Acknowledging Offender Trauma at Intake: A Qualitative Thematic Analysis of Canadian Correctional Policy

by

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A thesis submitted to the
School of Graduate and Postdoctoral Studies in partial
fulfillment of the requirements for the degree of

Master of Arts in Criminology

Faculty of Social Science and Humanities

University of Ontario Institute of Technology (Ontario Tech University)

Oshawa, Ontario, Canada

August 2023

THESIS EXAMINATION INFORMATION

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Master of Arts in **Criminology**

Thesis title: **Acknowledging Offender Trauma at Intake: A Qualitative Thematic Analysis of Canadian Correctional Policy**

An oral defense of this thesis took place on August 10, 2023 in front of the following examining committee:

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ABSTRACT

Trauma has seldom been discussed in the literature in relation to incarceration. The research that does exist has tended to be gendered, focusing predominantly on the trauma experiences of female offenders. The current study examined the written policies that guide the Offender Intake Assessment (OIA) process in Canada to assess the extent to which trauma is being considered at point of intake, particularly for male offenders. A descriptive research design was used to assess the level of policy specific attention given to trauma and trauma-informed correctional care (TICC). An examination of current policies, audits/reviews, and action plans revealed 11 key themes. The results of this study reveal a need for improved policy guidelines for addressing the trauma experiences of male offenders in Canada. Implications, limitations, and future directions are also considered.

Keywords: trauma; intake policy; male offenders; labelling; federal corrections

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ACKNOWLEDGEMENTS

My sincerest thanks to my supervisor Dr. Karla Dhungana-Sainju for her continuous kindness and mentorship. I appreciate everything you have done and continue to do in support of me.

My heartfelt appreciation goes to Dr. Carla Cesaroni, whose guidance and support helped me complete this project.

Finally, thank you to my friends and my big sister for always encouraging me to be my best. You are my people, and for that, I can never thank you enough.

DEDICATION

For my mother, Suzanne.

My work is a mere reflection of all yours. Thank you for that.

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LIST OF ABBREVIATIONS AND SYMBOLS

ASRS	Adult Self-Report Scale for Attention Deficit Hyperactivity Disorder
BSI	Brief Symptom Inventory
CCRA	Corrections and Conditional Release Act
CCRR	Corrections and Conditional Release Regulations
CD	Commissioner's Directive
CHA	Canada Health Act
CO	Correctional Officer
CoMHISS	Computerized Mental Health Intake Screening System
CRI	Criminal Risk Index
CSC	Correctional Service Canada
DHS	Depression, Hopelessness and Suicide Screening Form
GAMA	General Ability Measure for Adults
IAU	Intake Assessment Unit
MH	Mental Health
MHTS	Mental Health Tracking System
OIA	Offender Intake Assessment
OMS	Offender Management System
PO	Parole Officer
RTC	Regional Treatment Centre
SIR-R1	Statistical Information on Recidivism - Revised 1
TICC	Trauma-Informed Correctional Care

Chapter 1. Introduction

Trauma is part of the human experience and is something that all individuals endure at some point in their lives (Naidoo, 2021). Historically, service systems have failed to acknowledge, understand, or address the impact of trauma experiences on human behaviour and the need for tailored responses to such behaviour (Centre for Substance Abuse Treatment, 2014; SAMHSA, 2014). It has been suggested that unaddressed trauma can lead to emotional and psychological distress and impairment, resulting in maladaptive coping strategies such as anger, aggression, violence, and substance abuse (Burrell, 2013; Vaswani, Cesaroni, & Maycock, 2021; Wallace et al., 2011; Welfare & Hollin, 2015). Research over the last several decades has reliably demonstrated an association between exposure to traumatic events and a range of psychological outcomes, including anxiety, depression, substance abuse, suicide, self-injurious behaviors, and dissociation (Briere & Dietrich, 2016). In turn, these maladaptive coping strategies have been shown to play a prominent role in criminal and antisocial behaviour (Welfare & Hollin, 2015; Vaswani et al., 2021).

Trauma has seldom been discussed in the literature in relation to incarceration, whether in regard to traumatic precursors, trauma sustained in prison, trauma upon release, or the effect of trauma-related disorders on recidivism (Wallace et al., 2011). There is a paucity of research examining trauma experiences prior to incarceration and the effects of such experiences on rehabilitation efforts and rates of re-offending. The research that does exist has tended to be gendered, focusing predominantly on the trauma experiences of female offenders (Komarovskaya et al., 2011; Miller & Najavits, 2012), with a lack of academic, policy, and programming attention being given to the trauma

experiences of incarcerated men (Vaswani et al., 2021). Approximately three-quarters of incarcerated men have experienced some form of traumatic event in their life (Vaswani, Cesaroni, & Maycock, 2021). It is therefore problematic that few trauma-informed interventions exist to address such behaviours in incarcerated men (Miller & Najavits, 2012).

The Correctional Service of Canada (CSC) is responsible for the management of 43 institutions across the country. Of these 43, five institutions deal specifically with female offenders, while the remaining 38 deal with male offenders. As of 2020-21, CSC was responsible for 12,396 offenders under its care (Correctional Service of Canada, 2022). Of the total offender population, 618 (5.0%) were female, while the remaining 11,778 (95%) were male (Correctional Service of Canada, 2022). It is clear from this breakdown that most inmates in Canada are in fact male. Thus, it is interesting that the literature surrounding trauma-informed care, to date, has predominantly focused on female offenders.

CSC has an obligation to support the various needs of individuals incarcerated within federal institutions. In addition, there is a moral obligation to ensure those individuals returning to the community are not worse off than when they entered the institution. This obligation is one that CSC has towards offenders, but also to the communities to which these individuals are being released. Therefore, the policies and practices that CSC has implemented to address offender trauma and mental health are important for the maintenance of safe institutions and safe communities.

Unresolved trauma can lead to unmanageable behaviour and may make reintegration more difficult to accomplish (Miller & Najavits, 2021; Vaswani, 2014). In turn, this may

lead to higher rates of reoffending. There is therefore a need to understand the effects of trauma on rehabilitation efforts as well as to establish effective and efficient policies for treating trauma among offender populations. This study aims to review existing Canadian correctional policies to examine the extent to which trauma-informed practices are being considered at the federal level, and if guidelines exist to implement such practices during the OIA process, specifically in relation to male offenders. This research is important for understanding criminal recidivism and its relationship with trauma among federal offenders in Canada.

Chapter 2. Literature Review

2.1 A Definition of Trauma

Several definitions of trauma have been offered in the literature. Trauma has been defined by the American Psychiatric Association (2013) as an experienced or observed event that threatens the physical or psychological well-being of oneself or others, and produces feelings of fear, helplessness, or shock. Trauma is also commonly defined from the survivor's experience. According to the Substance Abuse and Mental Health Services Administration (SAMHSA; 2014, p.7), "trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and well-being." Randall and Haskell (2013) define trauma as an individual experience or event that reduces one's ability to cope with that event and in turn leads to feelings of fear, terror, hopelessness, and/or despair. Similarly, King (2017) describes trauma as an individual's experience of an event that considerably negatively affects their ability to cope with or recover from it, evoking emotions such as fear, hopelessness and a sense of violation. Abate et al. (2017), more broadly, claim that trauma should be defined as those events or series of events that are experienced by an individual as physically or emotionally harmful.

Different experts define trauma in different ways, and while Berliner and Kolko (2016) argue for the need to develop a common definition that can be operationalized across different systems, Mejia (2005) discusses the importance of maintaining a broad definition as trauma presents itself in many different forms. For the purpose of the current

study, trauma has been defined broadly as an experience or series of experiences that are deemed by an individual to be physically or emotionally harmful.

2.2 The Trauma-Crime Link

Research has revealed the link between histories of trauma and criminality (Honorato et al., 2016; Martin et al., 2014; Randall & Haskell, 2013). Wolff and Shi (2012), for example, recognize the overlap among trauma, mental health, substance abuse, and behavioural problems. They state that trauma in adolescence has consequences across the life course and predicts violence and criminality in adulthood (Martin et al., 2015; Wolff & Shi, 2012). The psychosocial difficulties stemming from traumatic events, according to Mohamed (2015), have come to be known as trauma symptoms. These symptoms include anger, aggression, self-destructive behaviour, flashbacks, nightmares, feelings of alienation, diminished empathy, or avoidance behaviours (Mohamed, 2015; Wolff & Shi, 2012), all of which can contribute to criminal behaviour. Moreover, trauma, according to Wolff and Shi (2012), is associated with higher rates of mental illness such as depression and anxiety.

2.3 Prevalence of Trauma in the Correctional Setting

There is consensus in the literature that rates of both childhood and adult trauma are high among offenders (Auty et al., 2022; Honorato et al., 2016; Martin et al., 2015; Maschi et al., 2011; 2022; Wolff & Shi, 2012). Much of the research conducted on the trauma-crime relationship has focused on young offenders (Ardino, 2012; Welfare and Hollin, 2015). While childhood trauma has been shown to be common among incarcerated populations, trauma experiences are also prevalent beyond childhood and

into adulthood. Maschi et al. (2011), note that there is a high frequency of accumulating traumatic life experiences among inmate populations.

According to Wolff et al. (2015), the lifetime trauma exposure rate for incarcerated men is far higher than that of the general population. Vaswani et al. (2021) predict that approximately three-quarters of incarcerated men have experienced some form of traumatic event in their life. Yet, trauma is far more likely to be addressed in female than in male offenders (Komarovskaya et al., 2011; Miller & Najavits, 2012). According to King (2015), compared with men, incarcerated women report higher rates of prior victimization, mental illness, and substance abuse. However, this discrepancy may be due to underreporting by men. While females tend to report greater exposure to trauma over the life-course, males frequently present with more symptoms, have lower usage of therapeutic interventions, and respond less well to treatment than females (Vaswani et al., 2021).

Based on a review of the literature, it is clear that male offenders experience trauma at higher rates than the general population. Moreover, men tend to present with more trauma symptoms (Vaswani et al., 2021) and are less likely than their female counterparts to have these symptoms addressed (Komarovskaya et al., 2011; Miller & Najavits, 2012). With the offender population in Canada being overwhelmingly male, it is beneficial to the safety of the community to establish guidelines and intervention strategies that address trauma symptoms in male offenders.

2.4 Trauma, Recidivism, and Barriers to Rehabilitation

Trauma has been conceptualized as a risk factor that impacts one's capacity to engage with treatment interventions (Fritzon et al., 2021; Holloway et al., 2018; Honorato

et al., 2016; Wallace et al., 2011). Individuals with a history of trauma may display behaviours out of their conscious control, including behaviours that are disruptive, aggressive, or highly emotional (DeHart & Iachini, 2019). These behaviours, according to Muskett (2014), serve as barriers to effective treatment and rehabilitation, making individuals less resilient and more vulnerable to negative outcomes, further complicating the reintegration process (Levenson & Willis, 2018).

Unresolved trauma and a lack of adequate resources to address compromised social well-being contributes to recidivism among offender populations (Ardino, 2012; Hecker et al., 2015; Komarovskaya et al., 2011; Leach et al., 2008; Maschi et al., 2011; Michalski, 2017). Unaddressed trauma can lead to maladaptive coping strategies that help to relieve the symptoms of unresolved trauma, such as anger, aggression, substance abuse, risk-taking, and violence (Honorato et al., 2016; Levenson & Willis, 2019; Martin et al., 2015; Vaswani et al., 2021). These behavioural reactions are often overlooked by criminal justice workers as trauma symptoms, leading to punitive responses such as segregation and the limitation of privileges (DeHart & Iachini, 2019). As a result, offenders with histories of trauma fail to receive adequate treatment and are instead subject to further traumatization within the walls of the institution.

Punitive responses to trauma within the correctional setting often exacerbates trauma symptoms which can, and often does, contribute to violence and criminal recidivism. To adequately and effectively manage and rehabilitate offenders with trauma histories, there must be a standard of care for treating these individuals. Specifically, there should be a set of guidelines for how offenders with histories of trauma are to be cared for within correctional institutions and how staff are to manage these offenders

throughout their sentence. Moreover, these guidelines should be gender-informed, as men and women present differently with trauma symptoms and mechanisms for coping with such symptoms.

2.5 Theoretical Framework - Labelling Theory and Addressing the Culture of Trauma

Labelling theory states that powerful individuals and the state create crime by labeling some behaviours as inappropriate. Becker (1963) defined deviance as a social creation in which "social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labeling them as outsiders" (p. 9). Labelling theory suggests that people's behavior is influenced by the label attached to them by society (Becker, 1963). Some individuals may be more susceptible to certain labels than others, depending on their characteristics. Men for instance are more likely to be labelled as perpetrators of violence and less likely to be labelled as victims (Mohamed, 2015). When it comes to trauma and rehabilitation, it is the simultaneous labelling of men as perpetrator and unsuitable victim that is problematic.

2.6 Perpetrator Trauma and the Male Offender

Labelling becomes a source of potential harm when it is paired with dehumanization. Bloom (2017) states that dehumanization justifies harmful behaviour because the individual is placed outside the realm of morality. In a criminological sense, it is the male offender who is often placed outside the realm of morality. Often in criminological literature, men are painted as perpetrators and therefore constructed as unsuitable victims (Cunico & Lermen, 2020). When it comes to studying crime and criminal behaviour, the stereotypical offender is male. Classical theories of crime address

the male offender as someone who is masculine, aggressive, violent, and predatory. For example, Agnew (2006) states in his General Theory of Crime, that men experience gender-specific strains that are more conducive to crime and therefore may explain why men commit crimes at higher rates than women. Similarly, Sutherland (1960) suggests that the social tendency to teach boys to be dominant and tough makes it more likely for them to engage in delinquent and criminal behaviour. As noted by Steffensmeier and Allan (1996), to acknowledge or address male trauma is at odds with male gender norms. Within criminological literature, women's trajectories of suffering are highlighted, while men are given the role of perpetrators of aggression, being rarely positioned as victims of aggression (Cunico & Lermen, 2020; Depraetere et al., 2020).

Mohamed (2015) argues that acknowledging the trauma experiences of perpetrators of crime is both appropriate and highly important, questioning why and how trauma is only associated with victims as opposed to perpetrators of crime. The culture of trauma, however, reinforces those divides, and it situates the experience of trauma squarely within the world of victims, who are often females (Mohamed, 2015). Even though perpetrators experience their acts as trauma, that fact is neglected in responses to mass atrocity, with the only mentions of trauma on the part of perpetrators expediently reframed as the trauma of a victim (Mohamed, 2015).

Perpetrator trauma does exist and has been largely overlooked in the literature. Most of the research that addresses trauma has focused on victim trauma, with very few studies suggesting that perpetrators of crime may also experience trauma (Mohamed, 2015). Acknowledging the ordinary humanity of perpetrators is productive because it forces us to examine the choices they made, and the paths that led them to commit their

crimes (Mohamed, 2015). Labelling male offenders one dimensionally as simply perpetrators of crime is problematic. Trauma is no longer simply the private experience of a single person. It becomes, rather, a destructive obstacle to the larger community's process of reconciliation and restoration (Mohamed, 2015).

2.7 Trauma-Informed Correctional Care (TICC)

Trauma-informed correctional care (TICC) is a topic that has garnered increased attention in recent years. A trauma-informed approach recognizes and understands the complexities of trauma responses and their developmental impacts (Randall & Haskell, 2013). The literature offers relative consensus around the core domains of a trauma-informed legal system but much less agreement on the specific policies and procedures that are required to put this into practice (Branson et al., 2017). According to Randall and Haskell (2013), TICC entails an awareness of the ways in which life trajectories are shaped by trauma experiences and the effects, and developing policies and practices which reflect this understanding.

TICC can help minimize trauma-related behaviours and symptoms that can be difficult for prison staff to manage (Fritzon et al., 2021; Martin et al., 2015). TICC can help in the quest to develop relevant and successful correctional programming, practices, and policies, as well as the most effective methods of delivery (Levenson & Willis, 2019; Martin et al., 2015; Miller & Najavits, 2012), which in turn, may help improve the desired outcomes of successful re-entry and reduced recidivism.

TICC involves providing comprehensive training for staff, creating safe and supportive environments, conducting thorough assessments, and providing trauma-specific services to inmates (AIR, 2013). A one-size-fits-all approach to trauma is

insufficient (Martin et al., 2015; Maschi et al., 2011). Although there has been a push in the juvenile institutions to adopt TICC, much less is being done in the adult system (Maschi et al., 2011). Furthermore, as noted by Levenson and Willis (2018), male correctional populations are among the last frontier for TICC implementation.

2.8 Gender Specific Approaches to TICC

Research on trauma has tended to be gendered through a focus on women, with men being overlooked (Komarovskaya et al., 2011; Matheson, 2012; Vaswani et al., 2021; Wolff & Shi, 2012). According to Wade et al. (2016), there is a need to more closely investigate the gender differences in treatment response to psychological interventions for trauma. Men and women differ in the nature of traumas experienced and in terms of behavioural manifestations of trauma experiences (Martin et al., 2015). Men and women, therefore, require different treatment and reintegration services (Levenson & Willis, 2019; Randall & Haskell, 2013). Furthermore, different practice and policy guidelines to inform these services for men and women are also required.

Some researchers have proposed that women and men can experience trauma and its long-term effects in ways that are determined by women's and men's distinct patterns of gender socialization (Brown, 1990; Sharpe & Heppner, 1991). However, when prison is considered as gendered, it is usually in relation to female inmates rather than males. It has been proposed that prison culture is shaped by gender, specifically masculinity (Ricciardelli, 2015). Masculinities are often constructed, maintained, and restructured according to particular social networks in each environment (Cesaroni & Alvi, 2010). In order to maintain a masculine identity that matches the prison ideology, men may be less likely to acknowledge their trauma experiences or express any vulnerabilities that may

damage this identity (Chan, 2014). Hyper masculine beliefs appear to enable males to justify violence on the grounds of demonstrating their identity, attaining status in a group, and/or protect themselves from a perceived threat (Phillips, 2001). In addition, Vaswani et al. (2021) argue that prison masculinities and the prison environment itself compound the trauma that incarcerated males experience, making help-seeking difficult, potentially re-traumatizing or causing new trauma**.**

Because the essential features of masculine ideology are toughness, fearlessness, and the denial of vulnerability, it is not surprising that individual men and society have been slow to acknowledge that men can indeed be victimized and that, like all victims, they can suffer (McCreary et al., 1996; Pleck, 1981). The problem, as stated by Vaswani et al. (2021), is that men fail to report trauma and mental health due to socially constructed ideals about masculinity and prison masculinity more specifically. In turn, masculine identities may foster treatment resistance, and men suffering from untreated trauma may be at greater risk of violence to themselves and others (Foster & Kelly, 2012).

2.9 Federal vs. Provincial Corrections

In Canada, the correctional system is divided into federal and provincial jurisdictions. The Provincial system is reserved for those who receive a sentence of less than two years. The Federal system, on the other hand, manages offenders who are handed sentences of two years or more. In general, the Federal correctional system deals with offenders who have committed more serious offences for which they have received longer sentences. Most inmates in Canada are located in Provincial jails rather than Federal prisons. As of 2021, there were approximately 20,000 inmates under the

supervision of the Provincial system, while the Federal system was responsible for approximately 12,500 offenders (Statistics Canada, 2022).

Sentences are determined based on the circumstances surrounding an offence, the severity of the offence, and the offender's degree of responsibility (Government of Canada, 2021). Federal offences, include murder, assault, manslaughter, drug trafficking, and robbery, among others. Provincial offences, in contrast, include trespassing, speeding, driving without a license, among others. By nature, Federal offences are typically considered more serious, and therefore tend to be met with harsher punishments. Due to the severe nature of Federal offences, it is reasonable to assume that those who commit these types of crimes may have suffered higher rates of trauma due to the nature of their offence. It has also been established in the literature that females receive more leniency in sentencing than do males (Gelb, 2010; Rodriguez et al., 2006). Specifically, females are less likely than males to receive a custodial sentence, and those that are sentenced to prison often receive a shorter term of imprisonment than their male counterparts (Gelb, 2010; Rodriguez et al., 2006). Men, therefore, may face a higher likelihood of retraumatization while incarcerated simply because they are serving longer sentences and are therefore spending more time in the correctional facility (Haney, 2002). Although the majority of offenders in Canada are serving time in Provincial jails, those that are serving Federal sentences are primarily men serving more time for more serious offences and are therefore at a higher risk for traumatization.

2.10 Federal Corrections in Canada

CSC is the federal government agency responsible for the management of offenders who have received a sentence of two years or more and are incarcerated in a

federal prison or on conditional release in the community. CSC operates under the *Corrections and Conditional Release Act* (CCRA; 1992), the *Corrections and Conditional Release Regulations* (CCRR; 2019), and a number of Commissioner's Directives. The CCRA (1992) sets out the legal framework for CSC's day-to-day management of federal offenders. The CCRR (2019) is operational and provides guidelines for how CSC is to carry out the requirements of the CCRA (1992). Commissioner's Directives are written policies for how CSC is to run and help correctional staff apply principles of the CCRA (1992) and CCRR (2019).

2.11 Intake Policy

Written policy provides a framework through which standard practices can be established and a standard of care outlined. Policy analysis is therefore a useful analytical tool for examining how practices and standards are informed and may be improved upon. *Commissioner's Directive 705 - Intake Assessment Process and Correctional Plan Framework* is the primary policy that governs the Offender Intake Assessment (OIA) process in Canada. However, there are several supporting documents that are relevant to the intake process. These documents outline the steps for admitting an offender into an institution and provide guidelines for correctional staff who are integral to the process. While what is common practice can, and often does, differ from what is explicitly written in policy, it is nonetheless important for written guidelines to exist to inform practices. While written policy is not to be mistaken for a direct interpretation of what is done in practice, a review of written policy can, at the very least, provide some insight into the practices and procedures that they have informed.

2.12 Offender Intake Assessment (OIA) Process

Upon admission to the federal correctional system, all offenders undergo an intake assessment which is designed to assess their risk and needs. The intake assessment is a comprehensive evaluation of an offender that is used to screen for immediate health (including mental) concerns at time of admission into the federal correctional system (Motiuk, 1997; Motiuk & Keown, 2021). The intake assessment process was implemented in 1994 as an attempt to standardize CSC's offender risk/needs assessment process such that federal offenders are assessed at point of admission into the federal correctional system in a comprehensive, integrated, and systematic way (Motiuk, 1997). The OIA process results in an intake assessment package which forms the basis of the correctional plan for each new federal admission (Motiuk & Keown, 2021). The correctional plan, in turn, serves as an individualized treatment and supervision strategy that lasts for the duration of an individual's sentence. In Canada, specialized Intake Assessment Units (IAUs) exist to facilitate this process.

2.13 Mental Health and Trauma Screening

Brink et al. (2001) examined the prevalence of mental health issues among newly sentenced, male federal offenders admitted to the IAU of one of the federal correctional regions in Canada. Brink et al. (2001) states that although all newly sentenced federal offenders participate in a detailed assessment protocol to identify their specific set of criminogenic factors, no clear diagnostic protocol exists at the reception level for the identification and referral of offenders to services. Moreover, there is no screening that is specific to male offenders. Brink et al. (2001) advocates for a systematic, focused, and specialized assessment protocol upon entry into the federal system. Similarly, Michalski

(2017) argues that the current screening process is both improper and insufficient for addressing mental health needs. Furthermore, the current screening process is not gender-specific and is therefore insufficient for addressing the unique needs of men and women.

While mental health screening is a part of the intake assessment process, there is no evidence that trauma screening is also included in this process. According to Maddaalozzo Tou (2020), the current mode of assessing risk and need includes the *Criminal Risk Index* (CRI) and the *Statistical Information on Recidivism - Revised 1* (SIR-R1), neither of which consider trauma as a part of static factor assessment. Paton et al. (2009) call for increased consideration of trauma when conducting assessments with offenders. More recently, Muskett (2014) and Vaswani (2014) advocate for the automatic and routine screening of offender trauma experiences at point of admission and throughout one's sentence.

2.14 The Current Study

CSC is responsible for the management of 43 institutions across the country, with the majority housing male offenders. Thus, it is interesting that the literature surrounding trauma-informed care in Canada, to date, has largely focused on female offenders. Further, the existing literature is in the context of the U.S. or countries abroad. With increased academic and public attention being directed towards the trauma crime link, there has been an increase in the development and examination of TICC practices and policies. Based on recent academic discoveries surrounding the relationship between trauma and crime as well as TICC, it is reasonable to assume that current correctional policy includes some guidelines and practices for addressing trauma at point of intake

into federal custody. An examination of existing policy is an important first step in uncovering the process for addressing trauma among male offenders in Canada.

The purpose of the current study is to examine the written policies that guide the OIA process in Canada in order to assess the extent to which offender trauma is being considered at intake and if guidelines exist for proper trauma screening and assessment. For the purpose of this study, mental health and trauma are being considered distinct but related concerns. By including mental health screening in this analysis, it is possible to include a more robust and comprehensive review of the intake policy.

Chapter 3. Methodology

3.1 Study Design

The current study utilizes a descriptive research design to address the level of policy specific attention given to trauma and TICC within the Canadian correctional system. Data for this study were gathered through an in-depth analysis of existing correctional policy in Canada. Federal correctional policy documents were located through the CSC website, the CSC Research Branch, other federal agencies, and a federal Freedom of Information Request. Policy documents were examined to determine whether provisions existed that dealt specifically with offender trauma at the point of intake. Building on prior research in the field, the aim of this investigation was to determine whether the policy that does exist recognizes the importance of addressing trauma and TIC within federal correctional institutions.

3.2 Data Collection

For this study, three types of documents were examined: policies, audits/reviews, and action plans. Policy documents were important in this study for understanding what kind of guidelines currently exist for addressing trauma at intake, specifically for male offenders. Moreover, the examination of policy across a large period of time (i.e., approximately 30 years) allowed for the consideration of changes in policy over time. Audits/reviews were included to assess how guidelines for addressing trauma that are outlined in existing policy are being evaluated and improved over time. Finally, action plans were examined to assess what kinds of changes in policy and practice are being recommended and/or planned moving forward, based on the audits/reviews of current and past policies.

Documents for this study were collected systematically from several sources. First, publicly available documents that were relevant to the nature of this study were gathered from the CSC website. Documents were filtered using keywords. Since trauma and trauma-informed care are fairly recent topics of attention, mental health was included as a broader search term. Documents mentioning '*mental health*', '*trauma*', '*trauma informed care*', or '*trauma informed correctional care*' were collected for further examination. These included the *Audit of Offender Intake Assessment* (2009), the *Mental Health Strategy for Corrections in Canada* (2012), the *Report on Plans and Priorities 2008-2009* (2008), and the *Report on Plans and Priorities 2010-2011 (2010).*

Several Commissioner's Directives were also collected from the CSC website and examined for the purpose of this study. These documents were also filtered using the keywords noted above. Only documents mentioning the keywords of interest were examined further. *CD 705 –Intake Assessment Process and Correctional Plan Framework*, in particular, was examined in detail. *CD 726 – Correctional Programs, CD 843 – Interventions to Preserve Life and Prevent Serious Bodily Harm*, and *CD 800 – Health Services* were also examined. Other publicly available documents were also gathered from other Federal agencies. Relevant documents included the *Canada Health Act* (1985), the *Canadian Human Rights Act* (1985), *Corrections and Conditional Release Act* (1992), *Corrections and Conditional Release Regulations* (2019), and *Mental Health and Drug and Alcohol Addiction in the Federal Correctional System* (2010). These documents were also collected on the basis that they make some reference to the key words noted above.

In addition, several research reports were requested from CSC's Research Branch to supplement the publicly available material acquired. These reports included *R126 - The Statistical Information on Recidivism Revised 1 (SIR-R1) Scale: A Psychometric Examination* (2002); *R268 - Federally Sentenced Offenders with Mental Disorders: Correctional Outcomes and Correctional Response* (2012); *R357 - National Prevalence of Mental Disorders among Incoming Federally-Sentenced Men Offenders* (2015); *R388 – Trauma-informed care for incarcerated offenders who engage in chronic self-injurious behaviour: A rapid evidence assessment* (2017); *R410 - An Examination of the Mental Health Continuum of Care* (2018); *R420 - Prevalence of Mental Disorder among Federally Sentenced Women Offenders: In-Custody and Intake Samples* (2018); and *R426 – A Comprehensive Study of Recidivism Rates among Canadian Federal Offenders* (2019). Only reports that contained the key words '*mental health*', '*trauma*', '*trauma informed care*', or '*trauma informed correctional care*' were included in the final analysis.

Finally, a Freedom of Information Request was completed in order to gain access to relevant policy documents that were not already publicly available. Documents requested were selected on their relevance to the current study. Documents mentioning '*mental health screening*', '*mental health status*', '*intake screening*', '*mental health*', '*trauma*', '*mental health concerns*', '*mental health guidelines*', '*assessment process*', '*mental health needs scale instruction guide*', '*information on risk assessment*', and '*mental health protocol*' were requested for this investigation. Although several of the documents requested for this investigation had previously been requested by other researchers, access to these documents was heavily regulated and restricted. This author

was unable to acquire access to these documents within the timeframe for completing this study. The lack of access to these policies is worth noting as it is one of the themes that reappears throughout this analysis.

The initial list of documents were examined in more detail to determine their relevance to the current study. Some documents that were at first glance thought to be relevant were deemed otherwise and were not included in the analysis. Specifically, documents that did not explicitly mention offender mental health or trauma, as well as documents that were centered around the prevalence of mental health rather than best practices for intervention, were excluded from the analysis. Moreover, some documents mentioned others that had not been included in the initial list of documents and were sought out and examined by the researcher. These included, *Agreement Among Three Mental Health Screening Measures* (2015), *CSC's Evaluation of Health Services* (2017), and *Commissioner's Directive 800 – Health Services* (2015). The final list included 21 documents (Appendix A). Each of these were examined in detail as a part of this investigation.

3.3 Analytic Approach

For this study, an in-depth content analysis was used to assess whether existing Canadian correctional policies addressed the importance of trauma, TICC, and gender-informed approaches within correctional settings. Documents that were gathered from the CSC website, the CSC Research Branch, and other federal agencies based on the key words noted above were examined in detail. Once a final list of documents was developed, each document was read through to obtain a general idea of what the aim of each document was. Documents were sorted chronologically by date of publication and

type of document (i.e., action plan, audit/review, or policy). Overall themes were also noted during the original read through.

Following the initial read through and sorting of the documents, each document was examined again, and meaning units were identified. For the purpose of this study, meaning units are defined as the smallest unit that contains some insight into the aim of the study. In other words, meaning units are sections of text that reveal some insight into if and how trauma is considered in current policy. A final list of meaning units was generated, and each meaning unit was labelled with a code (see Appendix B for full coding table). After a final list of meaning units was generated, each document was reread alongside the final list. Additional meaning units that were uncovered during this second read through were coded and added to the final list. After the second read through, the final list of meaning units was reviewed and condensed. Each meaning unit was transcribed into a condensed meaning unit for simplicity. Next, condensed meaning units were divided into categories.

Following the condensing of meaning units, the categorization process began. Themes and categories were identified. Categories were constructed such that no meaning unit fit into more than one category. Each category addresses a different attention of the study, and each meaning unit was placed in the category that this author felt it was best suited. Once meaning units were placed in categories, themes were established. Each category and its corresponding meaning units were examined to create a list of themes. This list of themes forms the basis of the discussion section.

Chapter 4. Results

4.1 Overview of Results

The aim of this study was to analyze the process for addressing trauma among male federal offenders in Canada through an analysis of current policy. The results of this analysis revealed 11 key themes. These themes have been categorized into areas of interest, with each area of interest representing a unique concept contributing to the aim of this study. In total, eight categories of interest emerged (see Table 4.1).

Table 4.1. Summary of Categories and Themes

Category	Corresponding Themes
Mental Healthcare is a CSC responsibility.	Mental health care is a CSC responsibility.
CSC's Mental Health Strategy.	CSC has been slow to implement all components of its Mental Health Strategy. Mental Health interventions must be sensitive to the trauma histories of offenders.
Correctional Planning	Mental health and trauma symptoms are viewed as safety/security issues.
CSC reported priorities for addressing mental health and trauma.	Mental health intervention and treatment has been reported as a priority by CSC.
Current screening tools and protocols, reliability and validity of screening measures, and effectiveness of OIA process.	Mental health screening occurs at intake. There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.

Allocation of Mental Health Resources.	CSC concentrates its resources on the most serious cases, and therefore, some offenders receive limited or no care. Additional resources are required to meet the multi-dimensional mental health needs of offenders.
Staff training.	There is a clear lack of mandatory training for intake staff.
Record Keeping and Access to Information.	Access to information and systematic recording of information is a problem

4.2 Mental Healthcare is a CSC responsibility

4.2.1 Mental health care is a CSC responsibility.

Federal offenders in Canada are not included in the *Canada Health Act* (1985) and their treatment is not covered by federal or provincial/territorial health systems during their incarceration. Therefore, under the CCRA (1992), CSC is responsible for the delivery of health care to offenders in federal institutions. CSC is also responsible for the delivery of "…non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community" (Mental Health and Drug and Alcohol Addiction in the Federal Correctional System, 2010, p. 13). Based on an analysis of the *Mental Health and Drug and Alcohol Addiction in the Federal Correctional System* (2010) and the *Mental Health Strategy for Corrections in Canada* (2012), the results indicate that there is a lack of consensus about what differentiates essential from non-essential mental health care and into which category offender trauma may fall. For example, both documents mention mental healthcare under essential healthcare, while also mentioning mental healthcare as non-essential, yet contributing to

reintegration and rehabilitation. In turn, it is unclear what kinds of needs fall under the label of essential versus non-essential, and the exclusion of trauma from these documents makes it unclear which category it may fall into. On the other hand, based on CSC's *Report on Plans and Priorities 2008-9* (2008), *Report on Plans and Priorities 2010-11* (2010), and *Evaluation of CSC's Health Services* (2017), it is clear that CSC is aware of their responsibility to provide mental health care to offenders and to adapt to the increasing and evolving needs of offenders.

4.3 CSC's Mental Health Strategy

4.3.1 CSC has been slow to implement all components of its Mental Health Strategy.

In 2008, following the death of Ashley Smith, CSC was tasked with developing a Mental Health Strategy. The goal of this framework is:

> to ensure that when individuals with mental health problems and/or mental illnesses are involved with the correctional system, an emphasis is placed on providing an opportunity to engage these individuals to ensure continuity of established treatment plans, to develop and implement new treatment plans, and to integrate the mental health services received in correctional settings with community-based treatment and follow-up services (Mental Health Strategy for Corrections in Canada, 2012; p. 9).

In 2010, a review of mental health and drug and alcohol addiction prevalence was conducted. As a part of this audit, CSC's *Mental Health Strategy* (2012) was critiqued. It was noted in the report that CSC has "…been slow to implement all components of its mental health strategy, and the delivery of mental health care has not changed

significantly…" since its inception (Mental Health and Drug and Alcohol Addiction in the Federal Correctional System, 2010, p. 38). It is noted in this report that, despite the growing needs of offenders, CSC has been unable to meet the mental health needs of all federal offenders. Furthermore, CSC's *Mental Health Strategy* (2012) has not accounted for the role of trauma in mental health, and there are no guidelines for addressing offender trauma within CSC's *Mental Health Strategy* (2012). Also absent from the strategy are any gender-specific procedures for addressing mental health or trauma concerns.

4.3.2 Mental Health interventions must be sensitive to the trauma histories of offenders.

CSC's *Mental Health Strategy* (2012; p.9) asserts that *"*Mental health services are client-centred, holistic, culturally sensitive, gender appropriate, comprehensive, and sustainable.*"* While this may have been true at the time of its inception in 2008, the mental health needs of offenders have changed and developed over the last 15 years, and it is naïve to assume that current mental health services are sufficient for dealing with the changing prison population. To be considered holistic, comprehensive, and sustainable, CSC's *Mental Health Strategy* (2012) ought to be flexible in addressing the needs of the changing prison population as well the gender-specific needs of men and women offenders.

Since the development of the *Mental Health Strategy* in 2008, it has been noted that offenders presenting with mental health issues tend to have overlapping trauma histories that have historically gone overlooked and unaddressed (R388 - Trauma-informed care for incarcerated offenders who engage in chronic self-injurious behaviour: A rapid evidence assessment, 2017). In 2017-18, three reviews were conducted by CSC's

research branch (i.e., *Evaluation of CSC's Health Services*, 2017; *R388 - Trauma-informed care for incarcerated offenders who engage in chronic self-injurious behaviour: A rapid evidence assessment*, 2017; *R410 - An Examination of the Mental Health Continuum of Care*, 2018). All three of these audits recognized and highlighted the prevalence of trauma in the federal correctional system and recommended enhancement of policies and practices to be trauma-driven and to, at the very least, consider offender trauma as a major player when assessing mental health and well-being. It is important to note here that while mental health and trauma are related concepts, the two are distinct and should be treated as such. Therefore, it is insufficient to simply consider trauma as a facet of mental health without considering its significance as a problem on its own. At the time that this is being written, CSC's *Mental Health Strategy* (2012) has not incorporated an understanding of trauma or TICC into its framework, despite recommendations from each of three previous audits to adopt measures to support a wider continuum of health care for offenders.

4.4 Correctional Planning

4.4.1 Mental health and trauma symptoms are viewed as safety/security issues.

It is noted in several of the audits and action plans examined as a part of this study that untreated mental health issues lead to problems with reintegration and recidivism (*Audit of Offender Intake Assessment*, 2009; *Evaluation of CSC's Health Services*, 2017; *Towards a Continuum of Care*, 2012). More specifically, offenders with untreated mental health issues are unable to fully engage with their correctional plans. In order for correctional planning to be effective, mental health issues and concerns should be integrated into an offender's correctional plan. *CD 705 -6 – Correctional Planning and*

Criminal Profile (2019) emphasizes this point, stating that the correctional plan should include "the offender's psychological, psychiatric, mental health and/or physical health information on risk, risk management strategies, and recommended interventions" (para. 35)." However, the results of this study reveal that mental health has been considered in correctional planning but mainly for security classification purposes. It is stated in policy, specifically the CCRA (1992), that any physical or mental illness or disorder suffered by [an] inmate ought to be considered when assigning a security classification to an inmate. The CCRA (1992) is one of a few policies that inform a series of Commissioner's Directive, all of which guide the CSC. Following the CCRA (1992), *CD 705-7 – Security Classification and Penitentiary Placement (2018)* states that in addition to the Custody Rating Scale, the offender security level takes into consideration a number of factors, one of which being mental illness suffered by an inmate. Both of these guiding policies assert that mental illness is to be considered part of institutional security. While it is important to consider the safety of inmates and staff, it is also essential that mental health and trauma are not only being considered as indicators of offender custody rating. Furthermore, there is no evidence in *CD 726 – Correctional Programming (2021)* that trauma has received any attention with regard to correctional planning.

4.5 CSC reported priorities for addressing mental health and trauma

4.5.1 Mental health intervention and treatment has been reported as a priority by CSC.

Most recent policies, reviews, and action plans reported trauma informed practices as a top priority for CSC. This is illustrated in CSC's reported priorities from *R388 - Trauma-informed care for incarcerated offenders who engage in chronic self-injurious behaviour: A rapid evidence assessment* (2017; p. 13):

- Treating needs in an integrated manner that acknowledges the overlap between offenders' multiple needs such as traumatic histories, mental health, substance abuse, and criminal behaviour;
- Considering the potential for challenging behaviours such as self-harm to be adaptations to stressful or triggering situations related to offenders' traumatic histories, and minimizing these triggers wherever possible;
- Providing coping skills to manage current stressors and help regulate emotions. CBT and DBT are two therapeutic approaches that appear to have the most support, either directly through prior systematic reviews, or through incorporation of elements of these approaches in trauma-specific interventions. The use of strength-based language in all interactions may support skill acquisition, and the effectiveness of clinical interventions;
- Addressing traumatic events directly only after stabilizing current symptoms, and in a safe environment. It is debated whether this is possible within a correctional institution, or if this is best done in a community setting.

In the same audit, it was noted that minimizing re-traumatization while incarcerated should be a CSC priority. This should include the "revision of policies to include less-intrusive measures and to identify procedures that may be harmful and disempowering to trauma-survivors" *R388 - Trauma-informed care for incarcerated offenders who engage in chronic self-injurious behaviour: A rapid evidence assessment* (2017; p. 8). During the current study, no reports were uncovered that examined the progress made toward fulfilling these priorities.

4.6 Current screening tools and protocols, reliability and validity of screening measures, and effectiveness of OIA process

4.6.1 Mental health screening occurs at intake.

Most of the documents examined in this study indicated that mental health screening has been incorporated into the OIA process. In 2007, an independent review panel was appointed to review the operations of CSC. Noted in CSC's *Audit of Offender Intake Assessment* (2009; p. 6), the panel recommended that "a comprehensive and recognized mental health assessment system be incorporated into the intake assessment process, so that a treatment strategy that is fully integrated with programming can be developed." In 2009, an internal audit of the OIA process was conducted to assess its efficiency and effectiveness. While the audit found that all offenders undergo an intake assessment upon admission into federal custody, it was also determined that, at the time of the audit, mental health screening was not occurring for every offender entering custody. Again, it was recommended in this audit that some kind of guidelines be established for screening all inmates for mental health upon admission into federal custody. More recently, CSC's *Evaluation of Health Services* (2017) reported that mental health intake assessments had been integrated into the OIA process and were being completed efficiently. It is worth noting here that while mental health screening has been reported to be occurring at intake, there was no evidence that trauma screening was also occurring.

4.6.2 There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.

According to the most recent *Evaluation of CSC's Health Services* (2017), mental health screening has been incorporated into the OIA process. However, the results of this study indicate that while mental health screening has been incorporated into the OIA process, there are inconsistencies in the completion of mental health assessments and the reliability of screening measures being used. While the results suggest that mental health intake assessments are being completed upon admission, it was also noted in the 2017 *Evaluation of CSC's Health Services* (p. 34) that "offenders undergo multiple assessments, any or all of which may identify a need for a mental health referral, resulting in multiple referrals for mental health follow-up and inefficiencies in the referral process." In other words, the duplication of information leads to the duplication of referrals, which impedes the efficient flow of offenders to services.

Based on a review of the *Agreement Among Three Mental Health Screening Measures* (2015) and *R410 - An Examination of the Mental Health Continuum of Care* (2018), three tools are currently used in the OIA process to screen offenders for mental health needs. These three tools are the 24-hour assessment, the 14-day assessment, and CoMHISS. In *Agreement Among Three Mental Health Screening Measures* (2015; p. 3), it was determined that "agreement across all three tools was 61%" and only "5% of the sample was flagged for follow-up by all three assessments." Additionally, it was noted in the *Evaluation of CSC's Health Services* (2017; p. 34) that "health services staff members reported that they experienced challenges in the efficient administration of the 24-hour assessment (30%, n=16), the 14-day assessment (43%, n=23) and COMHISS assessment (62%, n=13)." It was also noted in this report that, further research is needed to determine "which mental health assessment tool (or combination of tools) will effectively identify

offender mental health needs in the most efficient manner" (p. 37). It should also be noted that none of the three tools currently being used for mental health screening collect information about trauma histories or symptoms. It should also be noted that the same three assessment tools are used for offenders regardless of their gender.

4.7 Allocation of Mental Health Resources

4.7.1 CSC concentrates its resources on the most serious cases, and therefore, some offenders receive limited or no care.

The results of this analysis revealed that limited resources are budgeted for mental health and trauma related interventions within correctional settings. Therefore, CSC tends to concentrate these limited resources on the most serious cases, which leaves some offenders receiving limited, inadequate, or no care (*Mental Health and Drug and Alcohol Addiction in the Federal Correctional System*, 2010). A 2015 evaluation report noted that "screenings that are fast and easy to use can identify cases of higher need without expending limited resources unnecessarily on those of lower need" (*Agreement Among Three Mental Health Screening Measures*, 2015, p.1). This quotation illustrates the idea that limited resources ought to be optimized by prioritizing higher-need cases, and in turn, neglecting to address the lower-need offenders. Using the CoMHISS, offenders are only flagged for follow-up when they have at least a 73% likelihood of requiring services, report any current suicidal ideation on the DHS, or have an estimated IQ of less than 70. A 2010 evaluation report examined CSC's RTCs. It was determined that the capacity of the federal correctional system to treat mental illness is reserved for the most serious cases, with "most other mental health problems are either untreated or receive limited clinical attention." (*Mental Health and Drug and Alcohol Addiction in the Federal*

Correctional System, 2010; p. 11). It is also noted in this report that "fewer than 10% of offenders are ever admitted to or treated in the therapeutic environment of the RTCs*"* (*Mental Health and Drug and Alcohol Addiction in the Federal Correctional System*, 2010; p. 11). Overall, this suggests that the lack of resources dedicated to mental health and trauma is an impediment to some offenders receiving treatment. It should also be noted that there was no mention of trauma specific resources in any of the documents reviewed for this study.

4.7.2 Additional resources are required to meet the multi-dimensional mental health needs of offenders.

As mentioned above, several audits and action plans also noted the lack of resources available for addressing mental health and trauma, and many audits/reviews stated that additional resources are required to adequately address the needs of federal offenders. The following quotations illustrate this point:

> Effective management of the more challenging and complex offender population requires new training and equipment for staff, an increase in specialized services—most notably in the provision of mental health care for offenders—and more distinct and targeted interventions, all of which result in the need for additional resources (*Reports on Plans and Priorities 2008-9*; p. 22).
>
> According to interviews, there were issues with having the specialized resources, particularly psychologists, available to perform supplementary assessments. This assertion was supported by the results of file reviews, which indicated that not all cases which had been referred for a

> Psychological or Specialized Sex Offender Assessment received the required assessment and, less than 10% were completed within the established timeframes in both instances (*Audit of Offender Intake Assessment*, 2009; p. 33).

The general theme that resources are limited is common across document types. In the action plan *Towards a Continuum of Care* (2012), CSC notes ongoing priorities for addressing this issue. CSC notes that sustained funding is an issue that must be addressed to ensure a continuum of services. It is also noted in this action plan that staff recruitment and retention issues pose a challenge to the adequate delivery of services. In the 2017 audit titled *Evaluation of CSC's Health Services*, attention is again given to the allocation of resources. It is noted in this report that funding mental health services is one area of improvement. However, it is also noted that "the degree to which funds were expended relative to those allocated at the regional level could not be accurately determined because funding was not fully tracked in the financial system" (p. 87). The lack of record keeping in this instance is a theme that will be discussed in more detail below.

4.8 Staff training

4.8.1 There is a clear lack of mandatory training for intake staff.

Results of this analysis indicate a clear and consistent lack of mandatory mental health training for staff involved in the OIA process. In a 2009 audit of CSC's OIA process, it was noted that "there is no mandatory or specific training for Intake Parole Officers or Managers Assessment and Intervention working within the Intake Assessment Unit." (p. 3) Similarly, in *Mental Health and Drug and Alcohol Addiction in the Federal Correctional System* (2010), it was noted that COs at RTCs do not receive specialized

mental health training. Both the review committee and the Correctional Investigator asserted that CSC must provide mental health training for staff at RTCs in order to meet the diverse mental health needs of offenders. In the 2012 action plan *Towards a Continuum of Care*, it was noted that CSC developed a two-day mental health awareness training for frontline staff. However, it was unclear whether this training was mandatory or optional. Moreover, there was no evidence that any distinct staff training exists for managing offender trauma. Since 2012, there has been little discussion within the examined policies, audits/reviews, and action plans about staff training in the areas of mental health, trauma, and the OIA process.

4.9 Record Keeping and Access to Information

4.9.1 Access to information and systematic recording of information is a problem.

One theme that was consistent across documents, but has been noted more prominently since 2017, is that there is a clear problem with both the systematic recording of information and the access to this information within CSC. In the 2017 *Evaluation of CSC's Health Services,* it was noted that the current state of electronic records made it difficult to assess whether there was a continued need for treatment and what level of need and support were required upon release. It was recommended in this report that the CSC implement "effective management practices to ensure that current information on offender level of need is recorded electronically and that previous records are retained" (p. 86). While it is indicated in the report that Management Action Plans exist to address these and other recommendations, this author was unable to gain access from CSC's Research Branch at the time that this study was being conducted.

Furthermore, in *R410 - An Examination of the Mental Health Continuum of Care* (2018), it was noted that offender information "was not consistently retrievable within documentation sources and was not recorded in a systematic manner" (p. 10). This is further illustrated in the following quotation:

> "The lack of a central data source on mental health service delivery and unsystematic reporting of the information made it difficult to accurately assess the continuum of care being provided to offenders – especially with regard to release planning and community follow-up components. Given these issues, it is possible that mental health needs may have been overlooked and an opportunity to provide a continuum of care missed" (pp. 12-13).

Based on a review of the *Evaluation of CSC's Health Services* (2017) and *R410 - An Examination of the Mental Health Continuum of Care* (2018), results indicate that the unsystematic recording of offender information not only contributes to offender mental health needs going overlooked and unaddressed, but also makes it difficult to assess the mental health treatment that has been put in place for offenders. Without a systematic method for recording offender mental health information, it is virtually impossible to monitor offender mental health and to evaluate the continuum of care being delivered. The same can be said about monitoring offender trauma symptoms.

4.10 Summary of Results

An examination of current policies, audits/reviews, and action plans revealed 11 key themes, organized into 8 categories of interest. In summary, the results of the current investigation revealed that CSC has a responsibility to provide mental health care to

inmates and to incorporate trauma-informed practices into treatment plans, interventions, and programs. CSC has noted that addressing the trauma histories and symptoms of federal offenders is a high priority issue, however, there is limited evidence that trauma-informed practices are being integrated into current policy and practice. Results also indicate that the mental health interventions that do exist are not gender-informed. CSC's *Mental Health Strategy* (2012) is a primary example of this lack of progress. Inefficiencies in the intake screening process, allocation of mental health resources, lack of staff training, and insufficient record keeping are key concerns that have been uncovered during this investigation. Results indicate that in order to adequately address offender trauma and improve mental health care for offenders, these inefficiencies must first be addressed.

Chapter 5. Discussion

5.1 Discussion Overview

The purpose of this study was to conduct a review of existing Canadian correctional policies to examine the extent to which trauma-informed practices are being considered at the federal level, and if guidelines exist to implement such practices during the OIA process, specifically in relation to male offenders. Since trauma has rarely been mentioned in correctional policy and is far less likely to be considered in the context of male offenders, mental health was considered, more generally, alongside trauma. The results of this study indicate that while procedures for addressing mental health, in general, exist in policy, trauma is far less likely to be addressed. A primary critique of the documents examined in this study is the lack of distinction between mental health and trauma. Trauma can cause mental health issues and can increase one's vulnerability to mental illness. However, mental health and trauma are not interchangeable. It is important that the two are differentiated. Moreover, there were no gender-specific approaches to treating offender mental health and trauma noted during the analysis. The discussion has been organized in conjunction with the eight categories outlined in the results section. Within each category, key themes are discussed. Finally, a general summary of findings is discussed, and concerns noted. Implications, limitations, and future directions are also considered.

5.2 Mental Healthcare is a CSC responsibility.

Addressing the mental health needs of offenders promotes improved quality of life, reduces suffering, respects basic human rights, and meets legislative requirements under the CCRA to provide essential health care services and reasonable access to non-

essential services (Livingstone, 2009). A review of CSC policies, reviews, and action plans reveals that CSC is aware of their responsibility to provide offenders with mental healthcare that will contribute to the successful rehabilitation and reintegration of offenders. However, it has also been noted that CSC is not able to offer adequate treatment and support to the majority of offenders with mental health issues. Action plans reveal that priorities for improving mental health services are being voiced, while audits and reviews reveal that more needs to be done to address mental health issues among offenders. It is also worth noting that none of the documents examined as part of this study recognized or included guidelines for addressing trauma among correctional staff. Given the nature of correctional and frontline work, this is also a problem.

While CSC has tended to develop and update policies such that guidelines for addressing mental health and mental illness are stipulated, the responses are largely reactionary rather than proactive. The tragic death of Ashley Smith in 2007 seemed to kickstart CSC's prioritization of mental health among federal inmates. Nineteen-year-old Ashley Smith died by self inflicted asphyxiation in Grand Valley Institution in Kitchener, Ontario. The Ontario Coroner's Inquest into her death indicated that the case of Smith demonstrates how the federal correctional system can fail to provide mentally ill offenders with appropriate care, treatment, and support. Following the death of Smith in 2007, CSC formed The Working Group on Mental Health and developed a Mental Health Strategy. While the CCRA (1992) discusses mental healthcare as a CSC responsibility, there does not seem to be a prioritization of offender mental healthcare until after Smith's death in 2007, at which point working groups are formed, and strategies are developed to address offender mental health. This reactionary approach to addressing mental health is

apparent again following the Ontario Coroners' Jury into the death of Ashley Smith in 2014. Following recommendations laid out by the Ontario Coroner's Jury, CSC updated several Commissioner's Directives pertaining to the intake process and health services. In addition, a Mental Health Action Plan was developed to address offenders in distress or mental health crises. While both of these initiatives are positive and necessary, it is curious that such guidelines did not exist sooner.

5.3 CSC's Mental Health Strategy

CSC's *Mental Health Strategy* (2012) is a framework for integrating mental health services into offender treatment plans. The strategy is founded upon five key components: (1) mental health screening at intake; (2) primary mental health care; (3) intermediate mental health care; (4) intensive care at the regional treatment centres; and (5) transitional care for release to the community. Since its inception in 2012, CSC's *Mental Health Strategy* has not changed significantly. Although studies conducted by CSC's Research Branch support the development of trauma-informed approaches to addressing mental health, these recommendations have not at the time of writing been implemented into any strategy or action plan.

Within CSC's *Mental Health Strategy* (2012; p.9), it is stated that mental healthcare is "client-centred, holistic, culturally sensitive, gender appropriate, comprehensive, and sustainable." The multidimensional and diverse needs of offenders are recognized to some extent. However, the absence of trauma-centered practices within the strategy indicates that offender trauma is at least one component of mental health that is going under addressed. The concern here is that without adequate and effective intervention, offenders with trauma histories are not fully able to participate in their

correctional plan and, in turn, may face barriers to successful rehabilitation and reintegration.

Addressing the mental health needs of offenders throughout their sentence is crucial for effective rehabilitation. CSC's *Mental Health Strategy* (2012) provides a solid framework for assessing offender mental health needs at point of intake and throughout their sentence. What is missing from this strategy is guidelines for addressing offender trauma, which is a unique component of offender mental health. With the needs of offenders continually changing and becoming more complex, there is a need for policies and practices to reflect these changes in order to best address the needs of the offender population.

5.4 Correctional Planning

A common theme among documents is the recognition that mental health issues interfere with rehabilitation and reintegration success. More specifically, it was noted in CSC's *2008-9 Report on Plans and Priorities (2008)* that inmates with mental health concerns are unable to fully engage in their correctional plans. Therefore, correctional planning requires consideration of an offender's specific mental healthcare needs. What is missing from these reports is the similar role of trauma in impeding engagement in correctional plans. Levenson and Willis (2019) note that correctional programs have rarely addressed the role of trauma in offending and have been highly risk-centric, focusing more on mental health and trauma as safety and security issues.

The portrayal of mental health and trauma symptoms as safety/security issues was common across several documents. The CCRA (1992), as a policy that informs a series of correctional documents, is of particular importance when it comes to correctional

planning. The CCRA (1992) notes that mental illness is considered when assigning a security classification to an offender. During the security classification phase of the OIA process, the Custody Rating Scale is completed for each offender. A review of the Custody Rating Scale, however, would suggest that 'mental health' does not appear, aside from the mention of drug and/or alcohol addiction. It is unclear then how a well-rounded assessment of mental health is being considered during security classification.

5.5 CSC reported priorities for addressing mental health and trauma.

In recent reviews, CSC has noted the importance of addressing trauma symptoms and limiting re-traumatization among the inmate population. CSC's Mental Health Action Plan lays out a number of priority activities for addressing mental health in a correctional context, and provides a status update on each of these activities. The action plan mentions mental health, with an overarching emphasis on suicidal ideation. It fails to, however, make mention of any trauma experiences or symptoms. In *R388 - Trauma-informed care for incarcerated offenders who engage in chronic self-injurious behaviour: A rapid evidence assessment* (2017), trauma informed practices were noted as a key priority. Within this report, CSC notes the overlap between the trauma histories of offenders, mental health more generally, and criminal behaviour. It is noted within this report that there is a need to revise current policy to include procedures and guidelines for avoiding the re-traumatization of offenders with trauma histories. Although trauma and trauma informed practices have not been incorporated into CSC's Mental Health Action Plan, reports do exist that acknowledge the importance of addressing offender trauma within the correctional setting. However, no documents were uncovered during this investigation that reported any progress towards fulfilling the priorities discussed.

5.6 Current screening tools and protocols, reliability and validity of screening measures, and effectiveness of OIA process

As a part of this study, documents outlining and evaluating current screening tools and protocols were examined. The reliability, validity, and effectiveness of these tools were considered. It was determined that mental illness and mental health are being considered in the OIA process, and policy does exist to support mental health screening. However, the OIA process has not yet adequately incorporated an understanding of trauma into its framework, and the policy lacks clear guidelines for addressing the trauma symptoms of offenders. It remains unclear from the policies examined whether or not trauma is being recognized as a factor distinct from mental health, and there is a lack of evidence that trauma is being dealt with via mental health screening at intake. Moreover, there is a lack of evidence indicating that the screening that is occurring at intake considers the unique mental health concerns of male and female offenders.

The efficiency and effectiveness of trauma and mental health screening tools is questionable and limited research exists to assess the efficiency and effectiveness. Various assessment tools were noted in the documents reviewed for this study, and it was noted that offenders may undergo multiple assessments. Any, or all, of these assessments may lead to a referral for treatment which could potentially cause inefficiencies in the referral process. Moreover, each tool includes distinct inclusion criteria, and therefore it is unclear whether the multiple tools are reliable in identifying the same offenders for treatment. In fact, it was revealed during this analysis that there is repetition of mental health information collected through health services assessment tools (i.e., 24-hour, 14-day, CoMHISS), and through other assessment tools collected at intake (e.g., Immediate

Needs Checklist – Suicide Risk), and also duplication of mental health referrals. The three assessment tools used during the OIA process were reported to be repetitive with respect to mental health information being collected. Perhaps a more efficient use of resources would involve the collapsing of these three tools into one more expansive measure, which may free up some resources for a trauma screening tool to also be developed and implemented.

There are currently three assessment tools used by CSC during intake to assess mental health status of offenders. These are the CoMHISS and health care forms 1244 section I and Form 1244 section II (Wilton, Stewart & Power, 2015). CoMHISS is administered 3-14 days after an individual is administered into a federal institution (Wilton, Stewart & Power, 2015). The assessment is used to screen new admissions for mental health services, with a focus on depression, suicidal ideation, ADHD, and intellectual ability. Form 1244 Section I is completed within 24 hours of admission into a federal institution. This form is used to refer offenders for institutional mental health services (Wilton, Stewart & Power, 2015). Form 1244 section II is completed within 14 days of admission into a federal institution (Wilton, Stewart & Power, 2015). This section includes a more detailed mental health screening than section I. This assessment is used by staff to refer offenders to a psychologist or psychiatrist. Both sections I and II of form 1244 fail to mention trauma. However, section II is more sensitive of traumatic experiences, prompting the reporting of past traumatic events such as a significant loss, sexual abuse, or physical abuse. The problem here is that trauma should not only be considered as a facet of mental health. Rather, a distinct screening process should exist for assessing

offender trauma, preferably one that is also conscious of gender and the unique traumatic experiences of male and female offenders.

While it has been reported that several tools are used at intake, it seems that CoMHISS is the gold standard for mental health screening at intake. However, offenders are flagged for follow-up by CoMHISS only when they display at least a 73% likelihood of requiring services. Offenders who display a 17% or less likelihood of needing services are screened out. All other offenders (i.e., those between 17 and 73% likelihood of requiring services) are unclassified. The problem here is that while the most severe cases are likely being identified by CoMHISS, the majority of cases are being unclassified, which indicates that it is very likely that offenders who exhibit less severe mental health symptoms are not receiving adequate support and are therefore unable to engage fully with their correctional plan.

5.7 Allocation of Mental Health Resources

It has been noted in the literature that prisons, as they currently exist, are not adequate places for treating and rehabilitating offenders (Auty et al., 2022; Gideon et al., 2010; Manuel, 2021; Michalski, 2017). Correctional institutions do not have adequate resources to properly address offender mental health and are typically not made or designed to be sensitive to trauma (Auty et al., 2022; Maddaalozzo Tou, 2020; Michalski, 2016). Results of this analysis support these ideas, indicating that CSC's mental health resources are limited and that such limited resources are concentrated on the most serious cases. Although not surprising, this finding is problematic. While the most serious cases are assumed to receive the most attention and resources, those offenders who are not deemed to be at risk receive limited, inadequate, or no care. While it seems best practice

to focus limited resources on the most serious cases, it is problematic that the majority of offenders with mental health and trauma concerns are receiving less or no care.

Incarceration itself is a source of new trauma and re-traumatization (Auty et al., 2022; Malik et al., 2023; Vaswani et al., 2021). It has been noted in the literature that longer sentences can contribute to increased trauma (Haney, 2002). Given that CSC primarily manages men for more serious offences and longer terms of incarceration, CSC is also tasked with managing increased risks for trauma and retraumatization. Offenders who receive inadequate care are likely to experience an increase in trauma-related behaviours and symptoms, which in turn leads to challenges in behaviour management and reintegration. It is therefore essential that additional resources be budgeted to meet the mental health needs of offenders, and that these resources be available to all offenders requiring mental health or trauma-related interventions. Results from this evaluation indicate that while CSC is aware of the need to address mental health and trauma among offenders, limited resources have impeded that ability to implement effective strategies for doing so. However, it has been noted that trauma-informed approaches and treatment can result in cost savings and improved public safety outcomes.

5.8 Staff training

An important concern that emerged during this study is that there is a lack of mandatory mental health training, and training in general, for intake staff. Mention of inadequate staff training appeared in documents as early as 2009 and continues to appear in the most recent documents reviewed in this study. Results from this study found that there was no mandatory training for staff working in the IAU. Similarly, as of 2010, correctional officers working at RTCs also did not receive any specialized training. Other

than the development of a two-day mental health awareness training for frontline staff in 2012, it is unclear whether this has since changed. It was also unclear whether this two-day training was optional or mandatory. This lack of staff training is problematic because the staff's inability to recognize mental health and trauma symptoms leads to decisions based more on security than on treatment and rehabilitation. In turn, staff may inadvertently contribute to the further traumatization of inmates, or at the least, impede an inmate's ability to overcome histories of trauma.

A trauma informed organization understands the impact of trauma on individuals and is responsive to their needs by embedding this knowledge within the organization's policies, procedures, and practices (Auty et al., 2022; Hales et al., 2017). This includes staff training. Before TICC can be adequately implemented in a correctional setting, it is necessary to first develop and provide professional education to translate TICC concepts into practice and to prepare correctional staff for handling inmates with trauma histories (Baranyi et al., 2018; DeHart & Iachini, 2019). It is necessary to support and train all correctional staff to recognize and respond humanely and appropriately to trauma-related behaviours and to consider how such behaviours differ between men and women.

5.9 Record Keeping and Access to Information

One concern that emerged during this investigation is that there is a clear and consistent problem with both the systematic recording of information and the access to this information within CSC. It was indicated in several reviews that offender information, including mental health information, was not being recorded systematically nor consistently. Moreover, the information that was recorded was not always retrievable. Both the lack of recording and the lack of access to offender mental health information is

problematic because without this information, it is difficult to ensure that offenders are being flagged and/or referred for appropriate treatment and programming. The absence of offender mental health information within offender files, as well as the lack of access to such information, increases the likelihood that mental health needs may be overlooked and an opportunity to provide treatment and programming missed.

CSC is known to use a number of electronic record keeping software programs such as the Offender Management System (OMS), Mental Health Tracking System (MHTS), and OSCAR. The recent *Evaluation of CSC's Health Services* (2017) notes that the state of electronic record keeping makes it difficult to assess the level of support needed by offenders. The evaluation recommended that mental health needs be systematically recorded at various points throughout an offender's sentence and that this information be entered into a single document in a consistent manner. It was also noted in this evaluation that due to inconsistencies in data recording, it could not be determined if offenders were receiving clinical discharge planning. This becomes problematic when offenders are released back into the community with mental health issues that have not been resolved and no plan put in place to resolve them.

5.10 Revisiting the Culture of Trauma

The results of this study indicate that trauma-informed practices have not been outlined in CSC's intake policy. It has been noted in the literature that acknowledging offender trauma is at odds with the culture of trauma, which suggests that trauma be reserved for those labelled as victims of crime rather than those labelled as perpetrators. Few studies exist that acknowledge the experienced trauma of offenders. Interestingly, but not unexpectedly, this lack of attention to offender trauma has been mirrored in

policy. That is, there is minimal discussion of offender trauma in written policy. Rather, trauma is reserved for discussions of victim impact. However, this study reviewed a handful of documents that did address offender trauma and calls for the examination of offender trauma, suggesting that an understanding of trauma experiences may be evolving beyond the dichotomy of victim and perpetrator.

Trauma tends to be associated with victims as opposed to perpetrators of crime (Mohamed, 2015). However, perpetrators who have suffered trauma may have been victimized themselves, and the commission of certain crimes can cause trauma for these individuals. The culture of trauma promotes the idea that trauma belongs to victims, who are typically female. The failure to acknowledge and address the trauma of incarcerated men perpetuates this idea. Simply labelling male offenders as purely perpetrators of crime is simplistic and impedes and process of reconciliation. In the long term, the failure to recognize the trauma experiences of male offenders undermines rehabilitation efforts by failing to address trauma as a key contributor to criminal behaviour. In addition, constructed beliefs about masculinity may contribute to the undermining of rehabilitative efforts by perpetuating gendered stereotypes about men as perpetrators of crime, with trauma belonging to victims. Within the correctional setting, such gendered beliefs lead to policies and practices that are unsuitable for addressing trauma among male offenders and are therefore not as effective in reducing recidivism as they could be. TICC that is gender conscious entails an awareness of the ways in which life trajectories are shaped not only by trauma experiences, but also by gender identities, and developing policies that reflect this understanding.

In addition, the result of this analysis failed to uncover any gender-specific guidelines for screening offenders for trauma and mental health at intake. When it comes to establishing policies and practices that are trauma-informed, it is necessary to consider gender-specific approaches. It is also important to acknowledge that gender-informed approaches must not be exclusively tailored to women. It is important to remember that men also have gender and gender-informed approaches ought to be privy to this knowledge. Men experience different forms of trauma than do women, and the behavioural manifestation of this trauma are also different (Martin et al., 2015). In addition, constructed beliefs and labels surrounding masculinity impede men's willingness to report trauma and even deny vulnerability (Vaswani et al., 2021). It is beneficial and necessary for policies to acknowledge these gendered experiences in order to establish practices and procedures that are both effective and efficient in rehabilitating offenders with trauma histories.

These results also extend the broader literature that examines the trauma experiences of veterans. There are undeniable parallels between the military and corrections. For example, both veteran and correctional populations tend to be dominated by men and masculinity and military and correctional settings tend to be inherently traumatizing. Members of the military, according to Neilson et al. (2020), normalize, reinforce, and instill masculine labels and ideals as part of their training. Trauma experiences can lead to feelings of powerlessness and hopelessness, both of which are in direct opposition to such masculine ideals. In turn, male veterans face stigma seeking mental health and trauma treatment due to traditional masculine labels perpetuated by military culture. A similar dynamic exists among incarcerated men who experience a

similar culture surrounding masculine ideals and labels. The distinction here is that military personnel often hold an honourable role in society, whereas incarcerated men are often stripped of their worthiness as members of society and are instead treated as merely perpetrators of crime. To also be stripped of their manhood would only add another dimension of humiliation for these men. In both instances, help-seeking and trauma treatment are often perceived as threats to one's masculinity and are therefore avoided. Results of the current study support the need for policy changes that recognize masculine labels and culture within correctional settings, but also in other systems, such as the military, and larger social domains.

5.11 Summary of Findings

The aim of this study was to examine the written policies that guide the OIA process in Canada and to assess the extent to which trauma is being considered at point of intake, particularly for male offenders. The results of this study provide important insight into the OIA process in Canada and the current written procedures for addressing trauma and mental health among male offenders. The results of this study reveal areas in need of improvement when it comes to addressing trauma and mental health for offenders. It is without question that resources dedicated to mental health and trauma-informed practices have been insufficient, and there is a need to advocate for the allocation of funds to improve staff training, electronic record keeping, and research into the efficiency and effectiveness of current intake assessment tools. While it is clear that CSC has dedicated more attention to trauma and trauma-informed practice in recent years, the policies examined in this study indicate that guidelines for trauma-informed strategies have yet to

be laid out in their written policy. Whether this is true or not in practice is beyond the scope of this study and may be considered an area for future investigation.

Several documents examined in this study indicate that it has become standard practice for federal offenders to undergo mental health screening at intake. What was largely absent from the examined documents was an indication that trauma was being assessed as part of mental health screening. In fact, none of the intake assessment tools examined in this study contained a screening section for trauma symptoms. In addition, there were no guiding policies that laid out procedures for assessing offender trauma. Moreover, none of the documents examined in this study laid out gender-specific guidelines for addressing mental health or trauma. Results from this study support the idea that trauma ought to be considered a facet of mental health and must not only be considered but evaluated at the point of intake into federal custody. Specifically, an expansion of mental health screening at intake to include trauma symptoms is necessary to ensure trauma experiences are carefully reviewed and appropriate measures are put in place to support offenders throughout their incarceration. Specifically, intake policy must lay out guidelines for addressing trauma among inmates to ensure proper practices and procedures are being executed.

Chapter 6. Implications

6.1 Implications

The results of this study have several implications. First, the examination of prior audits, policies, and action plans indicated that the allocation of resources is a primary barrier to addressing offender mental health. Results of this study indicate that staff training is one area in need of additional resources. Several documents noted that staff working in IAUs and RTCs lack mandatory training for addressing mental health and trauma in offender populations. It has been noted in the literature that the consideration of offender trauma can contribute to the maintenance of safer and more secure facilities, as well as lower rates of recidivism following release (Briere & Dietrich, 2016; Ellis et al., 2017; Moore et al., 2013; Wallace et al., 2011). In contrast, correctional staff that are not intentionally trained to recognize and manage trauma symptoms appropriately are at risk of further traumatizing offenders and inadvertently perpetuating trauma symptoms. In turn, this leads to less secure and less safe environments for both staff and offenders. In order to provide efficient and effective trauma treatment and avoid the re-traumatization of offenders, appropriate practices and procedures must be implemented. Written policies and guidelines would be a strong first step in implementing such practices and procedures. Without some form of guiding framework, correctional staff cannot be reasonably expected to deliver trauma-informed interventions appropriately nor systematically.

In addition, the current state of electronic record keeping was revealed as a barrier to the adequate implementation of trauma-informed practices. In order for offenders to be assessed and referred for trauma-informed interventions, it is necessary for a systematic

record keeping system to be established. In order for the appropriate referral of services to be made, and the full continuum of care to be provided, there must be a systematic method for recording offender mental health and trauma information. The development of such a system would improve the efficiency of the referral process and assist in ensuring that offenders in need of intervention are not being missed. Without the establishment of some record keeping framework, any attempt at incorporating trauma screening into the OIA process would likely lead to further inefficiencies. Therefore, resources ought to be allocated to the development of a record keeping system that is both effective and efficient for recording accessing offender health information. Finally, the results of this study indicate that, generally, the intake screening process is not gender specific. Based on an understanding that male offenders present differently with mental health and trauma symptoms than do female offenders, and an understanding that male offenders experience unique barriers to reporting mental health and trauma, gender specific screening processes should be considered.

6.2 TICC in Practice: BC Corrections

The province of British Columbia (BC) has been one of the first in Canada to implement principles of TICC into its policies and practices. Over the last several years, BC Corrections has developed a strategic vision that involves the use of trauma-informed practices to understand why individuals enter correctional institutions and how to best meet their needs (Profile of BC Corrections, 2021). As part of this strategy, BC Corrections recognizes that many inmates have histories of trauma and strives to provide culturally appropriate and trauma-informed programs and services. According to the 2021 Profile of BC Corrections, trauma-informed practices within BC's provincial institutions

emphasizes “physical, psychological, and emotional safety and creates opportunities for offenders to rebuild a sense of self-control and empowerment” (p.10). In addition, policy and program analysts regularly consult with staff throughout the organization to identify approaches that are trauma-informed and aligned with the overall strategy.

BC Corrections has developed more intense training programs for staff. Specifically, correctional staff are trained to recognize that trauma is common among inmates and strive to provide services that are welcoming, appropriate, and safe (Profile of BC Corrections, 2021). Moreover, the development of cognitive behavioural programs has helped inmates improve their coping skills, develop positive thinking, and learn how attitudes contribute to behaviour (Profile of BC Corrections, 2021). Among several programs that have been developed, there are two programs that directly use a trauma-informed approach to recovery. The Thinking Leads 2 Change Program is a new program for medium to high-risk female offenders. The aim of the program is for women to explore the roots of their thoughts, beliefs, and emotions that may have contributed to their criminal behaviours (Profile of BC Corrections, 2021). In this program, offenders learn new strategies for conflict resolution, problem-solving, self-regulation, effective communication, and boundary setting (Profile of BC Corrections, 2021). The Animal Care Program at Okanagan Correctional Centre is another noteworthy program that is based on trauma-informed strategies (Profile of BC Corrections, 2021). This program functions based on the knowledge that horses have long been used to enhance the motional, behavioural, and cognitive skills of people with trauma histories (Profile of BC Corrections, 2021). Trained handlers guide offenders in this program as they feed, groom, and care for horses.

While there is limited evaluative information available on these programs specifically, the changes in policy and practices of BC Corrections is an example of the implementation of TICC. Given that TICC is a relatively new idea in the realm of corrections, it is understandable that the evaluative information is limited. However, BC Corrections serves as an exemplary case study for what the implementation of trauma-informed practices could look like.

Chapter 7. Limitations

This study is not without limitations. At the onset of this study, it was this author's intention to include policy documents that are not publicly available. However, at the time of writing, the Freedom of Information request that was submitted to access these documents has not yet been approved. Therefore, this study was only able to examine publicly available documents. While the scope of documents acquired for this study was sufficient for analysis, the inclusion of non-publicly available documents may have provided further insight into internal policies and practices that are privy to CSC.

In addition, this investigation took the form of a qualitative content analysis. By nature, this type of study can be easily subjected to the researcher's own beliefs, opinions, and biases. Reflexivity asserts that in qualitative research, the researcher is a part of the research process. As such, prior experience, assumptions, beliefs, and opinions will almost certainly influence the research process. For example, the documents selected for analysis, the meaning units extracted from the text, and the interpretation of these meaning units are all subject to the unique influence of the researcher. It is important to acknowledge this influence at the onset, as well as throughout the study, and to interpret the findings with this idea in mind. While not necessarily a limitation to the study, it is important to note when interpreting the results of this investigation.

Finally, it is important to consider that what is written in policy does not account for what occurs in practice. Rather, practices can, and likely do, differ from what is written. While the results of this study provide insight into the guidelines and protocols that have been documented in writing, there is no evidence that actual practices are limited to what is in writing. Therefore, findings may be best interpreted alongside an examination of

current practices. Written policy is meant to inform practice, and while beyond the scope of this study, how policy is translated into practice may be a fruitful area for further research.

Chapter 8. Future Directions and Conclusion

8.1 Future Directions

The current study examined the policies and guidelines that currently exist for addressing mental health and trauma at intake. This is an important first step for addressing mental health and trauma among federal inmates, and the findings indicate an area of research worthy of further exploration. From a policy review alone, it is impossible to know how and if what is on paper is being implemented in practice. Future studies may consider the examination of practices within institutions to assess how and if what is written in policy is translated into practice. Similarly, future projects may examine specific correctional programs that have been developed to fulfill what is outlined in written policy.

As discussed above, the current study only examined publicly available documents. Future research may consider the examination of non-publicly available documents. A comparison of the two may also be of interest to provide insight into how internal policies may differ from what is documented publicly. An additional area of future research may include input from key stakeholders and deliverers of policy (i.e., wardens, unit managers, the Correctional Investigator, clinical staff, etc.). There is limited research that considers the roles of these key stakeholders in the delivery of policy and its translation into practice. The unique experiences of these key players may provide

valuable insight into how written policy is viewed and translated into practice within correctional settings.

8.2 Conclusion

The current study is important for understanding criminal recidivism and its relationship with trauma among male federal offenders in Canada. The results of this study reveal a need for improved policy guidelines for addressing the trauma experiences of male offenders incarcerated in Canadian prisons. In the long term, the failure to recognize the trauma experiences of male offenders undermines rehabilitation efforts by failing to address trauma as a key contributor to criminal behaviour. Policies that fail to recognize the trauma experiences associated with criminal behaviour, as well as incarceration, lead to practices that can cause retraumatization and are therefore not as effective in reducing recidivism as they could be. TICC that is gender conscious entails an acknowledgement of the ways in which trauma and gender identity impact behaviour and allows for the development of correctional policies and practices that may be more efficient in addressing and mitigating such behaviour.

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Appendices

Appendix A. Descriptive Table of Documents

Document Title	Source	Brief Description
Agreement Among Three Mental Health Screening Measures	Correctional Service Canada. (2015). *Agreement Among Three Mental Health Screening Measures.* Ottawa, ON	Reception units were asked to provide data from offenders' health status admission assessments (i.e., CoMHISS, Form 1244 Section I and Form 1244 Section II). It was examined whether each assessment tool resulted in a referral for mental health follow-up.
Audit of Offender Intake Assessment	Correctional Service Canada. (2009, April 29). *Audit of Offender Intake Assessment.* https://publications.gc.ca/collections/collection_2021/scc-csc/PS84-123-2009-eng.pdf	The audit team reviewed a sample of offender files contained in the Offender Management System, performed interviews with CSC management and staff involved in the Offender Intake Assessment process and performed a review of other relevant documentation.
CD 705-3 Immediate Needs Identification and Admission Interviews	Correctional Service Canada (2018). *Commissioner's Directive 705-3: Immediate Needs Identification and Admission Interviews*. Ottawa, ON.	Outlines the process for identifying inmates' immediate needs on admission and provides standards for the admission interview.
CD 705-4 Orientation.	Correctional Service Canada (2014). *Commissioner's Directive 705-4: Orientation.* Ottawa, ON.	Outlines the standards for an orientation process for offenders admitted/transferred to a penitentiary.
CD 705-5 Supplementary Intake Assessments.	Correctional Service Canada (2017). *Commissioner's Directive 705-5: Supplementary Intake Assessments.* Ottawa, ON.	Outlines the requirements and procedures regarding supplementary assessments completed at intake.
CD 705-6 Correctional Planning and Criminal Profile.	Correctional Service Canada (2019). *Commissioner's Directive 705-6: Correctional Planning and Criminal Profile.* Ottawa, ON.	Outlines the process for the completion of offenders' Correctional Plans and Criminal Profiles.

CD 705-7 Security Classification and Penitentiary Placement	Correctional Service Canada (2018). *Commissioner's Directive 705-7: Security Classification and Penitentiary Placement.* Ottawa, ON.	Outlines the process for determining an inmate's security classification and penitentiary placement.
CD 726 – Correctional Programs	Correctional Service Canada (2021). *Commissioner's Directive 726: Correctional Programs.* Ottawa, ON.	Outlines the process for assigning inmates to correctional programs as well as the delivery of these programs.
CD 800 – Health Services	Correctional Service Canada (2015). *Commissioner's Directive 800: Health Services.* Ottawa, ON.	Provides guidelines for the delivery of health services within CSC.
CD 843 – Interventions to Preserve Life and Prevent Serious Bodily Harm	Correctional Service Canada (2017). *Commissioner's Directive 843: Interventions to Preserve Life and Prevent Serious Bodily Harm.* Ottawa, ON.	Outlines the process for ensuring the safety of inmates who are self-injurious, are suicidal, or have a serious mental illness with significant impairment.
CoMHISS Privacy Impact Assessment	Correctional Service Canada. (2021). *CoMHISS Privacy Impact Assessment.* Ottawa, ON. Retrieved from https://www.csc-scc.gc.ca/atip/007006-0010-en.shtml	Provides an overview of the CoMHISS and the risks associated.
Corrections and Conditional Release Act	Corrections and Conditional Release Act, SC 1992, c 20.	Sets out the legal framework for CSC's day-to-day business – that is, how CSC manages the care and custody of federal offenders.
Corrections in Ontario: Directions for Reform	Ministry of Community Safety and Correctional Services. (2021). *Corrections in Ontario: Directions for Reform - Independent Review of Ontario Corrections*. Retrieved from https://www.ontario.ca/page/corrections-ontario-directions-reform	Provides a targeted examination of select correctional practices in Ontario.
Evaluation of CSC's Health Services	Correctional Service Canada. (2017). *Evaluation of CSC's Health Services*. Ottawa, ON	Examines the relevance and performance of CSC's mental, clinical, and public health services, including the effectiveness and

		efficiency of the intake assessment process.
Mental Health Action Plan for Federal Offenders	Government of Canada. (2014). *Mental health action plan for federal offenders.* Ottawa, ON. Retrieved from http://publicsafety.gc.ca/cnt/cntrng-crm/crrctns/mntl-hlth-ctn-pln-eng.aspx	Outlines a full Government response to the recommendations of the Ontario Coroner's Jury into the death of Ashley Smith.
Mental Health and Drug and Alcohol Addiction in the Federal Correctional System	House of Commons. (2010). *Mental Health and Drug and Alcohol Addiction in the Federal Correctional System.* Ottawa, ON	Highlights the Committee's observations and recommendations based on its review of the policies, practices and programs adopted by CSC to provide treatment and support for federal offenders affected by mental disorders or addiction.
Mental Health Strategy for Corrections in Canada	Correctional Service Canada. (2012). *Mental health strategy for corrections in Canada: a federal-provincial-territorial partnership*. Ottawa, ON	A framework for building and managing a mental health system for those in the custody of CSC.
Reports on Plans and Priorities 2008-9	Correctional Service Canada. (2008). *Reports on plans and priorities 2008-09*. Ottawa, ON	Presents general information about CSC and focuses on the strategic context and priorities of the organization.
Reports on Plans and Priorities 2010-11	Correctional Service Canada. (2010). *Reports on plans and priorities 2010-11*. Ottawa, ON	Presents general information about CSC and focuses on the strategic context and priorities of the organization.
R388 - Trauma-informed care for incarcerated offenders who engage in chronic self-injurious behaviour: A rapid evidence assessment	Correctional Service of Canada. (2017). *Trauma-informed care for incarcerated offenders who engage in chronic self-injurious behaviour: A rapid evidence assessment (R-388).* Ottawa, ON	The review sought to synthesize the principles of trauma-responsive systems and the evidence that supports them. Second, the review summarized research on the effectiveness of trauma specific interventions.

R410 - An Examination of the Mental Health Continuum of Care	Correctional Service of Canada. (2018). *An Examination of the Mental Health Continuum of Care (R-410)*. Ottawa, ON	Federal offenders assessed as having significant impairment related to mental health problems were selected to be included in a file review to determine the extent to which they received the continuum of care to address their mental health needs.
Towards a Continuum of Care	Correctional Service Canada. (2012). *Towards a continuum of care.* Retrieved from http://www.csc-scc.gc.ca/002/006/002006-2000-eng.shtml.	Consolidates and updates components of CSC's Mental Health Strategy as reported in various previous documents, including annual Reports on Plans and Priorities (CSC, 2004, 2005, 2006, 2007, 2008a, 2009a) and internal documents produced by the Mental Health Branch.

Appendix B. Coding Table

Meaning Unit	Doc Type	Document Title	Condensed Meaning Unit	Code	Category	Theme
Correctional policies, programs and practices respect gender, ethnic, cultural, religious and linguistic differences, sexual orientation and gender identity and expression, and are responsive to the special needs of women, Indigenous persons, visible minorities, persons requiring mental health care and other groups.	Policy	CCRA (1992)	Correctional policies, programs, and practices respect gender, ethnic, cultural, religious, and linguistic differences and are responsive to special needs of offenders.	Policies and practices are responsive to special needs.	CSC's Mental Health Strategy.	Mental Health interventions must be sensitive to the trauma histories of offenders.
For the purposes of section 30 of the Act, the Service shall consider the following factors in assigning a security classification to each inmate: (a) the seriousness of the offence committed by the inmate; (b) any outstanding charges against the inmate; (c) the inmate's performance and behaviour while under sentence; (d) the inmate's social, criminal and, if available,	Policy	CCRA (1992)	CSC shall consider the following when assigning a security classification: -seriousness of offence -outstanding charges -offender behaviour -criminal history -physical/mental illness -potential for violence -involvement in criminal activities	MH is considered when assigning a security classification.	Correctional Planning	Mental health and trauma symptoms are viewed as safety/security issues.

young-offender history and any dangerous offender designation under the Criminal Code; (e) any physical or mental illness or disorder suffered by the inmate; (f) the inmate's potential for violent behaviour; and (g) the inmate's continued involvement in criminal activities.						
Inmates with untreated mental health disorders cannot fully engage in their correctional plans.	Action Plan	Report on Plans and Priorities 2008-9 (2008).	Untreated mental health disorders impede engagement with correctional plan.	Impedes engagement with CP.	Correctional Planning.	Mental health and trauma symptoms are viewed as safety/security issues.
It is an ongoing priority to improve CSC's capacity to address the mental health needs of offenders.	Action Plan	Report on Plans and Priorities 2008-9 (2008).	Priority to improve mental health treatment of offenders.	Mental health is a priority.	CSC reported priorities for addressing mental health.	Mental health intervention and treatment has been reported as a priority by CSC.
Effective management of the more challenging and complex offender population requires new training and equipment for staff, an increase in specialized services—most notably in the provision of	Action Plan	Report on Plans and Priorities 2008-9 (2008).	Staff training, specialized services, and targeted interventions are required for effective management of offenders, all of which requires additional resources.	Additional resources required.	Allocation of Mental Health Resources.	Additional resources are required to meet the needs of offenders.

mental health care for offenders—and more distinct and targeted interventions, all of which result in the need for additional resources.						
Federal inmates are excluded from the Canada Health Act and their treatment is not covered by Health Canada or provincial/territorial health systems during their incarceration. As a result, CSC provides a full-spectrum response to the broad and multi-dimensional mental health needs of offenders.	Action Plan	Report on Plans and Priorities 2008-9 (2008).	Federal inmates are excluded from the CHA. CSC is responsible for the MH needs of offenders.	CSC is responsible for offender MH needs.	Mental Healthcare is a CSC responsibility.	Mental Healthcare is a CSC responsibility.
Late in 2006-07, the Government of Canada provided two-year funding to address the most urgent requirements within three components of CSC's Mental Health Strategy, namely: clinical screening and assessment, enhanced provision of primary mental health care in all CSC institutions, and consistent standards and approach in CSC mental health treatment. Implementation	Action Plan	Report on Plans and Priorities 2008-9 (2008).	In 2006/7 the federal government provided funding to address assessment/screening for MH and consistent standards for MH treatment.	Funding for MH screening/ treatment.	Allocation of Mental Health Resources	Additional resources are required to meet the multi-dimensional mental health needs of offenders.

in these areas began in 2007-08.						
As per CSC's Mental Health Strategy, CSC will: -Enhance clinical screening and mental health assessment processes at intake; -Provide primary mental health care in all institutions; and -Ensure consistent standards and approach in CSC mental health treatment centres.	Action Plan	Report on Plans and Priorities 2008-9 (2008).	CSC will enhance MH intake screening, provide primary MH care in all institutions, and ensure consistent standards in MH treatment centres.	Enhanced intake screening and treatment.	CSC's mental health strategy.	Additional resources are required to meet the multi-dimensional mental health needs of offenders.
There is no mandatory or specific training for Intake Parole Officers or Managers Assessment and Intervention working within the Intake Assessment Unit.	Audit/Review	Audit of Offender Intake Assessment (2009).	No mandatory training for intake staff.	No mandatory training for intake staff.	Staff training.	There is a clear lack of mandatory training for intake staff.
During the course of our review, we noted a general lack of standardization in the completion of assessments, which poses a limitation to the effectiveness of performance reporting.	Audit/Review	Audit of Offender Intake Assessment (2009).	Lack of standardization across assessment completion.	Lack of standardization.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the

						efficiency of screening tools.
Upon admission to the federal correctional system, all offenders undergo an intake assessment which is designed to assess their risk and needs.	Audit/Review	Audit of Offender Intake Assessment (2009).	All offenders undergo an intake assessment which assesses risk and needs.	All offenders undergo an intake assessment.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
CSC policy indicates that the goal of the Offender Intake Assessment process is to place offenders to the most appropriate institution and to contribute to their timely preparation for safe reintegration while protecting society.	Audit/Review	Audit of Offender Intake Assessment (2009).	The goal of the OIA is to place offenders in appropriate institutions and to prepare for their reintegration into society.	OIA places offenders in appropriate institutions.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
In 2007, an independent panel was appointed to review the operations of CSC. In its Report of the Correctional Service of Canada Review Panel: A	Audit/Review	Audit of Offender Intake Assessment (2009).	In its 2007 report, the Review Panel identified areas to be strengthened, two of which directly impact the OIA process. One	Shortening of assessment period.	Current screening protocols, reliability and validity of screening	There are inconsistencies in the completion of assessments and the reliability of

Roadmap to Strengthening Public Safety, the Review Panel identified major areas to be strengthened, supplemented by several recommendations, two of which directly impact the Offender Intake Assessment process. One refers to the shortening of the intake assessment period and the second recommends incorporating comprehensive mental health assessments into the intake assessment process.			calls for the shortening of the assessment period and the second recommends incorporating comprehensive mental health assessments into the intake assessment process.		measures, and effectiveness of OIA process.	screening measures, and limited information is available on the efficiency of screening tools.
There is no mandatory or specific training for Intake Parole Officers or Managers Assessment and Intervention working within the Intake Assessment Unit.	Audit/Review	Audit of Offender Intake Assessment (2009).	There is no mandatory training for staff working in the Intake Assessment Unit.	No mandatory training for IAU staff.	Staff training.	There is a clear lack of mandatory training for intake staff.
The panel recommended that "A comprehensive and recognized mental health assessment system be incorporated into the intake assessment process, so that a treatment strategy that is fully integrated with programming can be developed".	Audit/Review	Audit of Offender Intake Assessment (2009).	The panel recommended that a comprehensive MH assessment system be incorporated into the OIA process so that a treatment strategy that is integrated with programming can be developed.	MH assessment incorporated into OIA process.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.

According to interviews, there were issues with having the specialized resources, particularly psychologists, available to perform supplementary assessments. This assertion was supported by the results of file reviews, which indicated that not all cases which had been referred for a Psychological or Specialized Sex Offender Assessment received the required assessment and, less than 10% were completed within the established timeframes in both instances.	Audit/Review	Audit of Offender Intake Assessment (2009).	There were issues with having psychologists available to perform assessments. Not all cases referred for assessment received the required assessment. Less than 10% were completed within the established timeframe.	Not all cases referred received the required assessment.	Allocation of Mental Health Resources.	Additional resources are required to meet the multi-dimensional mental health needs of offenders.
CSC's ongoing commitment to improving existing and developing new service-delivery practices in the areas of mental health and physical health ensure that services remain responsive to the needs of a diverse and changing offender population. Better health outcomes will lead to lower costs for Canadians.	Action Plan	Report on Plans and Priorities 2010-11 (2010).	More efficient screening processes will allow for more accurate identification of offenders who need intervention.	Efficient screening for accurate identification.	Outcomes of mental health and trauma-informed care	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.

CSC is facing increasing challenges regarding the effective and efficient delivery of correctional programs to an offender population which has increasing levels of educational and learning deficits, mental health disorders, shorter sentences, and higher security level ratings.	Action Plan	Report on Plans and Priorities 2010-11 (2010).	CSC's commitment to MH and physical health ensures services remain responsive and costs remain low for Canadians.	Mental health treatment is a priority.	CSC reported priorities for addressing mental health.	Mental health intervention and treatment has been reported as a priority by CSC.
Enhancements to the mental-health screening processes will enable CSC to more accurately and efficiently identify offenders who need mental health services.	Action Plan	Report on Plans and Priorities 2010-11 (2010).	CSC is challenged with effectively delivering programs to offenders with increasing levels of learning deficits, MH disorders, shorter sentences, and higher security concerns.	CSC's commitment to responsive services and low costs.	Allocation of Mental Health Resources.	Additional resources are required to meet the multi-dimensional mental health needs of offenders.
One priority is to achieve "Improved capacities to address mental health needs of offenders."	Action Plan	Report on Plans and Priorities 2010-11 (2010).	Improving mental health interventions is a priority.	Challenges to program delivery.	CSC reported priorities for addressing mental health and trauma.	Mental health intervention and treatment has been reported as a priority by CSC.
Under the CCRA, the delivery of health care to offenders in federal institutions is a CSC responsibility.	Audit/Review	Mental Health and Drug and Alcohol Addiction in the Federal Correctional System (2010).	Offender health care is a CSC responsibility.	CSC is responsible for offender healthcare.	MH care is a CSC responsibility.	Mental Healthcare is a CSC responsibility.

CSC is also required to provide every inmate with reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community.	Audit/Review	Mental Health and Drug and Alcohol Addiction in the Federal Correctional System (2010).	Non-essential mental health care that contributes to rehabilitation and reintegration is a CSC responsibility.	CSC is responsible for offender mental healthcare.	MH care is a CSC responsibility.	Mental Healthcare is a CSC responsibility.
Yet despite the need, the capacity of the federal correctional system to respond to and treat mental illness is largely reserved for the most acute or seriously chronic cases—those receiving psychiatric treatment in one of the five Regional Treatment Centres. Most other mental health problems are either untreated or receive limited clinical attention.	Audit/Review	Mental Health and Drug and Alcohol Addiction in the Federal Correctional System (2010).	The most serious mental health cases are most likely to receive attention. Most other mental health problems are either untreated or receive limited attention.	Most serious cases receive attention.	Allocation of Mental Health Resources	CSC concentrates its resources on the most serious cases, and therefore, some offenders receive limited or no care.
Only recently that CSC set up a system for tracking mental illness upon admission, and also because mild or moderate mental health problems are often difficult to detect.	Audit/Review	Mental Health and Drug and Alcohol Addiction in the Federal Correctional System (2010).	CSC's mental health tracking system is new. Mild and moderate mental health problems are difficult to detect.	Current screening protocols and effectiveness of OIA process.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	CSC has been slow to implement all components of its Mental Health Strategy.
According to the Correctional Investigator, CSC has, since 2004, been	Audit/Review	Mental Health and Drug and Alcohol	CSC has been slow to implement all components of the	Slow implementation of MH strategy.	CSC's mental health strategy.	CSC has been slow to

slow to implement all components of its mental health strategy, and the delivery of mental health care has not changed significantly since that date.		Addiction in the Federal Correctional System (2010)	mental health strategy. The delivery of mental health care has not change significantly as a result.			implement all components of its Mental Health Strategy.
Evidence given to the Committee while touring the correctional institutions confirmed that full psychological screening, when needed, is not taking place for all offenders upon admission into custody.	Audit/Review	Mental Health and Drug and Alcohol Addiction in the Federal Correctional System (2010)	Full psychological screening is not taking place for all offenders upon admission into custody.	Full screening is not taking place for all offenders.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
The Committee is concerned about the plight of inmates who receive no care, or limited care, because CSC must concentrate its mental health resources on inmates suffering from more serious or chronic mental illness.	Audit/Review	Mental Health and Drug and Alcohol Addiction in the Federal Correctional System (2010)	Some inmates receive no care or limited care as resources are concentrated on the most serious cases.	Less serious MH issues receive limited attention.	Allocation of Mental Health Resources.	CSC concentrates its resources on the most serious cases, and therefore, some offenders receive limited or no care.
The evidence indicates however that correctional officers who work with federally sentenced offenders on a daily basis cannot recognize the	Audit/Review	Mental Health and Drug and Alcohol Addiction in the Federal	Staff cannot recognize the symptoms of mental health problems and illness, despite their best intentions.	Staff cannot recognize MH symptoms.	Staff Training.	There is a clear lack of mandatory training for intake staff.

symptoms of mental health problems and illness, despite their best intentions.		Correctional System (2010)				
The demand for mental health services in the federal correctional system has increased considerably in recent years.	Audit/Review	Mental Health and Drug and Alcohol Addiction in the Federal Correctional System (2010)	Increased demand for mental health services in the federal system.	Need for MH services.	CSC reported priorities for addressing mental health	Mental Healthcare is a CSC responsibility.
The review highlighted the urgent need for an expansion of CSC's capacity to meet the growing needs of these offenders. The situation demands decisive federal government action; the Committee believes this should include the immediate allocation of additional financial resources to CSC for this purpose. The CSC should in turn give priority to improving how it deals with mental health disorders and addiction issues.	Audit/Review	Mental Health and Drug and Alcohol Addiction in the Federal Correctional System (2010)	The committee calls for allocation of additional funds to CSC for meeting the MH needs of offenders. CSC should in turn give priority to improving how it deals with mental health disorders and addiction issues.	Allocation of additional funds to CSC.	Allocation of Mental Health Resources.	Additional resources are required to meet the multi-dimensional mental health needs of offenders.
It is the responsibility of mental health professionals assigned to the regular institutions to recommend offenders (male and female) for admission to an RTC.	Audit/Review	Mental Health and Drug and Alcohol Addiction in the Federal	Only those offenders who meet the following conditions may be admitted to an RTC:	Only offenders meeting conditions are admitted to RTCs.	Allocation of Mental Health Resources.	CSC concentrates its resources on the most serious cases, and therefore, some

According to documentation provided by CSC, only those offenders who meet the following conditions may be admitted: -Offenders suffering from acute mental or psychiatric illnesses, such as psychoses; -Offenders with chronic mental illnesses; -Offenders with cognitive, cerebral disabilities or deficits, such as the full range of fetal alcohol syndrome disorders); -Older offenders with physical or mental problems, such as dementia orAlzheimer's; -Offenders in crisis, such as those who are suicidal, or cases of chronic self-injuring.		Correctional System (2010)	-those with acute mental or psychiatric illnesses -those with cognitive cerebral disabilities - Older offenders with physical or mental problems - Offenders in crisis			offenders receive limited or no care.
The situation is all the more alarming in that most federal offenders with mental disorders do not meet the admission conditions for RTCs. This is the case in particular of many offenders with personality disorders, anxiety, insomnia, brain injuries, depression and fetal alcohol syndrome disorders. The Correctional	Audit/Review	Mental Health and Drug and Alcohol Addiction in the Federal Correctional System (2010)	Most offenders do not meet admission requirements for RTCs. Fewer than 10% of offenders are ever admitted to or treated in RTCs.	Most offenders do not meet admission requirements for RTCs.	Allocation of Mental Health Resources.	CSC concentrates its resources on the most serious cases, and therefore, some offenders receive limited or no care.

Investigator points out in his report that fewer than "10% of offenders are ever admitted to or treated in the therapeutic environment of the RTCs."						
Staff training is recognized in the CSC Mental Health Strategy as an essential factor in providing services and programs that meet the needs of offenders with mental health issues.	Audit/Review	Mental Health and Drug and Alcohol Addiction in the Federal Correctional System (2010)	Staff training is an essential factor in providing services for offenders with mental health issues.	Staff training is essential for treating offenders with MH.	Staff Training.	There is a clear lack of mandatory training for intake staff.
The Committee was surprised to learn that corrections officers at RTCs do not receive specialized training. The Committee agrees with the Correctional Investigator that CSC must recognize the importance of mental health training by immediately providing suitable training for staff at RTCs.	Audit/Review	Mental Health and Drug and Alcohol Addiction in the Federal Correctional System (2010)	COs at RTCs do not receive specialized training. CSC must provide MH training for staff at RTCs.	COs at RTCs do not receive specialized training.	Staff Training.	There is a clear lack of mandatory training for intake staff.
In November 2008, the Heads of Corrections created the Federal-Provincial-Territorial Working Group on Mental Health (FPT WGMH). The WGMH served as an advisory body on mental health to the HOC and was	Audit/Review	Mental Health and Drug and Alcohol Addiction in the Federal Correctional System (2010)	In 2008, the FPT WGMH developed the Mental Health Strategy in consultation with the MHCC.	Mental Health Strategy was developed in 2008.	CSC's Mental Health Strategy.	Mental health intervention and treatment has been reported as a priority by CSC.

tasked to develop a Mental Health Strategy for Corrections in Canada in consultation with the Mental Health Commission of Canada (MHCC).						
The focus of the Framework is to ensure that when individuals with mental health problems and/or mental illnesses are involved with the correctional system, an emphasis is placed on providing an opportunity to engage these individuals to ensure continuity of established treatment plans, to develop and implement new treatment plans, and to integrate the mental health services received in correctional settings with community-based treatment and follow-up services.	Audit/Review	Mental Health Strategy for Corrections in Canada (2012).	When offenders with MH concerns enter the correctional system, an emphasis is placed on continuing treatment plans and integrating MH services.	Integrating MH services in treatment plans.	CSC's Mental Health Strategy.	Mental health intervention and treatment has been reported as a priority by CSC.
Mental health services are client-centred, holistic, culturally sensitive, gender appropriate, comprehensive, and sustainable.	Action Plan	Mental Health Strategy for Corrections in Canada (2012).	MH services are holistic, inclusive, comprehensive, and sustainable.	MH services are holistic, inclusive, comprehensive, and sustainable.	CSC's Mental Health Strategy.	Mental Health interventions must be sensitive to the trauma histories of offenders.
In addition to their involvement in correctional	Action Plan	Mental Health Strategy for	Offenders with MH problems face barriers	Barriers to obtaining	Correctional Planning.	Mental health and trauma

systems, individuals with mental health problems and/or mental illnesses experience a compounded stigma that creates barriers in their ability to obtain services, and also influences the types of treatment and supports received, reintegration into the community and their general recovery.		Corrections in Canada (2012).	in their ability to obtain treatment and successfully reintegrate.	treatment and reintegration.		symptoms are viewed as safety/security issues.
Early identification and ongoing assessment of mental health needs of individuals is essential for providing appropriate support and treatment for those who are at risk of harming themselves or others, for commencing timely treatment, and for informing placement and correctional planning.	Action Plan	Mental Health Strategy for Corrections in Canada (2012).	Early and ongoing assessment of MH needs is essential for treatment, placement, and correctional planning.	Early and ongoing assessment is essential.	Current screening tools and protocols, reliability and validity of screening measures, and effectiveness of OIA process.	Mental health screening occurs at intake.
Individuals who are identified as exhibiting behaviours indicative of mental health problems and/or mental illnesses are referred to and followed-up by a qualified and competent health care professional for a comprehensive mental health assessment.	Action Plan	Mental Health Strategy for Corrections in Canada (2012).	Offenders exhibiting MH problems are referred for a comprehensive MH assessment.	Offenders with MH problems are referred for MH assessment.	Mental Healthcare is a CSC responsibility.	Mental Healthcare is a CSC responsibility.

Individuals with mental health problems and/or mental illnesses who request or are assessed as needing treatment will have access to appropriate services in a timely manner.	Action Plan	Mental Health Strategy for Corrections in Canada (2012).	Offenders requiring treatment will have access to services in a timely manner.	Access to services in a timely manner.	CSC reported priorities for addressing mental health and trauma.	Mental health intervention and treatment has been reported as a priority by CSC.
Staff require ongoing support as well as comprehensive education and training in mental health to enhance their well-being, knowledge, and skills to interact effectively and provide appropriate support for individuals with mental health problems and/or mental illnesses.	Action Plan	Mental Health Strategy for Corrections in Canada (2012).	Staff require ongoing and comprehensive training in MH to provide adequate support for offenders with MH needs.	Ongoing and comprehensive training in MH	Staff Training.	There is a clear lack of mandatory training for intake staff.
The need for adequate screening and assessment, as illustrated by the number of offenders who are placed with general population without mental health services, was a concern for all those consulted.	Action Plan	Mental Health Strategy for Corrections in Canada (2012).	There is a need for adequate screening and assessment for MH services.	MH screening and assessment.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
Comprehensive mental health assessments, by qualified mental health	Action Plan	Mental Health Strategy for	Comprehensive MH assessments by	Comprehensive MH assessments by	Current screening protocols,	There are inconsistencies in the completion

professionals lead to proper treatment and intervention.		Corrections in Canada (2012).	professionals lead to proper treatment.	professionals lead to proper treatment.	reliability and validity of screening measures, and effectiveness of OIA process.	of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
Staff's inability to recognize symptoms of mental illness leads to decisions based more on security and repression than on treatment and intervention.	Action Plan	Mental Health Strategy for Corrections in Canada (2012).	Staff's inability to recognize symptoms of MH leads to decisions based on security.	Decisions based on security.	Staff Training.	There is a clear lack of mandatory training for intake staff.
The Committee must conclude that CSC is not able at this time to offer adequate treatment and support to the majority of inmates with mental health and addiction issues in its custody.	Action Plan	Mental Health Strategy for Corrections in Canada (2012).	CSC is not able to offer adequate treatment and support to the majority of inmates with MH and addiction issues.	CSC is not able to offer adequate treatment/ support.	Mental Healthcare is a CSC responsibility.	Additional resources are required to meet the multi-dimensional mental health needs of offenders.
Individuals in the correctional system experiencing mental health problems and/or mental illnesses will have timely access to essential services and supports to achieve their best possible mental health and well-being.	Action Plan	Mental Health Strategy for Corrections in Canada (2012).	Inmates will have timely access to essential services and supports to achieve their best possible mental health and well-being.	Timely access to MH services.	Current screening tools and protocols, reliability and validity of screening measures, and	Mental health intervention and treatment has been reported as a priority by CSC.

					effectiveness of OIA process.	
Screening is provided by a trained staff to all individuals upon arrival at the correctional facility in order to identify mental health problems and/or mental illnesses and to assist in identifying placement and supervision needs of individuals.	Action Plan	Mental Health Strategy for Corrections in Canada (2012).	Screening by trained staff to all offenders is provided to identify mental health problems and assist in the supervision needs of offenders.	Screening by trained staff.	Current screening tools and protocols, reliability and validity of screening measures, and effectiveness of OIA process.	Mental health screening occurs at intake.
Over the last several years, addressing the mental health needs of offenders has been identified as one of Correctional Service Canada's (CSC) top priorities.	Action Plan	Towards a Continuum of Care (2012).	Addressing MH needs of offenders is a CSC priority.	Addressing MH is a CSC priority.	CSC reported priorities for addressing mental health.	Mental health intervention and treatment has been reported as a priority by CSC.
Mental health services are delivered within a holistic framework, which merges all intervention models including medical, psychological, social, spiritual, correctional and recovery.	Action Plan	Towards a Continuum of Care (2012).	Mental health services are delivered within a holistic framework.	MH services are delivered within a holistic framework.	CSC's Mental Health Strategy.	Mental Health interventions must be sensitive to the trauma histories of offenders.
Mental health services respond to the diverse backgrounds and needs of offenders, with particular emphasis on women and Aboriginal offenders.	Action Plan	Towards a Continuum of Care (2012).	MH services respond to the diverse needs of offenders.	MH services respond to the diverse needs of offenders.	CSC's Mental Health Strategy.	Mental Health interventions must be sensitive to the trauma histories of offenders.

Effective screening and assessment to ensure timely identification of offenders with mental disorders can significantly contribute to CSC's goal of ensuring safer institutions for staff and offenders. Appropriate referrals to address mental health concerns early in an offender's sentence will enable CSC to proactively respond to their mental health issues as opposed to responding to mental health crises.	Action Plan	Towards a Continuum of Care (2012).	Effective MH screening can contribute to the goal of ensuring safer institutions.	Effective screening is a proactive step.	Correctional Planning	Mental health and trauma symptoms are viewed as safety/security issues.
Early identification of mental health concerns facilitates timely access to mental health services and assists in the development of an intervention strategy for offenders throughout their sentence. Mental health screening normally occurs within 3-14 days of the offender's admission to the institution and follow-up assessments occur within 3 months depending on their mental health needs and priority.	Action Plan	Towards a Continuum of Care (2012).	Early identification of MH concerns allows for timely access to services. Screening typically occurs within 3-14 days of admission and follow-up occurs within 3 months.	Early identification of MH concerns.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	Mental health screening occurs at intake.
A spectrum of mental health services is offered, including group and	Action Plan	Towards a Continuum of Care (2012).	Several MH services are offered including group and individual	MH services are respectful of diversity.	CSC's Mental Health Strategy.	Mental Health interventions must be sensitive

individual interventions in the areas of mental health promotion, prevention and early intervention, assessment and individualized treatment planning, and evidence-based treatment and support services in a manner respectful of diversity (i.e. Aboriginal and women offenders).			interventions. Services are offered in a manner respectful of diversity.			to the trauma histories of offenders.
Each region has a Treatment Centre to provide treatment for acute and sub-acute mental health needs.	Action Plan	Towards a Continuum of Care (2012).	Each region has a Treatment Centre for acute MH needs.	Treatment Centres for acute MH.	Allocation of Mental Health Resources.	CSC concentrates its resources on the most serious cases, and therefore, some offenders receive limited or no care.
CSC developed a two day mental health awareness training package tailored to the specific needs of various front line groups including case management staff, institutional health care nurses, and correctional officers. The training aims to enhance knowledge of mental health issues among staff and to provide	Action Plan	Towards a Continuum of Care (2012).	CSC developed a two-day MH training for staff. The aim is to enhance knowledge of MH among staff and develop interaction strategies.	Two-day MH training for staff.	Staff Training.	There is a clear lack of mandatory training for intake staff.

effective strategies when interacting with OMDs.						
Various tools support front-line staff understanding of complex behaviours (e.g. self-harm), legislation (e.g. information sharing) and other challenges that they may encounter. These tools may include guidelines, case scenarios and templates among others to facilitate consistent, efficient and effective mental health services. The development of similar tools to address future needs that may arise will support implementation and ongoing development of the strategy.	Action Plan	Towards a Continuum of Care (2012).	Guidelines, case scenarios and templates facilitate consistent, efficient and effective mental health services. The development of such tools supports the implementation of the MH strategy.	Consistent, efficient and effective mental health services.	Allocation of Mental Health Resources.	Additional resources are required to meet the multi-dimensional mental health needs of offenders.
Ensuring that staff are effectively supported in their work given the demands and unique challenges of providing mental health services in a correctional environment is a key priority for CSC.	Action Plan	Towards a Continuum of Care (2012).	Ensuring staff are supported in providing MH services is a priority for CSC.	Ensuring staff are supported.	CSC reported priorities for addressing mental health.	There is a clear lack of mandatory training for intake staff.
Mental health services are delivered within a holistic framework, which merges all intervention models including medical,	Action Plan	Towards a Continuum of Care (2012).	MH services are delivered in a holistic framework.	Holistic framework	CSC's Mental Health Strategy.	Mental health intervention and treatment has been reported as

psychological, social, spiritual, correctional and recovery.						a priority by CSC.
Mental health services respond to the diverse backgrounds and needs of offenders, with particular emphasis on women and Aboriginal offenders.	Action Plan	Towards a Continuum of Care (2012).	Mental health services respond to the diverse backgrounds and needs of offenders. Emphasis is on women and Aboriginal offenders.	Diverse MH services.	CSC's Mental Health Strategy	Mental Health interventions must be sensitive to the trauma histories of offenders.
The Computerized Mental Health Intake Screening System (CoMHISS) provides standardized processes to identify offenders that require a more in-depth mental health assessment and/or intervention.	Action Plan	Towards a Continuum of Care (2012).	CoMHISS standardizes the process of identifying offenders that require mental health services.	CoMHISS standardizes the process.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
Within 24 hours of arrival at an institution, an interview is conducted. One goal of this interview is to "complete the Immediate Needs Checklist – Suicide Risk (CSC/SCC 1433e) and document in a Casework Record.	Policy	CD 705-3 Immediate Needs Identification and Admission Interviews (2018).	Suicide risk is assessed within 24 hours of arrival at an institution.	Prioritize suicide risk assessment.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	Mental health screening occurs at intake.

During the admission interview, "areas of need requiring immediate attention and confirmation of referrals to appropriate services (e.g ., mental health and health care)" are documented in a casework record.	Policy	CD 705-3 Immediate Needs Identification and Admission Interviews (2018).	Areas of need requiring immediate attention and referrals to appropriate services are noted during the admission interview.	Areas of need are identified at admission.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	Mental health screening occurs at intake.
The orientation process includes information on "health care services, including psychological services and mental health services" and "suicide awareness and prevention workshop."	Policy	CD 705-4 Orientation (2014).	Information on mental health care and suicide awareness is included in the orientation.	MH information in orientation.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	Mental health screening occurs at intake.
The Manager, Institutional Mental Health, will ensure the completion of mental health screening, mental health assessments and psychological risk assessments, when required.	Policy	CD 705-5 Supplementary Intake Assessments (2017).	The Manager, Institutional Mental Health, is responsible for the completion of mental health screening, mental health assessments and psychological risk assessments.	Responsibility for MH screening.	Mental Healthcare is a CSC responsibility.	Mental Healthcare is a CSC responsibility.
Mental Health Services will complete the mental health screening within 14 days of admission. The results of the screening will be documented in accordance with professional standards,	Policy	CD 705-5 Supplementary Intake Assessments (2017).	Mental health assessment is completed within 14 days of admission.	Completion of MH assessment	Current screening protocols, reliability and validity of screening measures, and	Mental health screening occurs at intake.

and as outlined in the Integrated Mental Health Guidelines.					effectiveness of OIA process.	
The first step in understanding each offender's specific needs begins with an individualized assessment, including an intake assessment to assess and prioritize risk factors, and mental health screening to identify signs and symptoms associated with serious mental illness. From these comprehensive assessments, CSC is able to develop a Correctional Plan unique to the risk and health needs of every offender, men and women, young and old, to help guide the development of programs and other interventions, and an intervention strategy that includes necessary mental health programming, throughout an offender's sentence.	Policy	CD 705-5 Supplementary Intake Assessments (2017).	Offender mental health information is to be included in the CP with information on interventions and risk management.	Referral for services at intake.	Correctional Planning	Mental health and trauma symptoms are viewed as safety/security issues.
In the Correctional Plan, include the offender's psychological, psychiatric, mental health and/or physical health information on risk, risk management	Policy	CD 705-6 Correctional Planning and Criminal Profile (2019).	Offender MH information is to be included in the CP with information on interventions and risk management.	MH information in CP.	Correctional planning.	Mental health and trauma symptoms are viewed as safety/security issues.

strategies, and recommended interventions. In addition to the Custody Rating Scale, the offender security level takes into consideration mental illness suffered by inmate.						
The Manager, Institutional Mental Health, will ensure the provision of comprehensive mental health services to support rehabilitation and successful reintegration.	Policy	CD 800 – Health Services (2015).	The Manager, Institutional Mental Health, is responsible for ensuring the provision of comprehensive mental health services to support rehabilitation and successful reintegration.	Comprehensive MH services.	Mental Healthcare is a CSC responsibility.	Mental Healthcare is a CSC responsibility.
The Manager, Institutional Mental Health, and/or Chief Psychologist (community) will ensure processes are in place for the completion of psychological risk assessments, in accordance with relevant policies.	Policy	CD 800 – Health Services (2015).	The Manager, Institutional Mental Health, and/or Chief Psychologist (community) is responsible for ensuring processes are in place for the completion of psychological risk assessments.	Psychological Risk assessment.	Mental Healthcare is a CSC responsibility.	Mental Healthcare is a CSC responsibility.
This Mental Health Action Plan for Federal Offenders lays a foundation for a full Government response, anticipated in fall/winter 2014, to the	Action Plan	Mental Health Action Plan for Federal Offenders (2014).	The MHAP for Federal Offenders is a government response to the death of Ashley Smith.	Reactive approach to MH.	CSC reported priorities for addressing mental health and trauma.	Mental health intervention and treatment has been reported as a priority by CSC.

recommendations of the Ontario Coroner's Jury into the death of Ashley Smith.						
Only 5% of the sample were flagged for follow-up by all three assessments.	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	5% of the sample were flagged for follow-up by all three screening assessments.	5% were flagged for follow-up by all three tools.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
Using the CoMHISS as the only intake tool would have captured almost three-quarters (73%) of the offenders who were screened in for mental health services using all three tools.	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	CoMHISS captures 73% of offenders who were screened in for mental health services using all three screening tools.	CoMHISS captures 73% of offenders who were screened in.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
Several tools are used at reception centres in the Correctional Service of Canada (CSC) to screen	Audit/Review	Agreement Among Three Mental Health	Several tools are used to screen for MH. It is unknown if these tools identify the same	Effectiveness and efficiency of MH	Current screening protocols, reliability and	There are inconsistencies in the completion of assessments

offenders for mental health issues at intake. It is currently unknown, however, if these tools identify the same or different offenders. CSC requires more information on the tools currently in use to ensure an effective and efficient screening process.		Screening Measures (2015).	offenders for follow-up. More information is needed to ensure an effective and efficient screening process.	screening tools is unknown.	validity of screening measures, and effectiveness of OIA process	and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
Agreement across all three tools was 61%. In 56% of cases, there was agreement between the three assessments that no follow-up was necessary, but only 5% of the sample were flagged for follow-up by all three assessments. CoMHISS is the most inclusive of the three assessments, identifying in the largest number of unique offenders. Using the CoMHISS as the only intake tool would have captured the majority of offenders identified for follow-up using all the measures (i.e., 73% of offenders identified for follow-up were captured by CoMHISS).	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	Agreement across the three measures was 61%. Only 5% were flagged by all three tools. CoMHISS was the most inclusive. 73% of offenders identified for follow-up were captured by CoMHISS.	Agreement across the three measures was 61%.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.

The sensitivity of a screening tool, however, is only one of several criteria used to determine its utility. Additional considerations include the time required for administration (CoMHISS is more time consuming to administer, score, and interpret than the 1244 forms) and time to availability of results (results from CoMHISS are not available to decision makers as quickly as those on the Form 1244 Section I which is based on an interview completed within 24 hours of intake, a concern if offenders at risk for self-injury or suicide have recently entered the system). CoMHISS' inclusiveness may also result in the identification of offenders who do not, in fact, require follow-up service, decreasing the efficiency of a screening process by increasing staff workload. All of these factors must be considered in deciding which combination of accuracy and efficiently best meets the needs of CSC in	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	Time required for administration and availability of results are important criteria for determining the utility of assessment tools. CoMHISS is more time consuming to administer, score, and interpret than other measures. CoMHISS' inclusivity may decrease efficiency of screening.	CoMHISS' inclusivity may decrease efficiency.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.

choosing the tools used to screen offenders for mental health problems.						
An efficient and effective screening process is a key component of insuring that offenders who require mental health services are identified.	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	Efficiency and effectiveness of screening tools is important for identifying those in need of MH services.	Efficiency and effectiveness of screening tools.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
Screening can also assist in the appropriate allocation of resources and provide valuable information to management regarding the prevalence of mental health issues and changes over time so that appropriate resource planning can take place.	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	Screening assists in the allocation of resources for management and planning purposes.	Screening assists in the allocation of resources.	Allocation of Mental Health Resources.	CSC concentrates its resources on the most serious cases, and therefore, some offenders receive limited or no care.
Given the constraints of a correctional setting, a screening tool must be brief while maintaining a high level of sensitivity so that those in need of more in-depth assessments are accurately identified.	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	Screening tools must be both brief and sensitive for accurate identification of offenders.	Screening tools must be brief and sensitive.	Current screening protocols, reliability and validity of screening measures, and	There are inconsistencies in the completion of assessments and the reliability of screening measures, and

					effectiveness of OIA process	limited information is available on the efficiency of screening tools.
Screenings that are fast and easy to use can identify cases of higher need without expending limited resources unnecessarily on those of lower need.	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	Tools that are fast and easy to use allow resources to be directed to higher need cases.	Tools should be fast and easy to use.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
Early assessment is beneficial to both the offender, who receives treatment as soon as possible, and the institution, where the number of issues related to untreated offenders can be minimized.	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	Early assessment is beneficial to the offender receiving treatment and the institution.	Early assessment is beneficial.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	Mental health screening occurs at intake.
there is a "Current Mental Health" section that includes items for previous psychiatric admission, history of suicide attempts, current suicidal ideation or plan, history of self-	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	'Current Mental Health' section gathers information on suicide attempts and ideation, self-injury, anxiety, withdrawal, panic,	'Current Mental Health' section.	Current screening protocols, reliability and validity of screening measures, and	Mental health screening occurs at intake.

injurious behaviour, and evidence of anxiety, withdrawal, panic, vulnerability, or hopelessness.			vulnerability, and hopelessness.		effectiveness of OIA process	
In addition to a comprehensive history of offenders' physical health, the form includes a section on mental health which is more detailed than Form 1244 Section I. Questions on the form address areas such as past mental health diagnoses, past and current treatment or intervention, psychiatric medication, history of suicide and self-injury, abuse history, and problematic eating.	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	Section II includes a more detailed MH section, addressing past MH diagnoses, treatment, medication, suicide and self-injury, abuse, and problematic eating.	Section II is more detailed.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process	Mental health screening occurs at intake.
CoMHISS is currently comprised of four measures (described below): (1) the Depression, Hopelessness and Suicide Screening Form (DHS); (2) Brief Symptom Inventory (BSI); (3) Adult Self-Report Scale for Attention Deficit Hyperactivity Disorder (ASRS); and (4) General Ability Measure for Adults (GAMA).	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	CoMHISS is comprised of four measures: DHS, BSI, ASRS, and GAMA.	CoMHISS is comprised of four measures.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process	Mental health screening occurs at intake.
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Offenders are flagged for follow-up when they have at least a 73% likelihood of requiring services, report any current suicidal ideation on the DHS, or have an estimated IQ of less than 70.		Agreement Among Three Mental Health Screening Measures (2015).	Those with at least a 73% chance of requiring services, report suicidal ideation, or have an IQ below 70 are flagged.	Those with at least a 73% chance of requiring services, suicidal ideation, or IQ below 70 are flagged.	Allocation of Mental Health Resources.	CSC concentrates its resources on the most serious cases, and therefore, some offenders receive limited or no care.
Offenders with scores that indicate a likelihood of requiring services of 17% or less are screened out. Offenders between 17% and 73% likelihood of requiring services or offenders with more missing data than the algorithm allows are included in the "unclassified" category provided they did not report any current suicidal ideation on the DHS and had an IQ of 70 or greater. Unclassified offenders usually have some mental health issues but may or may not need mental health services. Further assessment – including, at minimum, a file review– is conducted for unclassified offenders.	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	Unclassified offenders (those between 17 and 73% of requiring services) usually have some MH issues. Further assessment is conducted for these offenders.	Unclassified offenders undergo further assessment.	Allocation of Mental Health Resources.	CSC concentrates its resources on the most serious cases, and therefore, some offenders receive limited or no care.

The DHS, initially developed and validated on medium security male inmates in Canada (Mills & Kroner, 2004), measures depression (17 items), hopelessness (10 items), and risk factors associated with suicide and self-injury (12 items). The 39 items in the questionnaire are answered dichotomously (True or False).	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	The DHS measures depression, hopelessness, and suicide/self-injury.	The DHS measures depression, hopelessness, and suicide/self-injury.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process	Mental health screening occurs at intake.
The BSI (Derogatis, 1993) is a 53-item self-report symptom inventory that assesses nine dimensions of clinically relevant psychological symptoms. Offenders rate how much they were distressed by each symptom in the previous seven days on a scale from 0 (not at all) to 4 (extremely). The nine dimensions include: Somatization, Obsession-Compulsion, Interpersonal Sensitivity, Depression**,** Anxiety, Hostility, Phobic Anxiety, Paranoid ideation**,** and Psychoticism.	Audit/Review	Agreement Among Three Mental Health Screening Measures (2015).	The BSI assesses offender distress from Somatization, Obsession-Compulsion, Interpersonal Sensitivity, Depression**,** Anxiety, Hostility, Phobic Anxiety, Paranoid ideation**,** and Psychoticism.	The BSI assesses offender distress.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process	Mental health screening occurs at intake.
The CoMHISS is more time consuming to administer,	Audit/Review	Agreement Among Three	The CoMHISS is more time consuming to	Results from the CoMHISS	Current screening	There are inconsistencies

score, and interpret than the Form 1244 Section I and II, and, thus, the results from the CoMHISS are not available to decision makers as quickly as those on the 1244 Section I form which is based on an interview completed within 24 hours of intake. Timing is a particular concern for offenders entering the system who are at risk for self-injury or suicide.		Mental Health Screening Measures (2015).	administer, score, and interpret than the Form 1244 Section I and II, and, thus, the results from the CoMHISS are not available to decision makers as quickly.	are not available as quickly.	protocols, reliability and validity of screening measures, and effectiveness of OIA process	in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
An inmate will be placed on Mental Health Monitoring by the Institutional Head or a health care professional when they are at risk for suicide or self-injury or have been identified by a health care professional as requiring an enhanced level of observation due to a serious mental illness with significant impairment. Frequency of monitoring will be determined by the health care professional.	Policy	CD 843 – Interventions to Preserve Life and Prevent Serious Bodily Harm (2017).	An inmate is placed on MH monitoring when they are at risk for suicide or self-injury or have been identified by a health care professional as requiring an enhanced level of observation due to a serious mental illness.	MH monitoring of inmates	Correctional Planning	Mental health and trauma symptoms are viewed as safety/security issues.
CSC has developed a Mental Health Need Scale to assess offenders' mental health need and determine the appropriate level of care required in accordance with	Audit/Review	Evaluation of CSC's Health Services (2017).	CSC's Mental Health Need Scale assesses offenders' mental health need and determines the appropriate level of	MH Need Scale for care required.	Current screening protocols, reliability and validity of screening	There are inconsistencies in the completion of assessments and the reliability of

its new refined model of mental health care (primary, intermediate, psychiatric hospital). The validity and reliability of this scale are yet to be assessed.			care required. The validity and reliability of this scale are yet to be assessed.		measures, and effectiveness of OIA process	screening measures, and limited information is available on the efficiency of screening tools.
The overall health services intake assessment tools and processes are effective in identifying offender health needs.	Audit/Review	Evaluation of CSC's Health Services (2017).	Health services intake assessment tools and processes are effective in identifying offender health needs.	Health intake tools are effective.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
Health Services contributes directly to addressing the mental health needs of offenders through timely assessment, effective management, appropriate intervention, relevant staff training and rigorous oversight.	Audit/Review	Evaluation of CSC's Health Services (2017).	Health Services contributes to addressing the mental health needs of offenders through timely assessment, effective management, appropriate intervention, relevant staff training and rigorous oversight.	Health Services addresses MH needs.	Mental Healthcare is a CSC responsibility.	Mental Healthcare is a CSC responsibility.
Effective earlier mental health diversion strategies could result in: cost savings	Audit/Review	Evaluation of CSC's Health Services (2017).	Earlier mental health diversion strategies could result in: cost	Earlier mental health	CSC reported priorities for addressing	Mental health intervention and treatment has

and improved public safety outcomes.			savings and improved public safety outcomes	diversion strategies.	mental health and trauma.	been reported as a priority by CSC.
CSC Health Services administers four main tools to assess offender health at intake: the 24-Hour Health Intake Assessment, the 14-day Health Intake Assessment, Infectious Disease Screening, and the Computerized Mental Health Intake Screening System (CoMHISS).	Audit/Review	Evaluation of CSC's Health Services (2017).	The four tools to assess offender health at intake: the 24-Hour Health Intake Assessment, the 14-day Health Intake Assessment, Infectious Disease Screening, and the Computerized Mental Health Intake Screening System (CoMHISS).	Four tools to assess offender health.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process	Mental health screening occurs at intake.
CSC will assess the validity and reliability of the Mental Health Needs Scale and will strengthen the process for recording and maintaining offender level of need data.	Audit/Review	Evaluation of CSC's Health Services (2017).	CSC will assess the validity and reliability of the MH Needs Scale and will improve the process for recording offender data.	Improve process for collecting and recording MH data.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
In addition to the CCRA, CSC is guided by a series of internal Commissioner's Directives (CDs) that support legislative obligations. CDs specific to	Audit/Review	Evaluation of CSC's Health Services (2017).	In addition to the CCRA, CSC is guided by a series of internal Commissioner's Directives (CDs) that	CSC is guided by CDs.	Mental Healthcare is a CSC responsibility.	Mental Healthcare is a CSC responsibility.

health services include the following: CD 800, CD 843, and CD 578.			support legislative obligations.			
The 24-Hour Health Status Intake Assessment is a tool administered by a nurse within 24 hours of an offender's admission to an institution. This assessment includes questions about offenders' immediate mental (e.g., suicidal or self-harming behaviour) and physical health needs (e.g., current physical health issues, allergies, and medications).	Audit/Review	Evaluation of CSC's Health Services (2017).	The 24-Hour Health Status Intake Assessment is a tool administered within 24 hours of admission to an institution. It includes information about immediate mental and physical health.	The 24-Hour Health Status Intake Assessment.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process	Mental health screening occurs at intake
The 14-Day Health Status Intake Assessment is an assessment tool completed by a nurse within the first two weeks of the offender's admission to the institution. At the time of the evaluation, this tool involved a series of questions about the offender's mental (e.g., stress management, etc.) and physical (e.g., diabetes, etc.) health.	Audit/Review	Evaluation of CSC's Health Services (2017).	The 14-Day Health Status Intake Assessment is completed within the first two weeks of admission. It involves questions about mental and physical health.	The 14-Day Health Status Intake Assessment.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process	Mental health screening occurs at intake
In his 2014-2015 Annual Report, the Correctional Investigator called for the	Audit/Review	Evaluation of CSC's Health Services (2017).	The Correctional Investigator called for CSC to identify	Correctional Investigator call for trauma-	CSC reported priorities for addressing	Mental health intervention and treatment has

Correctional Service of Canada (CSC) to "examine international research and best practices to identify appropriate and effective trauma-informed treatment and services for offenders engaged in chronic self-injurious behaviour, and that a comprehensive intervention strategy be developed based on this review." In response, CSC committed to conduct a literature review of international research and best practices in the provision of trauma-informed treatment for chronic self-injury.			appropriate and effective trauma-informed services for offenders engaging in self-injury and that a comprehensive strategy be developed. CSC committed to a literature review of best practices.	informed practices.	mental health and trauma.	been reported as a priority by CSC.
Minimizing re-traumatization: revision of policies to include less-intrusive measures and to identify procedures that may be harmful and disempowering to trauma-survivors, including the use of seclusion, physical restraints, strip searches and involuntary hospitalizations. Instances of seclusion and restraint use should be followed by a prevention focused analysis and debriefing in	Audit/Review	Evaluation of CSC's Health Services (2017).	Revision of policy to include less intrusive and disempowering measures. Seclusion should be reduced or eliminated.	Minimizing re-traumatization	CSC reported priorities for addressing mental health and trauma.	Mental health intervention and treatment has been reported as a priority by CSC.

order to ultimately reduce or eliminate its use. We note the following as potential priorities for correctional institutions: -Treating needs in an integrated manner that acknowledges the overlap between offenders' multiple needs such as traumatic histories, mental health, substance abuse, and criminal behaviour. -Considering the potential for challenging behaviours such as self-harm to be adaptations to stressful or triggering situations related to offenders' traumatic histories, and minimizing these triggers wherever possible. -Providing coping skills to manage current stressors and help regulate emotions. CBT and DBT are two therapeutic approaches that appear to have the most support, either directly through prior systematic reviews, or through incorporation of elements of these approaches in trauma-specific interventions. The	Audit/Review	Evaluation of CSC's Health Services (2017).	Priorities: -treating needs in an integrated manner and acknowledging trauma histories, MH, SA, and criminal behaviour. -Viewing challenging behaviours as responses to triggering situations related to trauma histories. -coping skills training to manage triggers. -Addressing trauma events directly after stabilizing current symptoms.	Priorities for addressing trauma.	CSC reported priorities for addressing mental health and trauma.	Mental health intervention and treatment has been reported as a priority by CSC.

use of strength-based language in all interactions may support skill acquisition, and the effectiveness of clinical interventions. -Addressing traumatic events directly only after stabilizing current symptoms, and in a safe environment. It is debated whether this is possible within a correctional institution, or if this is best done in a community setting.						
We recommend that the Mental Health Branch examine methods to improve electronic record keeping that will allow for more efficient monitoring of the degree of support and services offenders with mental health problems receive throughout their sentence.	Audit/Review	Evaluation of CSC's Health Services (2017).	Recommend improving electronic record keeping allowing for more efficient monitoring of MH services received by offenders.	Improving electronic record keeping.	Record Keeping and Access to Information.	Access to information and systematic recording of information is a problem.
Clear, consistent and accessible record keeping is necessary to allow ongoing monitoring of the full range of care throughout the full period offenders are under warrant.	Audit/Review	Evaluation of CSC's Health Services (2017).	Clear, consistent, and accessible record keeping is necessary to assess the full range of care for offenders.	Clear, consistent, and accessible record keeping.	Record Keeping and Access to Information.	Access to information and systematic recording of information is a problem.

The recent evaluation report on CSC's Health Services (CSC, 2017) noted that CSC's mental health intake assessments were completed efficiently and almost all offenders were assessed and identified through the Computerized Mental Health Assessment Screening System (CoMHISS).	Audit/Review	Evaluation of CSC's Health Services (2017).	CSC noted that MH assessments were completed efficiently and almost all offenders were identified through CoMHISS.	Almost all offenders were identified through CoMHISS.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	Mental health screening occurs at intake.
Recommendation 6 of the report specifically calls for CSC to ensure offenders are referred to the appropriate mental health services by implementing effective management practices to ensure that current information on offender level of need is recorded electronically and that previous records are retained.	Audit/Review	Evaluation of CSC's Health Services (2017).	To ensure offenders are referred to the appropriate MH services, effective management practices ought to be put in place.	Effective management practices.	Record Keeping and Access to Information.	Access to information and systematic recording of information is a problem.
The current state of electronic records in OMS, MHTS and OSCAR made it difficult to assess whether there was a continued need for treatment and what level of need and support were required upon release.	Audit/Review	Evaluation of CSC's Health Services (2017).	The current state of electronic record keeping made it difficult to assess the need for treatment.	Current state of electronic record keeping.	Record Keeping and Access to Information.	Access to information and systematic recording of information is a problem.

The creation of a systematic requirement to report mental health needs at various points in the sentence and for this information to be entered into a single document and in a consistent manner.	Audit/Review	Evaluation of CSC's Health Services (2017).	Requirement to report MH needs and enter this information in a consistent systematic manner.	Consistent systematic record keeping	Record Keeping and Access to Information.	Access to information and systematic recording of information is a problem.
Computerized Mental Health Intake Screening System (CoMHISS) is an offender self-administered assessment tool that specifically assesses mental health needs. It is completed within 3 to 14 days of admission and is used to identify offenders who are experiencing any mental health symptoms that may require further assessment and intervention. The assessment includes questions related to past or present mental health symptoms, diagnoses, medications or treatments, suicidal ideations, attention deficit hyperactivity disorder (ADHD), as well as cognitive deficiencies and intellectual abilities.	Audit/Review	Evaluation of CSC's Health Services (2017).	CoMHISS is a computer administered assessment measuring depression, suicidal ideation, anxiety, OCD, and psychotic disorders among others.	CoMHISS is a computer administered assessment.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	Mental health screening occurs at intake
Offenders undergo multiple assessments, any or all of which may identify a need	Audit/Review	Evaluation of CSC's Health Services (2017).	Multiple MH assessments results in multiple referrals for	Multiple MH assessments	Current screening protocols,	There are inconsistencies in the completion

for a mental health referral, resulting in multiple referrals for mental health follow-up and inefficiencies in the referral process.			follow-up and inefficiencies in the referral process.	results in inefficiencies.	reliability and validity of screening measures, and effectiveness of OIA process.	of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
Regional Complex Mental Health Committees have been established to assist and support institutions in providing an effective continuum of care to offenders with complex mental health needs.	Audit/Review	Evaluation of CSC's Health Services (2017).	Regional Complex Mental Health Committees have been established to support institutions in providing a full continuum of care to offenders with complex MH needs	MH committees support institutions in providing MH care.	Allocation of Mental Health Resources.	CSC concentrates its resources on the most serious cases, and therefore, some offenders receive limited or no care.
Additional research will be required to determine which mental health assessment tool (or combination of tools) will effectively identify offender mental health needs in the most efficient manner.	Audit/Review	Evaluation of CSC's Health Services (2017).	Additional research is needed to determine which mental health assessment tool (or combination of tools) will most effectively identify offender mental health needs.	Further research on assessment tools is needed.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.

Currently, CSC offers three different levels of institutional mental health care to offenders in mainstream CSC institutions or in a RTC, which include: primary, intermediate and psychiatric hospital care	Audit/Review	Evaluation of CSC's Health Services (2017).	CSC offers three different levels of institutional mental health care to offenders: primary, intermediate and psychiatric hospital care.	Three levels of MH care	Allocation of Mental Health Resources.	CSC concentrates its resources on the most serious cases, and therefore, some offenders receive limited or no care.
CoMHISS is a mental health screening process that is comprised of a computer administered psychometric test battery that objectively measures indicators of mental health including, but not limited to depressions, suicidal ideation, anxiety, and obsessive compulsive and psychotic disorders.	Audit/Review	R388 - Trauma-informed care for incarcerated offenders who engage in chronic self-injurious behaviour: A rapid evidence assessment (2017).	CoMHISS is a self-administered MH assessment. It is completed within 3 to 14 days of admission and is used to identify offenders who are experiencing any mental health symptoms that may require further assessment and intervention.	CoMHISS identifies offenders who are experiencing MH symptoms.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	Mental health screening occurs at intake.
It should be assumed that all clients have previously experienced trauma, in order to ensure that all policies are recovery-driven, avoid potential re-traumatisation, and ensure respectful and honest interactions with clients.	Audit/Review	R388 - Trauma-informed care for incarcerated offenders who engage in chronic self-injurious behaviour: A rapid evidence assessment (2017).	It should be assumed that all offenders have previously experienced trauma, to ensure that all policies are recovery-driven, avoid potential re-traumatisation, and ensure respectful and honest interactions with clients.	Assume all offenders have trauma histories.	CSC reported priorities for addressing mental health and trauma.	Mental health intervention and treatment has been reported as a priority by CSC.

The recent evaluation report on CSC's Health Services (CSC, 2017) noted that CSC's mental health intake assessments were completed efficiently and almost all offenders were assessed and identified through the Computerized Mental Health Assessment Screening System (CoMHISS).	Audit/Review	R410 - An Examination of the Mental Health Continuum of Care (2018).	The recent evaluation report on CSC's Health Services (CSC, 2017) noted that CSC's mental health intake assessments were completed efficiently and almost all offenders were assessed and identified through the CoMHISS.	MH intake assessments were completed efficiently.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
The information regarding pre-release planning was not consistently retrievable within documentation sources and was not recorded in a systematic manner.	Audit/Review	R410 - An Examination of the Mental Health Continuum of Care (2018).	Information on pre-release planning was not consistently retrievable and was not recorded systematically.	Information was not consistently retrievable.	Record Keeping and Access to Information.	Access to information and systematic recording of information is a problem.
The lack of a central data source on mental health service delivery and unsystematic reporting of the information made it difficult to accurately assess the continuum of care being provided to offenders – especially with regard to release planning and community follow-up components. Given these issues, it is possible that mental health needs may have been overlooked and	Audit/Review	R410 - An Examination of the Mental Health Continuum of Care (2018).	The lack of a central data source on mental health service delivery and unsystematic reporting of the information made it difficult to accurately assess the continuum of care being provided to offenders. It is possible that mental health needs may have been overlooked and an opportunity to provide	Lack of central data source on MH service delivery.	Record Keeping and Access to Information	Access to information and systematic recording of information is a problem.

an opportunity to provide a continuum of care missed.			a continuum of care missed.			
Current record keeping practices made it difficult to easily access information.	Audit/Review	R410 - An Examination of the Mental Health Continuum of Care (2018).	Current record keeping practices made it difficult to easily access information.	Difficult to access information.	Record Keeping and Access to Information	Access to information and systematic recording of information is a problem.
CoMHISS will allow CSC to improve mental health treatment planning and access to institutional mental health services by identifying offenders with mental health issues during the intake assessment process.	Audit/Review	CoMHISS Privacy Impact Assessment (2021).	CoMHISS will allow for improved mental health treatment planning and access to institutional mental health services by identifying offenders with mental health issues during intake.	CoMHISS will allow for improved MH treatment.	Current screening protocols, reliability and validity of screening measures, and effectiveness of OIA process.	There are inconsistencies in the completion of assessments and the reliability of screening measures, and limited information is available on the efficiency of screening tools.
Correctional planning requires the consideration of an offender's specific mental health care needs.	Policy	CD 726 – Correctional Programs (2021).	Correctional planning requires the consideration of an offender's specific mental health care needs.	Individualized MH care needs	Correctional planning.	Mental health and trauma symptoms are viewed as safety/security issues.
Offenders with mental health care needs or physical disabilities who are unable to meaningfully participate in national	Policy	CD 726 – Correctional Programs (2021).	Offenders with mental health care needs who are unable to meaningfully participate in national	Adapted programs to address MH.	Allocation of Mental Health Resources.	Additional resources are required to meet the multi-dimensional

correctional programs may be referred to adapted programs designed to meet their needs and/or therapeutic interventions as per their treatment plan.			correctional programs may be referred to adapted programs designed to meet their needs.			mental health needs of offenders.