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LA SÉCURITÉ, LA DIGNITÉ ET LE RESPECT POUR TOUS

Review of Mental Health Commitments

Internal Audit Sector

February 27, 2015

Canada

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Executive Summary

Background

The *Review of Mental Health Commitments* was conducted as part of CSC's 2013- 2016 Risk-Based Audit Plan (RBAP) and links to CSC's fourth departmental priority "*To improve capacities to address mental health needs of offenders*", as well as with CSC's first corporate risk: "*There is a risk that CSC will not be able to respond to the complex, diverse and evolving profile of the offender population*".[1]

One of CSC's current challenges lies in the increasing number of offenders with mental health issues[2].

Since 2007, CSC has made over six hundred (600) commitments related to Mental Health to address various recommendations deriving from reports such as *A roadmap to Strengthening Public Safety*[3] and the CSC's *Transformation Agenda* that followed; a number of CSC's *Reports on Plans and Priorities,* audits (both internal and external), numerous inquests, reports from the Office of the Correctional Investigator (OCI), reviews, evaluations and research. These commitments refer to an array of mental health related issues, and clearly reflect CSC's desire to fulfill its mandate on this front.

The objective of this review was to provide assurance that key commitments undertaken by CSC regarding mental health have been met, and effectively implemented.

To achieve this objective, the review team risk-assessed the pool of commitments made since 2007 and chose to review forty (40) commitments that represented the highest risk for the organization, always taking into consideration their evolution over time. To that end, the review team looked at key documentation and policies, conducted interviews with institutional, regional, national staff and external partners, and performed file reviews to assess compliance with guidelines and policies. The review was national in scope and included site visits to Regional Treatment Centres and the Regional Psychiatric Centre.

Conclusion

Overall, review results demonstrated that there were a high number of commitments made by CSC in terms of mental health; many of them were not specific, measurable, achievable, relevant and time-bound, making their progress difficult to assess.

While we assessed 36 of the 40 commitments reviewed as being met, we highlighted some areas of improvement in nine (9) of them in order to ensure their full effectiveness.

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[1] Correctional Service of Canada's (CSC) *Corporate Risk Profile, 2014-2015*
[2] CSC Corporate Risk Profile 2014-2015
[3] Government of Canada: *A Roadmap to Strengthening Public Safety*, October 2007

The four commitments that were assessed as not being met were:

- Develop and implement a partnership action plan to better integrate Community Mental Health Initiative (CMHI) community capacity and activities **(Commitment #9)**;
- CSC will continue to strengthen the continuum and continuity of specialized mental health support throughout the duration of offender's sentences, including conducting a planned evaluation of CSC's mental Health Services to provide a base of evidence in this area **(Commitment #23)**;
- Sustaining current correctional results for federal offenders with mental health disorders, as measured by: a) the percentage of federal offenders with mental health disorders returning to federal custody within two years of the end of their sentence; b) the percentage of federal offenders with mental health disorders returning to federal custody within five years of the end of their sentence **(Commitment #34);**
- Develop an approach for systemic collection and analysis of mental health prevalence data. A working group has been created to identify a systemic approach to collect and analyse mental health prevalence data to address this gap. MH prevalence rates are required for reporting on the RPP commitments and decision-making **(Commitment #37)**.

Please refer to **Annex D** for a list of all commitments and their status (met or not met).

The progress on these four commitments is further discussed under section 3.1 of this report, while the analysis for the commitments assessed as met but for which a need for further improvement still exists can be found under section 3.2 of this report.

In order to complete the implementation of the commitments that are still deemed relevant and strengthen the overall corporate Mental Health Strategy, we made the following three (3) recommendations:

Recommendation 1:

The Assistant Commissioner, Health Services should develop and implement an approach to respond to, track and report on recommendations regarding mental health in a comprehensive, consistent and standardized manner, thus ensuring that mental health-related commitments are specific, measurable, achievable, relevant and time-bound.

Recommendation 2:

We recommend that Health Services, in collaboration with other sectors, continue to lead the efforts to address the four commitments not met and discussed under section 3.1 of this report, and to fully implement the commitments met that are discussed under section 3.2.

Recommendation 3:

The Assistant Commissioner, Health Services, in collaboration with Regional Directors, Health Services and Executive Directors of Regional Treatment Centres / Regional Psychiatric Centre, should clarify policies where needed and strengthen processes to ensure that frontline staff are notified of and use relevant policies (such as the RTC Guidelines, the Guidelines for Sharing Personal Health Information, CD 843-Management of inmate self-injurious and suicidal behaviour).

Management Response

The Assistant Commissioner Health Services (ACHS) accepts Recommendations 1, 2 and 3.

The Health Services Sector has prepared a detailed action plan to address the issues raised in the Review. The Management Action Plan is scheduled for full implementation by 2016-12-31 (although Action Item #3, Recommendation 2 regarding the collection of data on offenders five years following end of sentence will be implemented by 2018-09-30).

The Sector is in agreement with the Report's findings with respect to the status of commitments met. It should be noted for ***Commitment #C-29*** ***-*** *Research project: Profile of mental health needs of women, that although a direct link could not be made with respect to achieving the expected result of reducing the number of offenders denied conditional release at eligibility due to unaddressed mental health problems, the Report was useful in informing the development of women-centred programs (eg. trauma-informed care and the revised model of Dialectical Behaviour Therapy (DBT)). Furthermore, additional improvements could be considered, such as research on women offender programming.*

1.0 Introduction

1.1 Background

The *Review of Mental Health Commitments* was conducted as part of CSC's 2013- 2016 Risk-Based Audit Plan (RBAP) and links to CSC's fourth departmental priority "*To improve capacities to address mental health needs of offenders"*, which is considered by CSC as a high corporate risk, both in terms of likelihood as well as in terms of impact.[4] It also links to CSC's first corporate risk: "*There is a risk that CSC will not be able to respond to the complex, diverse and evolving profile of the offender population"*.[5]

To this end, a number of mental health care services, initiatives and practices were to be put into place to improve correctional results and CSC's capacity to address mental health needs of offenders.

Additionally, since 2007, CSC has made over six hundred (600) commitments related to mental health to address various recommendations deriving from reports such as *A roadmap to Strengthening Public Safety*[6] and the CSC's *Transformation Agenda* that followed; a number of CSC's *Reports on Plans and Priorities,* audits (both internal and external), numerous inquests, reports from the Office of the Correctional Investigator (OCI), reviews, evaluations and research. These commitments refer to an array of mental health related issues, and clearly reflect CSC's desire to fulfill its mandate on this front.

While CSC has been addressing many challenges regarding mental health of offenders over the years, the increasing number of offenders with mental health issues requires that CSC pays constant attention to the situation[7].

This review aimed at providing assurance that CSC has met and effectively implemented its key commitments in the area of mental health.

1.2 Legislative and Policy Framework

CSC's obligations in terms of healthcare (including mental health) are entrenched in legislation. In fact, sections 85 to 89 of the *Corrections and Conditional Release Act (CCRA)* lay out the requirements, specifically under section 86 which states: *the Service shall provide inmates with essential health care and reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community.*

Under the *Canada Health Act* (1984), the provincial and territorial governments are responsible for the management, organization and delivery of health services to residents of their provinces

[4] Correctional Service of Canada's (CSC) 2010-11 to 2013-14 *Business Plan* , June 25, 2010.
[5] Correctional Service of Canada's (CSC) *Corporate Risk Profile, 2014-2015*.
[6] Government of Canada: *A Roadmap to Strengthening Public Safety*, October 2007
[7] CSC Corporate Risk Profile 2014-2015

or territories. This includes individuals incarcerated in provincial and territorial institutions, and all individuals serving a sentence in the community, irrespective of their sentencing level (federal, provincial or territorial).

In that legal context, another challenge for CSC resides in facilitating a seamless transition (continuity of services, access to mental health specialists, accommodation) between the institution and the community, for those federal offenders with mental health needs.

Several Commissioners' Directives (CD's) address mental health in CSC, including:

- CD 705-3: Immediate Needs Identification and Admission Interviews
- CD 800: Health Services[8]
- CD 803: Consent to Health Service Assessment, Treatment and Release of Information
- CD 835: Health Care Records
- CD 840: Psychological Services
- CD 843: Management of Inmate Self-Injurious and Suicidal Behaviour
- CD 850: Mental Health Services

Different sets of guidelines also support those directives (some of which were updated while we were proceeding with the review):

- Computerized Mental Health Intake Screening System Version 2.2: National Guidelines (last updated June 2014)
- Institutional Mental Health Services (Primary care) Guidelines (last updated June 2014)
- Guidelines for Sharing Personal Health Information (last updated October 2013)
- Compilation of Regional Treatment Centre (RTC) Guidelines (last updated April 2013)
- Community Mental Health Service Delivery Guidelines (last updated June 2014)

1.3 CSC Organization

CSC's Health Services Sector was created in 2007. The most recent governance model (April 1st, 2014) stipulates that the responsibility for all health services (including mental health in Regional Treatment Centres) falls under that Sector. These governance changes were effected for mental health care in mainstream institutions and the community starting April 1st, 2013.

As Regional Treatment Centres (RTC's) and the Regional Psychiatric Centre (RPC) operate as specialized facilities that constitute both "penitentiaries", subject to the provisions of the federal CCRA, and "hospitals"[9] subject to the provisions of the relevant provincial legislation, operational-specific functions continue to report to wardens. Prior to that governance model, the

[8] CSC is currently in the process of reviewing all Health Services related CD's and their amalgamation into one CD (i.e. CD 800). These CD's include CD 800,803,805,821,835,840,850.

[9] With the exception of the Centre Régional de Santé Mentale in Québec (CRSM) which is not considered a hospital under provincial legislation.

responsibility of all health services in RTC's and the RPC fell under the operational divisions of CSC in regions.

CSC's own Mental Health Strategy: *Towards a Continuum of Care-Correctional Service Canada Mental Health Strategy (last updated in 2010)* was developed to enhance its capacity to address and respond to the mental health needs of offenders in institutions and in the community.

2.0 About the Review

2.1 Review Objective

The objective of this Review was to provide assurance that key commitments undertaken by CSC regarding mental health have been met and effectively implemented. The specific criteria, covering eight themes related to the objective for this review, can be found below.

2.2 Review Scope

For the purpose of this review, a commitment was defined as an act binding CSC to a course of action, a promise (to another) to do something in the future.

The large volume of commitments CSC has publicly made with respect to mental health since 2007 (N=642), combined with their various types, presented a challenge for the review team; not all could be assessed in a timely manner. Given this limitation, the focus of this engagement was therefore to follow-up on those commitments aimed at mitigating areas that represented the highest risk for CSC, as of the beginning of this review, while recognizing their evolution over time.

Forty (40) commitments were assessed as such, and retained for review. They were classified under eight (8) mental health-related themes[10]:

- Mental Health Information (14 commitments)
- Human Resources - Recruitment/Retention (2 commitments)
- Need-Service Adequacy/Intensity of Care (3 commitments)
- Partnerships/Contracts (6 commitments)
- Finance (1 commitment)
- Review/Research/Performance measurement (4 commitments)
- Governance (5 commitments)
- Policy/Guidelines/Legislation (5 commitments)

The review was national in scope and included site visits to all Regional Treatment Centres / Regional Psychiatric Centre covering all five regions (see ***Annex A***).

The following areas were deemed to be outside the scope of this review:

- Commitments considered moderate or low risk as per the risk assessment conducted by the review team;
- Commitments that were previously reviewed/audited by the Internal Audit Branch, and identified as being completed and implemented (Ex: Review of *Practices in place to*

[10] These themes are inspired by the Mental Health Services Framework found in the *Mental Health Strategy for Corrections in Canada,* July 2012.

prevent/respond to death in custody, February 2012 and Audit of *Regional Treatment Centres and the Regional Psychiatric Centre,* January 2011);
- Commitments that duplicated other commitments (same intention but written differently);
- Commitments that were deemed not amenable to this review process (lack of clarity or impossible to ascertain completeness).

2.3 Approach and Methodology

In order to assess whether or not a commitment was met, we reviewed whether the organization had taken the action to which it had committed to and then, looked at the degree by which the action taken was effectively implemented.

Once the review team defined the term "commitment", evidence was gathered through a number of methods such as: review of documentation; detailed testing of files; interviews and communication with CSC staff (NHQ, Regions and Districts) and external partners.

Further details on the methodology are provided in ***Annex B***.

2.4 Previous Audit Work

Past CSC internal audits and external assurance work were used to assist in scoping the review work. Details are provided in ***Annex C***.

2.5 Risk Assessment

The review team proceeded with a risk identification and assessment of all commitments, based on interviews with the Office of Primary Interest (OPI) as well as with the help of an external expert in the area of mental health and justice.

3.0 Findings

A list of all commitments and their status can be found under ***Annex D***.

Overall, 36 commitments out of 40 were assessed as being met, while four were assessed as not being met. Of the 36 that were met, continued improvements would be beneficial to nine of them to ensure their full effectiveness.

3.1 Commitments not met:

Four commitments were assessed by the review team as not being met. The following section provides the supporting analysis, by mental health-related theme.

3.1.1 Partnerships/Contracts

Commitment #9: Develop and implement a partnership action plan to better integrate CMHI community capacity and activities. Mental Health, Health Services, will develop a Partners' action plan to identify specific actions related to community capacity building to address the gaps and facilitate the successful reintegration of offenders with a mental illness into Canadian communities. Upon completion of the gap analysis, mental health and health services will develop a partner's action plan.[11]

Through document review and interviews, the review team found evidence that a community mental health gap analysis was completed by CSC's Health Services in March 2010. This was followed by a review of existing mental health service delivery community partnerships across the country. An inventory of all successful partnerships was gathered and shared via memo by Health Services to the Assistant Deputy Commissioners, Corrections and Operations (ADCCO's), Health Services Executive Team (HSET) and District Directors (DD's), on January 9, 2012. The goal was to provide the regions with successful best practices from across the country that they could possibly replicate in their respective regions.

Through communication with CSC's Mental Health Branch staff, we received confirmation that this exercise represented their *Partner's Action Plan* and their response to the commitment to develop one. We found that this plan is no longer maintained at NHQ, as it is now left to the Regions and Districts to develop and implement their own action plans in the area of mental health partnerships (by identifying capacity-building activities, timeframes to develop and implement them, reporting capacities, etc).

[11] This commitment was made in response to recommendation # 8 of the Correctional Service Canada's Evaluation of Community Mental Health Initiative of 2008: *CSC should continue to support and enhance the level of services available to offenders with mental disorders in the community. Further, CSC should explore the development of additional partnerships/links with organizations (such as provincial governments and non-governmental organizations) to facilitate continuity of care following warrant expiry.*

Our findings showed that the implementation of the partner's action plan, as defined by Health Services, was not done systematically. In fact, only two regions confirmed following an official plan of action in terms of mental health-related partnerships.

We also found there was no governance mechanism through which mental health-related community capacity-building activities, partnership services and contracting opportunities could be coordinated, shared and reported on.

3.1.2 Needs-Services Adequacy/Continuum of Care

Commitment #23: CSC will continue to strengthen the continuum and continuity of specialized mental health support throughout the duration of offenders' sentences, including conducting a planned evaluation of CSC's Mental Health Services to provide a base of evidence in this area.[12]

The Evaluation of Health Services, including mental, clinical and physical health has started in late 2013 and is expected to be completed by March 2016.

Considering that the Evaluation is currently taking place and not yet completed, we assessed this commitment as not being met at this time.

3.1.3 Review/Research/Performance Measurement

Commitment #34: Sustaining current correctional results for federal offenders with mental health disorders, as measured by:

- The percentage of federal offenders with mental health disorders returning to federal custody within two years of the end of their sentence.

- The percentage of federal offenders with mental health disorders returning to federal custody within five years of the end of their sentence.[13]

In order to achieve this commitment, CSC was to capture and analyze the identified measures over a 3-year span. We found that CSC measured the data in 2008-2009 only, making it difficult to confirm whether correctional results were sustained as the results of the performance measures were not tracked for more than a year. We assessed this commitment as not being met.

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[12] This commitment was made in the 2013-2016 Corporate Business Plan Annex B - Plans and Initiatives # 6: *Strengthen the continuum and continuity of specialized mental health support throughout the duration of offenders' sentences, including conducting a planned evaluation of CSC's Mental Health Services to provide a base of evidence in this area.*

[13] *Correctional Service of Canada (2008-2009), Report on Plans and Priorities,* Ottawa, Ontario Correctional Service of Canada

3.1.4 Mental Health Information

Commitment #37: Develop an approach for systemic collection and analysis of Mental Health prevalence data. A Working Group has been created to identify a systemic approach to collect and analyse mental health prevalence data to address this gap. MH prevalence rates are required for reporting on the RPP commitments and decision-making. [14]

The Mental Health Strategy for Corrections in Canada[15] defines prevalence data as: *Information about the proportion of individuals in a population having a mental health problem and/or mental illness. Prevalence is a statistical concept referring to the number of cases of an illness that are present in a particular population at a given time.*

An approach for systemic collection and analysis of mental health prevalence data was developed, and resulted in CSC's Research Branch completing a preliminary prevalence study for major mental health disorders among incoming male federal offenders. This preliminary study was also used to inform EXCOM members on a refined model of care designed to maximize the effectiveness of CSC's mental health services, better target the right service and intensity level to individual patients and improve the efficiency of service delivery.

As a final omnibus research report containing the overall results (from all regions) has yet to be delivered, we assessed this commitment as not being fully met.

3.2 Commitments met but would benefit from continued improvements:

While our findings show that CSC has met most of the highest risk mental health-related commitments that we assessed, nine of them would benefit from continued improvements to ensure their full effectiveness. The following section provides their analysis, by mental health-related theme.

3.2.1 Need-Service Adequacy

Commitment #29: *Development of a profile of mental health needs of women offenders in order to identify their areas of special needs*[16].

This commitment was made by CSC in the 2010-2011 *Report on Plans and Priorities*, as an activity aiming to advance its Transformation Agenda. The purpose of this project was to inform and assist the achievement of the expected result of reducing, over five years, the number of offenders denied conditional release at eligibility due to unaddressed mental health problems.

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[14] This commitment was made as part of the 2011-12 National Action Plan to address the needs of offenders who engage in self-injury

[15] *Mental Health Strategy for Corrections in Canada-A Federal-Provincial-Territorial Partnership* (2012)
[16] *Correctional Service of Canada (2010-2011), Report on Plans and Priorities, Priority: Improved capacities to address mental health needs of offenders,* Ottawa, Ontario Correctional Service of Canada

A profile of mental health needs for women was developed by the Research Branch and published in May 2012: *Mental Health Needs of Federal Women Offenders.* The review team expected to find information on the status of implementation of this research project in either the *Departmental Performance Reports* or any other status report on the *Mental Health Strategy*, without success.

While there was some evidence that information (trauma related information) contained in the research project was considered in developing a targeted program (high-intensity program) for women offenders, both the Women Offender Sector and Health Services Sector have acknowledged that additional work should be completed to continue to improve our understanding of which approaches will best address the mental health needs of women offenders to assist their reintegration into the community. However, given the limited number of women offenders, it may take a number of years of research before CSC has sufficient data to be able to conclude on what is most effective.

3.2.2 Mental Health Information

Commitment #3: Development of a process to ensure that professional assessments are requested and shared with the decision maker prior to making any inmate segregation, transfer and disciplinary decisions.[17]

The notion of "professional assessments" referred to in this commitment was not defined in any policy (revoked or actual) on Segregation (CD 709), Transfer (CD 710-2) or Discipline (CD 580). These policies mainly referred, and still refer, to processes that include notions of consultation of health care professionals, provision of advice to decision makers and the obligation of documenting the outcome of that consultation and advice.

We found that all processes discussed above were developed and integrated into policy.

In the particular case of the disciplinary process, we found that a need for improvement existed in the provision of mental health-related information to the decision-makers, enabling them to make an informed decision. It also remained unclear where these mental health concerns were to be documented upon disciplinary decisions.

[17] This commitment was made in response to recommendation # 5 of the Correctional Service Canada's Audit of Regional Treatment Centre and Regional Psychiatric Centre in 2011: *The Regional Deputy Commissioners should put in place processes with the assistance of: 1) The Assistant Commissioner Correctional Operations and Program to ensure that consideration of the inmates mental health and mental health needs is documented when making decisions to transfer, administratively segregate and discipline inmates.*

3.2.3 Partnerships/Contracts

Commitment #12: The Panel recommends increasing the use of contracted and volunteer service providers and the resources required to support their work in assisting offenders under conditional release in the community.[18]

While we were provided with some data (derived from the mental health tracking system) on outreach and engagement activities stemming from the Community Mental Health Initiative's (CMHI) community capacity building portfolio, we found there was no governance mechanism through which data on mental health related community capacity-building activities, volunteer services and contracting opportunities could be coordinated, shared and reported on. We were therefore unable to assess if there was any increase in the use of contracted and volunteer service providers to assist offenders with mental health needs under conditional release in the community, as we were unable to assess if there was an increase in the resources required to support those services as well.

When looking specifically at contracted service providers offering accommodation for offenders with mental health needs in the community, statistics[19] showed that between March 2012 and December 2013, there was a growth of thirty (30) beds available to CSC at facilities specializing in mental health, bringing it to one hundred and thirty-four (134) beds as of December 2013. While bed space availability statistics exist, we found a need for improved data validation.

It was finally brought to our attention that CSC could benefit further from better identifying its corporate needs in terms of mental health, in order to increase its capacity to negotiate and communicate with partners; in turn, these partners would gain a stronger understanding of the needs prior to taking charge of the offenders while in the community.

Commitment #30: CSC will be convening in the coming year, a panel of correctional practitioners from other jurisdictions and mental health professionals, to assess the feasibility of

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[18] This commitment was made in response to recommendation # 51 of the 2007 Report of the CSC Review Panel**:** A Roadmap to Strengthening Public Safety: *The Panel recommends increasing the use of contracted and volunteer service providers and the resources required to support their work in assisting offenders under conditional release in the community. For the purpose of this Review, the Review team considered contracts as part as the overall partnerships (contracts, MOU's, agreements, etc).*

[19] Data provided by CSC COP Sector (CPRP) with the following note: *There may be some specialized beds that are not captured as the specialization...applies to specific facilities only. This does not include non-specialized facilities that may offer a few specialized beds. Also, although these available beds belong to facilities that specialize in mental health, they may not all be 'designated' specifically for Mental Health or continuously filled by Mental health offenders only, despite the listed specialization of the facility.*

developing standards for the recruitment and training of Correctional Officers (CO's) who work with offenders with mental health profiles.[20]

A panel of correctional practitioners was not held and the review team could not assess if CSC obtained the results of an assessment of feasibility of developing standards for the recruitment and training of Correctional Officers (CO's) who work with offenders with mental health profiles.

We nevertheless found that a number of activities to address the concern raised by the OCI through this commitment were completed, and other activities continue to be implemented. In fact, the evidence showed that work is currently underway to develop and customize standardized testing tools when hiring new correctional officers, as well as to expand and enhance further competency profiles for them. We encourage them to continue with this work.

3.2.4 Policy/Guidelines/Legislation

Commitment #1: A document highlighting good practices to take into consideration when managing an offender who self-injures is currently in the final consultation stage. It will be widely distributed to frontline staff and shared with the Federal Provincial Territorial Working Group on Mental Health (Heads of Corrections sub-committee) in August 2009.[21]

The document highlighting G*ood practices* to take into consideration when managing an offender who self-injures was developed, shared and integrated into policy (CD 843); the Working Group was also involved in looking into self-injury and suicide.

Despite the efforts made by managers to communicate and share the document on *Good practices* and CD 843 (and their content) with front-line staff, we found that the information did not reach the target audience as well as expected. In fact, the results of our interviews (staff and managers) confirmed that thirty-three (33) out of 61 interviewees (54%) said they were aware of CD 843 and 32 of 61 interviewees (52%) said they referred to the document on *Good practices* and/or CD 843 either sometimes, on a need basis or regularly. As for frontline staff in particular, 40% (4/10) had knowledge of these documents or their content.

As such, these findings support the need for further clarification and a more effective communication of those good practices and of CD 843 to the front-line staff.

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[20] This commitment was made as part of the response to recommendation #2 of the 37th Annual Report of the Office of the Correctional Investigator 2009-2010*: The Service renew its correctional officer recruitment standards to ensure new hires have the requisite knowledge, personal competencies and educational background to manage an increasingly demanding offender mental health profile.*

[21] This commitment was made in response to recommendation # 7 of the 36th Annual Report of the Office of the Correctional Investigator 2008-2009: *As a matter of priority, an inventory of "best practices" in the treatment and prevention of self-harm should be developed and distributed widely throughout the Service.*

Commitment #2: Consult with Legal services to create guidelines regarding the sharing of MH information across the continuum of care. Develop guidelines on sharing mental health-related information and communicate them to staff. Prepare guidelines for staff to clarify legislative and policy requirements around sharing of personal health information. Legal Services will then create Information Sharing Guidelines to assist front-line CSC staff in decision-making regarding the sharing of mental health information across the continuum of care and with various professional mental health care providers and others (individuals who have a need to know by virtue of their interaction with an offender).[22]

The Guidelines on sharing of mental health related information were developed, shared and integrated into policy. Managers also communicated the guidelines to staff, through meetings, orientation program, training, e-mails sent by managers, web-conferencing sessions or through an attestation sheet.

In verifying the staff's and managers' understanding of the guidelines, we found that 54% (38 out of 70) found the guidelines clear. Some managers also shared with us the fact that the guidelines can sometimes be interpreted in different ways, which can bring confusion (correctional/security versus health care/clinical psychology/psychiatry).

For those who did not find the guidelines clear, issues were raised about the confusion resting between the intent of CD 843 and CD 850 to strongly encourage interdisciplinary work, and the limits put on sharing of information between the interdisciplinary team members (namely between security or parole and mental health professionals). There were also concerns (from correctional staff, health care professionals and managers) about **what** information can be shared within the limits of their respective licensing bodies, namely with the Parole Board of Canada (PBC) as we were informed that PBC members have been requesting information on the diagnosis and medication of certain offenders in order to assess risk.

The findings support the need for further clarification of the guidelines, and possibly a more cohesive approach with federal/provincial legislation and licensing bodies involved.

Commitment #11: Develop and implement standardized mental health service guidelines at all Regional Treatment Centres.[23]

Commitment #13: RTCs will continue to audit patient files to ensure that all patients have a treatment plan on file. Executive Directors Treatment Centres (EDTCs) to work with their

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[22] This commitment was made in response to recommendation # 3 of the Correctional Service Canada's Evaluation of Community Mental Health Initiative of 2008: *CSC should explore and develop mechanisms to increase information-sharing across institutional and community mental health and case management teams.*

[23] This commitment was made in response to recommendation # 2 of the Correctional Service Canada's Audit of Regional Treatment Centre and Regional Psychiatric Centre in 2011: *The Assistant Commissioner Health Services should develop processes to standardize mental health practices at the treatment centres and provide guidance to the Regional Treatment Centres when required*

clinical managers to address areas of non-compliance. Compliance target for fiscal year 2012-2013 will be raised to 90% and above.[24]

The mental health services guidelines touch upon different components of an offender "continuum of care" in Regional Treatment Centres: referral, consent and admission, assessment/treatment planning/progress monitoring and discharge processes.

The guidelines were developed and communicated consistently to CSC staff and managers, mainly through orientation sessions. The guidelines were also found on the Infonet and specific information decks were available to the reader under each component of the RTC's continuum of care.

The documentation regarding the guidelines was found to be confusing, as there seemed to be two sets of guidelines. The first set (which included processes for assessment, treatment planning and progress monitoring) was labeled as being implemented in November 2012 and revised in October, 2013; the other set (which included processes for referral, consent but also assessment, treatment planning, progress monitoring and discharge planning) was dated December 2012 and updated April 2013. Within the Infonet, they were found as a *compilation* of Guidelines. The guidelines would therefore benefit from a revamping exercise (organizing the content in one flowing document that contains consistent messages, standard format, easy references, etc).

We found that CSC measures compliance to the guidelines through the Treatment Centre performance measurement framework, which is subsequently rolled into the Mental Health Branch report. The data is collected at each of the sites and submitted to NHQ for roll-up.

Most sites visited had an internal monitoring process in place to assess compliance to these guidelines; these processes varied from site to site. The results of our interviews with EDTC's and clinical managers also supported the finding that areas of non-compliance were being addressed in every RTC/RPC, through the implementation of specific action plans and internal measures designed to follow-up with non-compliant employees or group of employees.

Although both these commitments were assessed as being met for all the reasons described above, we found a strong need to improve the compliance to the guidelines, across the RTC's. Our testing of offender files under each component of the continuum of care demonstrated mixed results; the compliance target of 90% and above, set by CSC mainly for the presence of treatment plans in files, was not met. Our overall results demonstrated that the guidelines were not being followed. Please refer to ***Annex E*** for details on the overall results.

[24] This commitment was made as part of the Executive Director Treatment Centre (EDTC) action plan in the Treatment Centre: Performance Measurement Framework Report Fiscal Year 2011-2012.

Commitment #25: Produce and distribute a segregation handbook for staff to clarify the policy expectation for the timely review of these cases.[25]

A segregation handbook for staff addressing policy expectations for timely review of segregation cases was produced in 2008 and was accessible through Infonet; however, we found no evidence of other distribution.

As the handbook for staff dates back to 2008, it was suggested it be updated to reflect the changes of the recently (March 2014) promulgated policy on Administrative Segregation (CD 709). The update could also help clarify the confusion that we found with staff and mental-health professionals, on the difference between the segregation handbook to assist staff and the segregation handbook designed for offenders in segregation to inform them of their rights.

[25] This commitment was made in response to recommendation # 4 of the 2008 Report of the Correctional Investigator: A preventable Death: *I recommend that CSC issue immediate direction to all staff regarding the legislated requirement to take into consideration each offender's state of health and health care needs (including mental health) in all decisions affecting offenders, including decisions relating to institutional placements, transfers, administrative segregation and disciplinary matters. CSC decision-related documentation must provide evidence that the decision-maker considered the offender's physical and mental health care needs.*

4.0 Conclusion and Recommendations

4.1 Conclusion

Addressing the mental health needs of offenders under its jurisdiction constitutes a priority for the Correctional Service of Canada, as it represents one of its highest organizational risks. As the number of offenders with mental health needs is increasing, CSC is paying a constant attention to the situation.

In order to mitigate that risk, CSC has developed a comprehensive Mental Health Strategy and has made a high number of commitments in terms of mental health; unfortunately, many of those commitments were not specific, measurable, achievable, relevant or time-bound, making their progress difficult to assess definitively.

Our review focused on those forty commitments assessed as highest risk for the organization. We looked at the actions taken by CSC to meet their commitments, and assessed the degree by which the actions taken were effectively implemented.

While we assessed most of the commitments reviewed as being met (36 out of 40), we highlighted some areas of improvement in nine (9) of them in order to ensure their full effectiveness. The remaining four commitments that were assessed as not being met refer mainly to an Evaluation of Health Services (including mental health) currently occurring within CSC, the need to develop and maintain regional and local partnerships in terms of mental health, the completion of a report on mental health prevalence data and finally, the measuring of correctional results for offenders with mental health disorders.

In order to complete the implementation of the commitments that are still deemed relevant and strengthen the overall corporate Mental Health Strategy, we made the following three (3) recommendations.

4.2 Recommendations

Recommendation 1:

The Assistant Commissioner, Health Services should develop and implement an approach to respond to, track and report on recommendations regarding mental health in a comprehensive, consistent and standardized manner, thus ensuring that mental health-related commitments are specific, measurable, achievable, relevant and time-bound.

Management Response:

*This recommendation is **Accepted.***
The Management Action Plan indicates that an accountabilities grid will be developed by 2015-03-31 and maintained on an ongoing basis for the tracking of ongoing commitments, including those not addressed by this review.

Recommendation 2:

We recommend that Health Services, in collaboration with other sectors, continue to lead the efforts to address the four commitments not met and discussed under section 3.1 of this report, and to fully implement the commitments met that are discussed under section 3.2.

Management Response:

*This recommendation is **Accepted.***
The Management Action Plan identifies a number of action items to address the commitments that are not met or those that are met but for which continued improvements would be beneficial to ensure their full effectiveness. These include an evaluation of health services, the addition of performance indicators with respect to recidivism and the publication of research on mental health prevalence. It will be fully implemented by 2016-03-31 (although Action Item #3 b), Recommendation 2 regarding the collection of data on offenders five years following end of sentence will be implemented by 2018-09-30).

*The Sector is in agreement with the Report's findings with respect to the status of commitments met. It should be noted for **Commitment #C-29** - Research project: Profile of mental health needs of women, that although a direct link could not be made with respect to achieving the expected result of reducing the number of offenders denied conditional release at eligibility due to unaddressed mental health problems, the Report was useful in informing the development of women-centred programs (eg. trauma-informed care and the revised model of Dialectical Behaviour Therapy (DBT)). Furthermore, additional improvements could be considered, such as research on women offender programming.*

Recommendation 3:

The Assistant Commissioner, Health Services, in collaboration with Regional Directors, Health Services and Executive Directors of Regional Treatment Centres / Regional Psychiatric Centre, should clarify policies where needed and strengthen processes to ensure that frontline staff are notified and use relevant policies (such as the RTC Guidelines, the Guidelines for Sharing Personal Health Information, CD 843-Management of inmate self-injurious and suicidal behaviour).

Management Response:

*This recommendation is **Accepted.***
The Management Action Plan confirms that the policy documents identified will be reviewed, clarified and communicated to staff, the means of which will include the delivery of webinars. It will be fully implemented by 2016-12-31.

Management Response

The Assistant Commissioner Health Services (ACHS) accepts Recommendations 1, 2 and 3.

The Health Services Sector has prepared a detailed action plan to address the issues raised in the Review. The Management Action Plan is scheduled for full implementation by 2016-12-31 (although Action Item #3, Recommendation 2 regarding the collection of data on offenders five years following end of sentence will be implemented by 2018-09-30).

The Sector is in agreement with the Report's findings with respect to the status of commitments met. It should be noted for ***Commitment #C-29*** **-** *Research project: Profile of mental health needs of women, that although a direct link could not be made with respect to achieving the expected result of reducing the number of offenders denied conditional release at eligibility due to unaddressed mental health problems, the Report was useful in informing the development of women-centred programs (eg. trauma-informed care and the revised model of Dialectical Behaviour Therapy (DBT)). Furthermore, additional improvements could be considered, such as research on women offender programming.*

Statement of Conformance

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

The review conforms to the Internal Auditing Standards for Government of Canada, as supported by the results of the quality assurance and improvement program. The evidence gathered was sufficient to provide senior management with proof of the opinion derived from the internal audit.

Sylvie Soucy, CIA
Chief Audit Executive

Annex A: Location of Site Examination

Region	Site
ATLANTIC	• Shepody Healing Centre (Dorchester Institution) • Westmorland Institution • Atlantic Institution • RHQ
PRAIRIES	• Regional Psychiatric Centre (RPC) • Saskatchewan Penitentiary Maximum Unit • Saskatchewan Penitentiary Medium Unit ▪ RHQ
ONTARIO	• RTC (Millhaven and Collins Bay-temporarily) • Central Ontario District (Downtown Toronto Parole Office) • Grand Valley Institution for Women • RHQ
QUEBEC	• Centre Régional de Santé Mentale (CRSM) • District Est-Ouest (CCC Laferriere) • Établissement Joliette ▪ RHQ
PACIFIC	• Regional Treatment Centre (RTC)/Pacific Institution • Mission Institution • Ferndale Institution ▪ RHQ

Annex B: Review Approach and Methodology

The methodology employed both qualitative and quantitative measures. Information used to facilitate our assessment of the completion and implementation of these commitments was collected through:

Site visits: site visits were conducted at all RTC's/RPC in the five regions**.**

File review/Testing: 402 files were reviewed / tested, including Case Management, Health Care, Offender Management System (OMS), Psychology, Treatment Centre and Human Resource Management System (HRMS) files.

Document reviews: 136 documents were reviewed, including: Commissioner's Directives, various Guidelines, documents on best practices and other supporting documentation for key controls.

Meetings and videoconferences: Overall, 127 different people were interviewed, representing 26 different positions in the organization. These positions are: Regional Deputy Commissioners (RDC's), Regional Directors, Health Services (RDHS), Regional Coordinators, Community Mental Health (RCCMH), Executive Directors Treatment Centres (EDTC), Institutional Heads, District Directors (DD), Correctional Managers (CM), Correctional Officers (CX), Managers of Assessment and Intervention (MAI) , Parole Officers (institutional and community) , Psychologists, Clinical Case Coordinators (CCC), Clinical Managers (CM), Nurse Supervisors, Nurses and Serious Disciplinary Hearing Advisor (SDHA).

Communications with other CSC staff and external partners: Communications and/or discussions were also held with the Assistant Commissioner, Health Services (ACHS), Director General, Health Services and her team, Director Operations, Aboriginal Initiatives, Director, Citizen Engagement, Director, Community Planning, Resources and Partnerships (CPRP), Director General, Women Offender sector, Staff Training Coordinators, Independent Chairpersons (ICP's) and Project Manager, Institutional Reintegration Operations.

Annex C: Previous Audit Work

Audit of Regional Treatment Centres and Regional Psychiatric Centres (January 2011)

While the majority of the findings were related to mental health issues, only the following were retained as the most significant for the purpose of this review:

- We found that not all roles and responsibilities for mental health services within the mental health governance model were defined. The interrelationship between the roles and responsibilities of the clinical and correctional staff was not clear;
- We found no performance indicators based on treatment outcomes at RHQ, or at NHQ which would assist treatment centres in demonstrating that they were meeting their strategic goals or mandate;
- We found no consistent reporting framework for the treatment centres.

Review of Practices in Place to Prevent/Respond to Death in Custody (February 2012)

The review focused on a total of twenty-four (24) commitments made by CSC to better respond to/prevent deaths in custody. The findings revealed that:

- 22 of the 24 commitments were assessed as fully completed;
- Out of those 24 commitments, 11 were related directly to mental health. Ten (10) out of those 11 commitments were identified as being completed. The one outstanding commitment related to installation of cameras in the cell areas of all women's institutions.

Review of Mental Health Screening at Intake (February 2012)

The review concluded that the management framework over the mental health screening of offenders at intake met departmental expectations and was working as intended, with the following areas identified for improvement:

- Challenges with respecting the timelines for mental health screening at intake;
- No formal mechanism or systematized process in place to convey the status of an offender's mental health screening;
- No monthly regional reception centre performance reports; and
- No reporting of performance information related to immediate needs interview.

Recommendations had been made in the report to address areas for improvement.

Since the results of those audits have been presented, many actions have been taken by CSC to resolve the identified issues. This review may have helped determine how successful CSC has been.

Annex D: Table of Commitments and Status

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
14	**Data Collection** • Percentage of target staff trained in mental health awareness	MH Branch External Commitments - June 2013 (RPP)	1	Mental health information - Data	Yes
15	**Training: Assessment and treatment** To keep professional mental health staff current with new development in assessment and treatment, and to provide the training of correctional staff to effectively interact with and supervise offenders with mental health problems	Panel Report - Roadmap to strengthening public safety (2007)	1	Mental health information - Training	Yes
16	**Dialectical Behavior Therapy (DBT): Awareness and Training** Dialectical Behavior Therapy (DBT) awareness and Training for Management in Women`s Institutions is under development and will be implemented in the Fall-Winter 2008	Response of the CSC to the 35th Annual Report of the Correctional Investigator 2007-2008 (Rec.#9)	1	Mental Health information - Training	Yes
17	**Training for CO's in minimum security: Fundamentals of MH** Deliver Fundamentals of Mental Health to Correctional Officers who work in minimum security institutions	Mental Health Branch External Commitments - June 2013 (Corporate Business Plan 2013-2016)	1	Mental Health information - Training	Yes

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
18	**Dynamic security course** Develop a dynamic security refresher course.	CSC Progress Report Response to the OCI DIC study, the correctional investigator's report 2012 (Rec. #2)	1	Mental Health information - Training	Yes
19	**Training: Suicide awareness, prevention and intervention** Institutional Heads and DD`s will ensure that all CO`s have received the approved CSC Suicide Prevention and Intervention training either as a component of the Correctional Training program (CTP) or on a stand-alone basis. As well, all other staff who have regular interactions with offenders will receive the Suicide Awareness component of the New employee Orientation Program (NEOP) either as a component of their orientation or on a stand-alone basis. All staff who have regular interactions with offenders shall be provided with two hours of refresher training in suicide prevention every two years.	Response of the CSC to the 35th Annual Report of the Correctional Investigator 2007-2008 (Rec.#9)	1	Mental Health information - Training	Yes

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
20	**Data Collection:** Health services are available to all offenders in institutions and the community in accordance with professionally accepted standards. Performance indicators: Number of offenders receiving community mental health services; Number of offenders receiving institutional mental health services	Mental Health Branch External Commitments - June 2013 (RPP)	1	Mental health information - Data	Yes
22	**Timeliness of MH screening: compliance statistics** ACHS will continue to monitor and report compliance statistics on a quarterly basis on the timelines of mental health screening	Review of Mental Health Screening at Intake MAP update September 2012	6	Mental health information – Data	Yes
27	**MH assessment: OMS referrals to psychology for significantly distressed offenders** Those offenders identified through CoMHISS as significantly distressed will be referred for further mental health assessment; OMS will indicate that a referral to psychology for follow-up has been made	Community Mental Health Initiative MAP update March 2, 2010 (Rec.#2)	1	Mental health information - Assessment	Yes

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
36	**MH screening: electronic recording of data** ACHS, in collaboration with ACCOP and SDC, will identify possible options to develop a system to electronically record dates of completion of mental health screening (4) and alert management to late completions. The options should also allow the aggregation of information to produce monthly regional reception centre performance reports. SDC will develop a system to electronically record dates of completion of mental health screening (4) and alert management to late completions. The solution will allow the aggregation of information to produce monthly regional reception centre performance reports	Review of Mental Health Screening at Intake MAP update September 2012 (Rec.#3)	1	Mental Health information - Data	Yes
38	**Data reporting on referral timeframes, continuity of care and community outcomes** Referral timeframes, continuity of care and community outcomes will be reported for CDP and CMHS offenders, and remedial actions where required will be ongoing	Evaluation of the Community Mental Health Initiative (2008) (Rec.#10)	1	Mental Health information - Data	Yes

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
40	**Development of Interdisciplinary training by HRM** Human Resources Management will develop interdisciplinary training to be offered at all Treatment Centres	Audit of RTC/RPC MAP update March 2013 (Rec.#1)	1	Mental Health information - Training	Yes
3	**Development of a process on request of professional assessments: segregation, transfer and disciplinary** Development of a process to ensure that professional assessments are requested and shared with the decision maker prior to making any inmate segregation, transfer and disciplinary decisions.	Audit of RTC and the RPC Rec.# 5 a) and Outstanding Commitments of RTC's and RPC's 2011	1	Mental health information - information Sharing	Yes
37	**MH prevalence data: systemic collection and analysis** Develop an approach for systemic collection and analysis of Mental Health prevalence data. A Working Group has been created to identify a systemic approach to collect and analyse mental health prevalence data to address this gap. MH prevalence rates are required for reporting on the RPP commitments and decision-making.	National Action Plan to Address the Needs of Offenders who Engage in Self Injury	1	Mental Health information - Data	No
31	**Recruitment/retention of employees: communication initiatives** Specific initiatives planned for 2009-2010 include targeted recruitment and partnerships with universities and colleges, and marketing CSC employment opportunities	Response of the CSC to the 36th Annual Report of the Correctional Investigator 2008-2009 (Rec.#1)	2	Human Resources Recruitment/ Retention	Yes

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
	through advertising, participation in job fairs and practicum placements. Analysis of the results of the Public Service Employment Survey as well as an internal survey on values and ethics will be used to inform ongoing efforts to improve employee retention.				
32	**Community Mental Health Initiative positions: ensuring the filling of positions and vacancies** Fill all CMHI positions and continue to monitor and take action to fill developing vacancies without delay. In January 2009, all CMHI positions were substantively filled. In June 2009, positions remain filled. Mental Health, Health Services will continue to monitor and take action to fill developing vacancies without delay, as required. The Service will continue to target the recruitment of health care professionals, particularly in areas where such services are not readily available in the community.	Evaluation of the Community Mental Health Initiative (2008) (Rec. #1)	2	Human Resources Recruitment/ Retention	Yes

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
5	**Roundtable: management and treatment of self-injurious offenders** CSC will organize a roundtable of external subject matter experts, regarding the effective management and treatment of serious self-injurious offenders in a correctional environment. The roundtable will also be asked to look at other methods for measuring compliance with the law and policy. The themes of this roundtable will be made public.	CSC Response to OCI Annual Report 2011-12 (Rec. #1) and Mental Health Branch External Commitments - June 2013	3	Partnerships	Yes
33	**MH support for offenders after the end of their sentence: introduction or expansion of service agreements** CSC will work with federal, provincial and territorial correctional and health officials to identify ways to introduce and/or expand exchange of service agreements to provide mental health support in the communities to offenders after the end of their sentences.	Panel Report - Roadmap to strengthening public safety (2007)	3	Partnerships	Yes
9	**Partnership Action Plan** Develop and implement a partnership action plan to better integrate CMHI community capacity and activities Mental Health, Health Services, will develop a Partners' action plan to identify specific actions related to community capacity building to address the gaps and facilitate the successful reintegration of offenders with a mental illness into Canadian	National Action Plan to Address the Needs of Offenders who Engage in Self Injury + Community Mental Health Initiative MAP update March 2, 2010 (Rec. #8) + Evaluation of	3	Partnerships	No

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
	communities. Upon completion of the gap analysis, mental health and health services will develop a partner's action plan.	the community mental health initiative (2008)(Rec. #8)			
12	**Contracts in community : numbers and trends** Have contracts in place to assist offenders under conditional release in the community. The Panel recommends increasing the use of contracted and volunteer service providers and the resources required to support their work in assisting offenders under conditional release in the community.	Panel Report - Roadmap to strengthening public safety (2007) and CSC Review Panel Recommendations – Update – April 2013	3	Partnerships	Yes
35	**Community partnerships: maintain and expand** CSC is committed to maintaining and expanding community partnerships in the area of mental health where community capacity exists. This focus is key to providing the stability and support necessary for an offender to be released and remain in the community in a law-abiding manner. CSC has also engaged the not-for-profit community and, in any given month, over 100 beds are available for offenders with mental health care needs, across Canada, in community based residential facilities.	Annual report of the Correctional Investigator 2011-2012 (Rec. #2)	3	Partnerships	Yes

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
30	**Panel of correctional practitioners for development of standards in recruiting/retaining CO's** CSC will be convening in the coming year, a panel of correctional practitioners from other jurisdictions and mental health professionals, to assess the feasibility of developing standards for the recruitment and training of CO`s who work with offenders with mental health profiles.	Response of the CSC to the 37th Annual report of the Correctional Investigator 2009-2010 (Rec. #2)	3	Partnerships	Yes
4	**Provision of MH services: standards** CSC is committed to providing appropriate essential mental health services within professionally accepted standards and applicable legislation. Individual assessments will be conducted on those offenders who have been identified as the most chronic and complex cases of self-injury to provide assurances that appropriate treatment options are in place and if required, cases will be assessed as to whether a placement in a provincial mental health facility is possible.	Response of the CSC to the 38th annual report of the Correctional Investigator 2010-2011 (Rec. #5)	4	Needs-Service adequacy - Suicide and Self-Injury	Yes

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
23	**Strenghtening the Continuum of care: actions taken** CSC will continue to strengthen the continuum and continuity of specialized mental health support throughout the duration of offenders' sentences, including conducting a planned evaluation of CSC's Mental Health Services to provide a base of evidence in this area.	Mental Health Branch External Commitments - June 2013 (Corporate Business Plan 2013-2016)	4	Needs-Services adequacy - Continuum of Care	No
29	**Research project: Profile of MH needs for women** Development of a profile of mental health needs of women offenders in order to identify their areas of special needs	Overview of mental health commitments - RPP and DPR 2010-2011	4	Needs-Service adequacy – Women	Yes
26	**CD 709: Amendments required** In recognition of the importance of building appropriate safeguards around mental health and administrative segregation, CSC is strengthening its policy framework in the following ways: Adding explicit requirements to CD 709 Administrative Segregation for staff to assess, consider and properly document the mental health care concerns of an inmate being considered for segregation placement, including any plan to address the inmate's health concerns. Their assessment will also be documented as part of the immediate needs checklist. CD	Annual report of the Correctional Investigator 2011-2012 (Rec.#3)	5	Policy/ Guidelines/ Legislation	Yes

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
	709 is anticipated to be promulgated in September 2012; however, the Case Management Bulletin stipulating the requirement to complete the immediate needs checklist was promulgated on October 21, 2010.				
1	**Document on good practices: management of offenders who self-injure** A document highlighting good practices to take into consideration when managing an offender who self-injures is currently in the final consultation stage. It will be widely distributed to frontline staff and shared with the federal Provincial territorial WG on Mental Health (Heads of Corrections sub-committee) in August 2009.	Response of the CSC to the 36th Annual Report of the Correctional Investigator 2008-2009 (Rec.# 7)	5	Policy/ Guidelines/ Legislation	Yes
2	**Guidelines on sharing of MH-related information** Consult with Legal services to create guidelines regarding the sharing of MH information across the continuum of care. Develop guidelines on sharing mental health-related information and communicate them to staff. Prepare guidelines for staff to clarify legislative and policy requirements around sharing of personal health information. Legal Services will then create Information Sharing Guidelines to assist front-line CSC staff in decision-making regarding the sharing of mental health information across the	Evaluation of the community mental health initiative 2008 (Rec.#3)	5	Policy/ Guidelines/ Legislation	Yes

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
	continuum of care and with various professional mental health care providers and others (individuals who have a need to know by virtue of their interaction with an offender).				
11	**MH Service: Guidelines for RTC's** Develop and implement standardized mental health service guidelines at all Regional Treatment Centres.	Audit of RTC/RPC MAP update March 2013 (Rec.#2)	5	Policy/ Guidelines/ Legislation	Yes
25	**Segregation handbook** Produce and distribute a segregation handbook for staff to clarify the policy expectation for the timely review of these cases.	CSC Progress Report Response to the OCI DIC study, the correctional investigator's report (2012)	5	Policy / Guidelines/ Legislation	Yes
21	**Timeliness of MH screening: Review by RDC's and RD's** 1.a) RDCs, in collaboration with RDs Health Services, will review their intake process from a Mental Health screening perspective and identify challenges, issues and solutions to improve the timeliness of mental health screening at intake. The review will focus on the Comprehensive Nursing Assessment (14 days), the CoMHISS testing (3-14 days) and the Immediate Needs Interview (Atlantic Region) Review of MH Intake Screening and Assessment Process	National Action Plan to Address the Needs of Offenders who Engage in Self Injury + Review of Mental Health Screening at Intake MAP update September 2012	6	Review/ Research/ Performance measurement	Yes

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
28	**MH assessment for Aboriginals** The Panel recommends that CSC review its approach to mental health assessments of Aboriginals at intake and ensure effective screening techniques are in place	CSC Review Panel Recommendations – Update – April 2013	6	Review/ Research/ Performance measurement	Yes
39	**Validation of CoMHISS system** Validation of the CoMHISS: to what extent do these results relate to actual diagnosis for mental disorder or for need for service?	National Action Plan to Address the needs of offenders who engage in self-injury	6	Review/ Research/ Performance measurement	Yes
34	**Correctional results for federal offenders with MH disorders** Sustaining current correctional results for federal offenders with mental health disorders, as measured by: The percentage of federal offenders with mental health disorders returning to federal custody within two years of the end of their sentence. The percentage of federal offenders with mental health disorders returning to federal custody within five years of the end of their sentence.	Overview of mental health commitments - RPP and DPR 2008-2009	6	Review/ Research/ Performance measurement	No

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
6	**National inmate suicide prevention peer support program** Determine the feasibility of implementing a national inmate suicide prevention peer support program	National Action Plan to Address the Needs of Offenders who Engage in Self Injury	7	Governance	Yes
7	**MH screening at intake: corrective measures** 1.b) RDCs, in collaboration with RDs Health Services, will implement corrective measures, adapted to each reception unit needs, to improve the timeliness of mental health screening at intake	Review of Mental Health Screening at Intake _ MAP update September 2012 (Rec.# 2)	7	Governance	Yes
8	**Strategy to address various areas of management framework: self-injury** CSC has recently undertaken a review of incidents of self-injury. Results confirm that incidents of self-injury have grown by 73% over a period of 30 months, April 2006 through September 2008. Nevertheless, although only a relatively small percentage of inmates can be categorized as chronic self-harmers, CSC takes this issue very seriously and has a number of initiatives underway to address this. Nine (9) women and 27 men over this time period engaged in 6 or more acts of self-injury. A national WG has drafted a process for the management of inmates who self-injure. As well a review of best practices in the	Response of the CSC to the 36th Annual Report of the Correctional Investigator 2008-2009	7	Governance	Yes

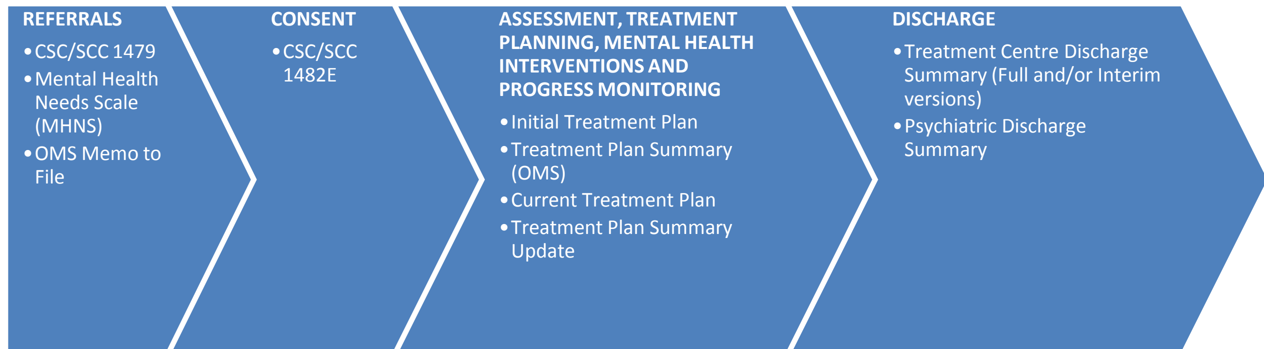
C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
	management of self-injury has been completed and research into common characteristics of self-injurers is well underway. These elements will be included in a comprehensive strategy that will address areas such as policy, improved processes for managing and monitoring of incidents involving self-injury, staff training, and roles and responsibility of staff and managers. The strategy will be issued in October 2009.				
10	**Correctional MH Strategy and Action Plan** Develop Pan-Canadian Correctional MH Strategy and Action Plan, which will include items related to stigma and discrimination. The Working Group, which includes representation from the Mental Health Commission of Canada, will work towards the development of a National Corrections Mental Health Strategy. This work will be informed and supported by an ad hoc working group on mental health. This working group will work towards the development towards a national corrections mental health strategy	National Action Plan to Address the Needs of Offenders who Engage in Self Injury and Community Mental Health Initiative MAP update March 2, 2010	7	Governance	Yes

C-#	Commitment	Reference	Criteria #	Theme	Commitment met (Yes/No)
13	**RTC's: Audit of patient's files** RTCs will continue to audit patient files to ensure that all patients have a treatment plan on file. EDTCs to work with their clinical managers to address areas of non-compliance. Compliance target for fiscal year 2012-2013 will be raised to 90% and above	Overview of Mental Health Results - Treatment Centre: Performance Measurement Framework Report	7	Governance	Yes
24	**Funding for Complex needs Units(CNU's)** Funding will also be sought for two (2) Complex Needs Units (CNU) to function as national resources for the most serious of repeat self-injurious male offenders to provide specialized program and services for male offenders who engage in persistent self-injurious behaviour.	Response of the CSC to the 37th Annual report of the Correctional Investigator 2009-2010 (Rec.#5)	8	Finance	Yes

Annex E: Results of file reviews (RTC Guidelines)

To verify the compliance to the RTC guidelines, we proceeded with the review of targeted files under each component of the continuum of care at RTC's. Our sample included offender files between February 1, 2013 and December 31, 2013.[26] The following diagram presents what we looked at for each process identified:

Treatment Centre Continuum of Care



Process category: Referrals

According to the RTC Guidelines, all referrals to RTC's (including emergency and non-voluntary referrals) should include the completion of:

1) The standardized *Regional Treatment Centre Referral Form (CSC/SCC 1479),* to be placed on the Treatment Centre (TC) file
2) The *Mental Health Needs Scale (MHNS),* to be found in the Psychology, TC and the Health Care (HC) files

Our findings in the review of forty-six (46) TC files showed that:

- Seventy-four percent (74%) did not have a *Regional Treatment Centre Referral Form* on file (CSC/SCC 1479)
- Seventy-six percent (76%) did not have a *Mental Health Needs Scale* document on file

All referral decisions should also be formally communicated to the referring staff/institution via an OMS *Memo to File – RTC Referral Decision* within fifteen (15) working days of receipt of referral. Our findings showed that out of the forty-six (46) OMS files reviewed, twenty-six (26) or 57% had the *RTC Referral Decision Memo* completed on OMS; twenty-four (24) of those referral decisions were posted within 15 working days.

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[26] RTC Guidelines were published December 2012; however, the Review team provided a buffer time to allow for implementation.

Process category: Consent

According to the RTC Guidelines, for all voluntary admissions, a signed copy of *the Voluntary consent to participate in Regional Treatment Centre Services (CSC 1482E)* must be obtained before any mental health assessment or treatment can be provided. Within twenty-four hours (24hrs) of admission, the consent form should be placed on the TC file.

Out of forty-six (46) TC files reviewed, 39 (87%) had a voluntary consent signed on file[27].

Process category: Assessment, Treatment Planning, Mental Health Intervention and Progress Monitoring

According to the RTC Guidelines, a ***RTC Treatment Plan*** (kept on the patient's TC file) and an ***Initial RTC Treatment Plan Summary*** *(*placed on Psychology, HC and Case Management (CM) files, copied to OMS, share-printed with the Parole Board of Canada (PBC) and shared with the patient) should be prepared within thirty (30) calendar days of admission[28]. An exception exists for emergency/acute patient admissions, for which an interim treatment/crisis intervention plan must be developed within two (2) working days of admission and placed on the TC file; and within thirty (30) calendar days of the stabilization of acute symptoms/behaviours, a regular treatment plan and an initial treatment plan summary should be completed. The review team considered this exception when reviewing files of emergency cases.

In addition to finding treatment plans in patient's files, we expected to find evidence that those files were being monitored by EDTC's to ensure compliance, and areas of non-compliance were being addressed.

Through document review, we found evidence that EDTCs were conducting and/or planning, on a quarterly or bi-annual basis, RTC compliance reviews to ensure the treatment plans were on file. In fact, CSC already measures compliance through the Treatment Centre performance measurement framework, which is subsequently rolled into the Mental Health Branch report. The data is collected at each of the sites and submitted to NHQ for roll-up.

CSC's latest Performance Measurement Report[29] showed a compliance rate of 73% for offenders admitted to RTC that had a treatment plan on file.

[27] Of the remaining seven files, only one met the provincial legislative requirement for certification.

[28] Note: In the RTC Guidelines, the word document explaining where the Initial Treatment Plan Summary file should be mentions it should be found in the Health Care, Case Management, Psychology and OMS files. However, in the example document provided, it is indicated that it should also be in the Treatment Centre file.

[29] CSC Mental Health Branch Performance Measurement Report Bi-Annual Results 2013-2014 (April 1st, 2013 to September 30, 2013).

Our findings in the review of forty-six (46) files (22 regular admissions and 24 emergency admissions) showed that:

- For regular admissions, 64% (14 out of 22) of the files had the *Initial treatment plan* on TC file
- For all admissions, 41% (19 out of 46) of the files had the *Current treatment plan* on TC file

When we looked at *Initial Treatment Plan Summaries*, we found that:

- Less than half[30] of the files reviewed had a *Treatment Plan Summary* on HC, Psychology and CM files
- More than a half (26 out of 46) of the files reviewed had it on OMS.

According to the RTC Guidelines, ***Treatment Plan Summary Updates*** are to be completed every ninety (90) calendar days, filed on the TC file and copied to the OMS, Psychology, HC and CM files, share-printed with the PBC, and shared with the offender.

Our findings in the review of forty-six (46) files showed that:

- Only thirty-four (34) required to have *Treatment Plan Summary Update* on TC, HC, Psychology, CM files and on OMS
- Out of those thirty-four (34), 50% or less[31] of the files had the *Treatment Plan Summary Update* completed
- In those cases where there was a completed *Treatment Plan Summary Update*, we looked at the time elapsed between the most recent update and the previous update (or the date of initial treatment plan summary): 62% (13 out of 21) had the most recent update completed within 90 calendar days of previous update (or the date of initial treatment plan summary).

Process category: **Discharge**

According to the RTC Guidelines, there are two main types of ***Discharge Summary*** reports: the ***Psychiatric Discharge Summary***, authored by a psychiatrist, to be placed on TC, HC, and Psychology files; and the ***Treatment Centre Discharge Summary*** (full and interim versions), authored by a clinical member of the interdisciplinary team designated by a clinical manager or clinical case coordinator, to be placed on TC, Psychology, HC, and CM files, as well as on OMS**:** Memo to File –RTC Discharge Summary - Full or Interim Version, share printed with PBC and shared with the offender.

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[30] HC file: 21/46; Psychology file :14/46 and CM file: 20/46
[31] TC file: 17/34; HC file: 12/34; Psychology file: 8/34; CM file: 13/34; OMS file: 17/34

Our findings in the review of fifty-one (51) offender files (TC and OMS) showed that:

- Sixty-seven percent (67%) had a *Treatment Centre Discharge Summary* on the TC file
- Most of them were completed within the prescribed timeframes and they were documented on OMS

We were unable to conclude on the file review of *Psychiatric discharge summaries* as in some regions, the same mental health professional (psychiatrist) wrote both documents and the reports were almost identical. The fact that one of these documents is to be placed on OMS could raise privacy concerns.

Annex F: Glossary

Commitment: Act binding CSC to a course of action, a promise (to another) to do something in the future.

Community Mental Health Initiative (**CMHI**): Refers to a service designed to ensure a continuum of mental health care between Correctional Service of Canada (CSC) institutions and the community to better manage and support offenders, with the ultimate goal of positively impacting public safety while improving the quality of life of offenders.

Finance: The review team included in this category funding and financial coding.

Governance: The review team included in this category any commitment referring to accountability, roles and responsibilities and administration.

Human Resources – Recruitment/Retention: The review team considered in this category all types of practices used within CSC to recruit and retain front line mental health care providers and mental health professionals.

Implementation: Carrying out, putting into action and/or practice a policy, program or activity; detection of its strength.

Mental Health Information: The review team included in this category any type of detection, assessment and communication of information, which includes:

- Assessment methods/tools (intake, follow-up, specialized etc.)
- Data: collection, input, retention analysis, trends, reports, performance/information management, systems
- Mental health awareness/training sessions: including multiple target groups
- Information sharing: between CSC and partners, between mental health professionals, between CSC staff

Mental Health Needs Scale (MHNS): Tool designed to organize findings and document the results of an assessment process, and completed by a licensed mental health professional (or mental health staff under the supervision of a licensed mental health professional). The scale consists of three main parts: ratings of Overall Mental Health Need, ratings of Mental Health Need in Specific Domains of functioning, and a notification that Immediate Action is required. There is also a section for adding Comments, if necessary.

Need-Service Adequacy/Intensity of Care: The review team included in this category the following:

- Treatment services and support: primary, intermediate, intensive care, transitional service
- Continuum of care: institution, community, transitional care, clinical discharge planning
- Suicide/Self injury: prevention and management

- Women: infrastructure, services, treatment
- Aboriginal population: infrastructure, services, treatment

Offender Management System (OMS): computerized file management system that manages information on federal offenders throughout their sentence.

Partnerships/Contracts: The review team considered in this category a variety of stakeholders, volunteers, contractors, partners under a memorandum of understanding (MOU), supporting CSC's achievement of mental health-related practices and interventions.

Policy/Guidelines/Legislative category: The review team considered in this category mental health-related legislation, Commissioner's Directives, Guidelines, Best practices, etc.

Review/Research/Performance measurement category: The review team considered in this category mental health-related research, management reviews, etc.