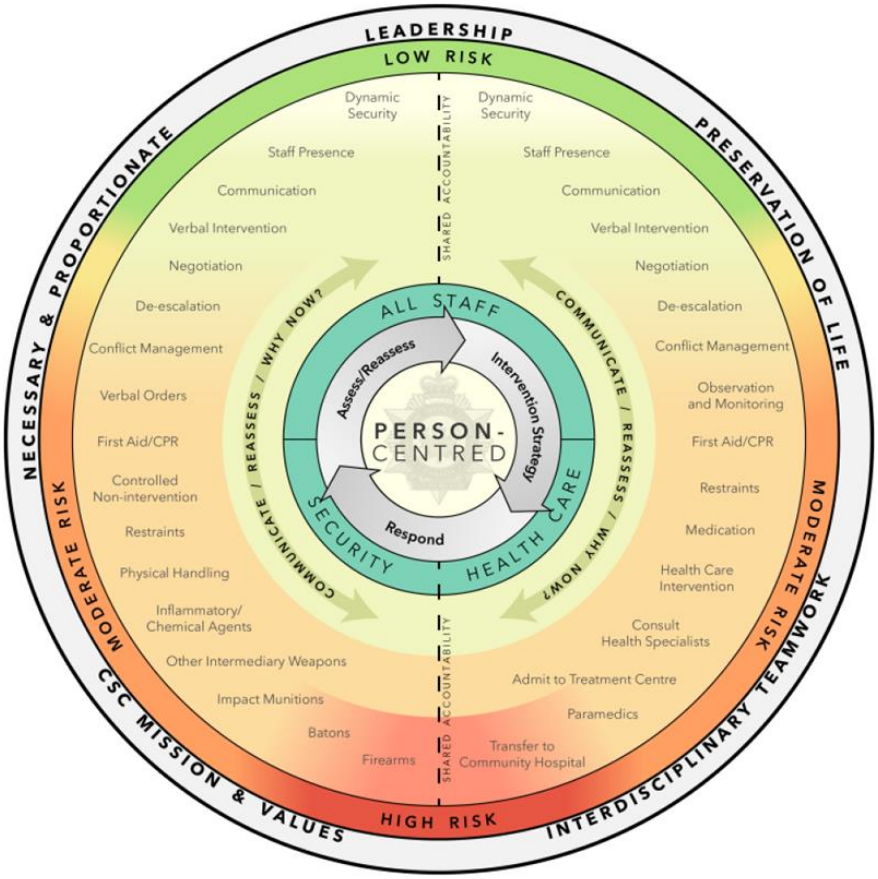
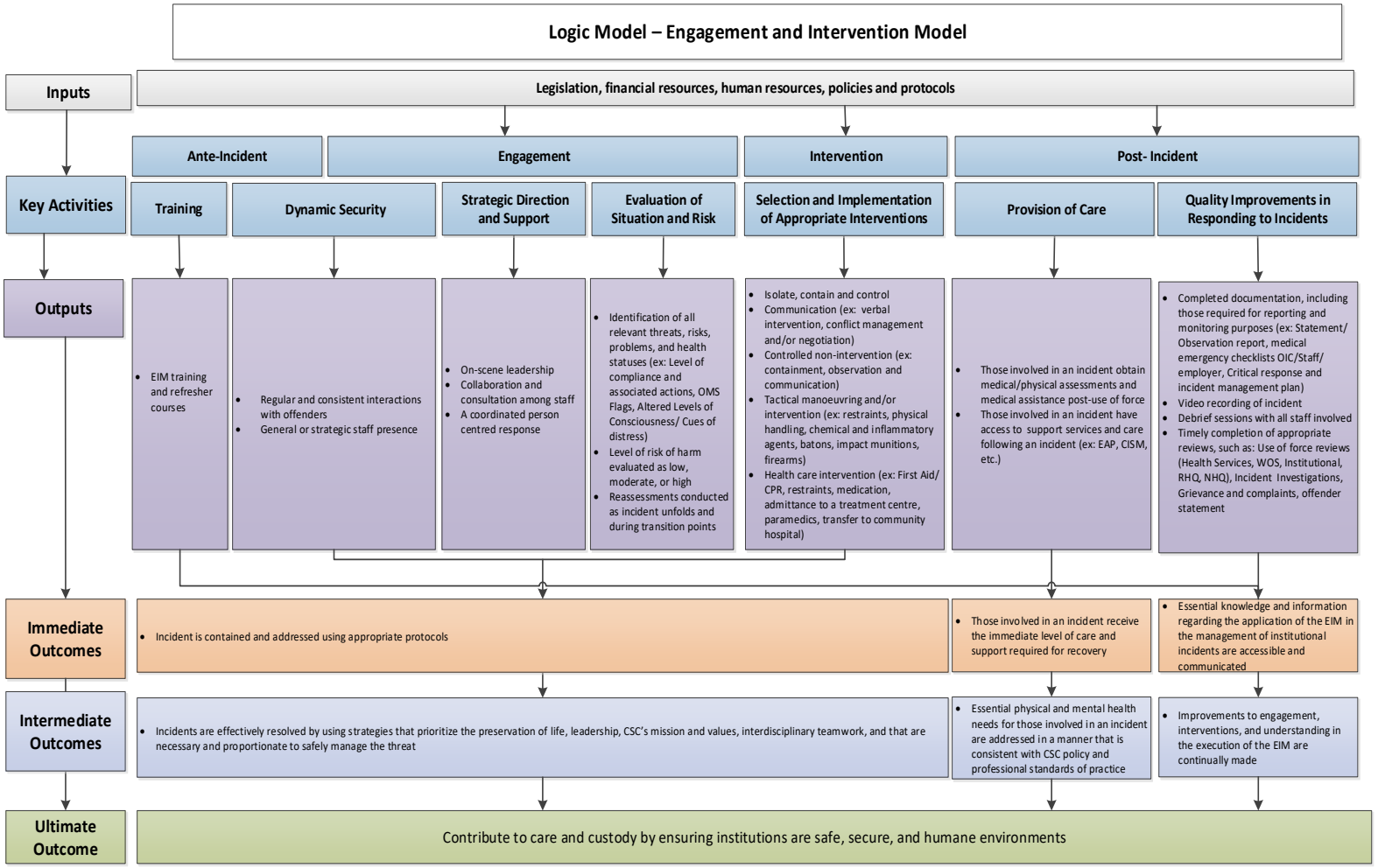


Figure A 1. Engagement and Intervention Model

Appendix B: Engagement and Intervention Logic Model



Appendix C: Design and Delivery Detailed Tables

Table C 1. Training Compliance Rates for the Introduction to the EIM – Online, by Region, as of September 30, 2019

Regions	Number of Competencies Required	Number of Competencies Granted	Compliance %
Pacific Region	2,353	2,238	95.1
Prairie Region	3,979	3,838	96.5
Ontario Region	3,428	3,255	95.0
NHQ	1,287	853	66.3
Quebec Region	3,732	3,428	91.8
Atlantic Region	1,789	1,708	95.5
Total	**16,568**	**15,320**	**92.5**

Note. NHQ = National Headquarters.

Table C 2. Training Compliance Rates for the EIM Scenario Based Training, by Region, as of September 30, 2019

Regions	Number of Competencies Required	Number of Competencies Granted	Compliance %
Pacific Region	1,182	1,079	91.3
Prairie Region	2,041	1,952	95.6
Ontario Region	1,729	1,580	91.4
NHQ[1]	-	-	-
Quebec Region	2,000	1,834	91.7
Atlantic Region	921	855	92.8
Total*	**7,873**	**7,300**	**92.7**

Note. NHQ = National Headquarters. [1]NHQ counts are excluded from the analysis due to the small number of counts associated with this region.

Table C 3. Percent of Incidents Involving a Use of Force for the SMM and EIM Periods

Use of Force Indicators	All Institutions		RTC	
	SMM (*n* = 36,737)	EIM (*n* = 42,097)	SMM (*n* = 4,117)	EIM (*n* = 3,670)
Use of Force	6.5% (2,375)	6.3% (2,646)	11.5% (474)	10.6% (389)
Average Population	14,298	14,072	-	-
Rate of Use of Force per 1,000 Offenders	166.1	188.0	-	-

Note. *** denotes overall significant difference at $p < .001$, ** $p < .01$, * $p < .05$ for % Use of Force. Bold font indicates significant difference where the effect sizes were at least "small."
RTC data for population and rate of Use of Force are not available.

Table C 4. Percent of Use of Force Packages in which Use of Force was deemed Necessary or Proportionate (*EIM Period* April 1st, 2018 to September 30, 2019)

Use of Force Indicators	All Institutions		RTC	
	Institutional Level (*n* = 2,380)	Regional Level (*n* = 1,024)	Institutional Level (*n* = 353)	Regional Level (*n* = 302)
Amount of Force Used was Necessary	94.9% (2,258)	87.2% (893)	95.5% (337)	92.4% (279)
Amount of Force Used was Proportionate	94.4% (2,246)	84.9% (869)	94.3% (333)	89.7% (271)

Table C 5. Percent of Use of Force Packages in which Use of Force was deemed Necessary and Proportionate (*SMM Period* April 1st, 2016 to December 31, 2017)

Use of Force Indicators	All Institutions		RTC	
	Institutional Level (*n* = 2,382)	Regional Level (*n* = 1,184)	Institutional Level (*n* = 477)	Regional Level (*n* = 476)
Amount of Force Used was Necessary and Proportionate	97.1% (2,313)	88.0% (1,042)	99.4% (474)	92.9% (442)

Table C 6. Percent and Rate of Use of Force Incidents Involving an Inmate with a GBA+ Consideration

Sub-population Types	Use of Force	Non-Use of Force	Subgroup *n*	Rate of Use of Force per 1,000 Offenders
Total Population	6.3% (2,646)	93.7% (39,451)	14,072	188.0
No GBA+	4.5% (538)	95.5% (11,344)	-	-
Any GBA+	7.0% (2,108)	93.0% (28,107)	-	-
Indigenous	7.4% (1,311)	92.6% (16,376)	4,050	323.7
Ethnocultural	8.6% (735)	91.4% (7,794)	2,224	330.5
Female	6.9% (266)	93.1% (3,588)	691	384.9
Younger Inmates	9.4% (907)	90.6% (8,700)	1,671	542.8
Older Inmates	4.1% (217)	95.9% (5,049)	3,484	62.3

Note. Use of force in diverse sub-populations of inmates compared to the general inmate population $\chi^2 = 86.82$, $p < .001$, $\varphi = .05$. No other statistical comparisons were made. Due to the possibility of an inmate belonging to multiple diverse sub-populations, incidents will not equal the total number of incidents among the "any GBA+" consideration category. It was not possible to calculate sub-population totals for "Any GBA+" due to a lack of available data, as a result a rate of Use of Force per 1,000 offenders could not be calculated for "No GBA+" and "Any GBA+" categories.

Table C 7. Percent of All Incidents Involving Use of Force by Offender Security Level for the SMM and EIM Periods

Use of Force Indicator	N/A		Minimum		Medium		Maximum	
	SMM (*n* = 3,993)	EIM (*n* = 4,315)	SMM (*n* = 3,323)	EIM (*n* = 3,341)	SMM (*n* = 19,483)	EIM (*n* = 22,717)	SMM (*n* = 9,938)	EIM (*n* = 11,724)
Force Used	1.2% (49)	1.9%* (83)	1.1% (35)	1.1% (36)	4.3% (830)	4.0% (908)	14.7% (1,461)	13.8% (1,619)

Note. *** denotes overall significant difference at $p < .001$, ** $p < .01$, * $p < .05$ between the SMM and EIM each security level. Bold font indicates significant difference where the effect sizes were at least "small." Incidents involved at least one offender with one of the above security levels. N/A indicates that there was no security level recorded for the incident. Security level N/A $\chi^2 = 6.43$, $p < .05$; Phi = .03.

Table C 8. Percent of Use of Force for Assault and Behaviour-Related Incidents for the SMM and EIM Periods

Incident Types	All Institutions		RTC	
	SMM	EIM	SMM	EIM
Assault-related	27.1% (826/3,050)	26.7% (988/3,699)	30.6% (147/481)	35.5% (161/454)
Behaviour-related	11.0% (1,168/10,595)	8.9%*** (1,115/12,570)	11.3% (197/1,737)	8.5%** (122/1,429)

Note. ***$p < .001$, **$p < .01$, *$p < .05$ between the SMM and EIM within each incident type. Cells with $n \leq 5$ are suppressed. Bold font indicates significant difference where the effect sizes were at least "small." Notably, findings with a negligible effect size may have a significant *p* value associated due to sample size. As such, caution is warranted when interpreting statistically significant findings. All institutions behaviour-related incidents $\chi^2 = 30.02$, $p < .001$; Phi = -.04. RTC behaviour-related incidents $\chi^2 = 6.80$, $p < .01$; Phi = -.05.

Table C 9. Percent of all Use of Force Incidents with the Following Uses of Force for the SMM and EIM Periods

Use of Force Types	All Institutions		RTC	
	SMM (*n* = 2,375)	EIM (*n* = 2,646)	SMM (*n* = 474)	EIM (*n* = 389)
Physical Handling	56.7% (1,347)	57.0% (1,508)	63.5% (301)	67.6% (263)
Discharge I/C Agent	47.6% (1,130)	43.5%** (1,151)	34.4% (163)	28.3% (110)
Restraint	32.3% (767)	28.0%** (742)	28.7% (136)	29.8% (116)

Note. I/C = inflammatory or chemical. ****p* < .001, ***p* < .01, **p* < .05 between the SMM and EIM within each institution type. Cells with *n* ≤ 5 are suppressed. Bold font indicates significant difference where the effect sizes were at least "small." Notably, findings with a negligible effect size may have a significant *p* value associated due to sample size. As such, caution is warranted when interpreting statistically significant findings. More than one type of force can be used, column totals do not equal 100%. All I/C Agent Discharged $\chi^2 = 8.40$, $p < .01$; Phi = -.04. All Restraint $\chi^2 = 10.77$, $p < .01$; Phi = -.05.

Table C 10. Offender Injury in Use of Force Incidents for the SMM and EIM Periods

Use of Force Indicator	All Institutions		RTC	
	SMM (*n* = 2,375)	EIM (*n* = 2,646)	SMM (*n* = 474)	EIM (*n* = 389)
Offender Injury from Use of Force	7.2% (172)	3.2%*** (85)	2.5% (12)	-

Note. ****p* < .001, ***p* < .01, **p* < .05 between the SMM and EIM within each institution type. Cells with *n* ≤ 5 are suppressed. Comparisons consisting of cells with *n* ≤ 5 are not tested for statistical significance. Bold font indicates significant difference where the effect sizes were at least "small." All Offender Injury χ^2= 41.85, *p* < .001; Phi = -.09. Staff Injuries were excluded due to low frequency reported.

Table C 11. Percent and Rate of Use of Force Incidents Resulting in an Injury among Diverse Sub-Populations of Inmates

Sub-population Types	Injury[1]	Non-Injury	Subgroup *n*	Rate of Use of Force Injury per 1,000 Offenders
Total Population	3.2% (85)	96.8% (2,561)	14,072	6.0
No GBA+	5.4% (29)	94.6% (509)	-	-
Any GBA+	2.7% (56)	97.3% (2,052)	-	-
Indigenous	2.0% (26)	98.0% (1,285)	4,050	6.4
Ethnocultural	2.9% (21)	97.1% (714)	2,224	9.4
Female	-	98.5% (285)	691	-
Younger Inmates	2.5% (23)	97.5% (884)	1,671	13.8
Older Inmates	5.1% (11)	94.9% (206)	3,484	3.2

Note. [1] There were 2 Use of Force injuries that were reported in incidents that did not use force. These were excluded from the analysis. Use of force resulting in Injury in GBA+ population compared to non-GBA+ population $\chi^2 = 10.30$, $p < .01$, $\varphi = -.06$. Due to the possibility of an offender belonging to multiple GBA+ sub-population groupings, GBA+ sub-population incidents will not total the total number of incidents among the "any GBA+" consideration category. It was not possible to calculate sub-population totals for "Any GBA+" due to a lack of available data, as a result a rate of injuries per 1,000 offenders could not be calculated for "No GBA+" and "Any GBA+" categories. Numbers and rates for injury resulting from use of force in females were excluded/suppressed due to low frequency.

Table C 12. **Percent of Planned and Spontaneous Use of Force Packages for the SMM and EIM Periods**

Spontaneity of Force	All		RTC	
	SMM (*n* = 2,382)	EIM (*n* = 2,721)	SMM (*n* = 477)	EIM (*n* = 412)
Spontaneous	90.6% (2,157)	87.1%*** (2,371)	82.8% (395)	79.6% (328)
Planned	10.6% (252)	14.3%*** (389)	19.1% (91)	21.8% (90)

Note. ***$p < .001$, **$p < .01$, *$p < .05$ between the SMM and EIM within each institution type. Cells with $n \leq 5$ are suppressed. Bold font indicates significant difference where the effect sizes were at least "small." Notably, findings with a negligible effect size may have a significant *p* value associated due to sample size. As such, caution is warranted when interpreting statistically significant findings. All Spontaneous $\chi^2 = 14.83$, $p < .001$; Phi = -.05. All Planned $\chi^2 = 15.98$, $p < .001$; Phi = -.06. Use of Force review packages may contain multiple incident events with both spontaneous and planned uses of force.

Table C 13. (Type of) Force Occurring during Self-Injurious Behaviour Related Incidents for the SMM and EIM Periods

Use of Force Indicators	All Institutions		RTC	
	SMM (*n* = 2,232)	EIM (*n* = 2,889)	SMM (*n* = 983)	EIM (*n* = 831)
Use of Force	11.6% (260)	11.9% (345)	10.7% (105)	8.8% (73)
I/C Agent Discharged	6.0% (135)	6.3% (181)	4.0% (39)	2.6% (22)

Note. I/C = inflammatory or chemical. ****p* < .001, ***p* < .01, **p* < .05 between the SMM and EIM within each institution type. Cells with *n* ≤ 5 are suppressed. Bold font indicates significant difference where the effect sizes were at least “small.”

Table C 14. Summary of Use of Force Review Package Data for Physical and Mental Health Related Indicators for the SMM and EIM Periods

Physical and Mental Health Indicators	All Institutions		RTC	
	SMM (*n* = 2,382)	EIM (*n* = 2,721)	SMM (*n* = 477)	EIM (*n* = 412)
Use of Force Prompted by Self-Injurious Behaviour	14.7% (350)	16.7% (454)	29.6% (141)	27.0% (111)
Suicide Alert	25.9% (616)	20.4%*** (555)	**59.7% (285)**	**37.4%*** (154)**
Occupies Mental Health Bed	23.8% (566)	21.0% (572)***	96.6% (461)	98.5% (406)
Medical Treatment	2.9% (68)	2.4% (64)	10.3% (49)	10.2% (42)

Note. ***$p < .001$, **$p < .01$, *$p < .05$ between the SMM and EIM within each institution type. Cells with $n \leq 5$ are suppressed. There were 9 packages where we did not have the offender security level information available to determine the institution type. Bold font indicates significant difference where the effect sizes were at least "small." All Suicide Alert $\chi^2 = 21.14$, $p < .001$; Phi = -.07. All Mental Health Bed $\chi^2 = 5.50$, $p < .001$; Phi = -.03. RTC Suicide Alert $\chi^2 = 44.25$, $p < .001$; Phi = -.22.

Table C 15. Percent of Total Incidents during which First Aid was Required for the SMM and EIM Periods

First Aid-Related Indicators	All Institutions		RTC	
	SMM (*n* = 36,737)	EIM (*n* = 42,097)	SMM (*n* = 4,117)	EIM (*n* = 3,670)
First Aid Required	6.6% (2,428)	5.4%*** (2,286)	5.5% (228)	2.9%*** (105)
Among required, First Aid Provided	98.3% (2,386)	98.6% (2,255)	96.9% (221)	100% (105)

Note. ***p < .001, **p < .01, *p < .05 between the SMM and EIM within each institution type. Cells with $n \leq 5$ are suppressed. Bold font indicates significant difference where the effect sizes were at least "small." All First Aid Required $\chi^2 = 48.49$, $p < .001$; Phi = -.03. RTC First Aid Required $\chi^2 = 33.97$, $p < .001$; Phi = -.07. No criteria were available about who required first aid during the use of force event, it could be an offender, a staff member, a visitor, etc.

Table C 16. Summary of Appropriate Response Protocols during Planned or Spontaneous Uses

Response Protocols	All Institutions		RTC	
	SMM	EIM	SMM	EIM
Health Guidelines Met	**71.8% (1,711)**	**61.0% (1,655)*****	**68.6% (327)**	**54.0% (222)*****
Health Services was Consulted Before Planned Use of Force	**43.5%** (73)**	**29.6% (86)**	87.7% (50)	90.0% (45)
If SMEAC was used, Health Services was Consulted before Planned Use of Force	46.5% (133)	41.0% (161)	76.9% (30)	55.9% (19)
Health Services Briefed After Spontaneous Use of Force	88.4%* (1,854)	86.3% (2,014)	91.9% (361)	89.5% (298)

Note. ****p* < .001, ***p* < .01, **p* < .05 between the SMM and EIM within each institution type. Cells with $n \leq 5$ are suppressed. Bold font indicates significant difference where the effect sizes were at least "small." Denominator is not the same across all columns as there are different requirements and guidelines for different types of interventions. Based on use of force package data in which health services/institutional reviews had been completed. All Health Guidelines Met $\chi^2 = 65.78$, $p < .001$; Phi = -.11. RTC Health Guidelines Met $\chi^2 = 19.77$, $p < .001$; Phi = -.15. All Health Services Consulted Before Planned Use of Force $\chi^2 = 9.09$, $p < .01$; Phi = -.14. All Health Services Briefed After Spontaneous Use of Force $\chi^2 = 4.31$, $p < .05$; Phi = -.03.

Table C 17. Percent of Use of Force Packages Where a Chemical or Inflammatory Agent is Deployed with Follow-Up Procedures for the SMM and EIM Periods

Indicators Related to Deployment of Chemical or Inflammatory Agent	All Institutions		RTC	
	SMM (*n* = 2,382)	EIM (*n* = 2,721)	SMM (*n* = 477)	EIM (*n* = 412)
Decontamination Shower	41.4% (986)	37.6%** (1,023)	26.8% (128)	24.5% (101)
Change of Clothes	42.2% (1,005)	36.6%*** (996)	28.7% (137)	22.1%* (91)
Decontamination Shower - Unintentionally Exposed	9.4% (224)	8.7% (237)	1.7% (8)	1.7% (7)
Opportunity to See a Healthcare Practitioner - Unintentionally Exposed	9.1% (216)	8.7% (238)	1.9% (9)	1.9% (8)

Note. ***$p < .001$, **$p < .01$, *$p < .05$ between the SMM and EIM within each institution type. Cells with $n \leq 5$ are suppressed. Bold font indicates significant difference where the effect sizes were at least "small." Reasons for data not being 'Yes' could be was not offered, was refused, was not applicable, etc. All Decontamination Shower $\chi^2 = 7.67$, $p < .01$; Phi = -.04. All Change of Clothes $\chi^2 = 16.63$, $p < .001$; Phi = -.06. RTC Change of Clothes $\chi^2 = 5.10$, $p < .05$; Phi = -.08.

Table C 18. Percent of Use of Force Packages in Which At Least One Staff or Inmate is Offered Health/Physical Assessments Post Use of Force for the SMM and EIM Periods

Health Assessment Types	All Institutions		RTC	
	SMM (*n* = 2,382)	EIM (*n* = 2,721)	SMM (*n* = 477)	EIM (*n* = 412)
Inmate Offered Initial Health Services Examination	89.8% (2,138)	87.7%* (2,386)	**96.2% (459)**	**86.2%*** (355)**
Staff Offered Physical Assessment	**91.1% (438)**	**73.0%*** (227)**	84.4% (27)	87.0% (20)

Note. ****p* < .001, ***p* < .01, **p* < .05 between the SMM and EIM within each institution type. Cells with *n* ≤ 5 are suppressed. Bold font indicates significant difference where the effect sizes were at least "small." All Inmate Offered Health Service Examination $\chi^2 = 5.40$, $p < .05$; Phi = -.03. All Staff Offered Physical Assessment $\chi^2 = 45.81$, $p < .001$; Phi = -.24. RTC Inmate Offered Health Service Examination $\chi^2 = 28.97$, $p < .001$; Phi = -.18. There were 4,301 overall packages and 833 RTC packages where the staff assessment was deemed N/A, these and 10 missing (1 in RTC) were removed from the analysis.

Table C 19. Percent of Use of Force Packages in which there was Incomplete Documentation for the SMM and EIM Periods

Types of Incomplete Documentation	All Institutions		RTC	
	SMM (*n* = 2,382)	EIM (*n* = 2,721)	SMM (*n* = 477)	EIM (*n* = 412)
Offender Offered 2 Options for Reporting Their Version of Events	90.6% (2,157)	85.3%*** (2,321)	**96.9% (462)**	**85.4%*** (352)**
Forms Not Completed Appropriately	7.7% (184)	9.1% (247)	15.3% (73)	14.3% (59)
Video Recording Issues Present	13.1% (313)	9.6%*** (260)	**16.8% (80)**	**7.8%*** (32)**

Note. ***p < .001, **p < .01, *p < .05 between the SMM and EIM within each institution type. Cells with $n \leq 5$ are suppressed. Bold font indicates significant difference where the effect sizes were at least "small." All Offender Offered 2 Options χ^2= 32.63, p < .001; Phi = -.08. All Any Video Issues χ^2 = 16.38, p < .001; Phi = -.06. RTC Offender Offered 2 Options χ^2 = 37.31, p < .001; Phi = -.21. RTC Any Video Issues χ^2 = 16.28, p < .001; Phi = -.14.

Table C 20. Percent of Use of Force Package Reviews Not Met Within the Timeframe

Review Types	All Institutions		RTC	
	SMM	EIM	SMM	EIM
Institutional Review	65.6% (1,562)	68.8%* (1,843)	**81.6%** **(389)**	**66.2%***** **(270)**
Regional Review	**46.2%** **(810)**	**60.7%***** **(572)**	**58.7%** **(277)**	**84.1%** **(175)*****
National Review	88.3% (1,341)	87.9% (601)	87.6% (353)	88.3% (136)

Note. ****p* < .001, ***p* < .01, **p* < .05 between the SMM and EIM within each institution type. Cells with $n \leq 5$ are suppressed. Bold font indicates significant difference where the effect sizes were at least "small." All Institutional Review $\chi^2 = 6.13$, $p < .05$; Phi = .04. All Regional Review $\chi^2 = 52.07$, $p < .001$; Phi = .14. RTC Institutional Review, $\chi^2 = 27.34$, $p < .001$; Phi = -.18. RTC Regional Review $\chi^2 = 41.95$, $p < .001$; Phi = .25. If there was no bring forward (BF) date present for the review level or no locked date, the use of force package was excluded from analysis, as overdue was calculated per level by subtracting the review first locked date from the BF data. When a BF date was present, there were 44 lock dates missing at the institutional level, 8 at the regional level. Additionally, not all use of force are sent for review at NHQ. In some cases, reviews are reported to be first locked on an earlier date than they are reported as received at the review level.

Table C 21. Percent of Use of Force Packages in which there was Violation of Law Flag at the Institutional Review Level for the SMM and EIM Periods

Violation of Law Indicators	All Institutions		RTC	
	SMM (*n* = 2,382)	EIM (*n* = 2,721)	SMM (*n* = 477)	EIM (*n* = 412)
Violation of Law Flag at Institutional Review Level	**78.8% (1,877)**	**93.3%*** (2,540)**	**60.2% (287)**	**86.7%*** (357)**

Note. ****p* < .001, ***p* < .01, **p* < .05 between the SMM and EIM within each institution type. Cells with *n* ≤ 5 are suppressed. Bold font indicates significant difference where the effect sizes were at least "small." All Violation of Law $\chi^2 = 231.04$, $p < .001$; Phi = .21. RTC Violation of Law Flag $\chi^2 = 77.66$, $p < .001$; Phi = .30.

Table C 22. Percent of Disciplinary Measures Actioned against Staff for Excessive Use of Force

Disciplinary Measures	SMM (*n* = 27)	EIM (*n* = 34)
Oral Reprimand	29.6% (8)	32.4% (11)
Written Reprimand	44.4% (12)	32.4% (11)
Suspension Without Pay	7.4% (2)	11.8% (4)
Financial Penalty	14.8% (4)	17.7% (6)
Termination	0.0% (0)	5.9% (2)
Other	3.7% (1)	0.0% (0)

Appendix D: Evaluation Questions and Matrix

Key Issues	Evaluation Questions	Performance Indicators	Data Sources
Core Objective #1: Relevance- *The extent to which a program addresses a demonstrable need, is appropriate to the federal government, and is responsive to the needs of Canadians.*			
Issue 1: Current need for Engagement and Intervention Model	*What is the current context under which the EIM is operating and what are the emerging issues?* *Does the EIM address a demonstrable need within federal corrections?*	• Evidence from research or reports that demonstrate the advantages of the Engagement and Intervention Model over the Situational Management Model <u>Inmate Population Characteristics:</u> • #/% of diverse inmate population • #/% of inmates with STG Affiliation • #/% of inmates with an identified physical and mental health need per 1,000 inmates in federal custody • #/% of inmates with altered level of consciousness	• CSC: OCI Reports, OCI investigations, previous evaluations, CDs, DP, DRR, internal audits, and inmate profile, Security Branch Reports, • Review of Government reports external to CSC and literature review • Performance Direct • CRS-M • CCRA • CCRR
Issue 2: Alignment with Government priorities	*How do the EIM objectives align with Government priorities?*	• Evidence that the key activities or outcomes of the EIM are aligned with government priorities	• Mandate Letters • CSC responses to OCI Annual reports • Criminal Code of Canada • CCRA • CSC Corporate Priorities • CDs • Corporate Documents (DP, DPR) • CCC • ICCPR

Key Issues	Evaluation Questions	Performance Indicators	Data Sources
Issue 3: Alignment with CSC roles and responsibilities	*How do the EIM objectives align with CSC roles and responsibilities?*	• Evidence that the key activities or outcomes of the EIM are aligned with CSC roles and responsibilities	• CSC: CSC vision, mission and priorities, DRR, DP, CDs, previous evaluations, internal audits • Security Branch and Health Services Branch objectives
Core Objective #2: Performance- *The extent to which effectiveness, efficiency, Design and Delivery, and GBA+ are achieved by a program*			
	Core Objective 2a: Effectiveness: *Management of institutional incidents*		
Issue 4: Achievement of key objectives	*To what extent are the goals and objectives of the EIM being implemented/administered in a way that address the issues identified from the SMM?*	• The extent to which the key activities that have been emphasized as a result of the issues identified under the SMM are being implemented under the EIM - Interdisciplinary Team Work - Assessment of Risk - Response options	• Key Informant Interviews • Staff Questionnaire
	Are there any barriers to quality improvements in the way that the EIM is currently functioning?	• The extent to which quality improvement activities under the EIM are being implemented - Debrief sessions - Use of force reviews - Disciplinary measures and Corrective actions - New roles and responsibilities for Management under the EIM - Documentation - Post–incident provision of care	• Use of Force Module (OMS Data) • Key Informant Interviews • Staff Questionnaire
	Are there any barriers or challenges to the effective implementation of the EIM when responding to incidents?	• The extent to which there are barriers or challenges to the effective implementation of the EIM when responding to incidents - Model philosophy - Implementation - Institutional Culture • The extent to which the EIM assists staff in managing incidents in the SIU - Staff perceptions on the effects of SIU implementation on the EIM	• Key Informant Interviews • Staff Questionnaire

Key Issues	Evaluation Questions	Performance Indicators	Data Sources
	Core Objective 2b: Design and Delivery: *Aligning EIM implementation /administration with identified outcomes*		
Issue 5: Design and Delivery	*Is the EIM being delivered in a manner that is in line with identified best practices?*	• The extent to which EIM delivery aligns with identified best practices - % of employees who have completed mandatory EIM training prior to the implementation of the EIM	• Key Informant Interviews • HRMS
	Has there been a decrease in the use of physical interventions and/or an increase in the use of de-escalation strategies when institutional incidents managed under the EIM are compared to the SMM?	• The extent to which the EIM results in a lower rate or decline in the #/% of physical interventions (Overall and at RTCs) *Overall Physical Intervention:* - decrease of use of force for all incidents (SMM/EIM) - decrease of use of force among behaviour-related incidents (SMM/EIM) *Type of Physical Intervention:* - % of use of force incidents with using physical handling (SMM/EIM) - % of use of force incidents with using non-routine restraint use (SMM/EIM) - % of use of force incidents with the use of chemical/ inflammatory agents (SMM/EIM) *Severity of Force:* - % of use of force incidents resulting in inmate injury *De-escalation:* - increase in the use of de-escalation strategies (SMM/EIM)	• Use of Force Module (OMS Data) • Key Informant Interviews • Staff Questionnaire
	Has there been an increase in the use of appropriate response protocols for institutional incidents involving physical or mental health distress when those managed under the EIM are compared to the SMM?	• The extent to which the EIM results in an increase in the use of appropriate response protocols for institutional incidents involving physical or mental health distress *Physical distress:* - % of use of force during medical treatment SMM/EIM - % of use of force incidents where first aid was required SMM/EIM *Mental Health:* - % use of force during an incident where inmate occupies a mental health bed SMM/EIM	• Use of Force Module (OMS Data)

Key Issues	Evaluation Questions	Performance Indicators	Data Sources
		- % of self injurious behaviour incidents resulting in use of force SMM/EIM - % of self injurious behaviour incidents resulting in use of force, where force used was chemical or inflammatory agents SMM/EIM - % of use of force packages where the use of force was deemed to be prompted directly by self injurious behaviour as deemed in use of force review SMM/EIM - % use of force incidents involving an inmate with an active suicide alert SMM/EIM *Appropriate response protocols:* - Increase in use of force incidents where interventions are conducted in accordance with health services guidelines (SMM/EIM) - Increase in of use of force incidents where health services were consulted during the SMEAC (SMM/EIM) - Increase in use of force incidents where health services were consulted during the intervention plan development (SMM/EIM) - Increase in use of force incidents where health services were briefed on the use of force (SMM/EIM)	
	Is there any evidence to suggest that there is a need to decrease the use of physical interventions for incidents involving specific sub-populations of inmates under the EIM?	• % of all incidents involving a use of force event on incident with an instigator with a GBA+ consideration (e.g., Indigenous ancestry, ethnocultural[37] community, women, transgendered, older inmates (50+), younger inmates (younger than 25 and under Federal	• Use of Force Module • Key Informant Interviews • Staff Questionnaire

[37] Based on the Corrections and Conditional Release Report definitions: Asian" includes offenders who are Arab, Arab/West Asian, Asian-East and Southeast, Asian-South, Asian West, Asiatic, Chinese, East Indian, Filipino, Japanese, Korean, South Asian, South East Asian. "Asiatic" includes offenders who are Asian-East and Southeast, Asian-South, Asian West, and Asiatic.

Key Issues	Evaluation Questions	Performance Indicators	Data Sources
		Jurisdiction), mental health, physical disability, cognitive impairment[38], etc.) • % of all incidents involving a use of force event on incident resulting in an injury in an inmate from a diverse sub-population (e.g., Indigenous ancestry, ethnocultural community, women, transgendered, older inmates, younger inmates, mental health, physical disability, cognitive impairment, etc.) • Lessons learned and best practices for dealing with diverse sub-populations of inmates	

"Hispanic" includes offenders who are Hispanic and Latin American. "Black" includes offenders who are black. "Other/Unknown" includes offenders who are European French, European-Eastern, European-Northern, European-Southern, European-Western, Multiracial/Ethnic, Oceania, British Isles, Caribbean, Sub-Sahara African, offenders unable to identify to one race, other and unknown

[38] Mental health – existence of 2 flags in OMS (Serious Mental Illness/Impairment and Mental Health Concern).

Physical disability – existence of 2 flags in OMS (Significant mobile impairment and Disability).

Cognitive impairment – existence of a flag in OMS (Cognitive impairment).

Appendix E: Evaluation Strategy/Methodology

A combination of qualitative and quantitative data collection methods and primary and secondary sources of information were used to address the evaluation questions regarding the EIM.

Literature and Document Review

An examination of peer-reviewed literature, grey literature, and internal documents such as CSC policies, legislation, evaluation reports, research reports, operational documents, and other relevant sources of information (national and international) was conducted to respond to questions related to the relevancy of the EIM. For instance, using a web search engine, the following search terms were utilized to find relevant documents: relationship between offender security threat group affiliation and institutional violence/incidents, scholarly work on mental and physical health of prison inmates, Prime Minister of Canada's 2019 Mandate Letter, international laws on humane treatment of inmate, among others.

Offender Management System (OMS) Data

Data extracted from the Offender Management System (OMS), an electronic filing system of offender-related data, were used in order to respond to evaluation questions related to the effectiveness, and design and delivery of the EIM, as well as considerations of diverse sub-populations under the model. For both institutional incidents and use of force review package data, the following categorization of federal institutions are used when referring to overall institutions and RTCs (Table E 1). RTCs were examined separately as CSC made a commitment to the OCI that this evaluation would provide information on achievements against expected results including those at RTCs.[lxv]

Table E 1. Institutional Labels used for OMS Data

Institution Labels	Definitions used in this Evaluation
All Institutions	Includes all maximum, medium, and minimum institutions, all women's institutions and all RTCs, as well as any other incidents occurring at any CSC institution during the specified periods.
Regional Treatment Centres (RTCs)[39]	Incidents that occurred in the following RTC institutions: Shepody Healing Centre, Millhaven Regional Treatment Centre, Bath Institution Regional Treatment Centre, Regional Treatment Centre (Pacific), Regional Psychiatric Centre (Prairie).

[39] It was not possible to distinguish RTC Archambault from other institutions at Archambault using data extracted from OMS, however they are all included in the "Overall" data.

- **Institutional incidents data**: These data were extracted from the Offender Management System (OMS) and analyzed using IBM SPSS Statistics Software (SPSS) version 25. All incidents[40] that occurred between April 1, 2016, and September 30, 2019, in a federal institution or a healing lodge were extracted on October 13, 2019. This extraction resulted in 36,737 unique incidents during the SMM period and 42,097 unique incidents during the EIM period.[41] Where feasible, different sub-populations of inmates were considered throughout the report adding a GBA+ lens to the analysis. In order to conduct the rate of use of force per sub-population of inmates, monthly population data was extracted for each in April 2020, and averaged over the SMM and EIM periods, respectively. Table E 2 below shows each diverse sub-population category[42] and definition.

Table E 2. Diverse Sub-populations and Definitions

Category	Definitions used in this Evaluation
Indigenous	The value of this field is set to yes if one of the offenders involved in the incident event had one of the following race indicated in OMS: Inuit, Metis or North American Indian.
Ethnocultural	The value of this field is set to yes if one of the offenders involved in the incident event had one of the following race indicated in the OMS: Arab/West, Asiatic, East Indian, Chinese, Filipino, Japanese, Korean, South Asian, South East.Asian, Arab, Asian-East/South East, Asian-South, Asian-West, Hispanic, Latin American, Black, Other, Unknown, Sub-Sahara, British Isles, Caribbean, Eastern European, Northern European, Southern European, Western European, European French, Multiracial/Ethnic, Oceania, Unable to Specify.
Female	The value of this field is set to yes if one of the offenders involved in the incident event had female indicated in OMS as their sex.
Older	The value of this field is set to yes if one of the offenders involved in the incident event was 50 years old or older.
Younger	The value of this field is set to yes if one of the offenders involved in the incident event was 25 years old or younger.
Any GBA+ Criteria	The value of this field is set to yes if any of the offenders involved in the incident met any of the GBA+ criteria.

- **Use of Force Review Package Indicators:** These indicators were extracted from the Use of Force Review Module in OMS in two parts: The first extraction took place on October 13, 2019, and the second extraction took

[40] An incident can comprise multiple incident events. If this was the case, the most serious incident event was retained as the incident in order to analyze unique incidents.

[41] Statistical analyses were conducted on unique incidents rather than incident events to avoid dependencies in the data.

[42] Data on mental health, physical disability or cognitive impairments was not included in the GBA+ analysis as the reliability of these data in OMS incident reporting could not be verified.

place on April 12, 2020, resulting in 2,382 packages during the SMM period and 2,672[43] during the EIM period. Package data were also analyzed using SPSS version 25.

EIM Training Compliance Data

The Learning and Development (L and D) branch of CSC provided training compliance reports from HRMS for EIM specific trainings. Training compliance reports provide the number and/ or percentage of employees who are:

- Compliant (have completed their required National Training Standards (NTS) courses),
- Within time limit, if applicable (have not completed their required NTS courses but are still within the timeframe identified to do so), and
- Outside time limit (have not completed their required NTS courses and have missed the deadline to do so).

In order to report on the number and percentage of staff who were EIM training compliant, compliance rates were examined.

L and D ran compliance reports to ascertain compliance rates for the Introduction to EIM training as of September 30, 2019. For data related to the EIM Scenario Based training, a report was created to ascertain compliance rates as of March 31, 2018. It was necessary to examine these data for this point in time, as training for this course had concluded by this date. Compliance rates were not tracked for the Safety for All - All Staff Briefings course and, as a result, compliance rates could not be reported. These data were used to inform the design and delivery of the EIM. Statistical comparisons were not made with the data as the data provided were in aggregate format.

Statistical Comparison between the SMM and the EIM

Chi-Squares were used to conduct statistical pre-post comparison of aggregated percentages between the SMM and EIM period incident and use of force review module package data included in the Design and Delivery Chapter. By averaging the outcomes over the 21-month period for each model, this analysis provides an easy-to-interpret representation of the outcomes averaged over time, or level effects, for each outcome during the respective time periods. Results were considered statistically significant at $p < .05$, which indicates that we are likely to find the same results or more extreme results 5% of the time or less, if there were truly no differences between model periods. However, statistically significant results can also occur because of a large sample size, and do not always indicate that the differences are practically relevant. Therefore, effect sizes were also reported in order to provide a measure of the magnitude of these changes or differences between model periods. Using the following guidelines for the effect size phi-squared where .1 to .29 = small effect, .3 to .49 = medium effect and ≥ .5 = large effect[44], considering the effect sizes alongside the statistical significance aid in interpreting and making judgements about the meaningfulness of findings.

[43] Two packages from the EIM period were excluded from the analysis as they were at the incident event level, and therefore created dependencies in the data.

[44] These are equivalent to Cohen's (1988) rules of thumb for r. Cohen, J., Statistical Power Analyses for the Behavioural Sciences (Vol. 2). Hillsdale, NJ: Lawrence Earlbaum Associates.

Data on Disciplinary Actions for Excessive Use of Force

HRMS also provided data on disciplinary actions taken for excessive use of force by staff which was used to inform the EIM's effectiveness in reducing excessive use of force by staff. These data were provided for two time periods - between April 1, 2016, and December 31, 2017 (SMM), and between January 1, 2018, and September 30, 2019 (EIM). For the same two time periods, the number of excessive use of force incidents by disciplinary action was analyzed.

Key Informant Interviews

Key informants who are directly or indirectly involved in, or familiar with, the EIM were interviewed (e.g., Project Officers, Chiefs of Mental Health, Assistant Wardens of Operations, etc.) to provide information on the design and delivery, effectiveness, efficiency, and considerations for the diverse sub-populations of inmates in the functioning of the EIM. A combination of snowball and purposive sampling was used to acquire a sample of key informants. The interview guides included approximately 20 open-ended questions. Interviewees provided informed consent to the interviewer to conduct the interview and for the interviews to be recorded using a tape recorder. The interviews were transcribed manually. Three Evaluation team members conducted a preliminary review of the interviews and read a subset of three interviews to identify common themes related to the evaluation questions. Then, each team member was assigned a set of evaluation questions and associated themes. They read the transcripts in order to identify all text excerpts that related to those themes. Team members reviewed each other's coding, and any disagreements were resolved through discussion. When describing the findings, the following terms were used to refer to the number of interviewees: a few/a small number of interviewees (*n* = 1-3), some interviewees (*n* = 4-6), about half of interviewees (*n* = 7-8), many interviewees (*n* = 9-11), and most interviewees (*n* = 12-14).

In all, 15 key informants were individually interviewed between August 20, 2020, and September 11, 2020. Participants were from the following sectors: Security Operations, Preventive Security and Intelligence, Health Services, Women Offender Sector, Indigenous Initiatives Directorate, Performance Measurement and Management Reporting, Incident Investigations Branch, and Learning and Development. There was representation from four regions (i.e., Pacific, Ontario, Quebec, and Atlantic) and NHQ. The interviews ranged from eight minutes to one hour, with an average duration of 40 minutes. Thirteen interviews were conducted in English and two were in French.

Electronic Survey Completed by Staff

Data from questionnaires (staff surveys) were included to answer questions regarding the design and delivery, effectiveness, and considerations for the diverse sub-populations of inmates of the EIM. The survey was designed to collect the perspectives of staff who were directly or indirectly involved with the EIM. The questions focused on the following themes in relation to the EIM: the institutional culture, EIM philosophy, implementation of the EIM, interdisciplinary teamwork, assessment of risk, response options, and communication, guidance and support of the model. GBA+ and the impact of the application of the EIM in SIUs were also considered. The Evaluation team, in collaboration with the Consultative Working Group, designed the survey. Microsoft FORMS Survey software was used to create the survey, which included open and closed-ended questions. Respondents were routed to specific

questions depending on their position and experience with delivering both the Situational Management Model (SMM) at least within 6 months prior to the introduction of the EIM (June 30, 2017) and from the introduction of the EIM to the date of survey completion (i.e., January 1, 2018-present).

A stratified random sample was used to extract participants from the HRMS in order to ensure equal and fair representation in the overall sample. This approach ensured that those who were invited to complete the survey were from the following job positions/classifications working within an institutional setting:

- Executive Group (e.g., Institutional Heads)
- Administrative Services (e.g., Assistant Warden, Security Intelligence Officer, etc.),
- Correctional Services (e.g., Correctional Officer, Correctional Staff Training Officer, etc.),
- Medicine (e.g., Chief of Health Services, Psychiatric Services, etc.),
- Nursing (e.g., Nurse, Regional Health Services Release Planner, etc.),
- Psychology (e.g., Psychologist, Mental Health Clinician, etc.),
- Social Work (e.g., Social Worker, etc.),
- Welfare Programs (e.g., Indigenous Liaison Officer, Parole Officer, Behavioural Counsellor, etc.), and
- Contractor (e.g., Chaplain, Elder, etc.).

An invitation to complete the survey was distributed by email on November 30, 2020, to potential staff participants in English and French. The survey was available online until December 31, 2020.

Invitations were originally sent to 2,000 staff members, although 43 people could not be reached and alternate contact information could not be located. A total of 1,957 staff were sent the survey invitation by email.

Staff Survey Analysis

A total of 239 individuals completed the staff survey (of the 1,957 who are assumed to have received the survey), thus 12.2% of those who were sent information about the evaluation completed the survey. Data from two respondents were excluded due to missing data or *I don't know* responses that were provided throughout the entire survey. As such, the responses for 237 participants were analyzed. Descriptive analyses (frequencies and percentages) were reported. Notably, any responses that were missing or that had responses of *I don't know* were excluded from analyses (frequency counts and percentages). This resulted in the total number of responses changing across the items. Additionally, given that the majority of staff survey items were rated on a 5-point Likert scale, reported responses were aggregated. For example, some items were rated from *Strongly Disagree* to *Strongly Agree* (see Appendix F for survey items and response options). As such, responses of *Somewhat Agree* or *Strongly Agree* were aggregated. Similarly, responses of *Strongly Disagree* and *Somewhat Disagree* were aggregated for reporting purposes. Finally, although overall responses were reported throughout, where possible, RTC staff responses were also examined and reported separately.

Staff Survey Sample Descriptives

There was representation from each of the five regions, with just under a third of respondents currently working in the

Prairie region (31.6%, *n* = 75), 22.8% from the Quebec region (*n* = 54), 21.5% from the Pacific region (*n* = 51), 15.2% from the Ontario region (*n* = 36), and the smallest proportion came from the Atlantic region (8.0%, *n* = 19). Most staff completed the survey in English (78.1%, *n* = 185).

Most respondents currently work at men's institutions (78.9%, *n* = 187). In contrast, 12.2% (*n* = 29) currently work at a women's institution, and very few respondents currently work at a RTC (5.9%, *n* = 14). Of those who work in men's institutions, 28.9% (*n* = 54) are from a maximum security institution, 34.8% (*n* = 65) are from a medium security institution, 8.0% (*n* = 15) are from a minimum security institution, and 27.3% (*n* = 51) are from a multilevel security institution. Table E 3 provides a breakdown of the various institution labels and associated definitions.

Table E 3. Institutional Labels used for Staff Survey Data

Institution Labels	Definitions used in this Evaluation
All Institutions	Include all institutions from maximum security, women's institutions and RTCs, as well as any other incidents occurring at any institution during the specified periods. This also includes minimum and medium security institutions.
Regional Treatment Centres (RTCs)	Incidents that occurred in the following institutions: Shepody Healing Centre, Millhaven Regional Treatment Centre, Bath Institution Regional Treatment Centre, Regional Treatment Centre (Pacific), and Regional Psychiatric Centre (Prairie).
Women's Institutions	Incidents that occurred in the following institutions: Nova Institution for Women, Joliette Institution, Grand Valley Institution for Women, Edmonton Institution for Women, Fraser Valley Institution, and Okimaw Ohci Healing Lodge.
Maximum Security	Incidents that involved an offender with a maximum-security level and occurred in the following institutions: Atlantic Institution, Donnacona Institution, Port-Cartier Institution, Special Handling Unit, Collins Bay Institution, Millhaven Institution, Edmonton Institution, Saskatchewan Penitentiary, Stony Mountain Institution, and Kent Institution

In terms of current job classification, just under half of respondents are part of Correctional Services (49.4%, *n* = 117), which primarily included Correctional Officers (67.5%, *n* = 79/117) and Correctional Managers (23.9%, *n* = 28/117). Just under a quarter of the sample are part of Welfare Programs (24.1%, *n* = 57), which primarily included Correctional Program Officers (33.3%, *n* = 19/57) and Parole Officers (31.6%, *n* = 18/57). Respondents currently classified in Administrative Services made up 10.1% of the sample (*n* = 24) and 5.5% were from Nursing Services (*n* = 13).

Of all respondents, 84.8% (*n* = 201) worked at CSC for at least 6 months prior to the implementation of the EIM on January 1, 2018. More specifically, as of the end of 2020, 152 respondents (64.1%) indicated that they have worked at CSC for more than 10 years, and 55 respondents (23.2%) have worked at CSC for over 2 years, but less than 10

years. However, in terms of respondents' current positions, 35.0% (*n* = 83) have occupied that position for more than 10 years, and 32.1% (*n* = 76) have occupied their current position for more than 2 years, but less than 10 years. In terms of training, 78.9% (*n* = 187) have received the EIM training, whereas of those who worked at CSC prior to the implementation of the EIM, 69.5% (*n* = 141) had received SMM training.

Appendix F: Staff Survey and Response Frequencies

Evaluation of Correctional Service Canada's Engagement and Intervention Model Staff Survey

Correctional Service Canada (CSC) is currently conducting an evaluation of the Engagement and Intervention Model (EIM). The objective of this evaluation is to provide stakeholders with an enhanced understanding of the EIM's performance in key areas since its implementation, and to provide CSC with the necessary information to make strategic policy, operations, and resource allocation decisions as they relate to the EIM.

As part of this evaluation, you are being asked to participate in the following staff survey. The survey aims to obtain information regarding your experiences with the EIM from the perspective of your current role. This survey asks about the implementation of the EIM, particular response strategies, communication, guidance, and teamwork, among other topics. The information collected through this survey will be compiled with additional sources of information to support findings and recommendations in the final evaluation report, which will be published on the CSC website when approved.

Your participation in this survey is completely voluntary. Your responses are anonymous and no personal identifying information will be presented.

Completing and submitting this survey implies that you consent to the use of your responses. You may also choose not to answer any question and may withdraw at any time up until the submission of responses.

The survey will take approximately 40 minutes to complete. Please note that this survey cannot be saved and should be completed during one block of time.

We thank you in advance for taking the time to share your views. We value your input.

Section A: Socio-demographic Information

1. In which **region** do you currently work?

***n* (%)**	**Response Options**
19 (8.0%)	Atlantic
54 (22.8%)	Québec
36 (15.2%)	Ontario
75 (31.6%)	Prairie
51 (21.5%)	Pacific
-- (--)	Other/Prefer not to answer

2. Please specify **your current primary work location**:

***n* (%)**	**Response Options**
187 (78.9%)	Men's Institution
29 (12.2%)	Women's Institution
14 (5.9%)	Regional Treatment Centre/Regional Psychiatric Centre
7 (3.0%)	Other /Prefer not to answer

3. [**If Q2 = "Other"**], please specify:

_____
_____

4. What is the **security level** of the institution/sector where you are currently working?

***n* (%)**	**Response Options**
55 (23.2%)	Maximum
65 (27.4%)	Medium
15 (6.3%)	Minimum
95 (40.1%)	Multi-level
7 (3.0%)	Not applicable/ Prefer not to answer

5. Please specify your current **classification:** (If acting, indicate your acting classification)

***n* (%)**	**Response Options**
24 (10.1%)	Administrative Services (AS)
117 (49.4%)	Correctional Services (CX)
5 (2.1%)	Executive Group (EX)
13 (5.5%)	Nursing (NU)
6 (2.5%)	Psychology (PS)
57 (24.1%)	Welfare Programs (WP)
5 (2.1%)	Hospital Services (HS)/ Social Work (SW)
10 (4.2%)	Other (including Contractors, Chaplains, etc.) / Prefer not to answer

6. What is your current **position**? (If acting, indicate your acting level)

Note. *The frequency of responses are too small to report for question six response options*.

Administrative Services	**Correctional Services**
Assistant Warden, Interventions	Correctional Officer I
Assistant Warden, Operations	Correctional Officer II
Deputy Warden	Primary Worker/ Kimisinaw
Deputy Director Healing Lodge, or Treatment Centre	Correctional Manager
Manager, Operations	Security Maintenance Officers
Security Intelligence Officer	Dog Detector Handler/ Search Specialist
Warden, Healing Lodges	Correctional Staff Training Officers
Prefer not to answer	Prefer not to answer
Other, Please Specify:	Other, Please Specify:

Nursing	**Psychology**
Chief, Health Services	Chief, Mental Health Services
Nurse	Mental Health Clinician
Nurse Practitioner	Psychologist
Prefer not to answer	Prefer not to answer
Other, Please Specify:	Other, Please Specify:

Medicine

Chief, Psychiatric Services

Prefer not to answer

Other, Please Specify:

Social Work

Social Worker

Prefer not to answer

Other, Please Specify:

Welfare Programs

Behavioural Counsellor

Behavioural Technologist

Indigenous Correctional Program Officer

Chief, Clinical Interventions

Correctional Program Officer

Employment Coordinator

Indigenous Liaison Officer

Manager, Assessment and Intervention

Manager, Intensive Intervention Strategy

Manager, Programs

Manager, Structured Intervention Unit

Parole Officer

Social Programs Officer

Prefer not to answer

Other, Please Specify:

Contractors

Chaplain

Elder

Prefer not to answer

Other, Please Specify:

Executive Group

Institutional Head/ Warden

Executive Director, Treatment Centre

Prefer not to answer

Other, Please Specify

Hospital Services

Practical Nurse

Client Care Attendant

Prefer not to answer

Other, Please Specify:

7. How long have you **been employed by CSC**?

***n* (%)**	**Response Options**
-- (--)	Less than six months
17 (7.2%)	Six months to two years
25 (10.5%)	More than two years to five years
30 (12.7%)	More than five years to ten years
152 (64.1%)	More than ten years
9 (3.8%)	Prefer not to answer/ Missing

8. How long have you occupied your **current position**?

***n* (%)**	**Response Options**
19 (8.0%)	Less than six months
49 (20.7%)	Six months to two years
44 (18.6%)	More than two years to five years
32 (13.5%)	More than five years to ten years
83 (35.0%)	More than ten years
10 (4.2%)	Prefer not to answer/ Missing

9. Have you received Engagement and Intervention Model (EIM) training?

***n* (%)**	**Response Options**
187 (78.9%)	Yes
17 (7.2%)	No
33 (13.9%)	Unsure/ Missing

10. Did you work at CSC for at least 6 months **prior to January 1, 2018**?

***n* (%)**	**Response Options**
201 (84.8%)	Yes
34 (14.3%)	No
-- (--)	Unsure/ Missing

11. [**If yes to Q10**] Have you received Situation Management Model (SMM) training?

***n* (%)**	**Response Options**
141 (69.5%)	Yes
23 (11.3%)	No
39 (19.2%)	Unsure/ Missing

Section B: Institutional Culture

Institutional culture generally refers to the values, assumptions, and beliefs people hold that drive the way the institution functions and the way people think and behave.

12. Based on **your experience with the EIM in the last 6 months**, please rate your level of agreement with the following statements: (frequencies and percentages are reported below for each response option).

Statements	**Strongly Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Strongly Agree**	**Don't know**
a) The culture at my current institution allows for the EIM to be successfully implemented as designed	25 (10.5%)	51 (21.5%)	42 (17.7%)	66 (27.8%)	30 (12.7%)	23 (9.7%)
b) The EIM has had a positive influence on the culture at my current institution	45 (19.0%)	48 (20.3%)	55 (23.2%)	50 (21.1%)	14 (5.9%)	24 (10.1%)
c) CSC's culture in general is conducive to the successful implementation of the EIM	38 (16.0%)	58 (24.5%)	54 (22.8%)	55 (23.2%)	8 (3.4%)	23 (9.7%)

Note. Missing data made up less than 5 responses for items 12a, b, and c. Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

13. Do you have any additional comments on the institutional culture at CSC or within your institution regarding the implementation of the EIM?

_____
_____

Section C: Model Philosophy

In January 2018, the EIM was implemented for use in the management of institutional incidents. As defined in Commissioner's Directive 567, *Management of Incidents*, the EIM approach is a risk-based, person-centered approach that is used by an interdisciplinary team to respond to and resolve incidents using the most reasonable engagement and intervention strategies.

One of the key philosophies behind the EIM is the consideration of inmates' mental and/ or physical health conditions in the management of incidents. The offender is placed at the centre of the model to represent a person-based approach to engagement and intervention.

14. Based on **your experience with the EIM in the last 6 months**, to what extent do you agree with the following statements?

Statements	Strongly Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Strongly Agree	N/A
a) I take a person-centered approach to engaging with the inmate when responding to an incident	6 (2.5%)	9 (3.8%)	17 (7.2%)	65 (27.4%)	117 (49.4%)	23 (9.7%)
b) I consider the inmate's physical well-being when responding to incidents	-- (--)	-- (--)	17 (7.2%)	50 (21.1%)	142 (59.9%)	23 (9.7%)
c) I consider the inmate's mental well-being when responding to incidents	-- (--)	-- (--)	27 (11.4%)	54 (22.8%)	129 (54.4%)	20 (8.4%)
d) I consider the safety of other personnel when responding to incidents	-- (--)	-- (--)	7 (3.0%)	21 (8.9%)	180 (75.9%)	22 (9.3%)
e) I am able to identify cues of distress or altered levels of consciousness when dealing with inmates	-- (--)	-- (--)	17 (7.2%)	77 (32.5%)	119 (50.2%)	16 (6.8%)
f) I am able to get the help needed to safely manage incidents of mental and physical distress situations when dealing with inmates	11 (4.6%)	27 (11.4%)	24 (10.1%)	78 (32.9%)	80 (33.8%)	15 (6.3%)
g) I am able to continuously re-assess situational factors as the incident unfolds and categorize the level of risk	5 (2.1%)	7 (3.0%)	16 (6.8%)	83 (35.0%)	105 (44.3%)	20 (8.4%)
h) I am able to determine the most appropriate intervention strategy	-- (--)	-- (--)	23 (9.7%)	92 (38.8%)	85 (35.9%)	19 (8.0%)
i) I am able to select appropriate force options when deemed necessary	10 (4.2%)	18 (7.6%)	24 (10.1%)	51 (21.5%)	77 (32.5%)	55 (23.2%)
j) I am able to employ de-escalation strategies when responding to incidents	-- (--)	-- (--)	24 (10.1%)	68 (28.7%)	102 (43.0%)	25 (10.5%)

Note. Missing data made up less than 5 responses for items 14a to 14j. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

Section D: Implementation

The EIM is a risk-based, person-centered approach that is used by an interdisciplinary team to respond to and resolve incidents using the most reasonable engagement and intervention strategies.

15. Based on **your experience with the EIM in the last 6 months**, to what extent do you agree that the EIM:

Statements	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree	Don't know
a) Is intuitive/easy to apply	34 (14.3%)	38 (16.0%)	39 (16.5%)	75 (31.6%)	31 (13.1%)	18 (7.6%)
b) Has an interdisciplinary approach	16 (6.8%)	23 (9.7%)	43 (18.1%)	66 (27.8%)	67 (28.3%)	18 (7.6%)
c) Promotes staff self-awareness	19 (8.0%)	37 (15.6%)	48 (20.3%)	62 (26.2%)	45 (19.0%)	22 (9.3%)
d) Allows for constant situational re-assessment	8 (3.4%)	20 (8.4%)	37 (15.6%)	84 (35.4%)	66 (27.8%)	17 (7.2%)
e) Has clearly defined roles as prescribed by CSC (as per Commissioner's Directive 567)	27 (11.4%)	36 (15.2%)	48 (20.3%)	64 (27.0%)	38 (16.0%)	20 (8.4%)
f) Results in resolving situations with inmates at the most appropriate level of intervention	24 (10.1%)	38 (16.0%)	44 (18.6%)	62 (26.2%)	46 (19.4%)	19 (8.0%)
g) Has resulted in a decrease in use of force	35 (14.8%)	32 (13.5%)	53 (22.4%)	30 (12.7%)	18 (7.6%)	67 (28.3%)
h) Is implemented as intended	27 (11.4%)	30 (12.7%)	53 (22.4%)	53 (22.4%)	25 (10.5%)	47 (19.8%)

Note. Missing data made up 5 or less responses for items 15a to 15h. Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

16. In the last 6 months of EIM implementation, have you worked as the **Sector Coordinator** during an incident?

***n* (%)**	**Response Options**
45 (19.0%)	Yes
179 (75.5%)	No
13 (5.4%)	Unsure/ Missing

17. [**If yes to Q16**] Based on your experience with the EIM in the last 6 months **as a Sector Coordinator**, please indicate how often you…

Statements	Never	Rarely	Sometimes	Often	Always	Don't Know
a) Made yourself easily identifiable	-- (--)	-- (--)	10 (21.3%)	13 (27.7%)	12 (25.5%)	-- (--)
b) Acted as the primary communicator to the Correctional Manager, Operations Desk	-- (--)	-- (--)	7 (14.9%)	20 (42.6%)	13 (27.7%)	-- (--)
c) Sought authorization for an intervention plan when time and circumstances permitted	-- (--)	-- (--)	12 (25.5%)	11 (23.4%)	15 (31.9%)	-- (--)
d) Used ongoing risk assessments to determine the appropriate response option	-- (--)	-- (--)	-- (--)	15 (31.9%)	23 (48.9%)	-- (--)
e) Provided guidance and directions to staff on scene	-- (--)	-- (--)	7 (14.9%)	16 (34.0%)	19 (40.4%)	-- (--)
f) Considered the use of partners such as mental health/healthcare workers, elders, etc., to de-escalate incidents	-- (--)	-- (--)	6 (12.8%)	15 (31.9%)	17 (36.2%)	-- (--)
g) Involved the appropriate partners to de-escalate incidents	-- (--)	5 (10.6%)	-- (--)	16 (34.0%)	16 (34.0%)	-- (--)
h) Ensured that inmates' mental and physical health were considered during interventions	-- (--)	-- (--)	-- (--)	18 (38.3%)	20 (42.6%)	-- (--)
i) Provided direction on the requirement for first aid/CPR	5 (10.6%)	-- (--)	5 (10.6%)	7 (14.9%)	20 (42.6%)	-- (--)
j) Implemented the role appropriately (as per Commissioner's Directive 567)	-- (--)	-- (--)	8 (17.0%)	11 (23.4%)	17 (36.2%)	-- (--)

Note. Missing data made up less than 5 responses for items 17a to 17j. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

18. [**If yes to Q16**], Based on your experience with the EIM in the last 6 months as **a Sector Coordinator**, please indicate to what extent you agree with the following:

Statements	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree	Don't Know
a) It is easy to transition from 1st Officer on the Scene to the role of the Sector Coordinator	11 (23.4%)	8 (17.0%)	8 (17.0%)	11 (23.4%)	-- (--)	-- (--)
b) The Sector Coordinator's roles and responsibilities complement those of the Correctional Manager	9 (19.1%)	5 (10.6%)	10 (21.3%)	15 (31.9%)	-- (--)	-- (--)

Note. Missing data made up less than 5 responses for items 18a and 18b. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

19. [**If no or unsure to Q18**] Based on your experience with the EIM in the last 6 months, please indicate how often the **Sector Coordinator**…

Statements	Never	Rarely	Sometimes	Often	Always	Don't Know
a) Could be easily identified during an incident	17 (8.9%)	21 (10.9%)	28 (14.6%)	28 (14.6%)	11 (5.7%)	81 (42.2%)
b) Acted as the primary communicator to the Correctional Manager, Operations Desk	14 (7.3%)	19 (9.9%)	19 (9.9%)	37 (19.3%)	9 (4.7%)	87 (45.3%)
c) Sought authorization for an intervention plan when time and circumstances permitted	15 (7.8%)	19 (9.9%)	20 (10.4%)	22 (11.5%)	15 (7.8%)	92 (47.9%)
d) Used ongoing risk assessments to determine the appropriate response option	12 (6.3%)	9 (4.7%)	27 (14.1%)	31 (16.1%)	15 (7.8%)	91 (47.4%)
e) Provided guidance and directions to staff on scene	13 (6.8%)	23 (12.0%)	30 (15.6%)	26 (13.5%)	14 (7.3%)	80 (41.7%)
f) Considered the use of partners such as mental health/health care workers, elders, etc., to de-escalate incidents	12 (6.3%)	22 (11.5%)	24 (12.5%)	30 (15.6%)	12 (6.3%)	85 (44.3%)
g) Involved the appropriate partners to de-escalate incidents	13 (6.8%)	13 (6.8%)	33 (17.2%)	31 (16.1%)	12 (6.3%)	81 (42.2%)
h) Ensured that inmates' mental and physical health were considered during interventions	10 (5.2%)	10 (5.2%)	23 (12.0%)	44 (22.9%)	17 (8.9%)	81 (42.2%)
i) Provided direction on the requirement for first aid/CPR	11 (5.7%)	11 (5.7%)	22 (11.5%)	34 (17.7%)	21 (10.9%)	85 (44.3%)
j) Implemented the role appropriately as prescribed by Commissioner's Directive 567	13 (6.8%)	13 (6.8%)	32 (16.7%)	26 (13.5%)	13 (6.8%)	88 (45.8%)

Note. Missing data ranged from 6 to 9 responses for items 19a to 19j. Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

20. In the last 6 months of the EIM, have you worked as the **Correctional Manager, Operations Desk** during an incident?

***n* (%)**	**Response Options**
19 (8.0%)	Yes
212 (89.5%)	No
6 (2.5%)	Unsure/ Missing

21. [**If yes to Q20**] Based on your experience with the EIM in the last 6 months as **a Correctional Manager, Operations Desk**, please indicate to what extent you agree with the following:

Statements	**Strongly Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Strongly Agree**	**Don't Know**
a) Sector Coordinators communicate with me in a timely manner during an incident	-- (--)	-- (--)	-- (--)	15 (65.2%)	-- (--)	-- (--)
b) Sector Coordinators ensure that all relevant information is communicated to me during an incident	-- (--)	-- (--)	-- (--)	11 (47.8%)	-- (--)	-- (--)
c) Sector Coordinators ensure that all information that is communicated to me is accurate during an incident	-- (--)	-- (--)	-- (--)	13 (56.5%)	-- (--)	-- (--)

Note. Missing data comprised less than 5 responses for items 21a, b, and c. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

Section E: Interdisciplinary Team Work

The EIM encourages collaboration between different staff in order to respond appropriately to the situation at hand.

22. In your current position, what is your **primary role** in incident management?

***n* (%)**	**Response Options**
103 (43.5%)	Direct involvement (on-scene)
45 (19.0%)	Indirect involvement (not on-scene, but involved in intervention planning or approval)
28 (11.8%)	Incident oversight only (compiling reports, monitoring trends, etc.).
61 (25.7%)	Unsure/ Missing

23. [**If indirect involvement in Q. 22**], Based on your experience with the EIM in the last 6 months, how often are the following staff or contractors involved in the **planning** of intervention strategies?

Staff/Contractors	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**	**Don't Know**
a) Correctional Managers	-- (--)	-- (--)	5 (10.6%)	14 (29.8%)	22 (46.8%)	-- (--)
b) Correctional Officers/ Primary Workers	-- (--)	-- (--)	6 (12.8%)	18 (38.3%)	16 (34.0%)	-- (--)
c) Sector Coordinators	-- (--)	-- (--)	8 (17.0%)	13 (27.7%)	6 (12.8%)	12 (25.5%)
d) Emergency Response Team	12 (25.5%)	9 (19.1%)	13 (27.7%)	-- (--)	-- (--)	5 (10.6%)
e) Crisis Negotiators	6 (12.8%)	12 (25.5%)	13 (27.7%)	7 (14.9%)	-- (--)	-- (--)
f) Health/Mental Health professionals	-- (--)	-- (--)	10 (21.3%)	16 (34.0%)	9 (19.1%)	-- (--)
g) Elders	7 (14.9%)	9 (19.1%)	13 (27.7%)	8 (17.0%)	-- (--)	-- (--)
h) Chaplains	9 (19.1%)	11 (23.4%)	12 (25.5%)	5 (10.6%)	-- (--)	-- (--)
i) Institutional Parole Officers	5 (10.6%)	8 (17.0%)	10 (21.3%)	13 (27.7%)	8 (17.0%)	-- (--)
j) Institutional Managers	-- (--)	-- (--)	5 (10.6%)	18 (38.3%)	13 (27.7%)	-- (--)
k) Any person who has a good rapport with the inmate	5 (10.6%)	7 (14.9%)	14 (29.8%)	13 (27.7%)	-- (--)	-- (--)
l) Other: please specify	8 (17.0%)	-- (--)	-- (--)	-- (--)	-- (--)	23 (48.9%)

Note. Missing data ranged from 2 to 10 responses for items 23a to 23l. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

24. Based on your experience with the EIM in the last 6 months, how often are the following **staff or contractors involved in the <u>application</u> of intervention strategies?**

Staff/Contractors	Never	Rarely	Sometimes	Often	Always	Don't Know
a) Correctional Managers	-- (--)	-- (--)	22 (9.3%)	83 (35.0%)	65 (27.4%)	48 (20.3%)
b) Correctional Officers/ Primary Workers	-- (--)	-- (--)	16 (6.8%)	58 (24.5%)	108 (45.6%)	46 (19.4%)
c) Sector Coordinators	9 (3.8%)	9 (3.8%)	30 (12.7%)	60 (25.3%)	37 (15.6%)	87 (36.7%)
d) Emergency Response Team	26 (11.0%)	50 (21.1%)	62 (26.2%)	19 (8.0%)	10 (4.2%)	65 (27.4%)
e) Crisis Negotiators	20 (8.4%)	61 (25.7%)	55 (23.2%)	24 (10.1%)	6 (2.5%)	66 (27.8%)
f) Health/Mental Health professionals	6 (2.5%)	26 (11.0%)	55 (23.2%)	64 (27.0%)	33 (13.9%)	48 (20.3%)
g) Elders	30 (12.7%)	49 (20.7%)	59 (24.9%)	29 (12.2%)	7 (3.0%)	58 (24.5%)
h) Chaplains	38 (16.0%)	59 (24.9%)	47 (19.8%)	-- (--)	-- (--)	61 (25.7%)
i) Institutional Parole Officers	36 (15.2%)	55 (23.2%)	37 (15.6%)	33 (13.9%)	16 (6.8%)	55 (23.2%)
j) Institutional Managers	21 (8.9%)	28 (11.8%)	52 (21.9%)	48 (20.3%)	20 (8.4%)	59 (24.9%)
k) Any person who has a good rapport with the inmate	17 (7.2%)	36 (15.2%)	71 (30.0%)	37 (15.6%)	17 (7.2%)	54 (22.8%)
l) Other: please specify	24 (10.1%)	9 (3.8%)	16 (6.8%)	-- (--)	-- (--)	118 (49.8%)

Note. Missing data ranged from 5 to 9 responses for items 24a to 24k. Item 24l was missing data on 66 respondents. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

25. Were you involved in the application of intervention strategies under the situation management model (SMM)?

***n* (%)**	**Response Options**
98 (41.4%)	Yes
106 (44.7%)	No
33 (13.9%)	Unsure/ Missing

26. [**If yes to Q25**] Please indicate the extent to which you agree with the following statements when considering the **application of intervention strategies**:

Statements	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree	Don't Know
a) Correctional Managers are more involved under the EIM compared to the SMM	16 (16.0%)	14 (14.0%)	24 (24.0%)	27 (27.0%)	9 (9.0%)	7 (7.0%)
b) Correctional Officers/ Primary Workers are more involved under the EIM compared to the SMM	17 (17.0%)	16 (16.0%)	36 (36.0%)	14 (14.0%)	9 (9.0%)	5 (5.0%)
c) Sector Coordinators are more involved under the EIM compared to the SMM	17 (17.0%)	8 (8.0%)	23 (23.0%)	25 (25.0%)	14 (14.0%)	9 (9.0%)
d) Emergency Response Team Members are more involved under the EIM compared to the SMM	21 (21.0%)	21 (21.0%)	33 (33.0%)	-- (--)	-- (--)	12 (12.0%)
e) Crisis Negotiators are more involved under the EIM compared to the SMM	13 (13.0%)	17 (17.0%)	30 (30.0%)	18 (18.0%)	10 (10.0%)	8 (8.0%)
f) Health/Mental Health Professionals are more involved under the EIM compared to the SMM	9 (9.0%)	13 (13.0%)	21 (21.0%)	32 (32.0%)	15 (15.0%)	7 (7.0%)
g) Elders are more involved under the EIM compared to the SMM	19 (19.0%)	15 (15.0%)	24 (24.0%)	22 (22.0%)	5 (5.0%)	12 (12.0%)
h) Chaplains are more involved under the EIM compared to the SMM	22 (22.0%)	17 (17.0%)	27 (27.0%)	14 (14.0%)	5 (5.0%)	12 (12.0%)
i) Institutional Parole Officers are more involved under the EIM compared to the SMM	19 (19.0%)	17 (17.0%)	25 (25.0%)	19 (19.0%)	5 (5.0%)	10 (10.0%)
j) Institutional Managers are more involved under the EIM compared to the SMM	12 (12.0%)	20 (20.0%)	22 (22.0%)	24 (24.0%)	6 (6.0%)	13 (13.0%)
k) Any person who has a good rapport with the inmate is more involved under the EIM compared to the SMM	13 (13.0%)	17 (17.0%)	22 (22.0%)	26 (26.0%)	5 (5.0%)	13 (13.0%)
l) Other: please specify who else is more involved under the EIM compared to the SMM	6 (6.0%)	5 (5.0%)	-- (--)	-- (--)	-- (--)	28 (28.0%)

Note. Missing data comprised less than 5 responses for items 26a to 23k. For 26l was missing data on 55 respondents. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

Section F: Assessment of Risk

In the EIM, staff evaluate each situation to determine the level of risk of harm relative to the threat by using the AIM (Ability, Intent, Means) tool.

Ability: physical and mental capacity and opportunity to carry out the threat.

Intent: shows intent to behave or act in a specific manner (verbal/non-verbal) to carry out the threat.

Means: has the means to carry out specific action or behaviour associated with the threat.

27. Based on your experience with the EIM in the last 6 months, to what extent do you agree with the following statements?

Statements	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree	Don't Know
a) The intent of the AIM tool is clear	12 (5.1%)	28 (11.8%)	31 (13.1%)	65 (27.4%)	63 (26.6%)	36 (15.2%)
b) The AIM tool is a useful tool for assessing risk	14 (5.9%)	24 (10.1%)	33 (13.9%)	68 (28.7%)	58 (24.5%)	36 (15.2%)
c) It is feasible to assess the level of risk using the AIM tool during an active incident	15 (6.3%)	33 (13.9%)	39 (16.5%)	65 (27.4%)	41 (17.3%)	40 (16.9%)
d) Considering the events post-incident, my assessment of risk does not change	8 (3.4%)	21 (8.9%)	50 (21.1%)	62 (26.2%)	26 (11.0%)	66 (27.8%)

Note. Missing data comprised less than 5 responses for items 27a to 27d. Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

Section G: Response Options

Under the EIM, once the level of risk has been determined and the goal is identified, a number of intervention strategies are available at the staff members' disposal.

28. Based on your experience with the EIM in the last 6 months, how often are the following engagement and intervention response options carried out at your institution in response to **incidents**?

Response Options	Never	Rarely	Sometimes	Often	Always	Don't Know
a) Dynamic security	-- (--)	-- (--)	13 (5.5%)	64 (27.0%)	109 (46.0%)	40 (16.9%)
b) Staff Presence	-- (--)	-- (--)	7 (3.0%)	68 (28.7%)	115 (48.5%)	36 (15.2%)
c) Communication	-- (--)	-- (--)	19 (8.0%)	61 (25.7%)	109 (46.0%)	32 (13.5%)
d) Negotiation	5 (2.1%)	17 (7.2%)	52 (21.9%)	73 (30.8%)	33 (13.9%)	51 (21.5%)
e) De-escalation	-- (--)	-- (--)	29 (12.2%)	86 (36.3%)	65 (27.4%)	43 (18.1%)
f) Isolate, Contain, and Control	-- (--)	-- (--)	30 (12.7%)	67 (28.3%)	79 (33.3%)	44 (18.6%)
g) Observation and Monitoring	-- (--)	-- (--)	25 (10.5%)	73 (30.8%)	86 (36.3%)	40 (16.9%)
h) Verbal Orders	-- (--)	-- (--)	29 (12.2%)	78 (32.9%)	75 (31.6%)	41 (17.3%)
i) Health Care Interventions (e.g., First Aid/CPR, medication, restraints, admittance to treatment centre, transfer to community hospital)	-- (--)	-- (--)	52 (21.9%)	72 (30.4%)	44 (18.6%)	46 (19.4%)
j) Tactical Manoeuvring	13 (5.5%)	30 (12.7%)	57 (24.1%)	43 (18.1%)	21 (8.9%)	65 (27.4%)

Note. Missing data ranged from 3 to 8 responses for items 28a to 28j. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

29. Are you familiar with the response options carried out during incidents at your institution during the SMM period?

***n* (%)**	**Response Options**
105 (44.3%)	Yes
75 (31.6%)	No
57 (24.1%)	Unsure/ Missing

30. [**If yes to Q29**] Please indicate the extent to which you agree with the following statements when considering the response options carried out at your institution in response to **incidents**?

Statements	**Strongly Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Strongly Agree**	**Don't know**
a) Dynamic security is used more often under the EIM compared to the SMM	19 (17.4%)	24 (22.0%)	37 (33.9%)	18 (16.5%)	-- (--)	-- (--)
b) Staff Presence is used more often under the EIM compared to the SMM	26 (23.9%)	28 (25.7%)	28 (25.7%)	19 (17.4%)	-- (--)	-- (--)
c) Communication is used more often under the EIM compared to the SMM	21 (19.3%)	23 (21.1%)	30 (27.5%)	23 (21.1%)	-- (--)	-- (--)
d) Negotiation is used more often under the EIM compared to the SMM	16 (14.7%)	14 (12.8%)	35 (32.1%)	28 (25.7%)	-- (--)	-- (--)
e) De-escalation is used more often under the EIM compared to the SMM	18 (16.5%)	17 (15.6%)	31 (28.4%)	30 (27.5%)	-- (--)	-- (--)
f) Isolate, Contain, and Control is used more often under the EIM compared to the SMM	26 (23.9%)	25 (22.9%)	35 (32.1%)	13 (11.9%)	-- (--)	-- (--)
g) Observation and Monitoring is used more often under the EIM compared to the SMM	19 (17.4%)	18 (16.5%)	33 (30.3%)	23 (21.1%)	-- (--)	-- (--)
h) Verbal Orders are used more often under the EIM compared to the SMM	25 (22.9%)	21 (19.3%)	34 (31.2%)	18 (16.5%)	-- (--)	-- (--)
i) Health Care Interventions (e.g., First Aid/CPR, medication, restraints, admittance to treatment centre, transfer to community hospital) are used more often under the EIM compared to the SMM	18 (16.5%)	20 (18.3%)	30 (27.5%)	21 (19.3%)	-- (--)	-- (--)
j) Tactical Manoeuvring is used more often under the EIM compared to the SMM	24 (22.0%)	17 (15.6%)	38 (34.9%)	11 (10.1%)	-- (--)	-- (--)

Note. Missing data ranged from 4 to 6 responses for items 30a to 30j. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

Section H: Communication, Guidance, and Support

As part of the EIM, once all required documentation has been completed, a Correctional Manager, in conjunction with the Chief of Health Services (where applicable) will conduct an operational debrief with the staff directly involved in the situation. This process is meant to provide an opportunity for participants to assess the strengths and opportunities where things could have been done differently during the response and to discuss lessons learned that can be implemented during future responses.

31. Have you ever been involved in an operational debrief?

***n* (%)**	**Response Options**
130 (54.9%)	Yes
97 (40.9%)	No
10 (4.2%)	Unsure/ Missing

32. [**If yes to Q31**] Based on your experience with the EIM in the last 6 months, please indicate how often a debrief following an incident has:

Statements	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**	**Don't Know**
a) Been conducted by a Correctional Manager and/or Chief of Health Services	-- (--)	13 (9.9%)	30 (22.9%)	30 (22.9%)	45 (34.4%)	-- (--)
b) Been conducted by someone other than the Correctional Manager and/or Chief of Health Services	33 (25.2%)	40 (30.5%)	22 (16.8%)	-- (--)	-- (--)	22 (16.8%)
c) Been attended by all directly involved staff	5 (3.8%)	28 (21.4%)	24 (18.3%)	46 (35.1%)	14 (10.7%)	11 (8.4%)
d) Provided an opportunity for staff to assess the strengths of the response	7 (5.3%)	16 (12.2%)	34 (26.0%)	43 (32.8%)	18 (13.7%)	11 (8.4%)
e) Provided an opportunity for staff to assess what could have been done differently during the response	7 (5.3%)	20 (15.3%)	32 (24.4%)	47 (35.9%)	13 (9.9%)	9 (6.9%)
f) Identified lessons learned that could be implemented going forward	9 (6.9%)	19 (14.5%)	34 (26.0%)	44 (33.6%)	14 (10.7%)	9 (6.9%)

Note. Missing data comprised less than 5 responses for items 32a to 32f. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

33. [**If yes to Q31**] Based on your experience with the EIM in the last 6 months, please indicate the extent to which you agree with the following:

Statements	**Strongly Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Strongly Agree**	**Don't Know**
a) Debriefs are a useful part of the EIM process	-- (--)	9 (6.9%)	9 (6.9%)	48 (36.6%)	52 (39.7%)	-- (--)
b) I am satisfied with the quality of debriefs at my institution	22 (16.8%)	21 (16.0%)	20 (15.3%)	41 (31.3%)	14 (10.7%)	11 (8.4%)
c) There are adequate staff resources to conduct debriefs with at least the main participants	29 (22.1%)	31 (23.7%)	14 (10.7%)	35 (26.7%)	8 (6.1%)	12 (9.2%)
d) There is adequate time to conduct debriefs	37 (28.2%)	34 (26.0%)	15 (11.5%)	27 (20.6%)	6 (4.6%)	9 (6.9%)
e) I am encouraged to give feedback about the incident(s) during the debrief process	10 (7.6%)	14 (10.7%)	17 (13.0%)	49 (37.4%)	27 (20.6%)	12 (9.2%)

Note. Missing data comprised less than 5 responses for items 33a to 33e. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

34. In your current position, are you involved in Use of Force reviews?

***n* (%)**	**Response Options**
42 (17.7%)	Yes
186 (78.5%)	No
9 (3.8%)	Unsure/ Missing

35 (**If Q34 = Yes**) Based on **your experience in the last 6 months of the EIM**, please indicate the extent to which you agree with the following:

Statements	**Strongly Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Strongly Agree**	**Don't Know**
a) There is sufficient guidance for corrective actions required for different types of non-compliance with use of force guidelines	-- (--)	11 (25.0%)	7 (15.9%)	15 (34.1%)	-- (--)	-- (--)
b) There is sufficient guidance regarding how to monitor whether the necessary corrective actions have occurred	-- (--)	8 (18.2%)	10 (22.7%)	14 (31.8%)	7 (15.9%)	-- (--)
c) The disciplinary measures for non-compliance are effective	7 (15.9%)	6 (13.6%)	9 (20.5%)	9 (20.5%)	5 (11.4%)	6 (13.6%)
d) Overall, there is sufficient guidance for how to conduct use of force reviews	5 (11.4%)	-- (--)	8 (18.2%)	16 (36.4%)	9 (20.5%)	-- (--)

Note. Missing data comprised less than 5 responses for items 35a to 35d. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

Section I: Gender-Based Analysis Plus

Gender-Based Analysis Plus (GBA+) is an analytical tool used to assess the potential impacts of policies, programs, services, legislation and other initiatives on diverse groups of women, men, and gender-diverse people. In addition to gender, it also looks at other factors (signified by the "plus") including sexual identity, age, race, income, culture, geographic location, and mental or physical disabilities (reference).

CSC strives for correctional policies, programs and practices that respect gender, ethnic, cultural and linguistic differences and are responsive to the special needs of women, Indigenous peoples, persons requiring mental health care and other groups.

36. Based on your experience with the EIM in the last 6 months, to what extent do you agree that there is a need to **decrease the use of physical interventions** among the following GBA+ sub-populations?

Sub-populations	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree	Don't Know
a) Women Offenders	21 (8.9%)	17 (7.2%)	32 (13.5%)	15 (6.3%)	15 (6.3%)	134 (56.5%)
b) Older Offenders (Over 50)	25 (10.5%)	21 (8.9%)	56 (23.6%)	27 (11.4%)	19 (8.0%)	85 (35.9%)
c) Younger Offenders (Under 25)	44 (18.6%)	29 (12.2%)	56 (23.6%)	12 (5.1%)	10 (4.2%)	81 (34.2%)
d) Offenders with Mental Health issues	25 (10.5%)	27 (11.4%)	47 (19.8%)	42 (17.7%)	24 (10.1%)	66 (27.8%)
e) Offenders with Physical Disabilities	20 (8.4%)	13 (5.5%)	55 (23.2%)	45 (19.0%)	24 (10.1%)	74 (31.2%)
f) Offender with Cognitive impairments (i.e. intellectual disabilities, learning disabilities, dementia, and other related cognitive impairments)	22 (9.3%)	24 (10.1%)	50 (21.1%)	44 (18.6%)	25 (10.5%)	68 (28.7%)
g) Indigenous Offenders	37 (15.6%)	26 (11.0%)	67 (28.3%)	18 (7.6%)	16 (6.8%)	69 (29.1%)
h) Ethnocultural Offenders	37 (15.6%)	24 (10.1%)	71 (30.0%)	17 (7.2%)	10 (4.2%)	74 (31.2%)
i) Offenders who identify as LGBTQ2+	36 (15.2%)	26 (11.0%)	69 (29.1%)	11 (4.6%)	11 (4.6%)	79 (33.3%)
j) Other, please specify:_____	8 (3.4%)	-- (--)	16 (6.8%)	-- (--)	-- (--)	108 (45.6%)

Note. Missing data ranged from 3 to 6 responses for items 36a to 36i. For 36j, missing data for 100 respondents. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

37. Based on **your experience with the EIM** to what extent do you agree that you have received the necessary **training** to **effectively de-escalate an incident** when dealing with the following sub-populations of offenders?

Sub-populations	**Strongly Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Strongly Agree**	**Don't Know**
a) Women Offenders	40 (16.9%)	11 (4.6%)	36 (15.2%)	27 (11.4%)	21 (8.9%)	95 (40.1%)
b) Older Offenders (Over 50)	38 (16.0%)	19 (8.0%)	56 (23.6%)	56 (23.6%)	28 (11.8%)	34 (14.3%)
c) Younger Offenders (Under 25)	38 (16.0%)	23 (9.7%)	55 (23.2%)	50 (21.1%)	30 (12.7%)	34 (14.3%)
d) Offenders with Mental Health issues	38 (16.0%)	39 (16.5%)	45 (19.0%)	50 (21.1%)	31 (13.1%)	27 (11.4%)
e) Offenders with Physical Disabilities	43 (18.1%)	28 (11.8%)	58 (24.5%)	45 (19.0%)	27 (11.4%)	30 (12.7%)
f) Offender with Cognitive Impairments (i.e. intellectual disabilities, learning disabilities, dementia, and other related cognitive impairments)	39 (16.5%)	42 (17.7%)	49 (20.7%)	38 (16.0%)	33 (13.9%)	30 (12.7%)
g) Indigenous Offenders	34 (14.3%)	19 (8.0%)	64 (27.0%)	47 (19.8%)	37 (15.6%)	30 (12.7%)
h) Ethnocultural Offenders	39 (16.5%)	23 (9.7%)	60 (25.3%)	43 (18.1%)	33 (13.9%)	33 (13.9%)
i) Offenders who identify as LGBTQ2+	39 (16.5%)	27 (11.4%)	58 (24.5%)	38 (16.0%)	31 (13.1%)	38 (16.0%)
j) Other, please specify:_____	11 (4.6%)	-- (--)	18 (7.6%)	-- (--)	6 (2.5%)	75 (31.6%)

Note. Missing data ranged from 6 to 7 responses for items 37a to 37i. For 37j, missing data for 118 respondents. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

38. To what extent do you agree that the following issues are a concern when it comes to the current use of force practices and **older offenders?**

Health Concerns	**Strongly Disagree**	**Somewhat Disagree**	**Neither Agree nor Disagree**	**Somewhat Agree**	**Strongly Agree**	**Don't Know**
a) Mental Health (e.g., dementia)	11 (4.6%)	14 (5.9%)	42 (17.7%)	72 (30.4%)	52 (21.9%)	42 (17.7%)
b) Physical disability (e.g., mobility issues)	10 (4.2%)	24 (10.1%)	41 (17.3%)	72 (30.4%)	46 (19.4%)	40 (16.9%)
c) Physical Health	11 (4.6%)	23 (9.7%)	47 (19.8%)	66 (27.8%)	46 (19.4%)	40 (16.9%)

d) Other, please specify:_____	7 (3.0%)	-- (--)	12 (5.1%)	-- (--)	8 (3.4%)	72 (30.4%)

Note. Missing data comprised less than 5 responses for items 38a to 38c. For 38d, missing data for 133 respondents. Some item frequencies were supressed due to a small number of respondents identified using – (--). Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

39. What additional comment, if any, would you like to give in regards to the current use of force practices and Older Offenders?

_____
_____

40. Have you interacted with inmates while they have been housed in a Structured Intervention Unit?

***n* (%)**	**Response Options**
112 (47.3%)	Yes
121 (51.1%)	No
-- (--)	Unsure/ Missing

{If Q40=yes}

Section J: Impact of the implementation of Structured Intervention Units

This section inquires about the impact the implementation of Structured Intervention Units (SIUs) has had under the EIM.

41. Please indicate to what extent you agree with each statement below, related to the implementation of SIUs.

Since the implementation of SIUs:

Statements	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree	Don't Know
a) The EIM philosophy assists staff to effectively manage inmates who are in the SIU	29 (25.4%)	16 (14.0%)	20 (17.5%)	28 (24.6%)	7 (6.1%)	11 (9.6%)
b) Incidents involving SIUs are better managed given the availability of staff and other resources at this institution	28 (24.6%)	26 (22.8%)	18 (15.8%)	18 (15.8%)	8 (7.0%)	11 (9.6%)
c) The EIM philosophy assists staff in effectively managing incidents in the SIU	31 (27.2%)	20 (17.5%)	22 (19.3%)	19 (16.7%)	6 (5.3%)	11 (9.6%)

Note. Missing data comprised less than 5 responses for items 41a, b, and c. Also, percentages may not align with the results in text since *I don't know* responses are included in the calculation of these percentages.

Appendix G: Key Informant Interview Protocol

Evaluation of Correctional Service of Canada's Engagement and Intervention Model
Interview Invitation

Correctional Service Canada (CSC) is currently conducting an evaluation of the Engagement and Intervention Model (EIM). The objective of this evaluation is to provide program officials and stakeholders with an enhanced understanding of the EIM's performance in key areas since its implementation, and to provide CSC with necessary information to make strategic policy, operations, and resource allocation decisions as they relate to the EIM.

As part of this evaluation, you have been selected to participate in an interview that will take approximately 30-60 minutes to complete. Given your position at CSC, you are able to provide an important perspective on the functioning of the EIM. Therefore, the objective of this interview is to obtain information regarding your experiences with EIM from the perspective of your current role. You will be asked questions about the implementation of EIM, particular response strategies, communication mechanisms, and guidance on use of force reviews and in the application of the EIM, among other topics. The information collected through this interview will be compiled with additional sources of information to support findings and recommendations in the final evaluation report.

Your participation is completely voluntary. The interview video and audio will be recorded and transcribed. Neither your name nor any other identifying information will be associated with the video and audio recording or the transcript. Only the EIM evaluation team will be able to listen to the recordings. Your responses will be aggregated with other data and no personal identifying information will be presented in any presentations or written products. Recordings will be deleted when the evaluation is completed and approved by the Commissioner. The final evaluation report will be available on the CSC website once completed and approved. You may also choose to not answer a question and may withdraw at any time, without consequence.

Agreeing to participate in this interview implies that you consent to the use of your responses, in aggregate form, in any presentations or written products that may be produced.

Consent

I understand the content and the purpose of the EIM evaluation interview and the manner in which the information I provide will be used. By signing below, I voluntarily consent to participate in this interview and know that I can ask questions or withdraw at anytime.

By signing this form I am also consenting to:

- ❑ having my interview recorded;
- ❑ to having the recording transcribed;
- ❑ the use of the written transcript in presentations and written products.

By checking the box in front of each item, you are consenting to participate in that procedure.

Name: _____ Signature:_____

Date: _____

Demographic Information

This section will capture your current work experience at the Correctional Service of Canada.

1. In which region do you currently work?

❑Atlantic
❑Québec
❑Ontario
❑Prairie
❑Pacific
❑NHQ

2. Please specify where you currently work:

❑Regional Headquarters
❑National Headquarters
❑Other (Please specify): _____

3. Please specify the EIM Stakeholder group you belong to:

❑Security Operations
❑Preventative Security and Intelligence
❑Health Services
❑Women Offenders Sector
❑Learning and Development
❑Indigenous initiatives Directorate
❑Performance Measurement and Management Reporting
❑Incident Investigations Branch
❑Other (Please specify): _____

4. How long have you been working with CSC?

❑Less than six months
❑Six months to two years
❑Two years and one day to five years
❑Five years and one day to ten years

❑More than ten years

5. How long have you occupied your current position/role?

❑Less than six months
❑Six months to two years
❑Two years and one day to five years
❑Five years and one day to ten years
❑More than ten years

Introduction:

Hello, my name is……I am an Evaluator at CSC and will be conducting today's interview. I wanted to start by first welcoming you and thanking you for volunteering to participate in this interview.

As you know, the Correctional Service of Canada (CSC) is currently conducting an evaluation of the Engagement and Intervention Model (EIM). The EIM is a risk based model design to assist CSC staff in responding to and resolving institutional incidents, using the most reasonable interventions. The EIM was introduced in January 2018, replacing the previous Situation Management Model (SMM) in its entirety.

Part of this evaluation includes obtaining the perspectives of key informants on the EIM.
The role you currently hold offers a higher-level organizational perspective on the functioning of the EIM and as such, your participation in this interview will be contributing to providing decision-makers with vital information to make strategic policy and resource decisions regarding the Engagement and Intervention Model.

During the interview, I will be asking you questions about your experience with the EIM model. The objective of this interview is to obtain information regarding your experiences with EIM from the perspective of your current role. You will be asked about:

- The extent to which key activities that have been emphasized as a result of the issues identified under the Situation Management Model are being implemented under the Engagement and Intervention Model.
- Strengths and weaknesses of the EIM in achieving expected aims and objectives.
- The extent to which there is sufficient training, guidance, communication, and oversight under the EIM.
- Lessons learned and best practices in dealing with specific inmate populations.

I want you to know that I am just interested in hearing about your experience and perspectives and that there are no wrong or right answers. This interview will consist of about XXX structured and semi-structured questions. During the interview, I may ask you additional questions to further clarify or elaborate your answer.

Throughout the interview, I encourage you to speak openly and honestly. I will ask that you do not speak about individuals by name, position, or other identifiable information. Know that none of your responses will be presented in a way that may identify you. Responses from the interview may be summarized and reflected throughout various evaluation documents. Direct quotes may also be presented; however, the source of the quote will never be identified.

Before we begin, I would like to reaffirm that your participation in this interview is completely voluntary and that you have consented to either having the interview recorded or transcribed for the purposes of analysis. You may exercise your right to not answer any particular question or questions at any point in this interview. Are you ready to begin?

Section A: General Effectiveness

For Interviewers Questions 1 to 6 apply to all interviewees with the exception of L and D and PMMR

1. **Please describe to what degree you are familiar with the EIM and the ways in which it differs from the SMM?**

   a. *In your role, describe in which ways, if any, have you seen these differences implemented or administered?*

   Prompts: Using a balanced approach to risk assessment using the AIM tool, Using a person centered rather than offender-behaviour centered approach to situational assessment, Using engagement and intervention strategies that have been broadened from security focused to also include inmate's physical and mental health, The use of non-security partners to de-escalate and resolve incidents, The reduction of physical harm through non-use of force responses to resolve situations with inmates at the lowest level, The demonstration of leadership from the sector coordinator role in resolving incidents.

2. **In your opinion, what is the general perception regarding the extent to how well the EIM has been implemented? Here you might think about your peers in a similar role, among colleagues, or in your department more generally.**

   a. *Do you agree with this perception, why or why not?*

3. **In your opinion, are there certain types of institutions where the EIM has been less effective in its implementation or administration?**

Prompts: RTCs, Women's Institutions, Maximum Security Institutions, Clustered institutions.

   a. *If yes, which ones?*
   b. *Why do you think that is?*

4. **In your opinion, are there certain types of institutions where the EIM has been more effective in its implementation or administration?**

Prompts: RTCs, Women's Institutions, Maximum Security Institutions, Clustered institutions.

   a. *If yes, what types of institutions?*
   b. *Why do you think that is?*

5. **Are there any improvements that have occurred under the EIM that stand out to you when compared to the SMM, given the nature of your role?**

   a. *If yes, what are they?*

6. **What, if anything, could be improved, order to enhance the ability of the EIM model to achieve its goals and objectives?**

Section B: Guidance, Communication and Oversight

For Interviewer Do not ask Questions 7 -9 to PMMR

7. **In your opinion, is there enough guidance material for the use of force reviews?**

Prompts: is there sufficient guidance for the nature of corrective actions required for different types of non-compliance? Is there sufficient guidance on how to monitor that any necessary or identified corrective actions have occurred?

a. *If yes, is it easily obtained?*
b. *If no, what could be improved?*

8. **In your opinion, is there enough guidance material for post-incident debrief sessions?**

a. *If yes, is it easily obtained?*
b. *If no, what could be improved?*

9. **To your knowledge, are the corrective actions or disciplinary measures for non-compliance with policy or violations of law effective?**

a. *If yes, why?*
b. *If no, Why not?*

For interviewers: Ask all interviewees Questions 10 and 11 except for PMMR

10. **Is the content of available EIM training sufficient to support the effective use of the Model?**

Prompts: Are correctional staff better able to identify Cues of Distress or altered Levels of Consciousness? Are staff able to act quickly to get help needed to safely manage mental and physical distress situations?

a. *If no, what is missing?*

11. **Is EIM training offered as frequently as it is needed?**

Prompt: Does refresher training occur as frequently as it is needed

a. *If no, what courses should be offered more frequently and why?*

For interviewers: Ask Q 12 to Security Operations only

12. **To your knowledge, to what degree are Assistant Wardens of Operations/Managers of operations fulfilling their roles and responsibilities in the implementation of the EIM?**

Prompts: Providing sufficient oversight related to the use of EIM. Providing corrections managers with sufficient support and guidance in relation to correctional manager's role in managing incidents. Identifying trends related to incident management, reinforcing appropriate applications of the EIM, and identifying any deficiencies.

a. Of their roles and responsibilities, what is most effective?
b. Of their roles and responsibilities, what could be improved?

For interviewers: Ask Q 13 to Health services only

13. **To your knowledge, to what degree are Chiefs of Mental Health services and Chiefs of Health services fulfilling their roles and responsibilities in the implementation of the EIM:**

Prompts: Providing sufficient general oversight of Health Care Professionals regarding the application of the EIM. Identifying trends related to the provision of health services during incidents.

a. Of their roles and responsibilities, what is most effective?
b. Of their roles and responsibilities, what could be improved?

For interviewers: Ask Q 14 to Security Operations and IIB only

14. **Are you aware of any differences in how regional and national investigators interpret and apply the model to investigation?**

a. If yes, what are the differences?

For interviewers: Ask Q 15 and Q16 to Security Operations, Health Services, Women Offender Sector and IID only

15. **To your knowledge, to what degree do management groups at the regional level liaise to address trends or deficiencies in the application of the EIM?**

a. Is this sufficient, could it be improved?
b. How could it be improved?

16. **To your knowledge, to what degree do management groups at the national level liaise to address trends or deficiencies in the application of the EIM?**

a. *Is this sufficient, could it be improved?*
b. *How could it be improved?*

For interviewers: Ask Q 17 to Q19 to Security Operations, Health Services, Women Offender Sector, IID and PMMR only

17. **Do you believe that there is sufficient performance monitoring and reporting at the regional level?**

    a. *If no, how could this be improved?*

18. **Do you believe that there is sufficient performance monitoring and reporting at the national level?**

    a. *If no, how could this be improved?*

19. **When it comes to performance monitoring, to your knowledge, are there any data quality issues that exist?**

    a. If yes, what are they?
    b. How could this be improved?

Section C: GBA+

Gender-Based Analysis Plus (GBA+) is an analytical tool used to assess the potential impacts of policies, programs, services, legislation and other initiatives on diverse groups of women, men, and gender-diverse people. In addition to gender, it also looks at other factors (signified by the "plus") including sexual identity, age, race, income, culture, geographic location, and mental or physical disabilities.

For interviewers: Ask Q20 and Q21 to all except PMMR

20. **Are you aware of any lessons learned and best practices for dealing with specific populations of offenders in implementing the EIM or dealing with a use of force?**

    a. Anything specific to older offenders in particular?
    b. Anything specific to offenders with mental health or physical health needs in particular?

21. **In your opinion, do institutional staff have the necessary skills and knowledge to effectively implement the EIM model when dealing with specific populations of offenders?**

a. Is there any training or experiences that are useful to gaining this knowledge?
b. Is there any particular knowledge that is lacking?
b1. Do you have any suggestions for how to improve this knowledge?

Section D: Conclusion

For interviewers: Ask Q 22 to all

22. Are there any strengths or challenges to the EIM that have not been covered in this interview that you would like to mention?

For interviewer

If interviewee only mentions challenges follow up with

a. You mentioned some challenges, have you also noticed any strengths? What are they?

If interviewee only mentions strengths follow up with

b. You mentioned some strengths, have you also noticed any challenges? What are they?

For interviewers: Ask Q 23 to all except for PMMR

23. Are there any best practices or lessons learned in the application of the EIM that have not been covered in this interview that you would like to mention?

For interviewers: Ask Q 24 to all

24. Is there anything else you would like to mention regarding the EIM model before we conclude the interview?

This concludes the interview. In the event that we have an opportunity to conduct more interviews, is there anyone you could recommend who would be a knowledgeable participant that we could contact for an interview?

Thank you very much for your participation in this interview.

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