



SAFETY, RESPECT  
AND DIGNITY  
FOR ALL

LA SÉCURITÉ,  
LA DIGNITÉ  
ET LE RESPECT  
POUR TOUS

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Evaluation Report:  
Community Mental Health Initiative

Evaluation Branch  
Performance Assurance Sector  
November, 2008



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Evaluation Report:  
Community Mental Health Initiative

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## Executive Summary

### Introduction

Addressing the mental health needs of federal offenders is one of Correctional Service Canada's (CSC) five strategic priorities (CSC, 2008a). In 2007/08, 10% of men offenders and 22% of women offenders in federal custody were identified as presenting with mental health problems at intake. These percentages represent 67% and 69% increases, respectively, since 1996/97 (CSC, 2008b). In the 2006 report of the Standing Senate Committee on Social Affairs, Science and Technology on mental health care in Canada, *Out of the Shadows at Last*, also known as the Kirby Report (Kirby, 2006), the Committee challenged CSC to meet the mental health standards of care for offenders under federal jurisdiction that are typically afforded to non-offender populations. Moreover, the Committee specifically recommended that CSC provide services to ensure continuity of mental health care from the institutions to the community.

CSC is mandated by legislation (86(1) of the Corrections and Conditional Release Act [CCRA], 1992) to provide mental health services to federally sentenced offenders although the provision of these services have been deemed inadequate (see Canadian Public Health Association, 2004; Correctional Investigator Canada, 2004; and Kirby, 2006). Findings and recommendations from the Kirby Report, as well as reports from the Office of the Correctional Investigator (2004), CSC Review Panel (2007), and the Government of Canada's Performance Report (2007b) have highlighted the need and provided additional support for the development of a comprehensive mental health strategy. CSC is implementing such a strategy for federal offenders, the fundamental goal of which is to ensure a continuum of mental health services to offenders from institutional intake to release into the community. This approach focuses on: (1) intake screening and assessment; (2) primary care; (3) intermediate care; (4) intensive care (at Regional Treatment Centres); and (5) transitional care. In 2005, following submission by the Health Service Branch, Treasury Board allocated funds to implement the Community Mental Health Initiative, the fifth component of the overall Mental Health Strategy.

The Community Mental Health Initiative (CMHI), implemented in 2005, falls within the transitional care component of the national mental health strategy. The key components of the CMHI are:

- Increased discharge planning, provided by clinical social workers, for offenders with mental disorders at men's and women's institutions;
- Allocating mental health specialists (clinical social workers and mental health nurses) to support offenders with mental disorders (OMDs) residing in the community [including Community Corrections Centres (CCCs) and Community Residential Facilities (CRFs)];
- Providing resources and services to respond to the special needs of OMDs in the community (e.g., contracts and funds for psychiatry and other mental health interventions, specialized assessments, tutors, etc.); and
- Providing mental health training to correctional services staff, halfway house staff, and community partners (Champagne, Turgeon, Felizardo, & Lutz, 2008).

### **CMHI Budget**

A total of \$29.1 million over a five year period for the Community Mental Health Initiative was approved in 2005. The majority of the funding (\$15.3 million) was designated for salaries, including \$7.8 million for operating costs and approximately \$6 million for common services, employee benefit plans, and accommodations.

### **Evaluation Strategy**

An evaluation strategy was developed by the Evaluation Branch in consultation with the evaluation consultative group, comprised of stakeholders from CSC Health Services, Aboriginal Initiatives Directorate, Women Offender Sector, Performance Management Branch, and Regional Psychiatric Centre Prairies Research Branch. The purpose of the evaluation was to provide information required to make investment decisions in the area of community mental health beyond the expiration of the funding in March 2010. Due to the recent implementation of the CMHI, the evaluation was primarily implementation focused, but immediate and intermediate outcomes were assessed where possible given the availability of data.

Qualitative and quantitative methodologies were utilized to conduct the evaluation. Information was collected through:

- Surveys of CSC staff members who had experience working with offenders with mental disorder in August 2008;
- Interviews with offenders in the community who received services from community mental health specialist teams;
- Consultations with regional coordinators to develop implementation timelines;
- Automated data collection, including queries of CSC's Offender Management System (OMS) and other databases created and maintained by Health Services and the Regional Psychiatric Centre (RPC);
- Review of relevant documentation, including implementation and post-implementation reports from the RPC, the mental health training summary report from CSC's Health Services Sector, operational documents, relevant CSC policies and procedures, and financial documentation from the Integrated Management Reporting System (IMRS); and
- Review of relevant literature, including government and non-government publications, reports from international jurisdictions, and academic and professional publications.

To examine the effectiveness of the CMHI in the successful reintegration of offenders into the community, outcomes for offenders who received discharge planning services and community mental health specialist services were compared to a historical comparison group that did not receive CMHI services.

## **Key Findings**

**SUMMARY FINDING:** The community mental health initiative remains consistent with CSC priorities, government-wide objectives, and practices in other jurisdictions and addresses a realistic need for mental health services among CSC offenders. The CMHI resulted in increased access to mental health services, including discharge planning services and mental health services in the community provided by community mental health specialists or contractors. Offenders who received community mental health specialist services were less likely to be suspended or revoked than the comparison group who did not receive CMHI services. Some implementation challenges were observed, including delays in staffing CMHI positions (which resulted in re-profiling and lapses of CMHI funding), challenges related to information sharing between the institution and the community, and some stakeholders reported that some offenders in need of mental health services were not being referred for services.

### **Objective 1: Relevance**

**FINDING 1:** The CMHI remains consistent with departmental and government-wide priorities

**FINDING 2:** Given the increasing number of offenders entering CSC with mental health disorders, there is a need to provide services for these offenders to address their mental health needs and assist them to successfully reintegrate into the community.

**FINDING 3:** The CMHI is consistent with other jurisdictions' practices, particularly those that employ community-based models of mental health intervention for offenders.

### **Objective 2: Implementation**

**FINDING 4:** Delays in implementing CMHI services were attributed primarily to staffing challenges. Successful implementation of the CMHI was more likely when there were: (1) dedicated human resource and administrative support to expedite the staffing processes; and (2) a wide recruitment campaign to draw many potential candidates to staff the initiative.

**FINDING 5:** Discharge planning referrals are not occurring in accordance with CMHI guidelines regarding timeframes (i.e., nine months prior to anticipated release date).

**FINDING 6:** The most common reason for CMHI referral rejections occurred because offenders did not meet inclusion criteria. Staff also suggested that some offenders in need of services were not being referred. Examination of findings suggests that this may be due to a lack of knowledge among CSC staff members regarding CMHI referral criteria, lack of reliable tools to facilitate early identification of those in need of services, and/or a lack of available services in the communities to which the offenders are being released.

**FINDING 7: Implementation challenges were reported related to coordination and information sharing among institutional and community mental health and case management teams**

**FINDING 8: Existing CMHI sites appear to be well-placed to serve offenders with mental health needs as demonstrated by the number of offenders with mental health needs at existing CMHI sites. However, there are several CSC sites with significant proportions of offenders with mental health needs that have not been identified for CMHI services.**

**FINDING 9: Implementation delays have led to several instances of re-profiling and lapses of CMHI funding. Financial data for the CMHI have not always been coded consistently utilizing the appropriate cost-centres in IMRS**

### **Objective 3: Success**

**FINDING 10: Mental health training was provided to 830 individuals in the community and 352 CSC institutional staff members who worked with individuals with mental disorders. Among institutional staff, trainees were primarily CSC nurses. The training was effective in improving community personnel's mental health knowledge and self-perceived competency to work with offenders with mental disorders.**

**FINDING 11: Offenders referred to, and accepted for, CMHI services, including discharge planning and community mental health specialist services, are receiving these services. However, data regarding their termination from these services may not always be consistently recorded in CMHI database.**

**FINDING 12: The number of CMHI service contracts and number of offenders receiving services have increased over time. Contract services are being delivered in a timely manner and few offenders referred for services were waitlisted or not provided with the services.**

**FINDING 13: Community capacity building efforts have increased over time and service-building contacts have generally focused on the areas of highest need or importance according to CMHI referrals.**

**FINDING 14: Stakeholders generally reported enhanced continuity of care and services, although some concern was reported regarding continuity of care after warrant expiry.**

**FINDING 15: Stakeholders generally reported that the CMHI contributed to an improved quality of life for offenders. However, the CMHI standardized assessment of quality of life was not administered to offenders per CMHI guidelines. As a result, findings pertaining to this assessment were inconclusive due to small sample sizes.**

**FINDING 16: The majority of offenders received either clinical discharge planning (CDP) or community mental health specialist (CMHS) services, but not both. Offenders receiving CMHS services were less likely to be suspended or revoked than the comparison group, after statistically controlling for pre-existing group differences. There was no evidence to suggest that the CDP group differed from the comparison**

group with respect to these outcomes. These preliminary findings should be interpreted with caution due to small sample sizes and short follow-up times.

#### **Objective 4: Cost-Effectiveness**

**FINDING 17:** Although the CMHI has demonstrated several positive short-term outcomes, limitations related to financial coding and the short implementation period precluded the ability to conduct a reliable cost-effectiveness analysis at this stage of the CMHI.

#### **Recommendations**

**RECOMMENDATION 1:** To sustain and enhance mental health services provided in the community, CSC should support the implementation of mental health services through the development of a strategic staffing process and recruitment campaign.

**RECOMMENDATION 2:** Procedures or processes to improve early identification of offenders' mental disorder and treatment needs should be explored in order to enable accurate identification of offenders with mental health needs, to better facilitate treatment referrals, and to establish continuity of care from an earlier stage.

**RECOMMENDATION 3:** CSC should explore and develop mechanisms to increase information-sharing across institutional and community mental health and case management teams.

**RECOMMENDATION 4:** Several sites that are not presently included in the CMHI that have large proportions of offenders with mental health needs should be considered for CMHI services, through reallocation or expansion of CMHI services.

**RECOMMENDATION 5:** CSC should ensure accurate, standardized coding of CMHI expenditures in financial databases to ensure that expenditures are adequately recorded and monitored and so the cost-effectiveness of the CMHI can be adequately assessed at some future time.

**RECOMMENDATION 6:** Additional mental health training should be provided to institutional staff members, including parole officers and other case management team members in order to assist in identifying OMDs and providing early referrals for CMHI services.

**RECOMMENDATION 7:** Offenders accepted for CMHI services should be tracked to ensure that treatment has been provided and to monitor the length of time that offenders receive services

**RECOMMENDATION 8:** CSC should continue to support and enhance the level of services available to offenders with mental disorders in the community. Further, CSC should explore the development of additional partnerships/links with organizations

**(such as provincial governments and non-governmental organizations) to facilitate continuity of care following warrant expiry.**

**RECOMMENDATION 9: CSC should review the Quality of Life Scale administration guidelines to ensure that guidelines for administration are practical and develop procedures to ensure that CMHI staff engage offenders in completing the assessment of quality of life as per the guidelines.**

**RECOMMENDATION 10: CSC should review the possible reasons for lack of continuity from CDP services to CMHS services. Based on this review, CSC should develop strategies and procedures to better impact community reintegration for CDP offenders.**

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## Acronyms

ACSS-MH	Alberta Continuity of Service Scale for Mental Health
ACT	Assertive Community Treatment
CDP	Clinical Discharge Planner
CSW	Clinical Social Worker
CD	Commissioner's Directive
CCC	Community Correctional Centre
CMHI	Community Mental Health Initiative
CMHS	Community Mental Health Specialist
CRF	Community Residential Facility
CS	Community Strategy
CPPR	Correctional Plan Progress Report
CSC	Correctional Service Canada
CCRA	Corrections and Conditional Release Act
DPR	Departmental Performance Report
HS	Health Services
IMRS	Integrated Management Reporting System
IPO	Institutional Parole Officer
LFI	Level of Functional Impairment
MH	Mental Health
MHCC	Mental Health Commission of Canada
MOU	Memorandum of Understanding
OIA	Offender Intake Assessment
OMD	Offenders with Mental Disorders
OMS	Offender Management System
PO	Parole Office
QoL	Quality of Life Scale
RPC	Regional Psychiatric Center
RPP	Report on Plans and Priorities
UN	United Nations
WED	Warrant Expiry Date
WHO	World Health Organization

## **Introduction**

### **Background – Mental Health: A Global Perspective**

In 2001, the World Health Organization (WHO) estimated that roughly 450 million people worldwide had a neuropsychiatric disorder, with depression being the most common, and the number of people with some form of mental illness was projected to increase dramatically. Despite the WHO's high estimate of the prevalence of mental illness worldwide, there is a general lack of mental health policies, programs, and community care worldwide (WHO, 2005a). The impact of mental illness is far-reaching, and has many immediate and long-term effects, both economic and social. For example, depression is considered to be the fourth leading cause of disability adjusted life years lost and is projected to become the second leading cause of disability worldwide by 2020 (WHO, 2001).

The stigma surrounding mental illness also continues to be a problem worldwide. The stigma or discrimination related to mental illness prevents some people from seeking help (Saxena, Thornicroft, Knapp & Whitefoot, 2007). However, there is some research that suggests that social networks and family support may be beneficial to those with mental illness (Hamid, Abanilla, Bauta & Huang, 2008).

In its World Health Report, the WHO (2001) made 10 key recommendations to all countries for improving mental health and mental health care. Of these, a few are of particular interest for CSC's Community Mental Health Initiative:

- Provide care in the community;
- Involve communities, families and consumers;
- Establish national policies, programmes and legislation; and,
- Link with other sectors, such as non-governmental organizations

The WHO emphasizes the need for countries to have national mental health legislation, which is important to prevent human rights abuses (including discrimination), to uphold basic human and legal rights and to provide access to appropriate mental health care (WHO, 2005b). However, according to the WHO, 25% of countries do not have any national mental health

legislation (WHO, 2003). While this should be a concern for all aspects of society, it is also a major issue for offenders with mental illness, including people with mental disorders who are incarcerated as an alternative to receiving treatment in the community or in mental health facilities (WHO, 2005b).

The large numbers of individuals with mental disorders incarcerated in prisons is a by-product of, among other things, the unavailability or reduced availability of public mental health facilities, the implementation of laws criminalizing nuisance behaviour, the widespread misconception that all people with mental disorders are dangerous, and the intolerance in society toward difficult or disturbing behaviour (WHO, 2005b). Furthermore, some countries lack legal traditions that promote treatment (as opposed to punishment) for offenders with mental disorders.

The United Nations (UN) has provided standards for mental health care generally, and for the mental health care treatment of offenders in particular. The UN (1966) outlines the right to the highest attainable standard of physical and mental health, which is a crucial right that is part of the *International Bill of Human Rights*.

UN documents (1977, 1988, 1990a, 1991) outline offenders' rights to mental and physical health care, whether they are in custody or in the community. Some of the factors emphasized by the UN include the need to treat people with mental disorders in the community whenever possible, a focus on reintegrating offenders back into the community, and the need to involve organizations beyond those directly involved in the criminal justice system, such as NGOs or other government agencies.

The UN (1977, 1988, 1990a, 1990b, 1991) also provides guidelines for the treatment of offenders. For example, persons with mental disorders or illness should both live in the community and be treated in the community. In addition, reintegration plans need to be started at the beginning of the offender's sentence, and psychiatric or psychosocial treatment should continue after release (UN, 1977). The UN (1977, 1990a, 1990b) suggests that community reintegration should involve governments, communities, social institutions, and other appropriate agencies in the reintegration of offenders.

## **The Federal and Provincial Perspective**

The federal government has increased support for mental health intervention in the past several years. The 2007 Speech from the Throne emphasized the need for “respect and dignity for people with mental illness” (Government of Canada, 2007a). The 2007 and 2008 budgets have shown an increasing commitment to mental health and assisting those with mental illness. As a result of the recommendations made in the report *Out of the Shadows at Last*, the federal budget in 2007 established the Mental Health Commission of Canada (MHCC), and committed \$15 million a year to this Commission, starting in 2009/10 (Department of Finance, 2007). In 2008, the federal government contributed another \$110 million to the MHCC for projects on mental health and homelessness (Department of Finance, 2008). At this time, the MHCC has many key initiatives and committees underway, including a research project examining homelessness, an anti-stigma campaign, and an advisory committee on mental health and the law (Mental Health Commission of Canada [MHCC], 2008).

According to a report describing expenditures on mental health and addictions for Canadian provinces for 2003/04, a total of \$6.6 billion was spent on mental health from both the public and private sectors (Jacobs et al., 2008). Canadian public mental health spending is lower than most developed countries and is below the minimum acceptable amount, which is 5% of health expenditures according to the Mental Health Commission Report in Europe. The national average for mental health spending is \$172.00 per person, per year (Jacobs et al., 2008) with Saskatchewan, Newfoundland, Labrador, and Ontario spending the lowest per capita amounts for mental health care among the provinces.

In keeping with the federal government’s increased spending on mental health initiatives, most provinces have funded programs and initiatives related to mental health or mental illness in their 2007 or 2008 budgets. Provincially-funded services have included, but are not limited to: addictions centres (Ontario, Newfoundland & Labrador); mental health emergency rooms (Manitoba); increasing the number of mental health and residential treatment beds (Alberta); creation of mental health courts (Alberta and Nova Scotia); enhancement of community-focused services (Nova Scotia & New Brunswick); and enhanced legal aid services for those who appear before the court under the Mental Health Act (Newfoundland and Labrador; Boudreau, 2008; Government of Newfoundland and Labrador, 2008; Province of Alberta, 2008; Province of Manitoba, 2008; Province of Nova Scotia, 2008; Province of Ontario, 2008).

## **CSC Policy and Legislation**

CSC is mandated by law to provide every inmate with:

- a) essential health care; and,
- b) reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community (*Corrections and Conditional Release Act* [CCRA], 1992, s. 86[1]).

In addition to the CCRA, *Commissioner's Directive (CD) 850: Mental Health Services* provides a policy framework within which CSC provides mental health services to offenders. The objective of the policy is to ensure that offenders have appropriate access to professional mental health services. These services are expected to contribute to the improvement and maintenance of inmates' mental health and adjustment to incarceration and assist them in becoming law-abiding citizens (CSC, 2002). Mental health services and programs for inmates shall provide a continuum of essential care for those suffering from mental, emotional, or behavioural disorders, consistent with professional and community standards (CSC, 2002).

Health care in Canada is typically the responsibility of the provincial/territorial governments. However, offenders residing in federal penitentiaries are the financial responsibility of the federal government (i.e., CSC). Once the offender is released to the community, government responsibility depends upon where the offender is released (CSC, 2008a). Offenders on full parole, statutory release and day parole who are residing in a Community Residential Centre (e.g., half-way houses), receive essential health services paid by the applicable provincial health care plan. CSC is still responsible for providing essential health services for offenders residing in Community Correctional Centres (CCC). The policy also states that CSC is responsible for other non-insured health care expenses for offenders residing in Community Correctional Centres or Community Residential Centres who are unemployed and have no other source of income and who are otherwise ineligible for all other forms of government/community assistance (CSC, 2008a).

CSC has implemented a strategy to ensure a continuum of mental health services to federal offenders from institutional intake to release into the community. This approach focuses on: (1) intake screening and assessment; (2) primary care; (3) intermediate care; (4) intensive

care (at Regional Treatment Centres); and (5) transitional care. In 2005, following submission to Treasury Board, funding was allocated to implement the Community Mental Health Initiative (which had been referred to previously as the *Substantive Support Initiative* as well as the *Community Mental Health Strategy* in some CSC documents), The Community Mental Health Initiative (CMHI) falls under the fifth transitional component of the overall Mental Health Strategy (i.e., transitional care).

### **The Community Mental Health Initiative (CMHI)**

In May 2005, funding was approved for the Strengthening Community Safety Initiative, of which the CMHI was a part. The Strengthening Community Safety Initiative included three new programs or activities for CSC, including: (1) the subject of the current evaluation - the CMHI; (2) the Integrated Police and Parole Initiative (designed to enhance information sharing to allow for the earlier apprehension of offenders who are unlawfully at large and to provide more effective supervision and intervention with higher-risk offenders); and (3) the provision of expanded information to victims (to be provided within existing CSC resources). The initiative also included funding for several activities in other departments, related primarily to the provision of additional services for victims and offenders with mental health needs. Other departments that also received funding through the Initiative included: National Parole Board, Office of the Correctional Investigator, Department of Justice, and Department of Public Safety.<sup>1</sup>

The CMHI was designed to aid offenders with serious mental disorders (OMDs) to reintegrate into the community by providing care through clinical discharge planning, support from mental health professionals in the community, training of CSC and mental health resource staff in the community, and assisting OMDs to access specialized services such as psychiatric care. These services are provided in conjunction with existing case management and community resources to maintain a high level of continuity of care for OMDs discharged to the community.

CMHI services from mental health specialists are targeted towards offenders with major mental disorders (i.e., schizophrenia and other psychotic disorders, mood disorders, and other psychiatric disorders) or personality disorders (excluding antisocial personality disorder) causing significant impairment of functioning. Offenders with moderate to severe impairment due to acquired brain injury, organic brain dysfunction, developmental disability, or intellectual

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<sup>1</sup> Formerly called the Department of Public Safety and Emergency Preparedness (PSEP)

impairment also qualify for these services (Champagne, Turgeon, Felizardo & Lutz, 2008). The CMHI was intended to improve correctional results and enhance quality of life for OMDs. The initiative was implemented in 2005 and has four key components (discharge planning, community mental health specialist services, contracts with community service providers, and staff training) each of which are discussed in greater detail next.

### **Discharge Planning**

Clinical discharge planning (CDP) is the transitional service that supports OMDs being released from the institution to the community. The discharge plan is designed to identify transitional needs of OMDs prior to their release into the community in an effort to promote a sense of stability for offenders who are particularly vulnerable at this time. The primary goal of clinical discharge planning services is to ensure the continuity of mental health care for released offenders (Champagne et al., 2008). The clinical discharge planner works collaboratively with the offender to assess his/her psychosocial needs, to identify required community resources, and to establish links between the offender and these resources. Offenders who meet the eligibility criteria are referred by the institutional parole officer to clinical social workers (CSW) for CDP services nine-months prior to their expected release date.

The referral criteria for clinical discharge planning services are:

- Major mental disorders
  - Schizophrenia and other psychotic disorders
  - Mood disorders (e.g., major depression, bipolar disorder)
  - Other disorders (e.g., obsessive-compulsive disorder)
- Moderate to severe impairment from:
  - Personality disorder excluding antisocial personality disorder (e.g., paranoid, borderline, schizoid)
  - Acquired brain injury or organic brain dysfunction (e.g., FASD)
  - Developmental disability or intellectual impairment

Following a referral by the institutional parole officer, the clinical discharge planner reviews the referral, including a review of the offender's file to determine whether or not the offender will be accepted for CDP services based on the above-indicated criteria.

### **Community Mental Health Specialists**

The focus of community mental health services is to ensure continuity of care for OMDs under federal supervision in the community. The key services offered by Community Mental Health Specialists (CMHS) are: comprehensive assessment and intervention planning; direct service provision; advocacy; coordination and support; implementation, monitoring and evaluation; and community capacity building. The CMHS (either a clinical social worker or a community mental health nurse) works with the offender's parole officer, community services, and support workers to further enhance integrated offender management. They also work toward removing barriers to service delivery and contribute to community capacity building. Collaborative efforts strive toward achieving successful community integration through promotion of public safety and enhancement of OMDs' quality of life. The offender referral criteria for CMHS services are the same as for the discharge planning services (see above).

### **Community Partnerships through Contract Services**

A key principle of the delivery of mental health services is the development of links or working relationships between CSC and non-CSC organizations that will provide OMDs with necessary support and resources after release (Champagne et al., 2008). Contracts for services are arranged by the regions, and are not limited to the 16 existing CMHI sites, thus expanding the breadth of the initiative to include CMHI services in additional areas beyond the 16 CMHI sites. Services range in nature but are frequently provided by psychiatrists, psychologists, community service agencies providing bed space for offenders to reside at their facilities, and personal aid workers assisting with daily functioning needs and socialization.

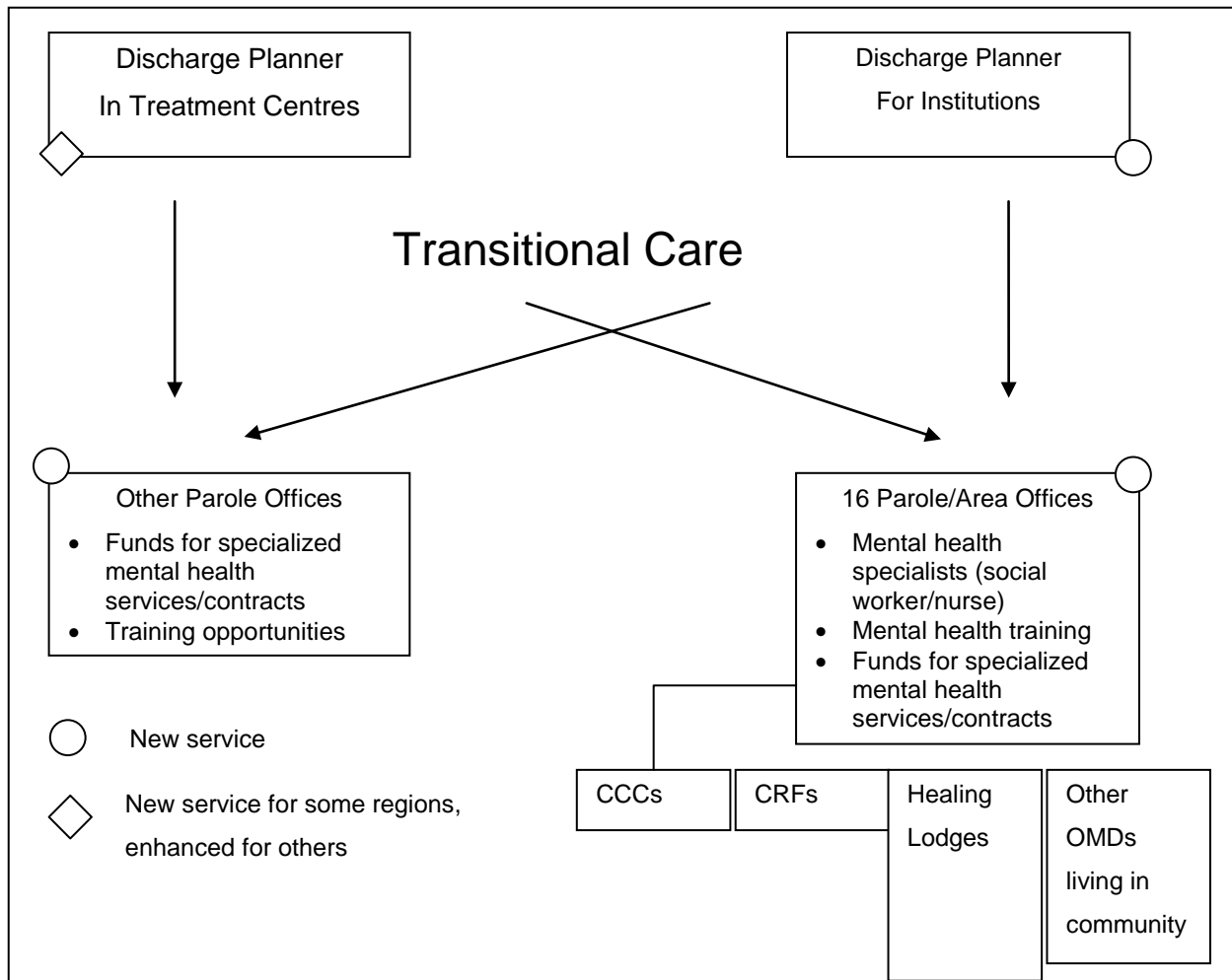
### **Mental Health Training for Community Correctional Staff**

The fourth component of the CMHI is mental health training. The objective is to provide "mental health training to correctional services, halfway house staff, parole offices and

community partners targeted to receive new community mental health positions” (Champagne et al., 2008, p. 3). Mental health training is coordinated by NHQ. National trainers are responsible for ensuring quality assurance and standardized delivery of the package nationwide and developing regional training capacity through the delivery of Train the Trainers sessions and co-facilitation. The national trainer provides training on the national training package to the CSWs and community mental health nurses, who in turn deliver the training locally. The training package covers nine modules over a 2 day period. These modules are: Introduction; Myths and Realities; What is Mental Disorder; Mental Disorders; Fetal Alcohol Spectrum Disorder (FASD); Risk and Mental Disorder; Effective Strategies; Resources; and Legislation. There are three forms of training packages: (1) a 2-day generic training which was delivered to all staff who work with OMDs; (2) a train the trainer (TtT) session package which is a 5 day training package that includes the 2 day generic training; and (3) a package specifically for women offenders which puts a greater focus on dialectical behaviour therapy, personality disorder (namely, borderline personality disorder), and the Mental Health Strategy for Women Offenders.

The CMHI is summarized schematically, and services that are newly implemented and others that are enhanced as part of the CMHI are identified in Figure 1 (Champagne et al., 2008, p. 4)

**Figure 1: Correctional Service Canada’s Community Mental Health Initiative**

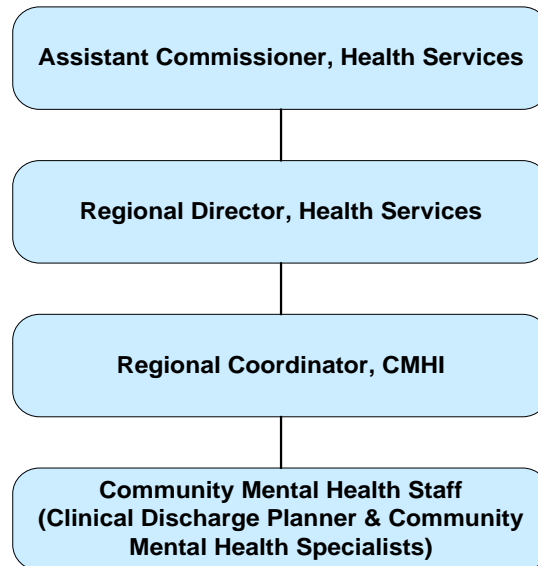


**Governance Structure**

The governance of the CMHI falls within the responsibilities of the Assistant Commissioner, Health Services. Regionally, the initiative is managed through the Regional Director, Health Services, and the Regional Coordinator of the CMHI. The front-line staff dedicated to the initiative (Community Clinical Social Worker, Clinical Social Worker – Discharge Planner in the institution, and Community Mental Health Nurse) fall under the direct supervision of the Regional Coordinator, CMHI. There may also be accountability to the Assistant Warden, Intervention, the Community Correctional Centre Director, or the Area

Director for some front-line staff, depending on their work location. The governance structure for the CMHI is presented in Figure 2.

**Figure 2: Governance Structure of the CMHI**



### **CMHI Financial Budget and Expenditures**

In May 2005, \$29.1 million over a five year period for the CMHI was approved, the majority of which (\$15.3 million) was designated to pay the salaries for 47 full-time CMHI positions,<sup>2</sup> including 8 discharge planners, 6 ambulatory care team members, 30 community mental health team members, 2 mental health trainers, 1 contract management individual, and 1 evaluation coordinator. Operating costs for the initiative totalled to \$7.8 million, and the remaining funds (approximately \$6 million) were designated for common services, employee benefit plans, and accommodations (see Table 1).

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<sup>2</sup> See the Results-based Management and Accountability Framework (RMAF) in Annex F of the Treasury Board Submission (2005)

**Table 1: Total Resources and Costs per Year (in Thousands)**

	2005/06	2006/07	2007/08	2008/09	2009/10	Total
FTEs	47	47	47	47	47	
Salary	1,792	3,380	3,388	3,388	3,381	15,329
Operating	930	1,725	1,715	1,715	1,725	7,810
Common Services	107	198	198	198	198	899
EBP	358	677	678	678	676	3,067
Accommodation	233	440	441	441	440	1,995
Total allocation	3,420	6,420	6,420	6,420	6,420	29,100

Although funding for the initiative was approved in May 2005, funding for the first year of the initiative was not received until December 2005.<sup>3</sup> In addition, implementation challenges resulted in significant delays staffing the CMHI positions. Given these issues, CSC sought to re-profile \$2 million from 2005/06 to 2006/07. In September 2006, CSC reported that delays in CMHI staffing (including the scarcity of health professionals) was expected to result in additional lapses. Therefore, CSC initiated a request to re-profile an additional \$3.3 million, of which \$1.1 million was to be carried forward each year for the fiscal years 2007/08 to 2009/10 (see Table 2). At this time, CSC also initiated some changes to the structure of the initiative. Specifically, ambulatory services and discharge planning were merged together as an integrated service in order to emphasize the discharge planning function and the transition of the offender from an institution or treatment centre to the community. Six additional CMHI positions were created to provide overall management and coordination (five Regional Coordinators and a National Coordinator). In total, 51.5 FTEs were designated for the CMHI.

On February 12, 2007, another request for re-profiling was submitted and approved, in which an additional \$2 million from 2006/07 was added to the original carry-forward plan, to be distributed over the next three fiscal years as shown in Table 2. In total, after all three re-profiles of funds, a little more than \$1.5 million was re-profiled to the CMHI budgets for each of the fiscal years 2007/08, 2008/09, and 2009/10 (i.e., from the original budgets of \$6.4 million, the budgets increased to just over \$8 million for each of the final 3 years of the initiative).

<sup>3</sup> The reason funds for the CMHI were released later than originally anticipated was because this was a new Initiative and the funds were to be released through Supplementary Estimates A, which were planned to be tabled to Parliament in September-October 2005. However, the Government was defeated in late 2005 and a general election was called for January 2006. The Treasury Board decision letter indicated that departments would have to manage the risks associated with any spending that occurred in advance of Parliamentary approval.

**Table 2: Funding for CMHI**

Budget (\$000)	2005/06	2006/07	2007/08	2008/09	2009/10	Total
Original Budget	3,420	6,420	6,420	6,420	6,420	29,100
1st Re-profile	(2,000)	2,000				
2nd Re-profile		(3,300)	1,100	1,100	1,100	
3rd Re-profile	0	(1,989)	755	655	579	
<b>Total Revised Budget</b>	<b>1,420</b>	<b>3,131</b>	<b>8,275</b>	<b>8,175</b>	<b>8,099</b>	<b>29,100</b>

Notes: Budget includes salary, operating, employee benefit plan, common services, and accommodation. Values presented in the parentheses represent funds carried forward from the year of interest.

Overall expenditures for each of the regions for the fiscal years 2005/06, 2006/07, and 2007/08 are shown in Table 3. Major areas of expenditures included: (1) discharge planning services; (2) community mental health specialists; (3) mental health training; (4) regional mental health contracts (5) adjunctive services; (6) valuation and research; and (7) management and coordination. Expenditures have increased from approximately \$500,000 in 2005/06 to just over \$3 million in salary and operating costs in 2007/08 when most of the regions were fully staffed and began accepting referrals. Expenditures were somewhat greater in the Prairie Region which was staffed and implemented earlier than the remaining regions.

**Table 3: Salary and Operating Expenditures by Region for Fiscal Years 2005/06, 2006/07, 2007/08**

Region	2005/06		2006/07		2007/08	
	Salary	Operating	Salary	Operating	Salary	Operating
Atlantic	67,842	29,563	180,479	141,485	551,468	374,331
Quebec	25,827	3,961	188,181	44,002	102,997	110,682
Ontario	0	3,205	30,642	29,786	2,048	76,092
Prairies	10,608	18,829	202,746	179,710	749,266	434,037
Pacific	65,968	15,212	288,514	240,122	281,930	332,389
NHQ	177,772	136,378	194,461	59,004	204,501	13
<b>Total</b>	<b>348,016</b>	<b>207,148</b>	<b>1,085,023</b>	<b>694,110</b>	<b>1,892,212</b>	<b>1,327,544</b>

Note that these figures include operating and salary costs only. Employee benefit plans, accommodations, and common services were not included.

Source: Comptroller's Branch

## **Evaluation Strategy**

### **Evaluation Goals**

The goal of the evaluation was to provide information required to make investment decisions in the area of community mental health beyond the expiry date of the funding at the end of March 2009/10. The continued relevance, success, cost-effectiveness, unintended outcomes, and implementation issues associated with the initiative were assessed. Note that implementation of the initiative was delayed due to difficulties staffing CMHI positions. Therefore, the evaluation was implementation focused. However, the success of the initiative as it related to achievement of immediate and intermediate outcomes were assessed where possible given the state of implementation and the availability of reliable data. The comprehensive evaluation matrix is shown in Appendix A, identifying the CMHI evaluation questions, performance indicators, and sources.

### **Logic Model**

The Logic Model for the CMHI is shown in Appendix B. As described earlier, the CMHI includes four main activities, namely: staff training, the provision of community mental health specialist services, clinical discharge planning, and establishment of community service partnerships through contracts.

Immediate outcomes of the CMHI include:

- Increased staff awareness of mental health issues;
- Standardized provision of services;
- Offender access to available services; and
- Increased availability of services and support for offenders with mental disorders being released and in the community.

Intermediate outcomes of the CMHI include:

- Improved services for offenders with mental disorders;
- Improved correctional outcomes for offenders with mental disorders; and

- Improved quality of life for offenders with mental disorders.

Ultimately, the goal of the CMHI is to contribute to the safe accommodation and reintegration of eligible offenders into Canadian communities by providing them with reasonable access to mental health care.

The extent to which these outcomes have been achieved will be explored further in the evaluation results.

### **Measures and Procedure**

A multi-method approach incorporating qualitative and quantitative methodology was utilized to address the evaluation objectives. This included a review of program documentation and reports (e.g., CMHI Guidelines), financial data, surveys and interviews with key informants, and offender data extracted from the Offender Management System (OMS) and CMHI-specific databases maintained by Regional Psychiatric Centre Prairies (RPC) and the Health Services (HS) at NHQ.

#### **Financial Data**

Financial information was collected from the Integrated Management Reporting System (IMRS). Representatives from the Comptrollers Branch provided a complete summary of CMHI budgets, re-profiles in funding, and expenditures.

#### **Key Informant Interviews and Surveys**

Feedback regarding issues related to the relevance, implementation, and success of the CMHI was obtained from three different key informant groups: (1) CSC staff; (2) offenders; and (3) community service providers.

#### *CSC Staff*

An electronic survey was distributed through CSC internal email announcements (i.e., General Communication) to CSC staff members who had experience working with offenders with mental disorders, including staff members who were directly involved with the CMHI as

well as others who were familiar with the CMHI. The survey was active for a period of 16 days from August 25, 2008 to September 9, 2008. Informal contacts were also held with national and regional CMHI personnel to establish implementation timelines and discuss implementation challenges.

### *Offenders*

Offender interviews were conducted at parole offices, CCCs, and institutions in each region. The Evaluation Branch selected the site in each region that had the most CMHI offenders currently under supervision. CMHS staff coordinated the offender interviews.

### *Community Service Providers*

Surveys were conducted with community service providers, including agencies (e.g., John Howard Society, Stella Burry Community Services, etc.) and individuals (e.g., psychiatrists) under contract to provide services directly to offenders through CMHI. These agencies were identified through bi-annual reports submitted to HS that also contained service providers' contact information. Where contact information was missing or out of date, agencies were contacted directly for an update. The original list of community service providers consisted of 42 independent agencies/organizations. Of these, 35 were contacted, and 7 were unreachable for a variety of reasons (e.g., invalid email addresses). The surveys were sent through email to the identified contact person at each agency, who was asked to complete the survey and to send it to any colleagues within their agency who had direct knowledge of the CMHI. A follow-up email was sent as a reminder to complete the survey, and also informed respondents that should they have difficulty accessing the survey in the email, alternate arrangements were available.

### **Automated Data Sources**

Finally, offender information (such as offender risk, need, demographic characteristics, correctional outcomes, time spent in the community, and other pertinent information) was extracted from the Offender Management System (OMS; automated database maintained by CSC) and other databases created and maintained by Health Services at National Headquarters and RPC. OMS is an electronic filing system designed to monitor and track offenders under the

supervision of the Correctional Service Canada. Data captured in OMS include the Offender Intake Assessment (OIA), a comprehensive and integrated examination of offenders at the time of their admission. The process begins with an assessment of immediate mental and physical health concerns, security risk and suicide potential and offender risk factors and dynamic need indicators. The OIA indicator “diagnosed as disordered currently” was used to identify those offenders with mental health needs who were released to parole offices and CCCs across Canada.

### **Measures**

There were three assessment instruments used in the evaluation of the CMHI. The first two, Alberta Continuity of Service Scale for Mental Health (ACSS-MH) and the Quality of Life Scale (QoL) were intended to be administered directly to the offender in the course of their treatment. Because very few ACSS-MH scales had been completed at the time of the evaluation, the ACSS-MH questions were incorporated into the offender interviews. The third measure, Level of Functional Impairment (LFI), was used for research purposes to rate the impairment of both the treatment and comparison groups. A training questionnaire was also administered to training participants.

#### *Alberta Continuity of Services Scale for Mental Health (ACSS-MH)*

The ACSS-MH (Adair et al., 2004) is a tool used to assess the service consumer’s (or in this case, federal offenders participating in the CMHI initiative) perception of continuity of services. The tool was adapted for use with CMHI participants (and certain questions were omitted) so results may not be directly comparable to results reported in the literature. The modified survey consisted of 40 items rated using a 5 point Likert scale from 1 (strongly disagree) to 5 (strongly agree). The scale was administered by an interviewer during a face-to-face interview by one of the evaluation staff members. Eighteen questions were worded negatively, so reverse coding was necessary before summing the item scores to derive a total score. The ACSS-MH is comprised of three subscales, namely system fragmentation (21 items), relationship base (9 items), and responsive treatment (10 items). Questions focus on areas such as service accessibility, service integration, individual or team mental health care providers, and the overall satisfaction with the services received.

### *Quality of Life Scale (QoL)*

The QoL was utilized to measure the overall quality of life of a client (Lehman, 1988). Offenders were asked to complete 26 self-report questions from the scale. The questions were answered on a 7-point scale ranging from “terrible” to “delighted” and focused on several key areas including: general life satisfaction, living situation, daily activities, social relations, family, finances, work, legal and safety issues, and health. According to CMHI guidelines,<sup>4</sup> the questionnaire was to be administered to offenders at one-month, three-months, and six-months after their receipt of community care. It can be administered by someone actively involved in their care such as their clinical social worker or nurse (i.e., CMHS). Due to initial implementation challenges, the QoL data were not collected on the majority of offenders. Data were available at time 1 and time 2 (one and three months) for 36 offenders in the CMHS group.

### *Level of Functional Impairment (LFI)*

The LFI scale was used as a research tool to assess treatment and comparison group offenders’ degree of impairment in four areas including daily living/personal hygiene, intellectual, occupational, and social/interpersonal functioning. OMS data were used to rate each item on a four-point scale (0 – 3), with higher aggregate scores indicating greater impairment (range of scale from 0 to 12). Total score ratings of 5 or greater constituted moderate to severe functional impairment (CSC, 2008d). Inter-rater reliability was obtained on the LFI Rating Scale. Five practice cases were rated, followed by 10 cases from the random sample. For the initial 10 cases, 8 out of 10 were consistently identified as being referred for services and an intra class correlation of  $r = 0.34$  for the overall functional impairment score. An additional 10 cases were then rated. Of these 10 cases, 7 received the same referral decision from the raters and an intra class correlation of  $r = 0.58$  for the overall functional impairment score was obtained. Another 10 cases were rated and resulted in 8 out of 10 receiving the same referral decision and an acceptable intra-class correlation ( $r = 0.86$ ) overall (CSC, 2008d). The LFI was originally designed to enable identification of a comparison group for outcome analysis in combination

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<sup>4</sup> *Additional Measures for the Community Mental Health Initiative – Resource Manual.*

with other indicators such as an Axis I diagnosis. Furthermore, LFI scores were used to provide descriptive information about the treatment and comparison groups.

#### *Training Evaluation Questionnaire*

Participants were asked to complete a 15 item mental health training evaluation form, in which 9 of the items asked participants to rate the usefulness of each of the nine modules of the training program (i.e., introduction, myths and realities, what is a mental disorder, types of mental disorders, cognitive disorders and FASD, risk and mental disorder, effective strategies, resources, and legislative requirements) and another 3 asked the participants to rate the usefulness of the participant resource manual, the trainer(s), and the overall training. These 12 items were rated on a 7 point scale from 1 (not useful) to 7 (very useful). Lastly, three open-ended questions were included to ask the participants to (1) provide suggestions for improvement of the training; (2) identify topics that should be addressed in follow-up training sessions; and (3) provide suggestions as to how the trainer could improve his/her delivery.

#### *Mental Health Knowledge Quiz*

Mental health training participants were asked to complete a 10 item mental health quiz prior to and immediately following training. The quiz was comprised of multiple-choice and true/false questions as well as fill-in-the-blank and open-ended questions. Topic areas addressed in the quiz included (but was not limited to) mental health disorders, mental health symptoms, treatments, side effects of psychotropic medications, and myths about OMDs.

#### *Self-Perceived Competency Scale*

The self-perceived competency scale is an 8-item scale designed to assess competencies that were targeted by the training. Sample items were “I have knowledge to work effectively with offenders with mental disorders” and “I have the skills to recognize symptoms suggestive of the need for interventions by a mental health professional”. Each item was rated on a 7 point scale from 1 (strongly disagree) to 4 (uncertain) to 7 (strongly agree). Participants of the mental health training were asked to complete this scale prior to and immediately following training.

## **Analysis**

### *Survey and Interview Data*

Themes were generated from open-ended survey and interview questions, and were compared across multiple team members to ensure agreement. Themes are presented in the appropriate Key Findings sections below (and detailed in Appendix C). Key informant interviews/survey questions were often asked on a 5-point Likert scale ranging from strongly disagree to strongly agree (1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; and 5 = strongly agree). In general, interview/survey results were collapsed across the agree and strongly agree categories to create an ‘agree’ category and the disagree and strongly disagree categories were combined to create a ‘disagree’ category.

### *Geospatial Analysis*

With the assistance of Public Safety Geomatics Division, evaluation team members created two series of maps using ArcGIS software to provide a visual representation of the locations of CMHI offices and the percentages of offenders who (a) were identified as having a mental disorder at each supervising office in each region, and (b) who received CMHI services, including CDP and CMHS services. The first set of maps identifies the percentage of offenders at each site who are identified by the OIA indicator “diagnosed as disordered currently” while the second set of map presents the proportion of offenders who received CDP and CMHS services. For both series of maps, the symbology identifies the type of office (Parole Office or CCC) and the presence or absence of CMHI services at each office.

### *Health Services (HS) Mental Health Training Summary Report*

HS maintained databases on all issues related to mental health training as part of the CMHI (e.g., attendance, training evaluation questionnaires, self-perceived competency scale, mental health knowledge quiz) and produced a summary report on the outcomes of all of the 2 day training sessions delivered from January 2007 through June 2008. At the time when the mental health training summary report was written, attendance records up to the end of 2007/08 were verified for accuracy against HRMS by HS staff for all CSC staff members. HS also provided the evaluation team with access to their mental health training databases for additional analyses reported in the present report.

### *Regional Psychiatric Centre (RPC) Data Analysis and Reports*

RPC is under a Memorandum of Understanding (MOU) with NHQ Health Services to manage CMHI data (e.g., referral and outcome data), and to provide a series of reports documenting the pre-implementation, implementation and post-implementation milestones and correctional outcomes at each stage of the initiative. According to the terms of the agreement, RPC was expected to provide:

- one pre-implementation report (documenting the establishment of the retrospective comparison group);
- five implementation reports (documenting the implementation of CMHI services for both treatment groups); and,
- two post-implementation reports (documenting the efficacy of CMHI in improving correctional outcomes and enhancing the quality of life for OMDs). RPC has provided some of the analyses included in the report and is cited as a source of these analyses where applicable.<sup>5</sup>

### **Limitations**

There were several limitations that impacted upon the ability to examine the evaluation objectives of CMHI, including the use of a historical comparison group, lengthy implementation delays, an inability to identify offenders who may have dropped out or had their CMHI services terminated shortly after accepting their referrals, the small number of offenders who received both CDP and CMHS services to date, and the use of the OIA indicator as an index of CMHI referral criteria.

The comparison group used for the effectiveness analysis was historical in nature. The CMHI treatment recipients documented in the effectiveness analysis received treatment from May to December 2007, but the comparison group was comprised of offenders eligible for release between April 1st, 2003 and March 31, 2005. This was necessary to ensure no confounds of the comparison group with respect to possible exposure to treatment through CMHI.

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<sup>5</sup> It should be noted that the first Post-implementation report was expected from RPC in March 2009. However, when the deadline for evaluation completion was brought forward by six months, RPC agreed to provide an additional Post-implementation report to be included in the evaluation

However, this adds a possible confound in that changes occurring over time might affect groups differentially (i.e., cohort effect). As documented in other sections of the report, mental health intervention is an increasing priority within the federal government and within CSC.

Enhancements to service availability and delivery in recent years in the institution may have had an impact on the treatment groups, but not the comparison groups. This possible confound may be limited as funding to begin to address elements of the institutional mental health strategy was only provided in April 2007. However, there is no way to isolate the CMHI in relation to other CSC initiatives occurring at the same time.

Lengthy delays in staffing positions resulted in delays in full implementation of the initiative. As the national implementation timelines illustrate (see implementation section of the report), there were many time consuming administrative tasks that took place prior to staffing positions through competitive processes (e.g., creating job descriptions, classifying positions, posting employment opportunities, running competitive process). Although the initiative was announced in May 2005, the first offender referral for CMHI service was not made until two years later in May 2007.

With a five-year initiative, implementation delays, and a requirement for an evaluation by June 2009, there was a limited follow-up period to examine offenders' progress in the community. The effectiveness component of the evaluation included a potential follow-up time for offenders of 6 to 13 months in the community (depending on when they began receiving services). Descriptive data for CMHI offenders was provided through to June 2008. However, the offender sample utilized for the outcome analysis (i.e., recidivism) included only offenders referred for service from the beginning of the initiative (May 2007) until December 2007, in order to allow for an adequate follow-up time in the community. Also, given the short period of time in which the initiative was operational, the treatment groups are small ( $n = 53$  for offenders receiving discharge planning services; and  $n = 79$  for offenders who have received community mental health specialist services). Furthermore, treatment dosage should be considered as short follow-ups (especially for CMHS participants) may limit the amount of CMHS service that can be delivered. Given these reduced samples and very short follow-up times, it was difficult to draw strong conclusions with the resulting data. Longer follow-up time and increased numbers within each treatment group will be required to provide more reliable results. Also, it was hoped that Aboriginal and women-specific correctional outcomes could be assessed. However, given

the small sample sizes, demographic information for these groups was reported but no further analyses could be performed.

The treatment group dataset was generated with the receipt of a completed Referral for Service form indicating that the offender was accepted for service. Once the CDP or CMHS staff received a referral form from an offender's parole officer, the hard copy was stored in the offender's file and an electronic copy was saved on the national network drive to be entered by HS analysts. Receipt of this form indicating the offender was accepted for service marked the offender as a treatment recipient. Acceptance to treatment was based on two criteria: (1) presence of a major mental disorder, or (2) a moderate to severe impairment from a personality disorder, acquired brain injury or organic brain dysfunction, or developmental disability or intellectual impairment. The offender must have met the criteria and voluntarily agreed to participate. If an offender was referred but refused to participate, the referral form would still be submitted but the refusal decision noted and he or she would not be included as part of the treatment group. However, if the offender received services that were later terminated (either by the service provider or himself/herself), that information may not always have been consistently recorded. Therefore, it is possible that offenders in the treatment group might not have received treatment for any significant period of time and it was not possible to differentiate these offenders from those who received more extensive treatment.

There were some offenders who received both CDP and CMHS services ( $n = 23$ ; CSC, 2008c). It is unclear why this number was so low because ideally, continuity of service should be provided from the institution through offender discharge planning, followed by CMHI services provided by the CMHS team. Because the majority of CMHS offices are in large urban centres, it was expected that more CDP recipients would have received CMHS services. Reasons for this limited continuity of service may be related to implementation issues, in that offenders being released to CMHI sites did not have adequate time to complete a CDP because the CDP service was not yet operational in their releasing institution. Similarly, offenders who received CDP services may have been released to sites that were not yet CMHS operational locations.

Because the group of offenders receiving both services was too small to analyse independently, the offenders who received both CDP and CMHS services were included in both treatment groups. Once the treatment group numbers increase, this group of offenders receiving

both services should be examined separately and in more detail to understand whether there is an enhanced effect of receiving both services.

For the geo-mapping exercise, two sets of data are presented, one based on those who received CMHI services and the other was a representation of offenders who have been identified as having a mental health need in the community. Mental health needs were identified using the OIA indicator “diagnosed as disordered currently”. The OIA indicator was used as a proxy measure for those who met the CMHI referral criteria. The OIA indicator is not an entirely accurate representation of those eligible for CMHI. First, the OIA indicator is based on offender self-reported information and it is static (i.e., assessed only at intake, and is not updated during the course of an offender’s sentence). In fact, a review of OMS data indicated that only 55% of offenders who were accepted for CMHI services<sup>6</sup> had the OIA indicator “diagnosed as disordered currently” on their OMS file, suggesting that not all offenders with serious mental health needs were being identified utilizing this indicator. Second, the OIA indicator does not take into account the referral criteria for the CMHI (described earlier, including the criteria of a major mental disorder or severe impairment in one of several areas of mental functioning). Based on a sample of CSC offenders with the OIA indicator selected for possible inclusion in the CMHI outcome analysis comparison group, only 61% of those with the OIA indicator actually met the CMHI referral criteria (CSC, 2008d).

## **Sample**

### *Offenders Included in Quantitative Outcome Analysis*

The sample included in the outcome (recidivism) analysis was comprised of three groups: the clinical discharge planning recipients (CDP), the community mental health specialist service recipients (CMHS), and a comparison group (CMHI Comparison; refer to Appendix D for profiles of offenders referred for services). The two treatment groups (CDP and CMHS) included all offenders who received services from the beginning of the initiative until December 2007, the cut-off date that allowed for a potential 6-month community follow-up for the treatment groups.

The comparison group was generated by using a historical cohort of offenders who were eligible for release between April 1st, 2003 and March 31, 2005, and who had the OIA indicator

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<sup>6</sup> This analysis was conducted for all offenders in the CMHI referral database who had been accepted for CMHI services (CDP or CMHS) as of June 2008

“diagnosed as disordered currently” (CSC, 2008d). Those offenders who met the referral criteria but did not receive services (because the CMHI had not been implemented at that time) became the CMHI comparison group. The referral criteria for CMHI services include the presence of a major mental disorder (e.g., schizophrenia, mood disorder) personality disorder (e.g., paranoid, borderline, schizoid) with moderate to severe functional impairment or acquired brain injury/organic brain dysfunction (e.g., FASD) or developmental disability/intellectual impairment with moderate to severe impairment. Offenders with the OID indicator “diagnosed as disordered currently” were identified and then rated using the LFI Scale to determine whether they met the criteria. Those who did formed the CMHI comparison group and those who did not were eliminated from further analyses.

Demographic and risk-related information is provided in Table 4. Overall, the majority of offenders in the CDP, CMHS and CMHI comparison group were relatively young, male, and had a low to moderate reintegration potential. However, some differences were observed between the groups. Both the CDP and CMHS groups were significantly younger at the time of index offence than the comparison group ( $F(2, 224) = 7.10, p < 0.05$ ; CSC, 2008d) and the CDP group was significantly younger at first release than both the CMHS and comparison groups ( $F(2, 218) = 5.25, p < 0.05$ ). There were a higher proportion of Aboriginal offenders in the CDP group than in the other two groups. The CDP group had the smallest percentage of offenders who had a high reintegration potential and the highest percentage of offenders who had a low reintegration potential. In addition, the offenders who were accepted for CDP services were held at higher levels of security (a variable usually associated with higher risk). The CMHS group had a smaller proportion of offenders with Schedule I offences and significantly longer ( $F(2, 224) = 6.48, p < .05$ ) index sentences than either the CDP or comparison group. The CDP group had significantly more total prior convictions ( $F(2, 224) = 3.10, p < 0.05$ ) than the CMHS group and the comparison group ( $p < .056$  on LSD post hoc analyses) and the differences on the number of violent and non-violent convictions approached significance (See Table 4; CSC, 2008d, p. 12.)

**Table 4: Demographic, Criminal History, Risk Variables and Security Level at Release for the CDP, CMHS and CMHI Comparison Groups**

	CDP (n = 53)	CMHS (n = 79)	Comparison Group (n =95)
Demographic Variables	Mean (SD)		
Age at Index Offence (years)	29.5 (8.6) <sup>a</sup>	31.5 (9.3) <sup>a</sup>	35.2 (9.7) <sup>b</sup>
Age at Release (years) <sup>a</sup>	32.2 (8.5) <sup>a</sup>	36.3 (10.3) <sup>b</sup>	37.8 (10.0) <sup>b</sup>
	Number (%)		
Marital Status - Married/CL	13 (24.5%)	19 (24.1%)	22 (23.2%)
Gender - Male	42 (79.2%)	64 (81.0%)	85 (89.5%)
Race – Aboriginal	23 (43.4%) <sup>a</sup>	18 (22.8%) <sup>b</sup>	16 (16.8%) <sup>b</sup>
Criminal History & Risk Variables	Number (%)		
Index Offence Type:			
Schedule I	39 (73.6%)	46 (58.2%) <sup>a</sup>	72 (75.8%) <sup>b</sup>
Sexual	4 (7.5%)	12 (15.2%)	13 (13.7%)
Security Classification at 1st Release <sup>1</sup> :			
Maximum	12 (22.6%) <sup>a</sup>	6 (7.6%)	7 (7.4%) <sup>b</sup>
Medium	31 (58.5%)	50 (63.3%)	60 (63.2%)
Minimum	6 (11.3%) <sup>a</sup>	19 (24.1%)	25 (26.3%) <sup>b</sup>
Missing Data/Prov/Unknown	4 (7.5%)	4 (5.2%)	3 (3.2%)
Reintegration Potential <sup>1</sup> :			
Low	30 (56.6%)	24 (30.4%) <sup>a</sup>	43 (45.3%) <sup>b</sup>
Medium	18 (34.0%)	36 (45.6%)	35 (36.8%)
High	5 (9.4%)	19 (24.1%)	17 (17.9%)
	Mean (SD)		
Index Sentence Length (years)	4.3 (3.1) <sup>a</sup>	6.2 (7.2) <sup>b</sup>	3.6 (2.8) <sup>a</sup>
Number of Prior Convictions:			
Non-Violent	22.6 (17.0) <sup>a</sup>	15.8 (16.8) <sup>b</sup>	16.9 (16.1) <sup>b</sup>
Violent	3.6 (2.6) <sup>a</sup>	2.6 (2.7) <sup>b</sup>	3.2 (2.9)
Sexual	0.2 (0.7)	0.6 (1.6)	0.6 (1.2)
Total	26.4 (17.5) <sup>a</sup>	19.0 (17.9) <sup>b</sup>	20.7 (16.5)
Region	Number (%)		
Atlantic	4 (7.5%)	19 (24.1%)	11 (11.6%)
Ontario	0 (0%)	9 (11.4%)	26 (27.4%)
Pacific	5 (9.4%)	17 (21.5%)	11 (11.6%)
Prairies	44 (83.0%)	33 (41.8%)	25 (26.3%)
Quebec	0 (0%)	1 (1.3%)	22 (23.2%)

Notes:

1) Post-hoc comparisons between pairs of groups were completed, where the overall test was significant, to determine whether there were any differences among the three groups. Statistically significant differences between the groups are identified with an a, b at  $p < .05$ .

2) 1 Security classification and reintegration potential had three level of the variable to be tested for each of the three treatment/comparison groups. In order to minimize the chance of erroneously finding a difference (i.e., family-wise error), comparisons were completed for CDP vs. comparison and CMHS vs. comparison groups only.

Additional information regarding the clinical profiles of the offenders in each of the CDP, CMHS, and comparison groups is summarized in Table 5 (CSC, 2008d). The most common type of mental disorder across all three groups was a major mental disorder, with mood disorder being the most common (34% for CDP; 32% for CMHS; and 38% for CMHI). Offenders with schizophrenia constituted 25%, 15%, and 37% of the CDP, CMHS, and comparison groups, respectively. There was a significant difference between the groups on the LFI,<sup>7</sup>  $F(2, 224) = 4.75, p < 0.05$ . *Post hoc* analyses indicated that the CDP group had significantly higher scores on the LFI scale ( $M = 5.7, SD = 2.1$ ) than the CMHS ( $M = 4.8, SD = 2.5$ ) and comparison groups ( $M = 4.4, SD = 2.3$ ). The CDP group's mean score of 5.7 corresponds to a moderate to severe functional impairment.

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<sup>7</sup> The LFI was used as a research tool as described in detail in the method section.

**Table 5: Types of Mental Disorders, Functional Impairment, and Substance Abuse for the CDP, CMHS and CMHI Comparison Groups**

	CDP (n = 53)	CMHS (n = 79)	Comparison Group (n = 95)
Types of Mental Disorders <sup>1</sup>	Number (%)		
Major Mental Disorders:	40 (75.5%) <sup>a</sup>	46 (58.2%) <sup>b</sup>	79 (83.2%) <sup>a</sup>
Schizophrenia & Other Psychotic Disorders	13 (24.5%)	12 (15.2%) <sup>a</sup>	35 (36.8%) <sup>b</sup>
Mood Disorders	18 (34.0%)	25 (31.6%)	36 (37.9%)
Other (e.g., PTSD, OCD)	17 (32.1%)	21 (26.6%)	24 (25.3%)
Schizophrenia & Mood Disorder	0 (0%)	2 (2.5%)	5 (5.3%)
Schizophrenia & Other	1 (1.9%)	2 (2.5%)	1 (1.1%)
Mood Disorder & Other	7 (13.2%)	9 (11.4%)	9 (9.5%)
Personality Disorder	11 (20.8%) <sup>a</sup>	19 (24.1%) <sup>a</sup>	39 (41.1%) <sup>b</sup>
Acquired Brain Injury/Organic Brain Dysfunction	16 (30.2%) <sup>a</sup>	13 (16.5%)	8 (8.4%) <sup>b</sup>
Developmental Disability/Intellectual Impairment	4 (7.5%)	5 (6.3%)	10 (10.5%)
Functional Impairment (Moderate to Severe, score of 2 or 3)	Number (%)		
Daily Living/Personal Hygiene	17 (32.1%)	26 (32.9%)	28 (29.5%)
Intellectual	21 (39.6%)	21 (26.6%)	17 (17.9%)
Occupational	40 (75.5%)	43 (54.4%)	44 (46.3%)
Social/Interpersonal	24 (45.3%)	30 (38.0%)	39 (41.1%)
Mean (SD) Total Functional Impairment Score	5.7 (2.1) <sup>a</sup>	4.8 (2.5) <sup>b</sup>	4.4 (2.3) <sup>b</sup>
Substance Abuse	Number (%)		
History of Abuse:	50 (94.3%)	66 (83.5%)	83 (87.4%)
Missing Data	0 (0%)	3 (3.8%)	3 (3.2%)

Notes:

- 1) 1 Diagnosis is based on actual psychiatric diagnosis(es) when available or any documented reporting of diagnosis(es) information in OMS for the comparison group.
- 2) Post-hoc comparisons between pairs of groups were completed, where the overall test was significant, to determine whether there were any differences among the three groups. Statistically significant differences between the groups are identified with an a, b at  $p < .05$ .

### *Staff Survey Respondents*

A total of 519 surveys were completed by staff members who had knowledge and experience working with OMDs.<sup>8</sup> Staff position titles are described in Table 6.

<sup>8</sup> A response rate could not be calculated as we did not know the total number of individuals at CSC who were familiar with the CMHI.

**Table 6: Staff Respondent Position Titles**

Position Title	Staff (N = 519)	
	(n)	(%)
Parole officer	130	25
Correctional Program Delivery Officer	41	8
Psychologist	40	8
Correctional officer	38	7
Nurse	29	6
Parole supervisor	23	4
Manager	17	3
Finance/Finance Clerk and admin/clerical	12	2
District/area director	11	2
Project Officer	11	2
Behavioural/Correctional counsellor	10	2
CMHI clinical social worker	16	3
CMHI nurse	9	2
CMHI discharge planner	7	1
CMHI regional coordinator	3	1
Unspecified	95	18
Other*	23	4
Missing	4	1

\*Note: The Other category includes: Chaplain, Teacher, Warden and ACLO. Percentages may not total 100 due to rounding.

### *Offender Interviewees*

The Evaluation Branch teams conducted interviews with offenders in the following locations: (1) St. Johns, Newfoundland (Parole Office and Her Majesty's Prison); (2) Montreal, Quebec (CCC Martineau); (3) Hamilton, Ontario (Parole Office); (4) Winnipeg, Manitoba (Parole Office, Stony Mountain Institution); and (5) New Westminster and Vancouver, British Columbia (Parole Offices). A total of 33 interviews were completed across the five regions in Canada: 4 from the Pacific Region, 12 from the Prairie Region, 5 from the Ontario Region, 5 from Quebec Region, and 7 from the Atlantic Region.

### *Community Service Provider Survey Respondents*

The original list of community service providers consisted of 42 independent agencies/organizations. Of these, 35 were contacted, and 7 were unreachable for a variety of

reasons (e.g., invalid email addresses). A total of 14 community service providers completed surveys, of which 5 were from one organization. Therefore, a total of 10 independent service organizations returned surveys. Thus overall, feedback was obtained from 24% of the 42 organizations.

## Key Findings

### Evaluation Objective 1: Relevance

Evaluation Objective: Does the initiative remain consistent with departmental and government-wide priorities, and does it realistically address an actual need?
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#### Government and Departmental Priorities

#### **FINDING 1: The CMHI remains consistent with departmental and government-wide priorities**

##### *Government of Canada*

According to Canada's Performance Report 2006/07, a report to parliament indicating the spending and outcome areas of the federal government, there are two outcome areas that support CMHI, both related to Social Affairs (Government of Canada, 2007b). First, the Government of Canada recognizes that mental health and mental illness are priority issues for Canadians that have broad economic and social impacts. The second spending area is related to the prevention of crime and victimization by offenders through the direct delivery of rehabilitation programs and services that reduce recidivism, delivery of such programs and services through partnerships and formal arrangements with local communities, and improved information-sharing with criminal justice partners.

##### *CSC Performance Report*

One of CSC's key priorities is: "improved capacities to address mental health needs of offenders". The CSC Departmental Performance Report (CSC, 2007b) lists several results commitments for mental health, including improved correctional results as measured by: (1) the percentage of OMDs whose parole has been revoked, with or without a new conviction or charge; (2) the percentage of OMDs returning to federal custody within two years of the end of their sentence (i.e., after warrant expiry); and (3) the percentage of OMDs convicted of a new offence within five years of the end of their sentence.

### *CSC Report on Plans and Priorities*

CSC reported, through the *2006-07 Report on Plans and Priorities (RPP)*, that several milestones had already been achieved in the implementation of the CMHI, namely: an evaluation plan and a measurement strategy were developed; national mental health training had been piloted; approximately 50% of newly created clinical positions were filled; and 25 regional contracts for services directly to offenders with mental disorders were in place (CSC, 2006).

### *Report of the CSC Review Panel*

Strengthening CSC's strategy to treat and effectively manage offenders with mental disorders was also highlighted in the recent *CSC Review Panel's Report of the CSC Review Panel: Roadmap to Community Safety Report (2007)*. The report documents 12 recommendations specifically related to improving the treatment and management of offenders with mental disorders, including enhanced community support and increased assessment of mental disorders.

### *Office of the Correctional Investigator*

The Office of the Correctional Investigator (OCI, 2007) noted twelve key barriers to public safety in its most recent Annual Report, the first of which was the full implementation of the CSC mental health strategy of which the CMHI is one component. According to the Annual Report, the Office of the Correctional Investigator supports the Mental Health Strategy in place at CSC and notes that CSC needs to build mental health care capacity.

### *Out of the Shadows at Last*

In the 2006 report of the Standing Senate Committee on Social Affairs, Science and Technology on mental health care in Canada, *Out of the Shadows at Last*, which was also known as the *Kirby Report* (Kirby, 2006), the Committee challenged CSC to meet mental health standards of care for offenders under federal jurisdiction that are typically afforded to non-offender populations. Moreover, the Committee specifically made recommendations to CSC in three key areas: (1) to achieve equivalent standards of care within the institutions and post-release as those accessed by the general population; (2) that offenders should receive a full

mental health assessment by trained professionals at the time of their arrival into CSC custody; and (3) that CSC take responsibility for ensuring continuity of care post-release. These recommendations support the services offered by the CMHI.

CSC has made important changes internally to strengthen the commitment to mental health provision. The CSC comprehensive mental health strategy was approved by Executive Committee in 2004. In 2007, CSC also received almost \$22 million to fund the Institutional Mental Health Initiative over the next two years and \$16.6 million per year permanent funding in 2008. In addition to the comprehensive mental health strategy and increased funding, the new Health Services Sector governance model established in 2007 created a Mental Health Branch to focus on these issues specifically.

Given all the above priorities placed on strengthening the response to the needs of offenders with mental disorders, the goals and objectives of CMHI are consistent with achieving governmental and CSC objectives.

### **Need for Services to Address Mental Health Needs of Offenders**

**FINDING 2: Given the increasing number of offenders entering CSC with mental health disorders, there is a need to provide services for these offenders to address their mental health needs and assist them to successfully reintegrate into the community.**

The prevalence of mental disorders is higher among offenders than among the general population (Brink, Doherty & Boer, 2001). Almost one-fifth (20%) of the federal offender population has been previously hospitalized in a mental health facility (Motiuk, Boe & Nafekh, 2003). Major mental disorders (e.g., schizophrenia and mood disorders) are two to three times more common in offenders than among the general population, and rates of most disorders are higher for incarcerated women than incarcerated men. Not only is the prevalence of mental disorders higher in incarcerated individuals, but the rate of mental disorders is increasing. The changing offender profile indicates that since 1996/97, the prevalence of mental health problems at intake among men and women federal offenders have increased 67% and 69%, respectively (CSC, 2008b). More than one-out-of-ten male offenders and one-out-of-five female offenders in federal custody have been identified at admission as presenting with mental health problems.

Since 1997 there has been an almost 80% increase in offenders who were on prescribed medication at the time of admission. Overall, 14% of inmates had recent psychiatric or psychological treatment prior to their incarceration.<sup>9</sup> Overall, 10% of men offenders and 22% of women offenders are identified as having a mental health disorder at intake (CSC, 2008b).

Further, a recent evaluation of CSC's correctional programs indicated that male offenders who were identified at admission as having a mental disorder did not achieve successful correctional results in several program areas (e.g., family violence and substance abuse) and had limited results in other program areas (e.g., sex offender programs; Nafekh et al; under review). These findings suggest that offenders with mental disorders may have more limited treatment gains through participation in mainstream correctional programs.

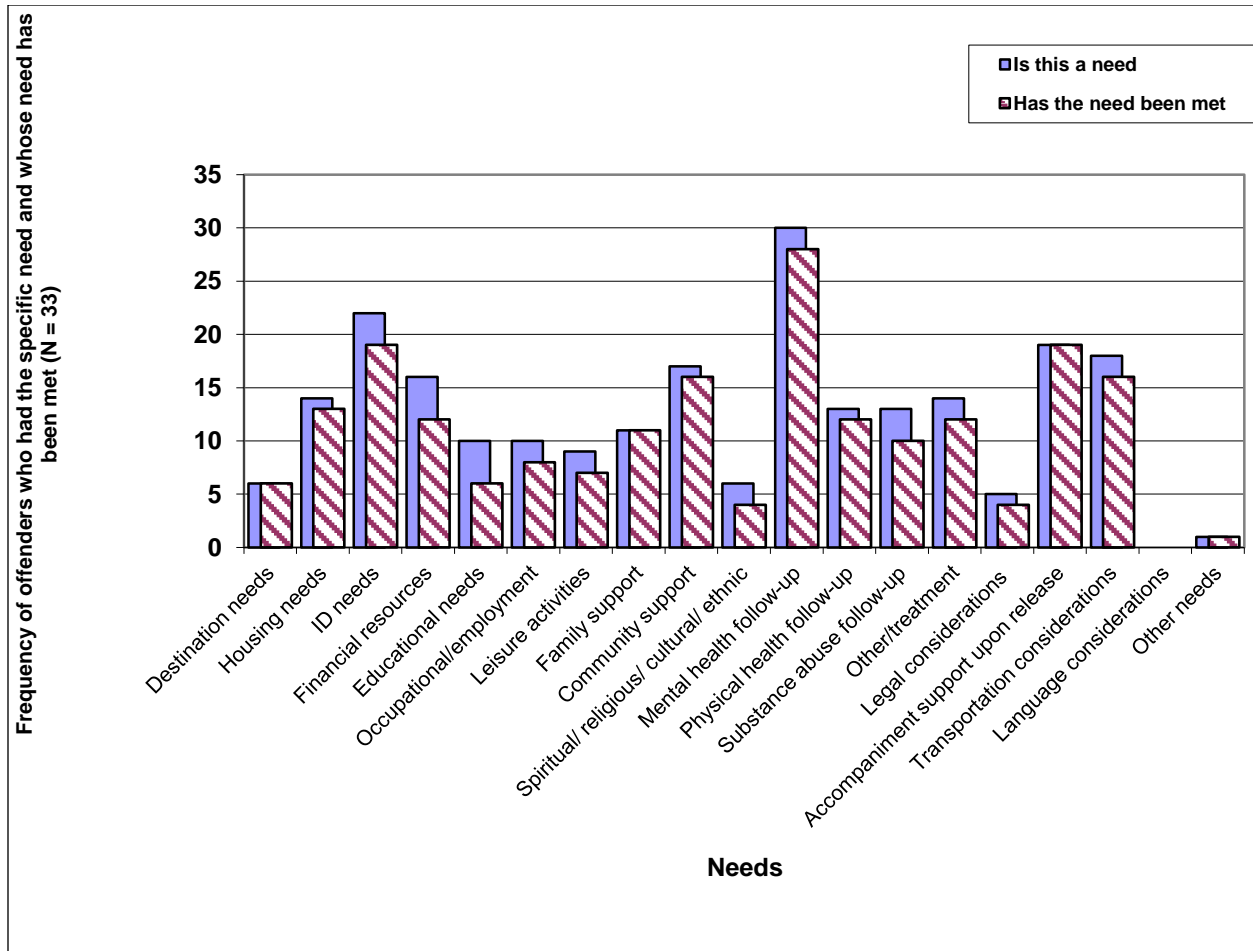
Serious mental disorders are associated with other problems for offenders related to an increased risk of re-offending, and a lack of stable accommodation and employment. The characteristics of OMDs often place them at higher risk of repeat arrests and incarcerations especially in the first few months following discharge. They are at a higher risk for failure in treatment, continued criminality, violent behaviours, and violations of parole conditions (Lurigio, Rollins, & Fallon, 2004).

Offenders suffering from a mental disorder often have many associated treatment needs that should be incorporated into their case management. Offenders receiving treatment under the CMHI were asked to indicate their needs when reintegrating from the institution into the community and whether these needs have been met through the CMHI during the evaluation interviews. The following results highlight the multiple need areas of offenders and the extent to which they report that these needs have been met (Figure 3). It should be noted that mental health follow-up was the highest reported need of the CMHI offender respondent group (91%;  $n = 30$ ).

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<sup>9</sup> Source – CSC's Offender Management System

**Figure 3: Reintegration Needs of Offenders Interviewed for the Evaluation**



Note. The counts represent only those offenders who indicated that they had the need (out of a total of 33 offenders). Note that there was some missing data evident for some of the needs indicators shown in the graph; therefore, the total number of respondents may not always be 33 for each indicator. Offenders who indicated that they had the need were then asked to indicate whether the need had been met.

### Consistency with Other Jurisdictional Practices

**FINDING 3: The CMHI is consistent with other jurisdictions’ practices, particularly those that employ community-based models of mental health intervention for offenders.**

As previously discussed, the UN suggests that people with mental disorders should be treated in the community whenever possible (1991). The UN reports that offenders should live in the community, be treated in the community, and their reintegration plans should be initiated at

the start of an offenders' sentence (1977). Offering mental health services to OMDs residing in the community is common practice among many countries (Roberts, Cummings, & Nelson, 2005; Wolff, 2005).

A popular approach to community treatment for individuals with major mental disorders is Assertive Community Treatment (ACT), a multidisciplinary approach to mental illness that encompasses a variety of services that are provided at all times (National Alliance on Mental Health, 2008). The individuals who benefit most from this type of program are those suffering from major mental disorders and those who struggle to function in their everyday lives. ACT programs have often been found to achieve better mental health outcomes at lower cost than in- or out-patient care at hospitals (Roberts et al., 2005).

ACT programs are similar to the CMHI in that care is designed to address multiple needs. Community Mental Health Specialists work regularly with the offenders and advocate on their behalf and establish other community partnerships with agencies, either through CHMI contracts or other services. ACT programs have been widely used in Canada, the US, and the UK and have been shown to be less expensive than institutionalized programming and other community based programs (Chandler, Spicer, Wagner, & Hargreaves, 1999.)

A few other examples of initiatives similar to the CMHI have been found that support the community-based model of mental health interventions for offenders:

- New Jersey Prisons offers four re-entry programs to offenders with mental disorders. The most intensive of these, the “super extensive re-entry coordination” program is most similar to CMHI and provides reintegration planning for offenders 6 months prior to release and follow-up services for 12 months following their release into the community. (Wolff, 2005)
- The Netherlands provides programming to offenders with mental disorders with the goals of reduced recidivism and improved reintegration into society. Upon release, the institution is responsible for making contact with probation services to establish the appropriate connections for the individual (de Kogel, 2006).
- In the United Kingdom, newly released OMDs are entitled to the same arrangements as those who are being discharged from the hospital. The prison will allow the opportunity for the Prison In-Reach team, Mental Health Team or Care Coordinator to contact the

appropriate services for the community based services that are needed by the OMD (Department of Health, National Institute for Mental Health in England, 2005).

Based on these examples, the CMHI appears congruent with the practices of other jurisdictions with respect to the treatment available to offenders with mental disorders upon release.

### **Evaluation Objective 2: Implementation**

Evaluation Objective: The CMHI was organized in such a way that goals and objectives can be achieved. This involves appropriate linkages between activities, outputs, outcomes and long-term outcomes.
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### **CMHI Implementation and Staffing**

**FINDING 4: Delays in implementing CMHI services were attributed primarily to staffing challenges. Successful implementation of the CMHI was more likely when there were: (1) dedicated human resource and administrative support to expedite the staffing processes; and (2) a wide recruitment campaign to draw many potential candidates to staff the initiative.**

In May 2005, funding was approved for the Strengthening Community Safety agenda, of which CMHI was a part. The funding for CMHI included \$29.1 million to be spent over a five year period up to and including fiscal year 2009/10. Implementation of the initiative was delayed, in part due to finalization of job classifications, creation of job descriptions, hiring staff through competitive process in each of the regions, and other implementation challenges. The first referral for service through the initiative was not made until May 2007.

#### *National Implementation*

One of the first steps toward national implementation was selecting the CMHI sites across Canada. In order to identify CMHI community sites, each region was asked to submit a proposal identifying up to four parole offices for receipt of mental health specialist services (i.e., placement of two mental health specialists). Twenty sites were proposed for inclusion in the

CMHI, and 16 of those sites were selected to receive one or two mental health specialists. The sites were selected by a committee specifically established to review the regional submissions.<sup>10</sup>

The review committee made decisions regarding sites based on three criteria:

- 1) The prioritized regional submissions (each region rank ordered their proposed sites in order of which sites had the greatest need);
- 2) Data from CSC's Research Branch on the number of inmates in each region who had the OIA indicator "has a current disorder" at intake; and,
- 3) Specific information from review committee members regarding the mental health needs at various sites.

Site selection results are presented in Table 7. All of the proposed sites from the Prairie and Atlantic Regions were accepted by the review committee. In Ontario Region, the Ottawa Parole Office was proposed but not approved, and in Quebec, Martineau CCC and Maisonneuve Parole Office were proposed but not selected. In the Pacific region, Kelowna and Kamloops were proposed and the approval was given for either Kelowna or Kamloops, but not both. In the end, the decision was made to move the office from Kelowna or Kamloops to Vernon because Vernon was central to both of these sites and services could be expanded to incorporate a larger geographic region if the CMHI site was located in Vernon.

Quebec had four sites proposed, two of which were approved. Quebec Region had fewer offenders identified as having a current mental disorder than any other region (7% compared to, for example, 20% in Pacific Region). Martineau CCC was already providing mental health needs for offenders who resided in that facility (i.e., mental health follow-up, pharmaceutical assistance, referrals to community agencies, recreational activities, etc.). It was decided that because there were existing resources already being committed to the provision of community mental health services at Martineau CCC, this site would not receive additional resources.<sup>11</sup>

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<sup>10</sup> Memorandum from Françoise Bouchard, Director General, Health Services, to Assistant Deputy Commissioners, Correctional Operations, December 12, 2005

<sup>11</sup> CMHI National Coordinator, Health Services, Personal Communication, August 2008.

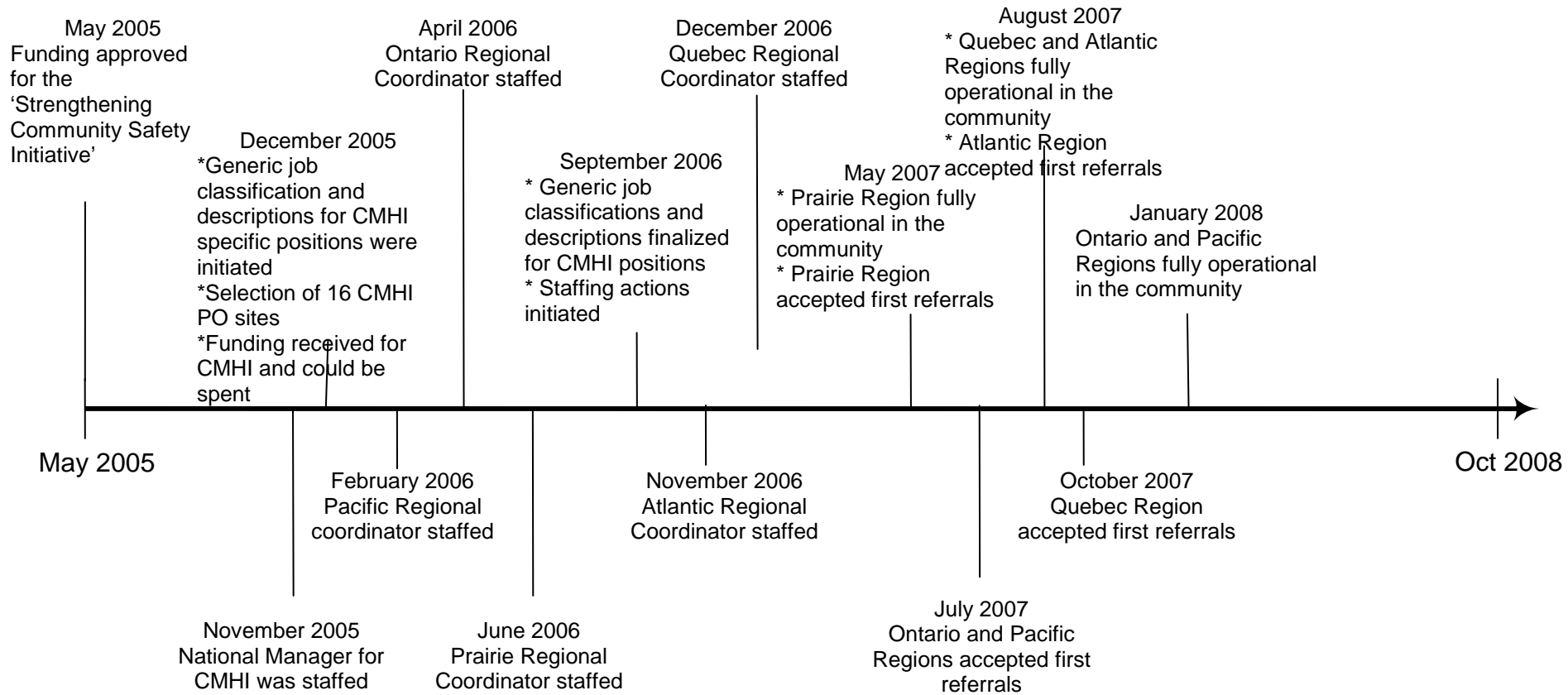
**Table 7: CMHI Sites Selected in Each Region**

Region	Offenders with OIA Indicator "Has a current disorder" (%) <sup>a</sup>	Parole Office Selected for CMHI
Atlantic Region (4 sites)	17%	Moncton (New Brunswick) Saint John (New Brunswick) Halifax (Nova Scotia) St. John's (Newfoundland)
Quebec Region (2 sites)	7%	Quebec City (Quebec East/West) St Jerome (Laurentides)
Ontario Region (3 sites)	13%	Hamilton Toronto (Keele) Kingston
Prairie Region (4 sites)	11%	Edmonton (Alberta) Calgary (Alberta) Winnipeg (Manitoba) Regina (Saskatchewan)
Pacific Region (4 sites)	20%	New Westminster Vancouver Kelowna or Kamloops (the actual final location was Vernon)

<sup>a</sup> Data provided from the Research Branch to Health Services cited in: Memorandum from Françoise Bouchard, Director General, Health Services, to Assistant Deputy Commissioners, Correctional Operations, December 12, 2005.

Although the funding for CMHI was announced in May 2005, there was a 7 month delay between approval and receipt of the funds. The CMHI position of National Manager was staffed in advance of the receipt of resources (November 2005) to oversee the initiative from National Headquarters. The first task for the initiative was to create generic job descriptions for each of the CMHI positions (e.g., Clinical Social Worker – Discharge Planning, Clinical Social Worker – Community, Nurse). The generic job descriptions took 10 months to complete (from December 2005 until September 2006). Staffing actions were not initiated until these were finalized. In the interim, each region had an individual acting as a Regional Coordinator or manager of the initiative. Positions were then finalized through regional competitive processes. Refer to Figure 4 for an overview of CMHI implementation milestones.

**Figure 4: Overview of CMHI Implementation**



### *Regional Implementation*

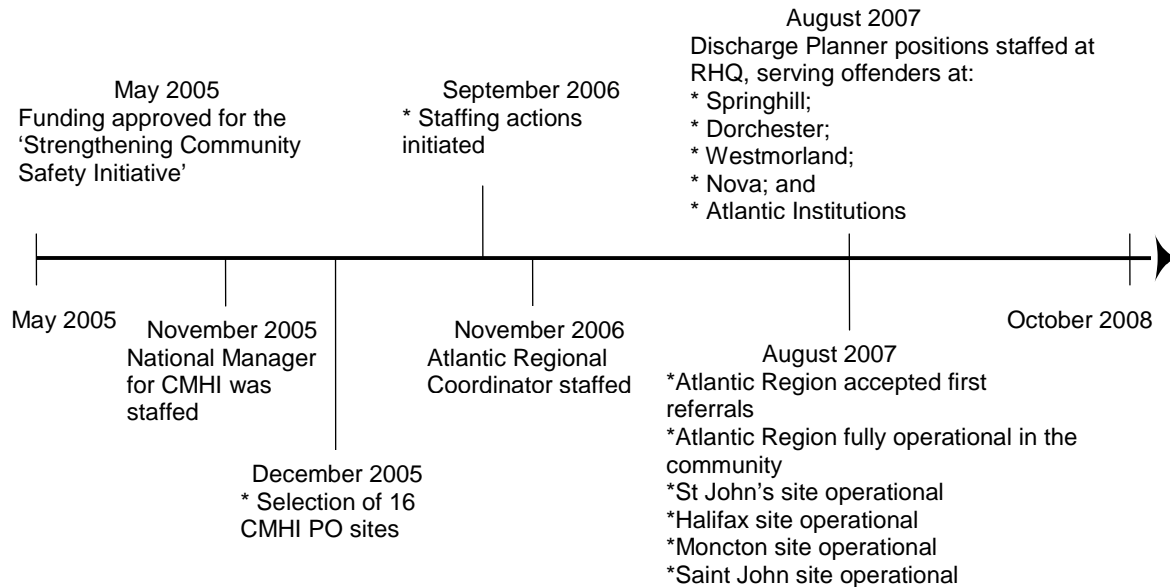
Implementation began at the same time across all regions, but different approaches were used to recruit and hire staff that ultimately affected the implementation timeframes for each region. Regional implementation timelines and challenges will be discussed below. For each regional implementation description, there is a corresponding timeline providing documentation on implementation milestones. The date that the first position was staffed at each site is reported through the timeline staffing dates.<sup>12</sup>

*Atlantic Region.* In the Atlantic Region, all community and institutional sites were staffed in August 2007. The staffing process for Atlantic Region took 12 months from beginning to end (September 2006 to August 2007). Staffing challenges were reported in the region but were focused mainly on the length of time the staffing process took. The positions were advertised on the Government of Canada's website; many applications were received and no recruitment challenges were reported. Refer to Figure 5 for further details regarding regional implementation milestones.

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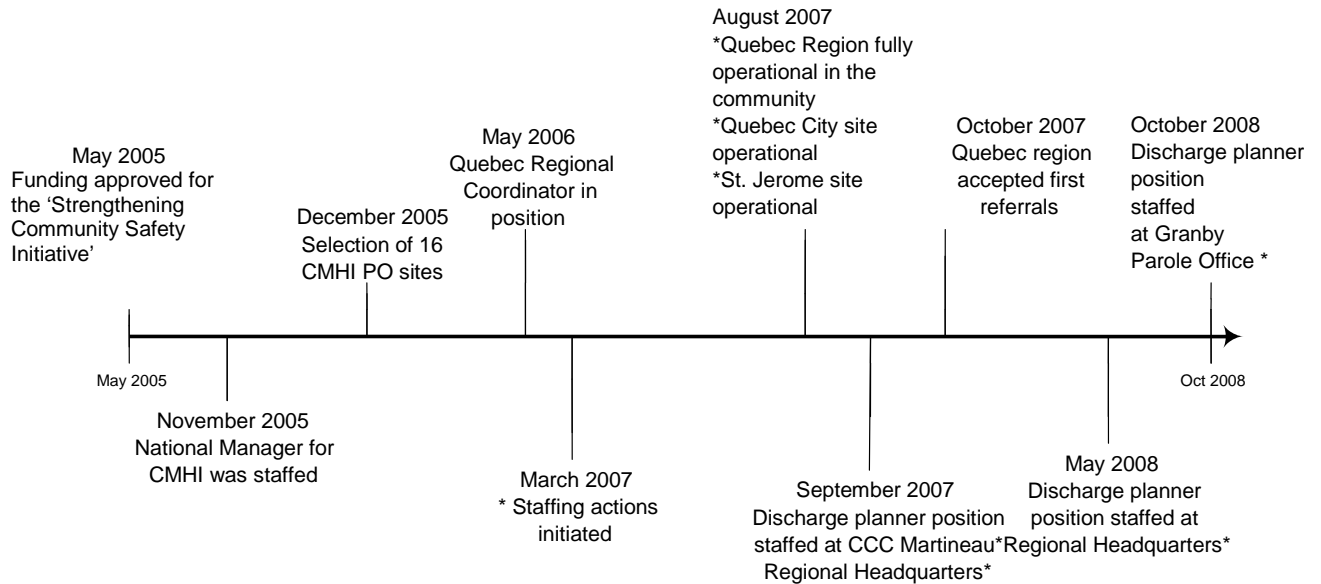
<sup>12</sup> There has been staff turnaround within the CDP and CMHS positions. The site implementation dates reported are only for the first person in that position. There have been vacancies in some of the positions since it was initially staffed. However, these vacancies are not reported

**Figure 5: Atlantic Region CMHI Implementation Timeline**



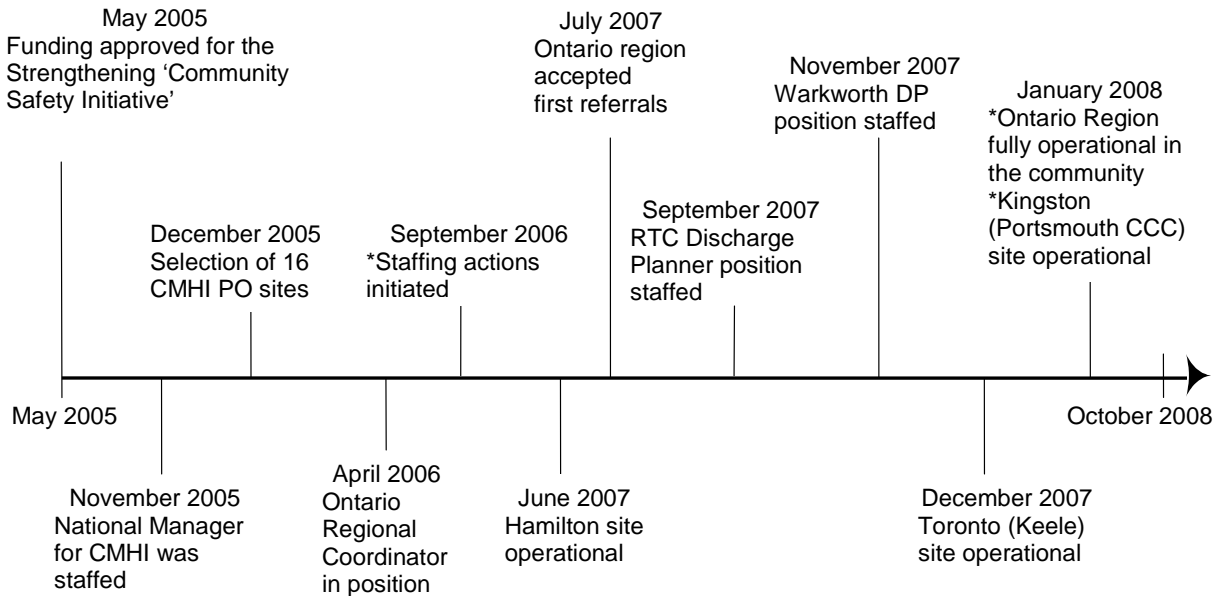
*Quebec Region.* In the Quebec Region, all community sites were staffed by August 2007, and their first referrals were accepted in October 2007. The staffing process for CMHI community staff in Quebec Region took 7 months from beginning to end (March 2007 to August 2007). The staffing process for Clinical Discharge Planners (the institutional counterparts of the initiative) was not completed until October 2008 (taking one year and seven months). The main staffing challenges reported in the region were that there were few applicants to the positions, many of the applicants were screened out, and lengthy delays were experienced for second language evaluations. The region reported receiving limited human resource assistance in staffing the positions. They advertised the positions on the Government of Canada's website. Refer to Figure 6 for further details regarding regional implementation milestones.

**Figure 6: Quebec Region CMHI Implementation Timeline**



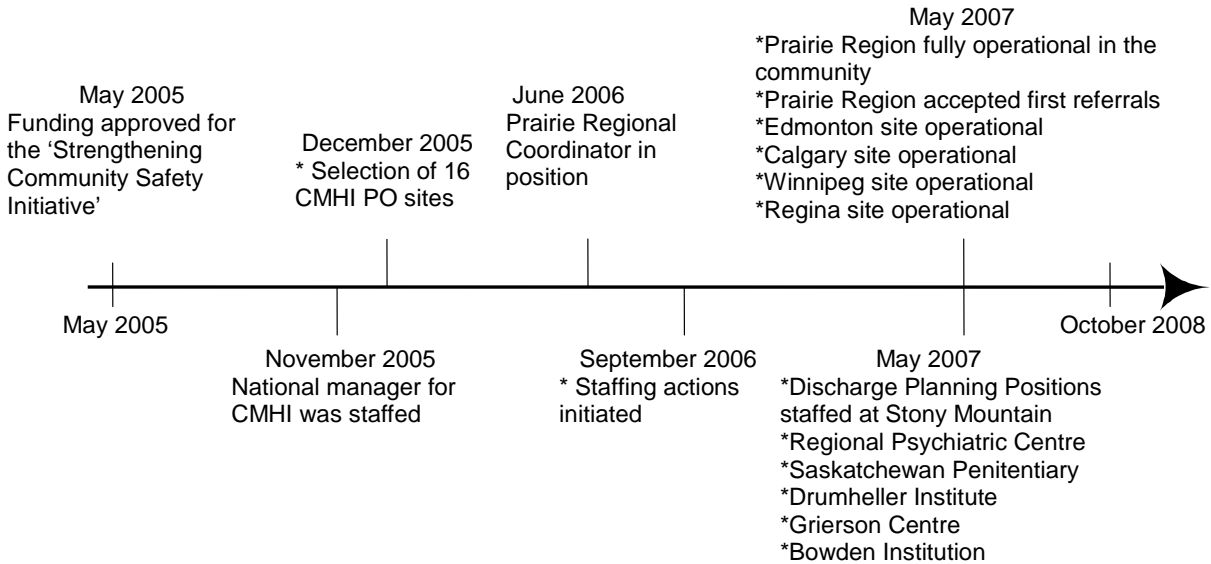
*Ontario Region.* In the Ontario Region, all community sites were staffed by January 2008 and the first referrals were accepted in July 2007. The staffing process for Ontario Region took one year and five months from beginning to end (September 2006 to January 2008). Staffing challenges were reported in the region, particularly pertaining to the length of time it required, the lack of qualified applicants who applied, and difficulty using recruitment strategies other than the Government of Canada’s website. Despite attempts, no national advertising for the positions was initiated, and a process was initiated with Interchange Canada that was unsuccessful in attracting any employees. Interchange Canada offers nation-wide employee exchanges within federal provincial and private organizations. Refer to Figure 7 for further details regarding regional implementation milestones.

**Figure 7: Ontario Region CMHI Implementation Timeline**



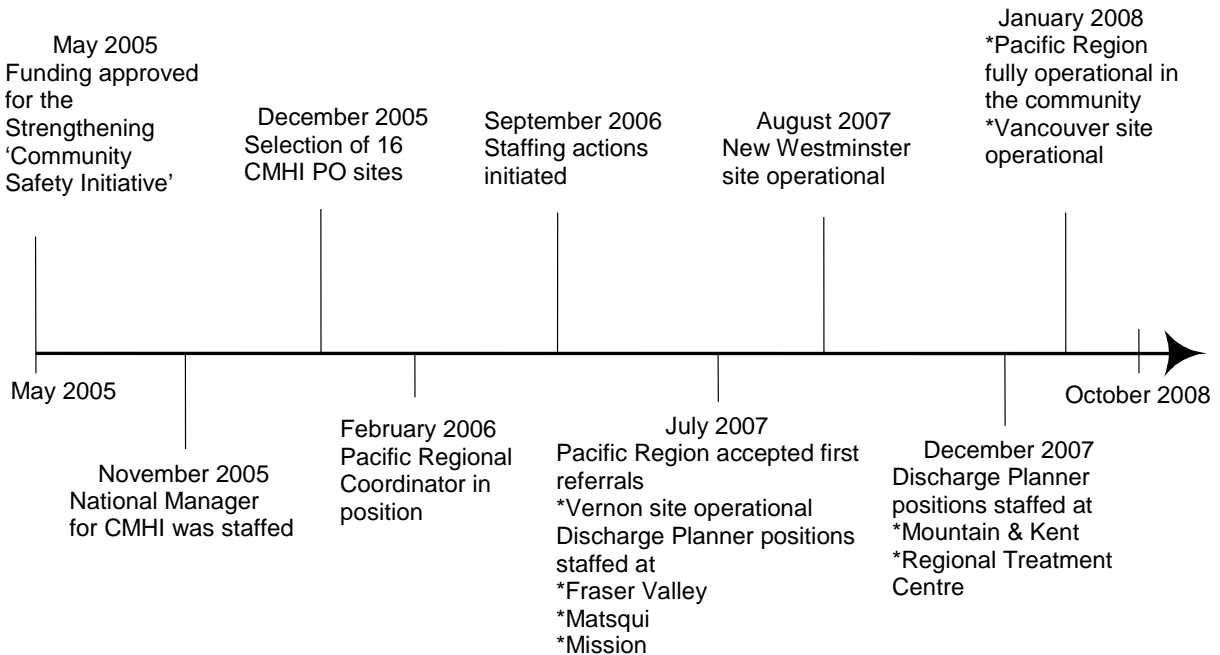
*Prairie Region.* Prairies Region was the first region to hire staff, accept referrals, and become fully operational in both the community and institutional sites (May 2007). The staffing process took only 9 months (September 2006 to May 2007). Very few staffing challenges were reported for this region. Additional Human Resource assistance was utilized and an extensive national advertising campaign was generated, including advertisements in newspapers and professional association websites. This advertising brought many prospective employees into the competitive process that resulted in successful candidates for each of the positions. Refer to Figure 8 for further details regarding regional implementation milestones.

**Figure 8: Prairie Region CMHI Implementation Timeline**



*Pacific Region.* In the Pacific Region, all community sites were staffed by January 2008, and first referrals were accepted in July 2007. The staffing process for Pacific Region took one year and five months from beginning to end (September 2006 to January 2008). Recruitment was advertised in newspapers and with the boards of registration for nurses and social workers. Staffing challenges were reported in the region, particularly around the length of time it required to complete human resource tasks, and the lack of qualified applicants who applied. Refer to Figure 9 for further details regarding regional implementation milestones.

**Figure 9: Pacific Region CMHI Implementation Timeline**



*Summary of Implementation Challenges*

The CMHI encountered implementation challenges, particularly pertaining to staffing, that caused lengthy delays in implementation.<sup>13</sup> Some regions took more than one year from the time they initiated staffing actions until the positions were filled (see Table 8). From the approval of the initiative in May 2005, it took between two years and two years and eight months to have the community sites fully staffed. The Prairie Region can be viewed as a best practice for the successful and timely implementation of CMHI. Not only did the region have the first site staffed, but staffing all positions (community and institution) in this region took the least amount of time. There was also a greater level of agreement among CSC staff survey respondents from

<sup>13</sup> It was suggested that some regions faced challenges when trying to recruit health professionals (e.g., labour shortages, difficulty attracting health care workers), and that wage disparities across regions and economic and labour variations across the country may have selectively affected particular regions (CMHI National Coordinator, personal communication, December 8, 2008).

the Prairie Region that implementation had occurred according to schedule, and that positions had been staffed in a timely manner (see Table 8). If the initiative were to expand or a similar initiative were to be launched, it is possible that something could be gained by following some of the practices implemented by the Prairie region (e.g., dedicated administrative support to assist with human resources, wide advertisement of the positions, etc.). Implementation milestones across regions and results from the staff surveys regarding implementation schedules and timeliness are summarized in Table 8.

**Table 8: Regional Implementation Timelines and Staff Survey Results**

Region	First position staffed in the community	First Referral	All Community sites staffed	Length of time for Community staffing process*	Elapsed time from CMHI approval to full community staffing	Staff agreement that implementation occurred according to schedule (%)	Staff agreement that positions filled in timely manner (%)
Atlantic	August 2007	August 2007	August 2007	12 months	2 years 3 months	29%	42%
Quebec	August 2007	October 2007	August 2007	7 months	2 years 3 months	31%	29%
Ontario	June 2007	July 2007	January 2008	1 year and 5 months	2 years 8 months	27%	20%
Prairies	May 2007	May 2007	May 2007	9 months	2 years	49%	54%
Pacific	July 2007	July 2007	January 2008	1 year and 5 months	2 years 8 months	30%	20%

\* Note: Length of time for staffing process was calculated using the dates staffing actions were initiated in the region until all the sites in the community were staffed.

As previously described, the funding for the initiative was announced in May 2005 and it was not until May 2007 that the initiative accepted its first referral for service, in the Prairie Region. As noted, there were many operational milestones that were required prior to staffing regional positions. This delay limited the amount of time to follow the treatment recipients' progress in the community. The CSC RPP (2008a) specifies that recidivism results should be reported: (1) while under CSC supervision; (2) within two years of the end of sentence; and (3) within five years of the end of sentence. The potential follow-up time for this evaluation was only 6 to 13 months after the offenders' first referral to service. In many cases, the offenders were still under community supervision and had not reached their warrant expiry dates. This greatly limits the ability of this evaluation to examine long-term correctional outcomes (e.g.,

violent and non-violent recidivism) which would require several additional years of data in order to fully evaluate.

**RECOMMENDATION 1: To sustain and enhance mental health services provided in the community, CSC should support the implementation of mental health services through the development of a strategic staffing process and recruitment campaign.**

### **CMHI Referrals**

**FINDING 5: Discharge planning referrals are not occurring in accordance with CMHI guidelines regarding timeframes (i.e., nine months prior to anticipated release date).**

**FINDING 6: The most common reason for CMHI referral rejections occurred because offenders did not meet inclusion criteria. Staff also suggested that some offenders in need of services were not being referred. Examination of findings suggests that this may be due to a lack of knowledge among CSC staff members regarding CMHI referral criteria, lack of reliable tools to facilitate early identification of those in need of services, and/or a lack of available services in the communities to which the offenders are being released.**

#### *Referral Criteria*

Referral criteria for the CMHI included the diagnosis of a major mental disorder (e.g., schizophrenia, mood disorder, or other disorders), or moderate to severe impairment from personality disorder, acquired brain injury/organic brain dysfunction, or developmental disability or intellectual impairment. CSC staff members were asked to rate their familiarity with the inclusion criteria of the CMHI given that the staff (mainly the offenders' parole officers) make the referrals to CMHI services. Slightly more than half (57%;  $n = 290$ ) of CSC staff members indicated that they were at least moderately familiar with the inclusion criteria for the CMHI,<sup>14</sup> and all (100%;  $n = 13$ ) of the community service providers who responded to the survey question indicated that they were at least moderately familiar with the inclusion criteria for offenders with mental disorders.

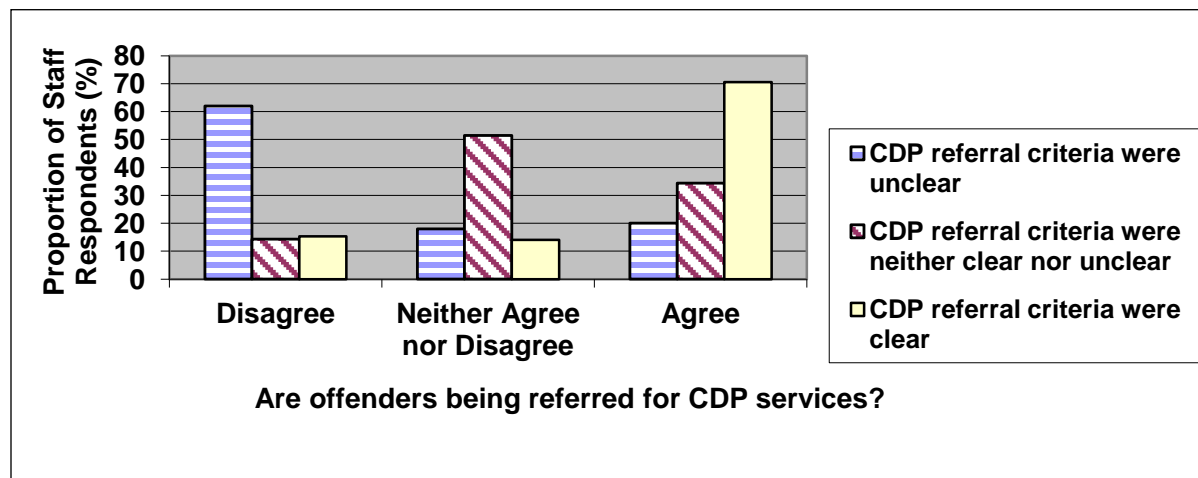
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<sup>14</sup> The General Communication email sent to all CSC staff asked that "staff who have experience and knowledge in the area of working with offenders with mental disorders" complete the survey. This invitation for participation does not require staff respondents to be in a position to refer offenders for service in which case they would be explicitly familiar with the referral criteria of the CMHI

*Community Mental Health Specialist (CMHS) Referrals.* Approximately one-half of CSC staff respondents indicated that offenders were being referred to the CMHS prior to their release (48%;  $n = 169$ ). Approximately half of CSC staff members (43%;  $n = 132$ ) also suggested that the first contact that offenders had with the CMHS (i.e., the initial communication between the CMHS and the offender) occurred in a timely manner. Among offenders accepted to receive services, the majority were scheduled to begin receiving CMHS services within one month of referral (75%;  $n = 143$ ). Only 5% ( $n = 9$ ) were waitlisted, with the majority of candidates on the waitlist coming from Atlantic Region ( $n = 4$ ) and Pacific Region ( $n = 4$ ).

*Clinical Discharge Planning (CDP) Referrals.* Approximately half of CSC staff members (48%) agreed that offenders with mental disorders were being referred to clinical discharge planning services. It is also important to note that only about half (51%,  $n = 197$ ) of CSC staff agreed that the procedures to refer offenders for clinical discharge planning were clear.<sup>15</sup> Also, staff members who indicated that the CDP procedures for referral were unclear were also likely to disagree that offenders were being referred for CDP services (see Figure 10: Perceptions of Clarity of CDP Referral Criteria by Perceptions of CDP Referral). Therefore, it is possible that clarity and staff awareness of referral procedures may be impacting upon referrals for clinical discharge planning services.

**Figure 10: Perceptions of Clarity of CDP Referral Criteria by Perceptions of CDP Referral**



<sup>15</sup> Approximately one-third (29%) disagreed, and the remaining staff provided a neutral response

CMHI guidelines also suggest that discharge planning should be performed 9 months prior to the offender's anticipated release date (Champagne et al., 2008). The mean time from CDP referral to anticipated release was 5.0 months nationally (CSC, 2008c). Quebec Region had the shortest average period from referral to release (3.9 months) and the Prairie Region had the longest period (5.6 months). Given these results, it appears that efforts should be made to identify appropriate candidates for discharge planning earlier in their sentences to provide sufficient time to complete the discharge plan, to create links to community services prior to release and to ensure adherence to CMHI guidelines.

Referrals to CDP services must be completed by institutional parole officers. Whereas mental health training has benefited community staff, the individuals who initiate CMHI services (i.e., institutional parole officers) have not been targeted for mental health training. Furthermore, institutional correctional officers and other case team members are two staff groups that have considerable contact with OMDs in the institutions and could benefit from an enhanced knowledge of mental health issues.

*Percentage of Offenders Receiving Services Based on Referrals.* According to referral records, a total of 507 unique offenders were referred for CMHI services nationally from the first reported referral in May 2007 (Prairies Region) to June 2008 (CSC, 2008c).<sup>16</sup> Table 9: Clinical Discharge Planning and Community Mental Health Specialist Referrals and Acceptance Region presents the referral and acceptance rates by region and by type of service (CDP and CMHS).

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<sup>16</sup> It should be noted that referral records included all offenders whose referral forms had been sent to NHQ for inclusion in the referral dataset by June 2008. Those offenders who were referred prior to June 2008, but whose referral forms had not yet been transferred to NHQ would not have been included in this analysis

**Table 9: Clinical Discharge Planning and Community Mental Health Specialist Referrals and Acceptance Region**

Region	CDP				CMHS			
	Referred	Accepted	Not Accepted	Unknown	Referred	Accepted	Not Accepted	Unknown
Atlantic	55	38 (69%)	11 (20%)	6 (11%)	76	57 (75%)	12 (16%)	7 (9%)
Ontario	9	8 (89%)	1 (11%)	0 (0%)	53	29 (55%)	17 (32%)	7 (13%)
Quebec	15	2 (13%)	1 (7%)	12 (80%)	14	6 (43%)	1 (7%)	7 (50%)
Prairies	125	95 (76%)	16 (13%)	14 (11%)	86	56 (65%)	14 (16%)	16 (19%)
Pacific	38	33 (87%)	5 (13%)	0 (0%)	59	42 (71%)	13 (22%)	4 (9%)
National	242	176 (73%)	34 (14%)	32 (13%)	288	190 (66%)	57 (20%)	41 (14%)

Notes.

- 1) Percentages may not total to 100 due to rounding.
- 2) A total of 23 cases received both CDP and CMHS services and are counted in both the CDP and CMHS groups. The total number of unique individuals referred to CDP and/or CMHS services was 507.
- 3) Offenders not accepted for reasons such as not meeting inclusion criteria, offender refusal of services, offenders UAL, and other reasons.

Two-hundred and forty-two offenders were referred for CDP services and 73% of these were accepted for services. Two-hundred and eighty-eight offenders were referred for CMHS services and 66% of this group were accepted for services.<sup>17</sup> Overall the majority of those referred for CDP (86%) and CMHS (85%) were male, and approximately one-quarter to one-third of CDP (35%) and CMHS (23%) referrals were Aboriginal offenders.<sup>18</sup> Most frequently, referrals were rejected from services because the offenders did not meet referral criteria (47% of CDP rejections and 42% of the CMHS rejections) or because offenders refused to receive the service (12% for CDP,  $n = 4$ ; and 14% for CMHS,  $n = 8$ ).

*Percentage of Offenders who should be Referred for Services, Who are Not Referred.*

Among community service provider respondents, the majority (64%;  $n = 7$ ) agreed that the right offenders were being identified as meeting criteria for the CMHI. Slightly more than half of CSC staff (58%) agreed that the referral criteria for the CMHI were appropriate. However, many respondents (68%;  $n = 145$ ) also indicated that there were at least several offenders who were eligible for services who did not receive them. When asked to explain why these offenders did

<sup>17</sup> Twenty-three offenders were referred to, and received both, CDP and CMHS services.

<sup>18</sup> Additional information regarding referrals by region, race, and gender are presented in Appendix D

not receive services, the most frequently identified reasons were lack of services or offenders' refusal of services. Some staff members also suggested that there was a lengthy waitlist and indicated that the tools that were used to identify offenders who needed services were unreliable. However, others indicated that referrals for services were not being made, or that offenders were not being identified for the services, possibly due to perceptions that the eligibility criteria were too restrictive. When asked to describe changes to the CMHI that might improve the correctional outcomes of CMHI offenders, a few staff members (6%;  $n = 12$ ) indicated that the inclusion criteria were too restrictive or offenders who had not been diagnosed still presented with mental health issues and could not access the services/resources that they needed

Currently, the only objective way to assess the number of CSC offenders in need of CMHI services nationally is through examination of the OIA indicator "diagnosed as disordered currently". However, this does not appear to be an accurate indicator of the need for these services as not all offenders with the OIA indicator meet the CMHI criteria<sup>19</sup> and not all offenders who meet the criteria for the CMHI are identified with the OIA indicator at intake (e.g., offenders who have moderate to severe impairment as a result of personality disorder, acquired brain injury/organic dysfunction, or developmental disability or intellectual impairment). Furthermore, according to guidelines, referral for CDP services should be initiated at least 9-months prior to an offender's scheduled release. Mental health status may have changed between intake and referral to CDP services which would not be captured in the OIA indicator at intake. Due to lack of an accurate indicator or identification tool administered to all offenders to objectively identify those who should receive services, it is not possible to accurately identify how many CSC offenders should be receiving CMHI services at this time.

**RECOMMENDATION 2: Procedures or processes to improve early identification of offenders' mental disorder and treatment needs should be explored in order to enable accurate identification of offenders with mental health needs, to better facilitate treatment referrals, and to establish continuity of care from an earlier stage.**

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<sup>19</sup> Note that when a sample of files of offenders with the OIA indicator were coded for research purposes by RPC and CSC Health Services staff, it was found that not all offenders with the OIA indicator would have qualified as a participant for the CMHI.

## Coordination and Information Sharing

### **FINDING 7: Implementation challenges were reported related to coordination and information sharing among institutional and community mental health and case management teams**

Evidence of information sharing was observed based on data collected through community capacity building records gathered for the initiative. Results indicated that there were 388 internal (within CSC) capacity building contacts initiated for the purposes of information sharing for CDP and CMHS services (CSC, 2008c). In addition, numerous consultations between various CSC staff members (e.g., parole officers, psychologists, health care staff, etc.) and CDP or CMHS service providers were recorded for the purpose of case reviews and discussions. A total of 2,439 consultations were recorded between April 2007 and April 2008. Furthermore, all (100%) of the offenders interviewed indicated that their Parole Officers and CMHS staff work together to ensure that all of their mental health and correctional needs are met in a balanced way.

However, some implementation challenges, particularly with respect to coordination and communication (e.g., information sharing) between institutional and community staff (mental health and case management teams), were reported by CSC staff members. Implementation challenges were reported by the majority of staff with respect to coordination/information sharing amongst the institutional mental health team, the community mental health team, and the case management team in the context of CDP and CMHS services (see Table 10: Implementation Challenges with respect to CDP and CMHS).

**Table 10: Implementation Challenges with respect to CDP and CMHS**

Implementation challenges with respect to CDP:				
	<i>n</i>	No	Maybe	Yes
Coordination/information sharing with the institutional mental health team (IMHT)	128	41 (32%)	11 (9%)	76 (59%)
Coordination/information sharing with the institutional case management team (e.g., institutional parole officer)	129	37 (29%)	20 (16%)	72 (56%)
Coordination/information sharing with the community case management team (e.g., community parole officer)	121	31 (26%)	18 (15%)	72 (60%)
Implementation challenges with respect to CMHS				
	<i>n</i>	No	Maybe	Yes
Coordination/information sharing with the community mental health team	136	50 (37%)	17 (13%)	69 (51%)
Coordination/information sharing with the community case management team (e.g., community parole officer)	137	52 (38%)	19 (14%)	66 (48%)

Issues related to information sharing and communication were also raised by respondents at several points throughout the CSC staff survey. For example, some respondents indicated that offenders were not being referred to community-based services for mental health interventions due to a lack of communication/consultation with CMHI staff. When asked if there was anything about the CMHI that could be changed to improve the correctional outcomes for offenders participating in the initiative, a number of staff members suggested improved communication, information-sharing, and collaboration between institutional staff and community staff (e.g., correctional and mental health staff). Increased communication and collaboration among the parties involved in offender case management was also described as a best practice in the implementation of the CMHI.

**RECOMMENDATION 3CSC should explore and develop mechanisms to increase information-sharing across institutional and community mental health and case management teams.**

## Location of CMHI Sites

**FINDING 8: Existing CMHI sites appear to be well-placed to serve offenders with mental health needs as demonstrated by the number of offenders with mental health needs at existing CMHI sites. However, there are several CSC sites with significant proportions of offenders with mental health needs that have not been identified for CMHI services.**

As shown in Table 11, the regions with the highest national percentage of OMDs as identified by the OIA indicator ‘diagnosed as disordered currently’, are the Prairies and Ontario Regions, with over one-quarter of all offenders in each of these regions. In addition, the highest proportion of Aboriginal OMDs is being supervised in the Prairie Region. Quebec Region has the smallest percentage of offenders with a current mental disorder which is consistent with the previous finding upon which the CMHI site selection was based.

**Table 11: Percentage of Offenders with Women and Aboriginal Sub-population Offenders with Current Mental Disorder by Region**

Region	All offenders	Women offenders	Aboriginal offenders
Prairies	25%	15%	37%
Ontario	25%	17%	15%
Atlantic	19%	13%	5%
Pacific	18%	8%	25%
Quebec	14%	11%	7%

### *Regional Geographic Analysis of Offenders with Mental Health Needs*

Two sets of maps were created for each region to illustrate: (1) the percentage of all federal offenders who received CMHI services at each office until June 2008; and (2) the percentage of all federal offenders supervised at each office who had identified mental health needs (as per the OIA indicator “diagnosed as disordered currently”) between August 2007 and June 2008.

The maps below illustrate the locations of CSC’s Parole Offices and Community Correctional Centres across each region. . The colour of the markers indicates the presence of a

CCC/CRF with or without CMHI services (red), or a parole office with or without CMHI services (blue). The dot within the markers indicates whether the CCC/CRF or parole office has (white) or does not have (black) CMHI services. Maps are presented by region, with the first map for each region displaying the percentage of all federal offenders at each office who were ‘diagnosed as disordered currently’ according to the OIA indicator, and the second map identifying the proportion of offenders at each site who received CDP and CMHS services, respectively.<sup>20</sup> Note that offenders reported in the CDP group received these services at an institution prior to their release and the maps indicate their community locations after release. Also note that some CDP offenders were released to non-CMHI sites. As discussed in the limitations section, relying on the OIA indicator as a proxy measure for those who would meet the referral criteria for participation in the CMHI may not be an entirely accurate representation of those requiring services as it relies solely on the OIA indicator “diagnosed as disordered currently” and does not take into account the degree or type of mental disorders.

As illustrated in the following maps, with a few exceptions, CMHI sites appear to be in the most appropriate locations for the majority of sites. A regional analysis is provided below.<sup>21</sup> The tables in the following sections detail the CMHI parole offices, and the corresponding CCC, that together comprise the CMHI sites.

### *Atlantic Region*

The CMHI sites in this region appear to be located at the most appropriate offices, given the percentage of offenders with identified mental health needs supervised at each of these sites (refer to Table 12). The site with the highest proportion of OMDs during this period was Moncton Parole Office (4%) and there were correspondingly high proportions of CDP and CMHS offenders supervised through this site (9% and 8%, respectively).

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<sup>20</sup> Note that OMDs may have received services through contracts at some of these sites.

<sup>21</sup> The tables in the following sections detail the CMHI parole offices, with the corresponding CCCs identified below, which together comprise the CMHI site

**Table 12: National percentages of offenders with identified mental health needs and offenders receiving CMHI services in the Atlantic Region**

CMHI Site	Identified Need (N = 957)	CDP (N = 109)	CMHS (N = 227)
Moncton	3.6%	9.2%	7.5%
Saint John PO	1.6%	2.8%	4.0%
Parrrtown CCC	1.7%	3.7%	3.1%
Halifax PO	2.2%	1.8%	3.1%
Carlton CCC	1.0%	0.9%	2.6%
St John's PO	1.6%	0.9%	4.0%
Newfoundland CCC	1.3%	0.9%	4.0%

Note: 5 offenders received both CDP and CMHS services through the Moncton Parole Office; 1 offender received both CDP and CMHS services through the Saint John Parole Office; and 2 offenders received both CDP and CMHS services in the Halifax area through the Halifax Parole Office and Carlton CCC.

**Figure 11: Offenders with Identified Mental Health Needs in Atlantic Region Offices**



1. Percentage (%) next to each office indicates the percentage of offenders supervised at each office who are identified by Offender Intake Assessment indicator "current mental disorder".
2. Current as of August 31 2008.
3. Mapping: Facilities Branch, CSC

- |  |  |  |   |
|--|--|--|---|
|  | CCC/CRF with CMHI<br>CCC/ERC couvert par l'ISMC        |  | PO with CMHI<br>BLC couvert par l'ISMC        |
|  | CCC/CRF without CMHI<br>CCC/ERC non-couvert par l'ISMC |  | PO without CMHI<br>BLC non-couvert par l'ISMC |

**Figure 12: Offenders Receiving CMHI Services in Atlantic Region Offices**



1. Percentages (% , %) next to each office indicate the percentage of offenders supervised at each office who are receiving Discharge Planning and CMHS Specialist Services, respectively.
2. Current as of August 31 2008.
3. Mapping: Facilities Branch, CSC

- |  |   |
|--|---|
|  CCC/CRF with CMHI<br>CCC/ERC couvert par l'ISMC        |  PO with CMHI<br>BLC couvert par l'ISMC        |
|  CCC/CRF without CMHI<br>CCC/ERC non-couvert par l'ISMC |  PO without CMHI<br>BLC non-couvert par l'ISMC |

### *Quebec Region*

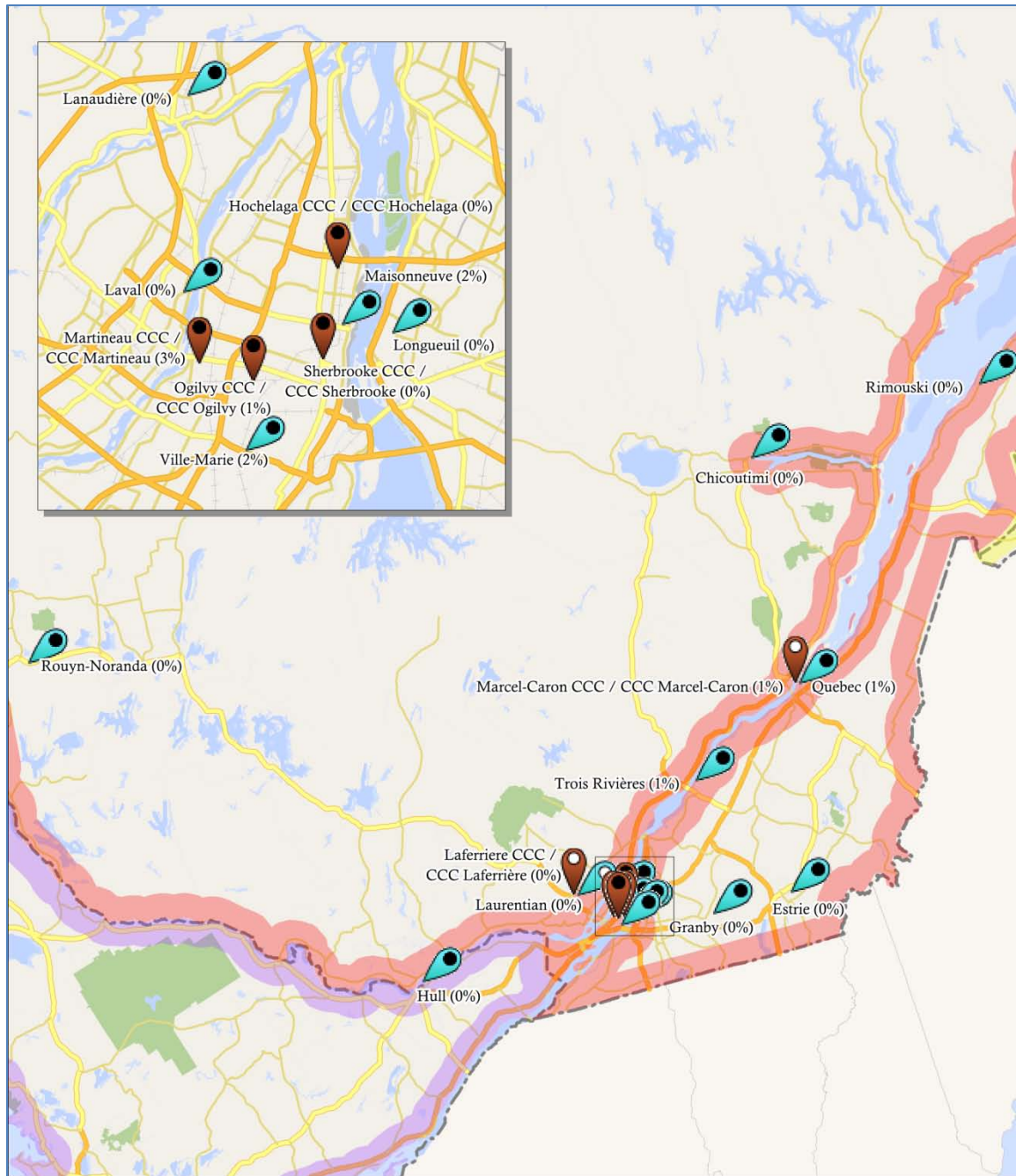
Martineau CCC supervises the greatest proportion of offenders in need of CMHI services (3%; refer to Table 13) than any other office in Quebec and approximately 2% of the CMHS offenders are supervised by this site (although it is technically not a CMHI designated site). In addition, it appears that the greater Montreal area has a relatively substantial percentage of offenders with a current mental disorder. In comparison to the Martineau CCC, parole offices in Montreal have similar proportions of offenders with a current mental disorder (Ville-Marie with 2% and Maisonneuve with 2%). In light of these findings, considerations to add a CMHI site to service OMDs in the greater Montreal area (e.g., through expansion of the CMHI or relocation of existing services) may be warranted.

**Table 13: National percentages of offenders with identified mental health needs and offenders receiving CMHI services in the Quebec Region**

CMHI Site	Identified Need (N = 957)	CDP (N = 109)	CMHS (N = 227)
Quebec PO	1.0%	0%	0%
Marcel Caron CCC	0.7%	0%	0.9%
Laurentian PO	0.3%	0%	0%
Laferriere CCC	0.3%	0%	2.6%
Martineau CCC*	2.9%	0.9%	1.8%

Note: \* Martineau CCC was not designated as a CMHI site because this site had existing resources devoted to the provision of community mental health services prior to the implementation of the CMHI. No locations were identified in Quebec where offenders received both CDP and CMHS services during this time-period.

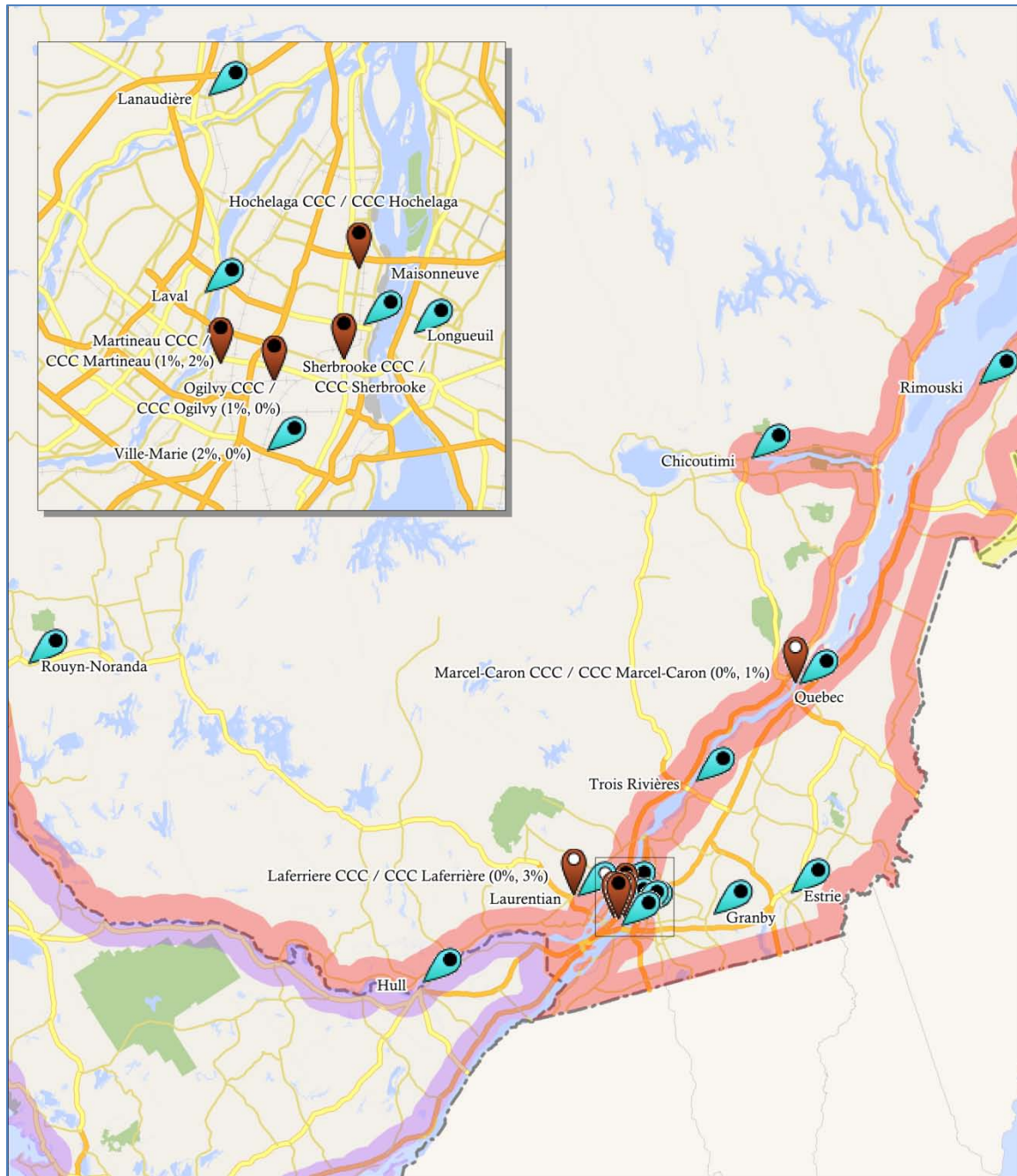
**Figure 13: Offenders with Identified Mental Health Needs in Quebec Region Offices**



1. Percentage (%) next to each office indicates the percentage of offenders supervised at each office who are identified by Offender Intake Assessment indicator "current mental disorder".
2. Current as of August 31 2008.
3. Mapping: Facilities Branch, CSC

	CCC/CRF with CMHI CCC/ERC couvert par l'ISMC		PO with CMHI BLC couvert par l'ISMC
	CCC/CRF without CMHI CCC/ERC non-couvert par l'ISMC		PO without CMHI BLC non-couvert par l'ISMC

**Figure 14: Offenders Receiving CMHI Services in Quebec Region Offices**



1. Percentages (% , %) next to each office indicate the percentage of offenders supervised at each office who are receiving Discharge Planning and CMHS Specialist Services, respectively.
2. Current as of August 31 2008.
3. Mapping: Facilities Branch, CSC

- CCC/CRF with CMHI  
CCC/ERC couvert par l'ISMC
- PO with CMHI  
BLC couvert par l'ISMC
- CCC/CRF without CMHI  
CCC/ERC non-couvert par l'ISMC
- PO without CMHI  
BLC non-couvert par l'ISMC

### *Ontario Region*

Among the CMHI sites in the Ontario Region, the Hamilton Parole Office and CCC, Toronto Team Supervision Unit and Keele CCC, and Kingston Parole Office and Portsmouth CCC supervise the highest proportion of OMDs in this region (refer to Table 14 and the Ontario Region map). These three sites therefore appear to be appropriately designated as CMHI sites. The Ottawa Parole Office, a non-CMHI site, also supervised a relatively substantial proportion of offenders with mental health needs (3%) during this time, suggesting that Ottawa may warrant future considerations for CMHI services.

**Table 14: National percentages of offenders with identified mental health needs and offenders receiving CMHI services in the Ontario Region**

CMHI Site	Identified Need (N = 957)	CDP (N = 109)	CMHS (N = 227)
Hamilton PO	2.8%	2.8%	5.7%
Hamilton CCC	1.1%	0%	2.6%
Toronto Team	0.9%	0.9%	0%
Keele CCC	2.9%	0.9%	5.7%
Kingston PO	1.1%	0.9%	0%
Portsmouth CCC	2.0%	0%	5.7%

Note: 1 offender received both CDP and CMHS services through the Toronto Team Supervision Unit and Keele Community Centre; and 1 offender received both CDP and CMHS services through the Kingston Parole Office and Portsmouth Community Centre.

**Figure 15: Offenders with Identified Mental Health Needs in Ontario Region Offices**



1. Percentage (%) next to each office indicates the percentage of offenders supervised at each office who are identified by Offender Intake Assessment indicator "current mental disorder".
2. Current as of August 31 2008.
3. Mapping: Facilities Branch, CSC

- |  |  |  |   |
|--|--|--|---|
|  | CCC/CRF with CMHI<br>CCC/ERC couvert par l'ISMC        |  | PO with CMHI<br>BLC couvert par l'ISMC        |
|  | CCC/CRF without CMHI<br>CCC/ERC non-couvert par l'ISMC |  | PO without CMHI<br>BLC non-couvert par l'ISMC |

**Figure 16: Offenders Receiving CMHI Services in Ontario Region Offices**



1. Percentages (% , %) next to each office indicate the percentage of offenders supervised at each office who are receiving Discharge Planning and CMHS Specialist Services, respectively.
2. Current as of August 31 2008.
3. Mapping: Facilities Branch, CSC

	CCC/CRF with CMHI CCC/ERC couvert par l'ISMC		PO with CMHI BLC couvert par l'ISMC
	CCC/CRF without CMHI CCC/ERC non-couvert par l'ISMC		PO without CMHI BLC non-couvert par l'ISMC

### *Prairie Region*

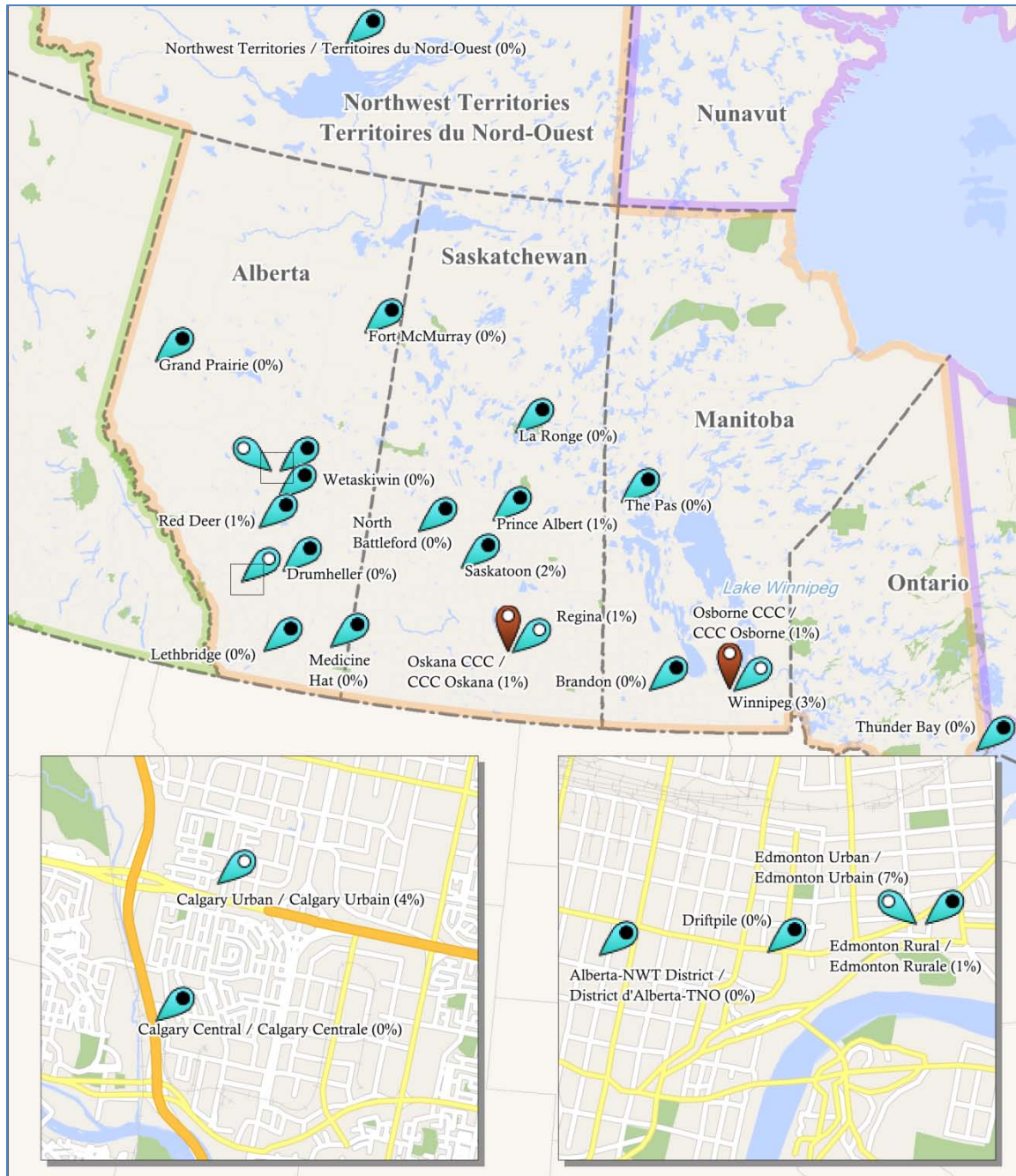
CMHI sites in the Prairie Region are placed in appropriate locations, given the percentages of offenders with identified mental health needs supervised by these offices (refer to Table 15). One other area with a relatively high percentage of offenders with mental health needs was Saskatoon, which had approximately 2% of OMDs with identified need. In addition, 5% of all federal offenders receiving CDP services were being supervised in Saskatoon, but no CMHS service was available in this location. Ideally, offenders would receive both CDP and CMHS services. Given the high proportion of offenders receiving CDP services in Saskatoon, this site may be one that should be considered as a potential future CMHI site where CMHS services could be delivered.

**Table 15: National percentages of offenders with identified mental health needs and offenders receiving CMHI services in the Prairies Region**

CMHI Site	Identified Need (N = 957)	CDP (N = 109)	CMHS (N = 227)
Edmonton Urban PO	6.9%	6.4%	2.6%
Calgary Urban PO	4.1%	3.7%	4.8%
Winnipeg PO	3.5%	12.8%	10.1%
Osborne CCC	0.5%	0%	2.2%
Regina PO	1.1%	2.8%	0.9%
Oskana CCC	1.4%	2.7%	4.4%

Note: 1 offender received both CDP and CMHS services in the Edmonton area through the Edmonton Parole Office; 3 offenders received both CDP and CMHS services through the Calgary Urban Parole Office; and 7 offenders received both CDP and CMHS services in the Winnipeg area through the Winnipeg Area Parole Office.

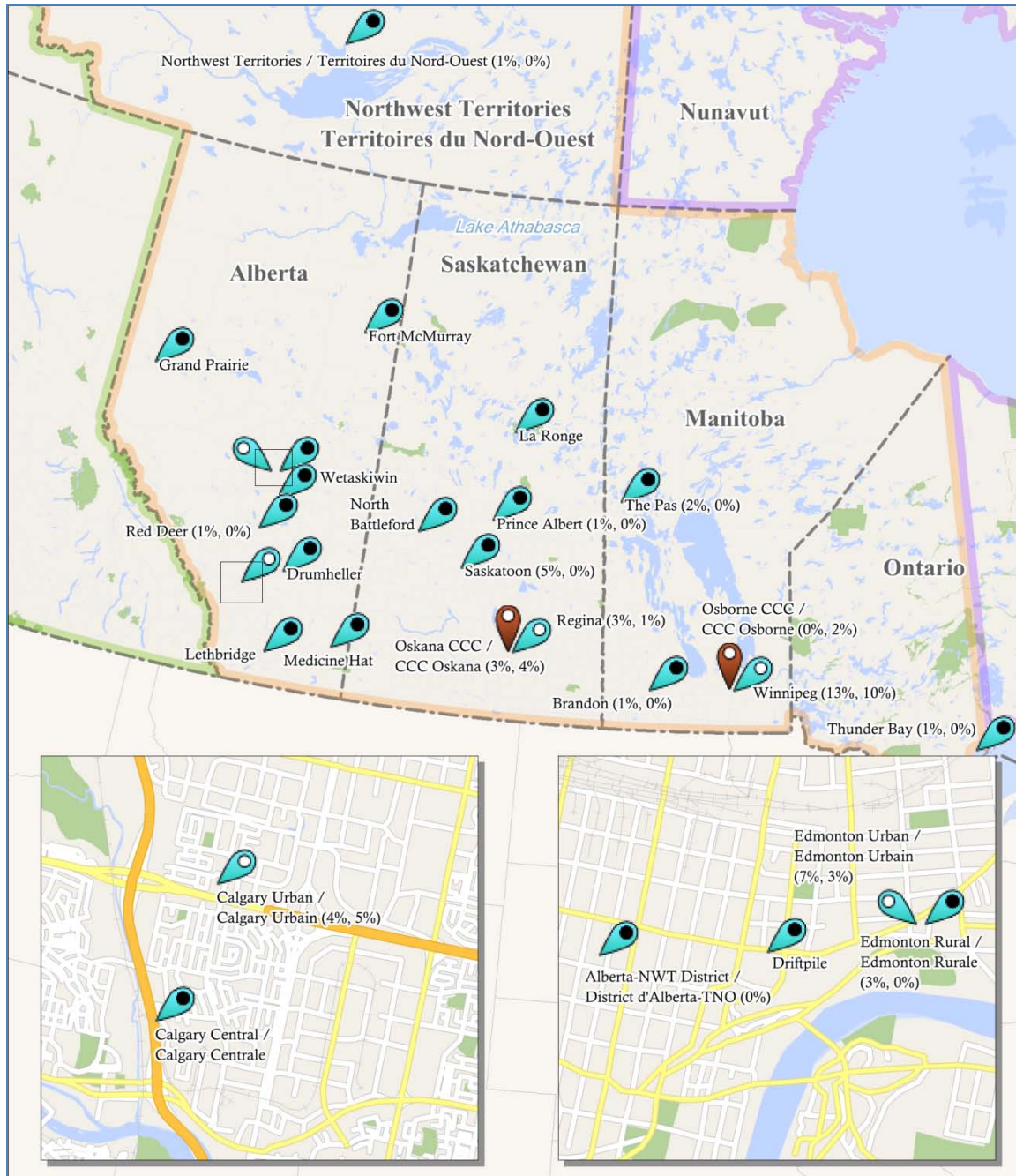
**Figure 17: Offenders with Identified Mental Health Needs in Prairies Region Offices**



1. Percentage (%) next to each office indicates the percentage of offenders supervised at each office who are identified by Offender Intake Assessment indicator "current mental disorder".
2. Current as of August 31 2008.
3. Mapping: Facilities Branch, CSC

- |  |  |  |   |
|--|--|--|---|
|  | CCC/CRF with CMHI<br>CCC/ERC couvert par l'ISMC        |  | PO with CMHI<br>BLC couvert par l'ISMC        |
|  | CCC/CRF without CMHI<br>CCC/ERC non-couvert par l'ISMC |  | PO without CMHI<br>BLC non-couvert par l'ISMC |

**Figure 18: Offenders Receiving CMHI Services in Prairies Region Offices**



1. Percentages (% , %) next to each office indicate the percentage of offenders supervised at each office who are receiving Discharge Planning and CMHS Specialist Services, respectively.
2. Current as of August 31 2008.
3. Mapping: Facilities Branch, CSC

	CCC/CRF with CMHI CCC/ERC couvert par l'ISMC		PO with CMHI BLC couvert par l'ISMC
	CCC/CRF without CMHI CCC/ERC non-couvert par l'ISMC		PO without CMHI BLC non-couvert par l'ISMC

### *Pacific Region*

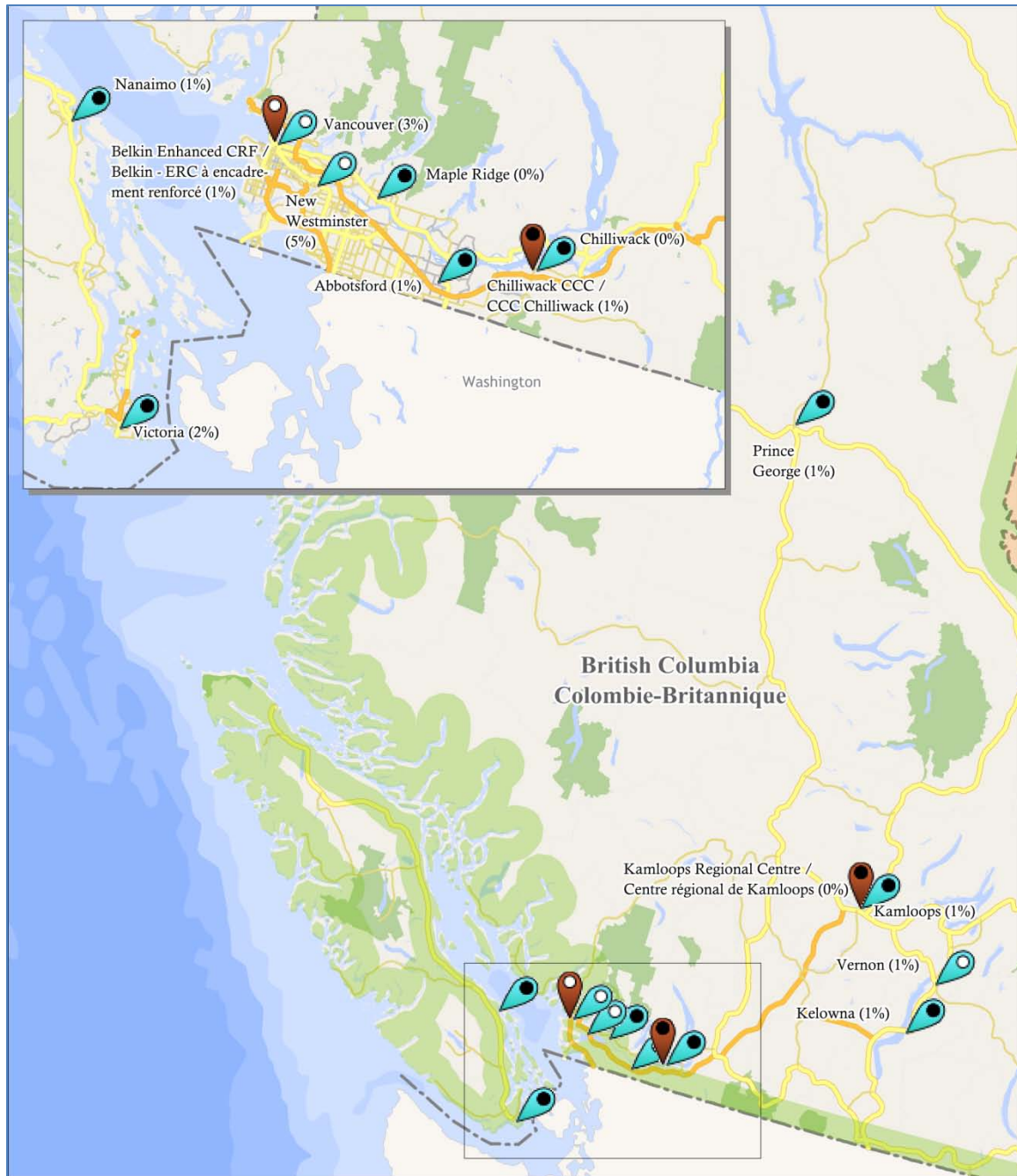
New Westminster and Vancouver sites are well placed given the percentage of offenders with identified mental health needs at those sites (refer to Table 16). Approximately 5% of offenders with mental health needs were supervised out of the New Westminster Parole Office and relatively high proportions of CDP and CMHS offenders were supervised out of this office (6% and 13%, respectively). Vernon was selected because it was central to Kamloops and Kelowna and the CMHS staff could cover offenders being supervised in each of these three offices. The three offices combined contain only 3% of offenders with a current mental disorder (with 1% in Vernon, 1% in Kamloops and 1% in Kelowna). If the initiative were to expand into another site, there appears to also be a need for services in Victoria as well, with 2% of offenders identified with mental health needs.

**Table 16: National percentages of offenders with identified mental health needs and offenders receiving CMHI services in the Pacific Region**

CMHI Site	Identified Need (N = 957)	CDP (N = 109)	CMHS (N = 227)
New Westminster	5.2%	6.4%	12.8%
Vancouver	3.2%	4.6%	3.5%
Belkin Enhanced Unit CRF	1.4%	2.8%	0%
Vernon	0.8%	0%	0.9%
Kelowna	1%	1.8%	3.5%
Kamloops	1%	0%	0.9%

Note: 2 offenders received both CDP and CMHS services through the New Westminster Parole Office.

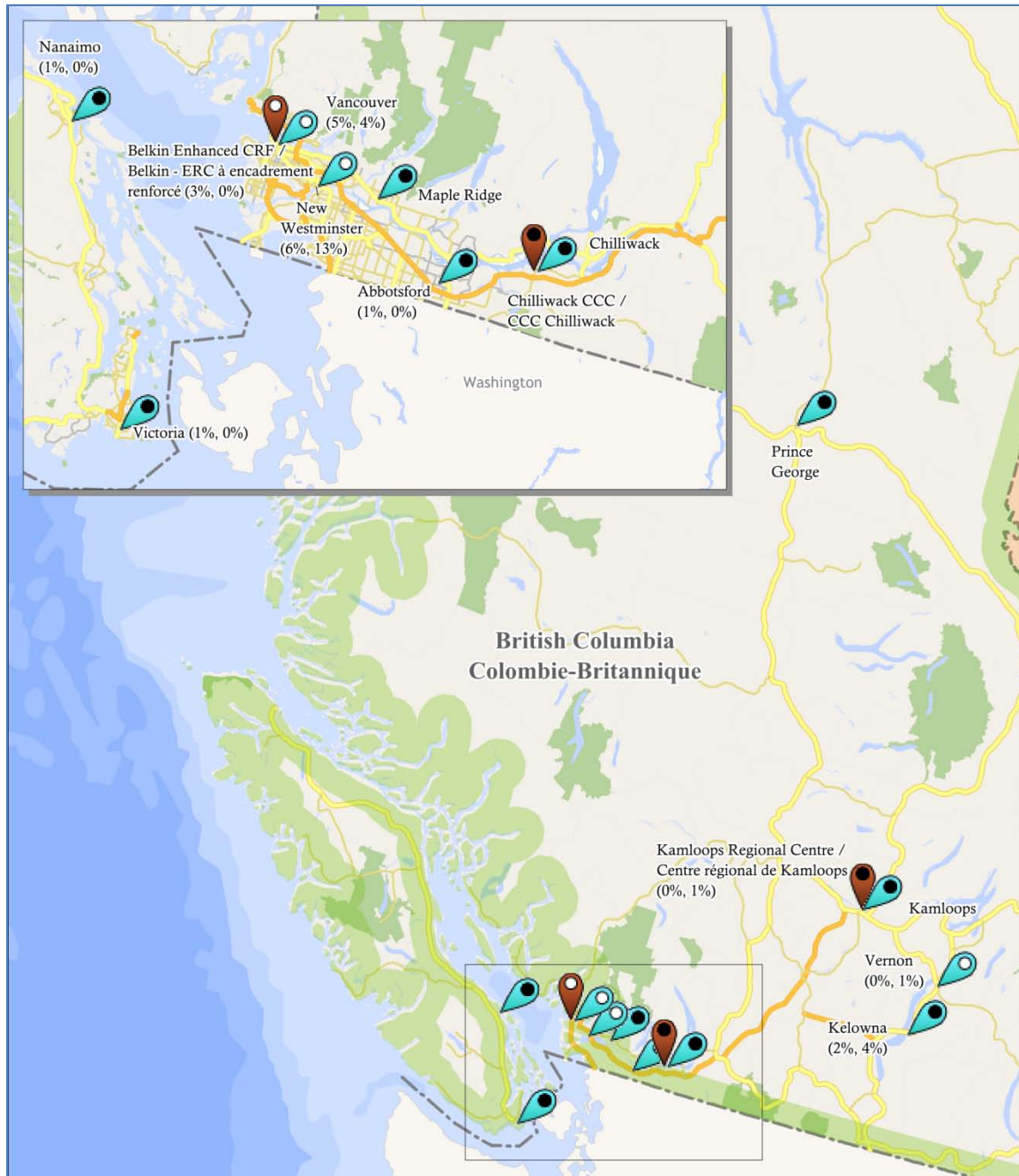
**Figure 19: Offenders with Identified Mental Health Needs in Pacific Region Offices**



1. Percentage (%) next to each office indicates the percentage of offenders supervised at each office who are identified by Offender Intake Assessment indicator "current mental disorder".
2. Current as of August 31 2008.
3. Mapping: Facilities Branch, CSC

- |  |  |  |   |
|--|--|--|---|
|  | CCC/CRF with CMHI<br>CCC/ERC couvert par l'ISMC        |  | PO with CMHI<br>BLC couvert par l'ISMC        |
|  | CCC/CRF without CMHI<br>CCC/ERC non-couvert par l'ISMC |  | PO without CMHI<br>BLC non-couvert par l'ISMC |

**Figure 20: Offenders Receiving CMHI Services in Pacific Region Offices**



1. Percentages (% , %) next to each office indicate the percentage of offenders supervised at each office who are receiving Discharge Planning and CMHS Specialist Services, respectively.
2. Current as of August 31 2008.
3. Mapping: Facilities Branch, CSC

- |  |  |  |   |
|--|--|--|---|
|  | CCC/CRF with CMHI<br>CCC/ERC couvert par l'ISMC        |  | PO with CMHI<br>BLC couvert par l'ISMC        |
|  | CCC/CRF without CMHI<br>CCC/ERC non-couvert par l'ISMC |  | PO without CMHI<br>BLC non-couvert par l'ISMC |

**RECOMMENDATION 4: Several sites that are not presently included in the CMHI that have large proportions of offenders with mental health needs should be considered for CMHI services, through reallocation or expansion of CMHI services.**

### CMHI Budget and Expenditures

**FINDING 9: Implementation delays have led to several instances of re-profiling and lapses of CMHI funding. Financial data for the CMHI have not always been coded consistently utilizing the appropriate cost-centres in IMRS**

As a result of several factors (i.e., late receipt of funding for the first year of the initiative, delays in staffing), CMHI funding has been re-profiled several times. Overall, this resulted in a smaller than intended budget in the first two years of the initiative (2005/06 and 2006/07), and increased budgets in the last 3 years of the initiative, from 2007/08 to 2009/10. In total, after all three instances of re-profiling, just over \$1.5 million was re-profiled to the CMHI budgets for each of the fiscal years 2007/08, 2008/09, and 2009/10. Thus, from the original budgets of \$6.4 million per year, the budgets for the first two years of the initiative have decreased significantly (\$1.4, and \$3.1 million), and the budgets have increased to just over \$8 million for each of the last three years of the initiative (refer to Table 17).

**Table 17: Re-profiling of CMHI Funding (in thousands)**

Budget	2005/2006	2006/2007	2007/2008	2008/2009	2009/2010	Total
Original Budget	3,420	6,420	6,420	6,420	6,420	29,100
1st Re-profile	(2,000)	2,000				
2nd Re-profile		(3,300)	1,100	1,100	1,100	
3rd Re-profile	0	(1,989)	755	655	579	
Total Revised Budget	1,420	3,131	8,275	8,175	8,099	29,100

Note: Budget includes salary, operating, employee benefit plan, common services, and accommodation.

CMHI budget and expenditures for fiscal years 2005/06, 2006/07, 2007/08, including salary, operating, employee benefit plan, common services, and accommodations, are shown in Table 18. Overall, the percentage of the CMHI budget spent in each year ranged from 51% (2007/08) to 84% (2006/07). Total expenditures to the end of fiscal year 2007/08 represent 61%

of the CMHI budget with close to \$5 million in lapsed spending (including all salary, operating, employee benefits, common services, accommodations). CSC Health Services and Financial staff have suggested that it is possible that financial expenditures for the CMHI may have been inaccurately coded in IMRS (i.e., incorrectly coded to some other initiative or project). Therefore, expenditures may have been somewhat greater than actually reported in IMRS. However, it was not possible to identify and objectively verify any such coding errors/omissions. Finally, it should be noted that the CMHI was not fully implemented until part way through 2007/08, so it is expected that CMHI expenditures relative to budgeted amounts will increase in 2008/09 when the initiative will have been fully implemented in all regions for a full fiscal year.

**Table 18: Budgeted and Actual CMHI Spending for All Canada (in thousands)<sup>22</sup>**

	2005/06	2006/07	2007/08	Total
Revised Budget (after re-profiling)	\$1,420	\$3,131	\$8,275	\$12,826
Actual Expenditures	\$965	\$2,634	\$4,237	\$7,836
% of Budget Spent	68%	84%	51%	61%
Lapsed \$	\$455	\$497	\$4,038	\$4,990

Note: These amounts include salary, operating, employee benefit plan, common services, and accommodations.

#### *CMHI Expenditures by Cost Centre*

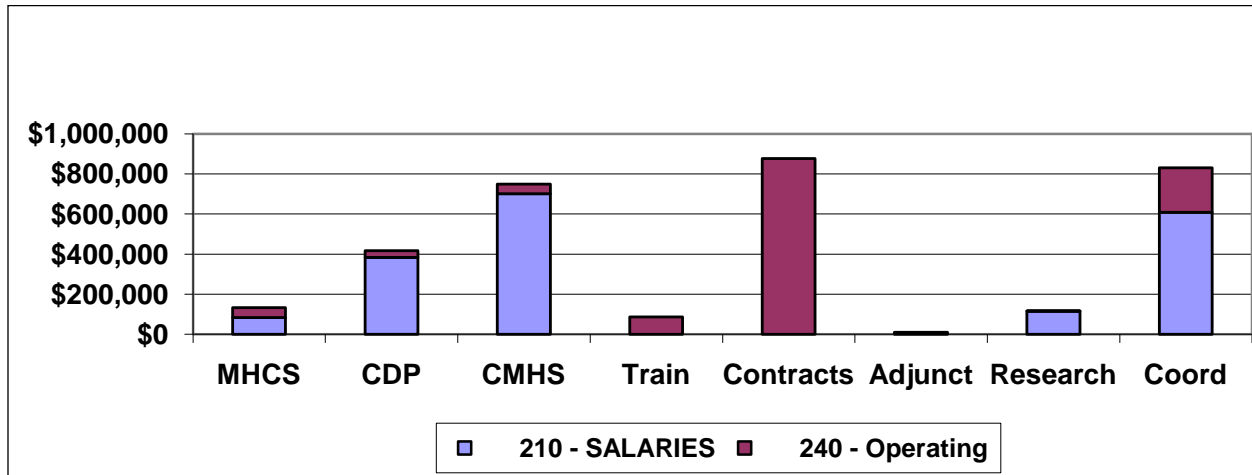
When the CMHI was initiated, a general category was created in IMRS to track CMHI expenditures, labelled “Mental Health Community Strategy”. Over time, additional cost centres were created in IMRS to more accurately track CMHI expenditures according to major spending areas, including: (1) discharge planning services; (2) communality mental health specialists; (3) mental health training; (4) regional mental health contracts; (5) adjunctive services; (6) evaluation and research; and (7) management and coordination. The general category of Mental Health Community Strategy was closed during fiscal year 2007/08. Since that time, all CMHI related spending is required to be coded according to the seven major categories of spending listed above.

National CMHI expenditures (operating and salary only) for 2007/08, broken down by each of the major spending areas, are shown in Figure 21. Overall the majority of expenditures were designated for service contracts and management/coordination, followed by CMHS and

<sup>22</sup> Source: Financial Information provided from IMRS by CSC Comptroller’s Branch

CDP services. This pattern of expenditures likely reflects the fact that CMHS and CDP services were not fully implemented for the full year, and it would be expected that expenditures in these areas (CMHS and CDP, and potentially other areas as well) would rise in subsequent years.

**Figure 21: CMHI National Expenditures (Operating and Salary) for 2007/08**

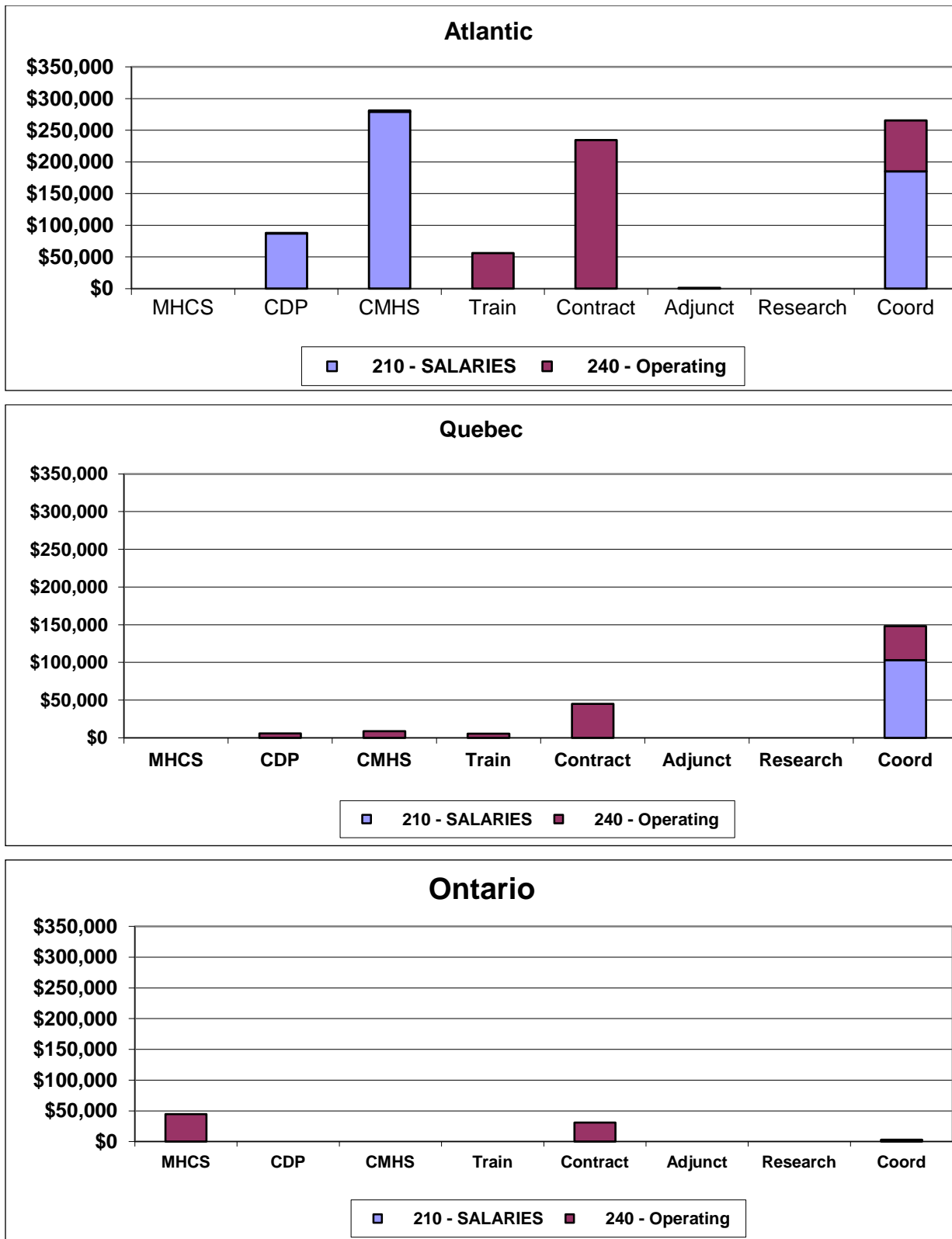


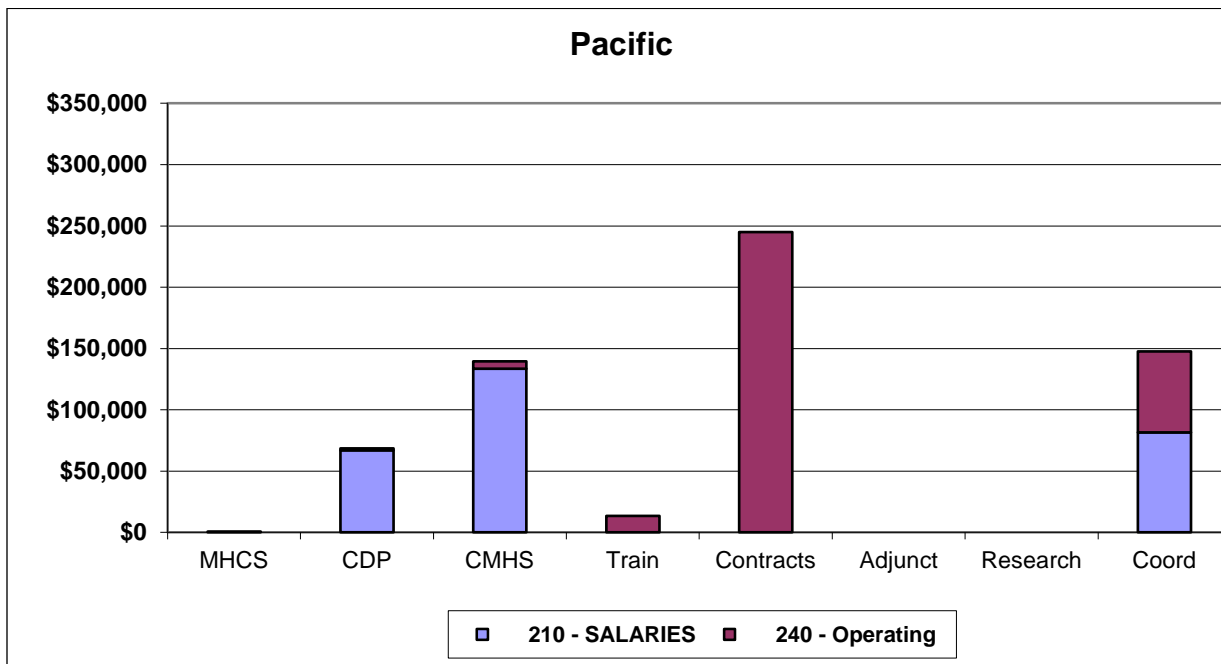
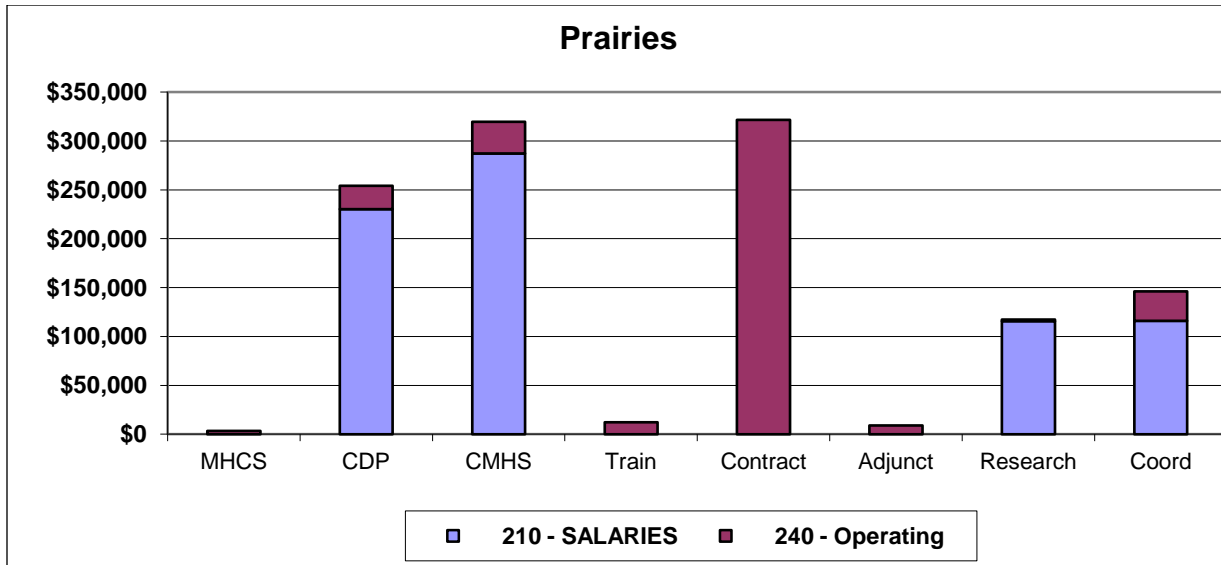
Note: MHCS = Mental Health Community Strategy; CDP = Discharge planning services; CMHS = Community MH specialists; Train = Mental Health Training; Contract = Regional MH contracts; Adjunct = Adjunctive services; Research = Evaluation and Research; Coord = Management and Coordination

CMHI expenditures by cost centre for each of the regions for 2007/08 are shown in Figure 22. Overall, expenditures were higher in the Prairies, followed by Atlantic Region, which were among the first regions to be fully operational in the community in 2007. A review of the graphs indicates that not all regions appeared to be coding financial data in the same manner. For example, the “Mental Health Community Strategy” financial code was still in use by two of the regions (Ontario, Prairies).<sup>23</sup> Additionally, it seems possible that the Ontario Region was utilizing the Mental Health Community Strategy category to report expenditures for CDP and CMHS services as well, since the Ontario Region was offering CDP and CMHS services in 2007/08, but no expenses were recorded for those categories.

<sup>23</sup> Note that, although not shown in the graphs, the financial code of “Mental Health Community Strategy” was still in use by NHQ as well during 2007/08.

**Figure 22: CMHI Expenditures by Cost Centre and Region for 2007/08**





Note: MHCS = Mental Health Community Strategy; CDP = Discharge planning services; CMHS = Community MH Specialists; Train = Mental Health Training; Contract = Regional MH contracts; Adjunct = Adjunctive services; Research = Evaluation and Research; Coord = Management and Coordination

**RECOMMENDATION 5: CSC should ensure accurate, standardized coding of CMHI expenditures in financial databases to ensure that expenditures are adequately recorded and monitored and so the cost-effectiveness of the CMHI can be adequately assessed at some future time.**

### Evaluation Objective 3: Success

Evaluation Objective: The extent to which the CMHI is delivering the expected outputs, outcomes and objectives in relation to resources used.

#### Impact of Community Mental Health Training

**FINDING 10: Mental health training was provided to 830 individuals in the community and 352 CSC institutional staff members who worked with individuals with mental disorders. Among institutional staff, trainees were primarily CSC nurses. The training was effective in improving community personnel's mental health knowledge and self-perceived competency to work with offenders with mental disorders.**

##### *Receipt of Training*

*Community Personnel who Received Mental Health Training.* In a 1.5 year period (January 2007 to June 2008), a total of 830 community personnel participated in the national two day mental health training (refer to Table 19). Two-thirds (66%) of community personnel who received the training were CSC community staff members.<sup>24</sup> The remainder were primarily CRF staff members who worked with community-based agencies on contract to provide services for CSC offenders. Seventy-two percent of community trainees received the generic training package while 20% received the women offenders' training package, and the remaining 8% received the train the trainers' package.

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<sup>24</sup> For CSC staff, mental health training attendance records up until the end of 2007/08 were cross-referenced with HRMS to verify accuracy by HS staff

**Table 19: Number of community personnel who received the national mental health training packages**

Training Package	Frequency (%)		
	CSC Community Staff	Non-CSC Staff	Total
Generic	460 (84%)	140 (50%)	600 (72%)
Train the Trainer	60 (11%)	2 (1%)	62 (8 %)
Women Offenders	29 (5%)	139 (49%)	168 (20%)
<b>Total</b>	<b>549 (100%)</b>	<b>281 (100%)</b>	<b>830 (100.0%)</b>

Note. Data were derived from mental health training attendance records that had been cross-referenced with entries in the Human Resources Management System (HRMS) to verify accuracy. Percentages may not total 100% due to rounding.

*Institutional Staff Members who Received Mental Health Training.* According to attendance records maintained by Health Services, a total of 352 institutional staff members received mental health training (303 nurses, 19 correctional officers, and 30 institutional parole officers). Most of the nurses (271/303) received CMHI mental health training in FY 2008/09,<sup>25</sup> while all of the other institutional staff received training in 2007/08. Although some institutional staff did receive training, few of the staff members who are responsible for referring OMDs for CDP services (i.e., institutional parole officers) received mental health training from the CMHI.

Earlier, it was noted that referrals to CDP services must be completed by institutional parole officers. Whereas mental health training has benefited community staff, the individuals who initiate the CDP service (i.e., institutional parole officers) have not been targeted for mental health training. Furthermore, institutional correctional officers and other case management team members have considerable contact with OMDs in the institutions, and could therefore benefit from an enhanced knowledge of mental health issues.

### *Training Evaluations*

In general, participants rated the mental health training favorably. Participants were asked to complete a 12 item mental health training evaluation form, of which 9 items corresponded to each of the 9 modules (i.e., introduction, myths and realities, what is a mental disorder, types of mental disorders, cognitive disorders and FASD, risk and mental disorder, effective strategies, resources, and legislative requirements). For each item, participants were asked to rate the

<sup>25</sup> Note that at the time the mental health training summary report was completed, data for FY 2008/09 had not been verified for accuracy against HRMS records

usefulness of the specific item on a 7 point scale from 1 (not useful) to 7 (very useful). Participants provided an average rating of 6.22 ( $SD = 0.88$ ,  $n = 516$ ) for the overall training. A rating of six was not defined but the closest anchored marker was 7 ‘very useful’. For each of the 9 modules, the mean ratings were positive, ranging from 5.57 (legislation) to 6.27 (mental disorders). The average rating of the usefulness of the participant manual was 6.21 ( $SD = 0.96$ ).

Participants were also asked to identify areas in which they wished to receive follow-up training. The most common areas identified were risk management/effective strategies/skills training ( $n = 81$ ), medications/interventions ( $n = 59$ ), mental disorders (symptomology and DSM;  $n = 52$ ), resources ( $n = 45$ ), and FASD ( $n = 31$ ). Furthermore, participants provided suggestions to improve the training, and most frequently suggested the provision of additional time for training ( $n = 69$ ) and more information/details during training ( $n = 61$ ).<sup>26</sup>

#### *Training Impact: Pre- and Post-Training Mental Health Knowledge Quiz*

Across the three training packages (i.e., generic, TtT, and women offenders), participants showed a 58.6% improvement on scores on the mental health knowledge quiz after training (refer to Table 20). Participants were given a 10 item mental health knowledge quiz before and after training to assess their knowledge in areas addressed in training. Total scores could range from 0 to 17. The average scores before and after training were 8.63 ( $SD = 3.47$ ) and 13.69 (2.84), respectively, with TtT participants showing the least improvement. This is to be expected as these individuals had mental health backgrounds prior to training and had high average scores at baseline.

**Table 20: Average Pre- and Post-Training Mental Health Quiz Scores**

Training Package	M (SD)		t (df)	% Improvement
	Pre-Training	Post-Training		
Total ( $n = 616$ )	8.63 (3.47)	13.69 (2.84)	-39.15*** (615)	58.63%
Generic ( $n = 420$ )	8.17 (3.41)	13.28 (2.93)	-33.35*** (416)	62.55%
Train the Trainer ( $n = 60$ )	11.35 (2.54)	14.60 (1.86)	-9.65*** (59)	28.63%
Women Offenders ( $n = 136$ )	8.88 (3.44)	14.55 (2.64)	-19.67** (135)	63.96%

Note. \*\*\*  $p < .001$ .

<sup>26</sup> Results provided by Health Services training summary report

Generally, when there was opportunity for improvement (i.e., the recipients did not receive a perfect score at pre-training), the majority of participants improved on their knowledge rating. Training recipients demonstrated increased knowledge in the areas of symptoms, recovery versus medical models of mental health, side effects of psychotropic medications, and effective strategies for working with offenders with FASD (refer to Table A in Appendix E).

#### *Self perceived competency ratings*

Participants' self-perceived competency ratings improved significantly after training.<sup>27</sup> Each participant was asked to rate eight items on a 7 point scale from 1 (strongly disagree) to 7 (strongly agree). The total mean post-training score was 42.36 ( $SD = 9.37$ ) whereas the pre-training score on the competency ratings was 32.35 ( $SD = 9.23$ ), which corresponds to an average improvement of 31%. Significant improvements in ratings were observed on each of the eight items (see Appendix E). Mean scores on each item ranged from 3.29 to 4.91 at pre-training and 5.04 to 5.59 at post-training.

In addition, CSC staff members who responded to the evaluation survey were asked to rate their competence to work with OMDs (using the same questions from the self-perceived competency scale administered prior to and after mental health training). Responses of CSC staff members who received the training were compared to those who did not. Just under half of all the staff survey respondents indicated that they received training (199/480 or 42%).<sup>28</sup> Results from the CSC staff survey administered for the present evaluation indicated that CSC staff members who participated in the mental health training rated their competence to work with offenders with mental disorders significantly higher than CSC staff members who did not receive training (refer to Table 21). This suggests the training had a positive impact, even in the longer term, not just directly after training was received.

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<sup>27</sup> The results presented in this paragraph were obtained from ratings completed before and immediately after training,  $t(569) = -22.42, p < .001$

<sup>28</sup> It was hypothesized that these results may have been due to a disproportionate number of CSC staff members who, by the nature of their profession, had pre-existing training in mental health issues within the group of staff who indicated that they had received mental health training as part of the CMHI. These analyses were analyzed a second time excluding all CMHI staff, psychologists, and nurses. The pattern of results was the same in that CSC staff members who participated in mental health training as part of the CMHI provided significantly higher rating on their competence to work with OMDs than their counterparts who did not participate in training

**Table 21: Self-Perceived Competence in Working with Offenders with Mental Disorders: Results from the CSC Staff survey<sup>29</sup>**

	Received mental health awareness training under the CMHI	N	Mean	t (df)
I have the knowledge to work effectively with offenders with mental disorders	No	266	3.30 (1.31)	-7.49*** (462)
	Yes	198	4.12 (0.92)	
I have the skills and abilities to work effectively with offenders with mental disorders	No	262	3.43 (1.28)	-5.81*** (457)
	Yes	197	4.05 (0.92)	
I have the skills to recognize symptoms suggestive of the need for intervention by a mental health professional	No	267	3.67 (1.18)	-5.79*** (464)
	Yes	199	4.23 (0.79)	
I am able to support offenders with mental disorders by consulting and collaborating with mental health professionals, community resources, and families	No	264	3.63 (1.21)	-6.09*** (459)
	Yes	197	4.24 (0.86)	

Notes. All survey respondents were asked whether they participated in mental health training as part of the CMHI initiative and then asked to rate each of the statements listed in the table.

\*\*\*  $p < .001$ .

**RECOMMENDATION 6: Additional mental health training should be provided to institutional staff members, including parole officers and other case management team members in order to assist in identifying OMDs and providing early referrals for CMHI services.**

### Receipt of DPS and CMHS Services

**FINDING 11: Offenders referred to, and accepted for, CMHI services, including discharge planning and community mental health specialist services, are receiving these services. However, data regarding their termination from these services may not always be consistently recorded in CMHI database.**

Funding for the CMHI initiative provided three new categories of services: clinical discharge planning in the institutions, community mental health specialists in 16 selected parole offices/CCCs, and specialized mental health contracts in the community. This section focuses on the overall number of recipients of CDP and CMHS services and the perceptions of offenders,

<sup>29</sup> Respondents were asked to rate their agreement with the statements on a scale from “strongly disagree” (1) to “strongly agree” (7)

CSC staff members, and community service providers with respect to the availability and accessibility of clinical discharge planning and community mental health specialist interventions. Accessibility of mental health contracts will be explored in the following section.

### *Clinical Discharge Planning Services*

A total of 176 offenders were accepted for clinical discharge planning services nationally from the start of the initiative until June 2008 (CSC, 2008c). The largest number of offenders accepted for discharge planning came from the Prairies Region, followed by Atlantic, Pacific, Quebec, and the fewest coming from the Ontario Region. Of these accepted referrals, 38% were Aboriginal offenders and 85% were male (see Table 22).

**Table 22: Total CDP Accepted Referrals by Region, Race, and Gender**

Region	Total CDP(n)	Aboriginal (n)	Male(n)
Atlantic	38	2	29
Ontario	8	1	8
Quebec	2	0	2
Prairies	95	49	82
Pacific	33	14	28
Total	176	66 (38%)	149 (85%)

Almost half of offenders interviewed (47%;  $n = 14$ ) reported having received CDP services in the institution prior to their release.<sup>30</sup> Offenders who received CDP services generally reported positive experiences with the service. All of those who reported receiving discharge planning services (100%;  $n = 14$ ) reported that the discharge planning had been helpful in their transition from the institution to the community and most noted that they had a good working relationship with their discharge planner (86%;  $n = 12$ ). The majority of the offenders indicated that their discharge planners were knowledgeable about their needs (79%;  $n = 11$ ) and encouraged them to take an active role in their discharge planning (86%;  $n = 11$ ). However,

<sup>30</sup> Note that official records gathered by CMHI staff show that there was only a small number of offenders who had received both CMHS and CDP services ( $n = 23$ ). It seems unlikely that the level of receipt of discharge planning services among the small sample of offenders interviewed would be as high as was found in this evaluation. Therefore it is possible that some of the offenders interviewed misunderstood the question and they did not receive CDP services but perhaps had some pre-release discussions with their institutional parole officers. For this reason, the results presented regarding offender perceptions of discharge planning services should be interpreted with some caution.

implementation challenges such as clarity of referral criteria and timely staffing of positions (discussed in detail in the implementation section earlier) may have affected the early availability and accessibility of this service.

*Community Mental Health Specialist Services*

A total of 190 offenders were accepted for community mental health specialist services nationally from the start of the initiative until June 2008 (CSC, 2008c). The largest number of accepted referrals for community mental health specialist services came from the Atlantic Region, followed by Prairie Region, Pacific Region, Ontario Region and the fewest came from Quebec Region. Of these accepted referrals, 24% were Aboriginal offenders and 85% were male (see Table 23).

**Table 23: Total CMHS Accepted Referrals by Region, Race, and Gender**

Region	Total CMHS (n)	Aboriginal (n)	Male (n)
Atlantic	57	2	43
Ontario	29	6	28
Quebec	6	0	6
Prairies	56	27	50
Pacific	42	10	35
Total	190	45 (24%)	162 (85%)

Offenders who were interviewed generally reported positive experiences with the CMHS services. Of those interviewed, half reported meeting with CMHS staff once per week (52%; 16/31). All of the offenders (100%; 28/28) indicated that they felt that their social worker or nurse has been helpful in their reintegration into the community. All but one offender (97%; 29/30) indicated that their social worker or nurse was available to them when needed, and the majority (90%; 26/29) indicated that the CMHS staff encouraged them to take an active role in their treatment planning. Most offenders also indicated that the CMHS staff members were knowledgeable about their mental health needs (94%; 29/31).

One area that may require improvement is the timeliness of offenders' first contact with CMHS staff, as almost half (48%;  $n = 14$ ) of the offenders indicated that they had their first contact with CMHS staff as soon as they were released, while almost the same proportion of offenders indicated otherwise (44%;  $n = 13$ ). However, it is possible that offenders may have

been released prior to the implementation of the CMHI in these regions. Therefore, delays in first contact may have been a function of early implementation challenges, but will be something to review again at a later date once all regions have been fully operational for a sufficient period of time.

### *Limitations*

One of the challenges related to the identification of treatment recipients is that the treatment recipient database, utilized for evaluation purposes, was generated with the receipt of a completed referral for service form. According to the referral procedure, the clinical discharge planner or community mental health specialist reviews the referral forms (completed by the parole officer) and determines whether an offender is accepted for treatment or not. A copy of the referral form is then stored on the offender's file and an electronic copy is provided to Health Services, NHQ, for evaluation purposes. Acceptance to treatment was based on two criteria. The offender must meet the criteria and they must voluntarily agree to participate. If the offender was referred but refused to participate in the services, their refusal would be noted on the referral form and they would not be included in the treatment group. However, if the offender received services and was terminated (either by the service provider or himself/herself), this information may not have always been consistently recorded. Therefore, even if an offender was referred to and originally accepted to participate in CMHI services, it is possible that they may not have received these services, or they may not have received these services for any significant period of time. It was not possible to differentiate offenders with respect to the length of service provision.

**RECOMMENDATION 7: Offenders accepted for CMHI services should be tracked to ensure that treatment has been provided and to monitor the length of time that offenders receive services**

### **Community-Based Contract Services**

**FINDING 12: The number of CMHI service contracts and number of offenders receiving services have increased over time. Contract services are being delivered in a timely manner and few offenders referred for services were waitlisted or not provided with the services.**

The number of offenders receiving contract services each year is increasing. The most frequent service received was psychiatric care. Very few offenders were on a waitlist and, of the offenders interviewed, the vast majority indicated that they received services in a timely manner and that the service providers were knowledgeable about their needs.

Over a two year period, 42 community contracts were implemented,<sup>31</sup> four of which have since been terminated (CSC, 2008c; refer to Table 24). A total of 973 service requests were made, indicating that offenders were referred either to more than one contracted agency/individual, or they had multiple referrals to the same contracted service (CSC, 2008c). The types of contracted services provided fell into 5 categories: (1) psychiatric services (57%;  $n = 556$ ); (2) leisure/ daily living support (34%;  $n = 335$ ); (3) addictions (4%;  $n = 43$ ); (4) employment (2%;  $n = 24$ ); and (5) women specific services (2%;  $n = 15$ ).

**Table 24: Community Contracted Services and Utilization**

	2006/07 Apr - Sept	2006/07 Oct - Mar	2007/08 Apr - Sept	F2007/08 Oct - Mar	Total
Number of Contracts <sup>a</sup>	3	20	26	39	n/a
Number of services requested	20	175	394	384	973
Types of Services					
Addictions	0	11	16	16	43 (4.4%)
Employment	0	24	0	0	24 (2.5%)
Leisure/Daily Living	0	66	122	147	335 (34.4%)
Psychiatric Services	11	74	256	215	556 (57.1%)
Women Specific Services	9	0	0	6	15 (1.5%)

Notes.

1) a Contracts in place during more than one reporting time period were counted in each of the subsequent reporting periods.

2) n/a = cannot be summed due to overlap between time periods

Of the contract services that were requested ( $n = 973$ ), the majority of these requests have been completed (68%,  $n = 662$ ). The majority of completions were from the Pacific region (43%,  $n = 283$ ), followed by the Prairies (22%,  $n = 143$ ) and Ontario regions (14%,  $n = 95$ ). Atlantic region constituted 13% ( $n = 84$ ) of the completions and Quebec 9% ( $n = 57$ .) A significant

<sup>31</sup> Re-profiled funding that was not utilized in previous years has been used to pay for contract services. Once the CMHI is fully implemented, contract services will not be able to be maintained at the same level within the current level of funding (CMHI National Coordinator, Personal Communication, December 8, 2008)

percentage of the sample had missing data (i.e., their status was not recorded at the end of the reporting period), so it was unclear whether they completed their contract service or not (15%;  $n = 150$ ). Few offenders were waitlisted (1%;  $n = 7$ ) or were not provided with services (4%;  $n = 36$ ) and 12% had contract services terminated (voluntarily  $n = 19$  or involuntarily  $n = 99$ ). The most common reason for not providing services was that the offenders were not eligible for the services.

Despite these results indicating that few offenders were on waitlists, not all staff respondents indicated that services had been provided in a timely manner. When asked if offenders were receiving services from the community service providers in a timely manner, only 42% ( $n = 119$ ) of staff surveyed agreed that they were, 27% ( $n = 78$ ) stated they were not and 31% neither agreed nor disagreed. It is unclear why there is a discrepancy between staff opinions and the implementation report findings. However, based on the relatively large percentage of respondents who neither agreed nor disagreed (31%), it is possible that staff members simply did not have enough information to reliably report on this question. Alternatively, it is possible that staff respondents may have been referring more broadly to any services provided in the community, rather than only those services provided by community agencies under contract with CSC through the CMHI.

The majority of offenders interviewed reported that they had received services through a community service provider under contract (61%;  $n = 20$ ). The most frequent need addressed by contract services was mental health follow-up (90%;  $n = 18$ ). Most also indicated they had received access to these services in a timely manner (85%;  $n = 17$ ). The majority of respondents agreed that the contracted community service providers were knowledgeable about their needs (85%;  $n = 17$ ) and all respondents indicated that they were treated respectfully (100%;  $n = 20$ ).

All 14 of the community service providers indicated that they were at least moderately able to meet the needs of offenders under the CMHI, with 36% ( $n = 5$ ) indicating that they were able to completely meet the needs of CMHI federal offenders. The majority of the community service providers (85%;  $n = 11$ ) indicated that their organizations had existing contracts for services with CSC prior to the implementation of the CMHI, but most (64%;  $n = 7$ ) also indicated that there had been changes to the services that they provide as a result of the

implementation of the CMHI.<sup>32</sup> Specifically, most of the community service providers indicated a slight (20%) to substantial (60%) increase in the variety of services available to CSC federal offenders. However, respondents generally indicated that the CMHI had little impact on the number of beds available to CSC federal offenders (100%,  $n = 4$ ), the number of days between referral and admission (80%,  $n = 4$ ), and the number of CSC offenders on waitlists (68%,  $n = 4$ ).

Most of the CSC staff survey respondents agreed that since the implementation of the CMHI, there had been an increase in the availability of community mental health interventions (such as counselling and assessment, 65%), resources/supports for CSC (63%), and offender participation in community correctional services delivered by CSC or community partners (61%).<sup>33</sup> Over half of CSC staff members (55%) agreed that offenders were attending mental health interventions/services to which they were referred. Staff members suggested that offenders might not attend mental health interventions because they refused to participate in services/did not indicate that they needed the services or that the services/supports were not available in the community. Two thirds of CSC staff members agreed that difficulties accessing community-based services are being identified (66%) but only one-quarter (24%) agreed that they were being resolved. The majority of the community service providers (92%), however, indicated that their agencies had the capacity to provide services to additional federal offenders.

### **Community Capacity Building**

**FINDING 13: Community capacity building efforts have increased over time and service-building contacts have generally focused on the areas of highest need or importance according to CMHI referrals.**

Table 25 shows the number of contacts for community capacity building for CDP and CMHS services from April 2007 to April 2008. Nearly 1,800 contacts have been made by CDP and CMHS staff members and other organizations during this time period, of which 60% ( $n = 1,057$ ) were for information sharing purposes, and 40% ( $n = 698$ ) were for service building activities. The total number of contacts for information sharing purposes increased across

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<sup>32</sup> Note that these comments should be interpreted with some caution as they are based on a small number of respondents from a small number of community service organizations

<sup>33</sup> Most of the remaining respondents indicated there had been no change

2007/08 but the number of contacts for service building purposes decreased from the third to the fourth quarters (CSC, 2008c).

**Table 25: National Community Capacity Building for CDP and CMHS Services by Quarter**<sup>34</sup>

Community Capacity Building	Apr-Jun 2007	Jul- Sep 2007	Oct-Dec 2007	Jan-Mar 2008	FY 2007/08 Total
Total Number of Contacts <sup>a</sup>	50	478	649	578	1755
Information Sharing with Organizations	36	199	375	447	1057
CSC Internal	14	68	139	167	388
Psychiatric/Psychological Services	9	22	53	31	115
Housing	0	16	44	49	109
Non-government organizations (e.g., Elizabeth Fry)	6	14	12	24	56
Correctional (CRF/Provincial)	0	8	18	25	51
Mental Health Information and Referral	1	4	17	19	41
Employment	0	12	9	16	37
Addictions	1	6	10	17	34
Other <sup>b</sup>	5	49	73	99	226
Service Building Activities with Organizations	14	279	274	131	698
Psychiatric/Psychological services	3	54	66	35	158
Housing	1	35	24	17	77
Mental Health information/referral	2	27	33	6	68
Non-government organizations (e.g., Elizabeth Fry)	3	13	29	11	56
Addictions	0	31	19	3	53
Employment	1	24	18	10	53
Other <sup>c</sup>	4	95	85	49	233

Notes.

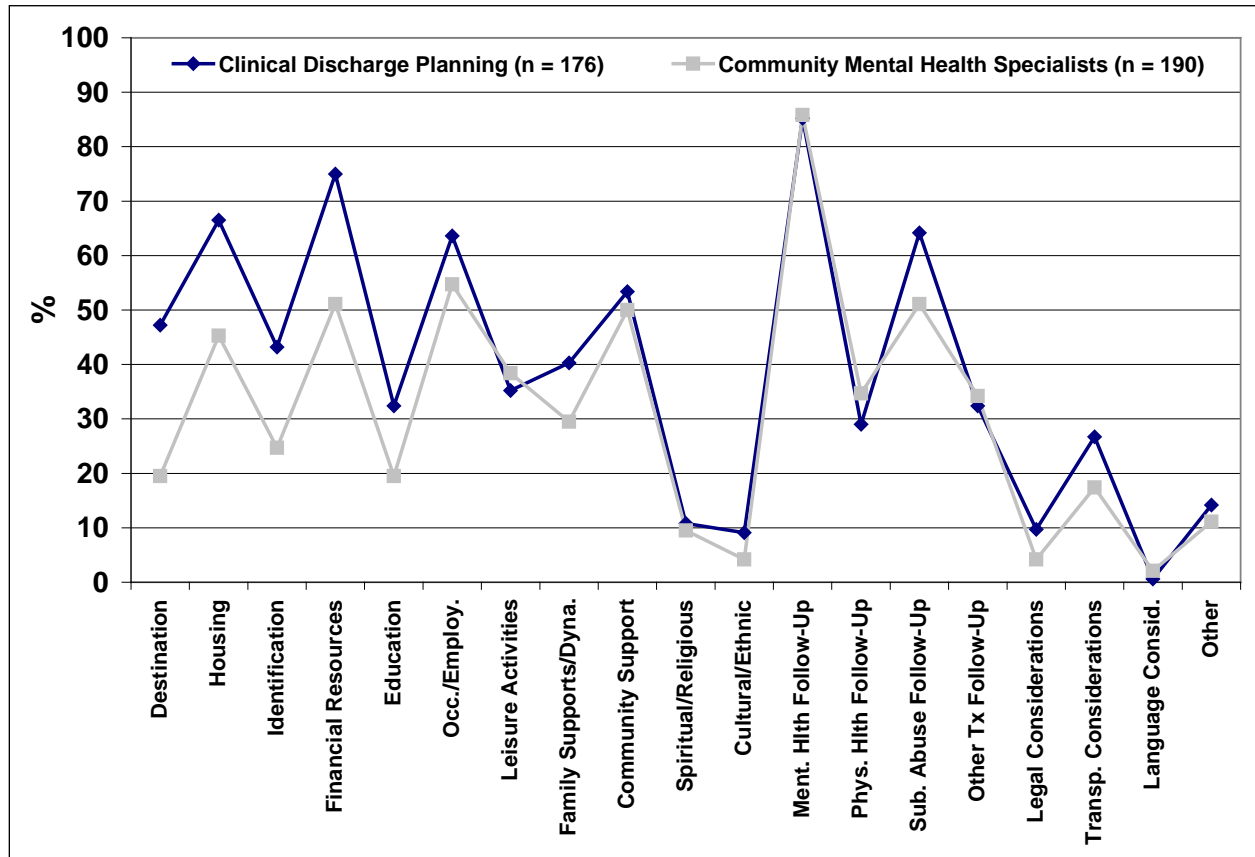
- 1) This table only includes services for which there were 40 or more contacts in the total period.
- 2) a Excludes 47 entries on the Community Capacity Building records that were not appropriate capacity building activities. Examples of such activities included attending CSC's new employee orientation, delivering a two-day mental health training package, and meetings with offenders to complete assessments.
- 3) b Includes categories that had small frequencies such as Aboriginal culture-specific services, provincial/municipal government agency, and education.
- 4) c Includes categories such as physical health, CSC (internal), and Aboriginal culture-specific services.

Three of the most frequent categories of service building contacts were for psychiatric/psychological, housing, and mental health information/referral services. Consistent with the

<sup>34</sup> Source: CSC (2008c).

pattern of service building contacts, mental health follow-up was identified as the most frequently anticipated need among OMDs referred to CMHI services (see Figure 23; CSC, 2008c, p. 18).

**Figure 23: Percentage of CMHI Accepted Offenders Identified with Anticipated Discharge Needs at Referral**



Notes:

- 1) a Anticipated need areas are not nationally representative as the numbers differ across regions
- 2) Data presented in this figure were collected from referral forms completed by institutional and community parole officers which include information about release, inclusion criteria, and anticipated needs areas.

Furthermore, the overwhelming majority (98%;  $n = 355$ ) of CSC staff members surveyed indicated that mental health follow-up was considerably to very important in the reintegration of OMDs from the institution to the community. Similarly, 95% of staff members rated housing needs to be considerably to very important. Finally, the majority of staff (97% to 99%) rated

financial, occupation/employment, and substance abuse needs/follow-up to be moderately to very important for CMHI offenders.

To summarize, the results on contracts and community capacity building efforts (i.e., contacts) suggest that the capacity to provide community-based services is not problematic. Rather, other difficulties such as staff awareness of available services in the community and provision of services after warrant expiry may require further examination (the latter issue is discussed in the next section). For instance, the majority of CSC staff members indicated that the CMHI contributed to an increase in advocacy for community services by CDP and CMHS staff (72%), and community capacity building (69%). In addition, the majority of the offenders (85%;  $n = 17$ ) agreed that the services that they had received from the community service providers helped in their successful integration into the community while one individual (5%) disagreed. All but one offender (97%;  $n = 29$ ) indicated that the services that they received through the CMHI helped them to live successfully in the community. Moreover, a majority of the offenders indicated that they were very to extremely satisfied with the CDP services, CMHS services, services provided by community-based service providers, and the CMHI overall (64% to 90%). Furthermore, community capacity building efforts have focused on the areas of greatest need according to needs recorded on referral forms. Finally, as discussed in the section on availability and accessibility of CMHI services, from April 2006 to March 2008, contract services were provided to 84% to 100% of all the offenders who requested services and the most frequent reason for refusal of services was that the offender was not eligible for the services.

### **Continuity of Services**

**FINDING 14: Stakeholders generally reported enhanced continuity of care and services, although some concern was reported regarding continuity of care after warrant expiry.**

Continuity of services from the institution to community was rated positively by the offenders based on their responses to an adaptation of the ACSS-MH (Adair et al., 2004).<sup>35</sup> Overall, offenders scored an average of 154 ( $SD = 17.1$ ) which corresponds to an overall positive rating (see Table 26). Offenders also scored positively on system fragmentation (offenders'

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<sup>35</sup> Refer to Appendix E for a description of the scale and scoring methodology

perceptions of continuity across the services; for example: “I have to deal with a confusing number of agencies and programs”), relationship base (the extent to which the offender perceives a consistent and dependable relationship with his/her treatment providers as being important; for example: “I can count on my social worker/nurse to help me when I am in need”), and responsive treatment subscales (extent to which services are provided to address the offender’s needs; for example: “After release from the institution, I had to wait a long time before I received mental health services”). These findings are consistent with ratings by CSC staff members and offenders with respect to continuity of services. The majority of CSC staff members indicated that the CMHI increased the continuity of services from the institution to the community (prior to Warrant Expiry Date [WED]; 73%). Also, approximately half of staff respondents agreed that continuity of care of mental health services after warrant expiry had also increased (51%).

**Table 26: Offender Perception of the Continuity of Services as Rated Using the Alberta Continuity of Services Scale for Mental Health**

	Mean (SD)	Observed Range of Scores	Possible Range of Scores
System Fragmentation	84 (10.2)	62 to 105	21 to 105
Relationship Base	39 (4.1)	32 to 45	9 to 45
Responsive Treatment	31 (4.5)	24 to 40	8 to 40
Total	154 (17.1)	124 to 190	38 to 190

The majority of offenders indicated that their discharge planner helped to establish contact with community service providers prior to their release (85%). In addition, most offenders reported that CMHS staff assisted them in accessing community resources and services that they required (81%) and followed up after referring them to services to ensure that they were receiving the services (93%). CSC staff members also indicated that there was an increase in linkage to community mental health services while the offender is under CSC community supervision (71%). Finally, the majority of CSC staff members (73%) reported that the CMHI had contributed to an increase in comprehensive integration planning.

*Community-Based Services after Warrant Expiry*

One particular area that may require additional attention is the provision of community-based services after offenders have completed their sentences (i.e., after WED). As noted by

Champagne and colleagues (2008), “a lack of substantive support for OMDs in the community increases the likelihood that they will return to the criminal justice system through repeated arrests and incarceration or be admitted and re-admitted to psychiatric hospitals” and “effective mental health treatment can significantly contribute to CSC’s goal of ensuring safer communities” (p. 3). Concerns about public safety do not cease at warrant expiry. One of the service delivery gaps identified in an evaluation of the Texas Mental Health Initiative (Arrigona, Prescott, Brown & Hook, 2003) was that the initiative lacked transitional services to facilitate continuity of services after offenders were terminated from the Mental Health Initiative. Of the 1,507 adult probationers who were terminated from the Mental Health Initiative, only 38% had continued involvement with mental health services at a 60 day follow-up. Arrigona and colleagues suggested that the model be modified to include a gradual transition from the intensive supervision and mental health services to program termination in order to increase the likelihood that the successes and improvements achieved through the offender’s participation in the initiative are sustained beyond termination.

According to the *Correctional Service of Canada Community Mental Health Initiative Clinical Discharge Planning and Community Integration Service Guidelines*, CMHSs are responsible for initiating “appropriate referrals to address immediate and longer term community integration needs after the OMDs’ WED” (Champagne et al., 2008, p. 25). Furthermore, “CMHSs encourage OMDs to maintain post-termination contact with them after completion of sentence in the community, at their discretion, in order to support them for a transitional period of time” (p. 26). Half of CSC staff members (51%) indicated that the CMHI has contributed to an increase in continuity of mental health services after warrant expiry but a large proportion also indicated that there has been no change (43%). Less than one-fifth (18%) of CSC staff respondents indicated that they were aware of mechanisms/procedures in place for CMHS staff members to facilitate the continuity of services for offenders after warrant expiry although the majority of CSC staff respondents indicated that such mechanisms/procedures should be in place (91%).

Staff members who indicated that they were aware of existing mechanisms most frequently identified contact with, or referral to, non-governmental community-based service providers (45%) and government agencies/departments (e.g., provincial health, social services; 15%). Several staff members also suggested that continuity of care could be facilitated after

sentence completion, by developing partnerships, MOUs, agreements, and engaging in information sharing with service providers (government or non-government) to provide services beyond WED. Overall, the most commonly identified strategies to facilitate continuity of care after WED included referring offenders to service providers after WED or arranging appointments/case conferences with agencies involved in post-WED care, and CSC/CMHI staff providing follow-up for at least a short-term or temporary basis following warrant expiry.

The majority of offenders reported considerable to complete agreement with the statement that they had all of the necessary services in place at the end of their sentence (71%). Approximately one-fifth (18%) of the offenders indicated 'a little' to 'moderate' agreement and the remainder (11%) indicated not at all.<sup>36</sup> When asked to explain their responses, offenders most frequently indicated that the needed services are already in place (21%), although some also reported that they were concerned about having access to services after warrant expiry (15%). The majority of community service providers (77%) surveyed indicated that CSC federal offenders are eligible to access services from their agency beyond WED although half of the community providers (50%) indicated that there are changes to the services provided after WED.

Although there was a general perception of increased continuity of care for offenders through the CMHI, the importance of extending continuity of care up to and beyond warrant expiry cannot be overemphasized. The *Kirby Report* stresses the importance of this by recommending that CSC take responsibility for ensuring continuity of care post-release (Kirby, 2006). Health care in Canada is typically a provincial responsibility unless offenders are residing in CSC facilities (including CCCs; see review of policy in the policy and legislation section). Once the offenders have reached warrant expiry, CSC no longer has responsibility for this care. However, given the increased priority the government has placed on providing better care for mentally disordered people and offenders, offender needs at warrant expiry should be considered, in terms of services that may be arranged prior to WED to provide continuity of services after WED. Given the general transfer of responsibility to the province following WED, CSC may wish to develop additional links with provincial governments to facilitate continuity of care after warrant expiry.

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<sup>36</sup> It may be important to note that the majority (73%;  $n = 24$ ) of the offenders who were interviewed had been released for 1 year or less at the time of the interview

**RECOMMENDATION 8: CSC should continue to support and enhance the level of services available to offenders with mental disorders in the community. Further, CSC should explore the development of additional partnerships/links with organizations (such as provincial governments and non-governmental organizations) to facilitate continuity of care following warrant expiry.**

### Offender Quality of Life

**FINDING 15: Stakeholders generally reported that the CMHI contributed to an improved quality of life for offenders. However, the CMHI standardized assessment of quality of life was not administered to offenders per CMHI guidelines. As a result, findings pertaining to this assessment were inconclusive due to small sample sizes.**

Administration guidelines (as reported in the *Additional Measures for the Community Mental Health Initiative – Resource Manual*) indicate that the Quality of Life Scale is to be administered within the first month of release, at the third month of release, and every 6 months thereafter. QoL data were available for 36 CMHS offenders<sup>37</sup> for the first time period (i.e., Time 1; refer to Table 27, adapted from CSC, 2008d, p. 27).

**Table 27: Quality of Life Scores for the CMHS Group within the First Month of Release**

Domain	Mean (SD) (n = 36)
Legal and Safety a	5.3 (0.9)
Activities	5.0 (1.3)
Social Relations a	4.9 (1.3)
General Life Satisfaction	4.8 (1.3)
Work a	4.7 (1.3)
Living	4.7 (1.4)
Health	4.5 (1.3)
Family a	4.8 (1.6)
Finances	3.6 (1.6)

Notes:

1) Missing data for CMHS in family (n = 32), social relations (n = 35), work (n = 20) and legal and safety (n = 34).

<sup>37</sup> Data were reported for ten CDP offenders at Time 1, five of whom also received CMHS services. According to the guidelines, the Quality of Life scale should be administered to offenders in the community. It is unclear why Quality of Life scale was administered to the other five CDP offenders who did not receive CMHS services. However, only data for the CMHS offenders, who were supposed to complete the Quality of Life scale as per the CMHI guidelines, are presented here

2) In order to assist in interpretation of mean scores presented in the table, the scale is rated from 1 to 7 where: 1 = terrible; 2 = unhappy; 3 = mostly dissatisfied; 4 = mixed; 5 = mostly satisfied; 6 = pleased; 7 = delighted.

At the 3-month interval (i.e., Time 2), data were available for only 16 CMHS offenders and at the 6 month interval (i.e., Time 3) there were too few data to analyse (data were available for 4 offenders only). There were no significant differences in scores between these two time periods although the small number of cases at Time 2 precluded any interpretation of the impact of the CMHI on quality of life. For the most part, average scores ranged from 4 to 5, indicating that in general offender perceptions of quality of life were “mixed”, or “mostly satisfied”. Given the small samples and missing data, however, these results should be interpreted with caution.

Although the results from the QoL Scale were inconclusive, key stakeholders reported that the CMHI has contributed to improved quality of life for OMDs. The majority of community service providers (85%) indicated that the CMHI has contributed to an increase in the quality of life for OMDs. In addition, the majority of offenders (81%) indicated that the CMHI has increased their quality of life (substantially, 67%) while one individual (3%) indicated that the CMHI has resulted in a substantial decrease in his/her quality of life. Furthermore, the majority of CSC staff members (68%) indicated that the CMHI had contributed to an increase in OMDs’ quality of life while they were supervised in the community and just under half of the staff (47%) indicated an increase in quality of life after warrant expiry. Almost half of the staff members (46%) indicated that there has been no change to OMDs’ quality of life after warrant expiry. This may be related to the finding that only 18% of CSC staff respondents indicated that they were aware of mechanisms/procedures in place for CMHS staff members to facilitate the continuity of care services for offenders after warrant expiry. When asked whether or not they agreed that offenders served through the initiative experienced a reduction in symptomology, almost half (46%;  $n = 116$ ) neither agreed nor disagreed, while 42% ( $n = 104$ ) agreed and 11% ( $n = 28$ ) disagreed.

Overall, survey and interview responses suggest that staff and offenders believe offender quality of life has been enhanced as a result of participation in CMHI. It will be important to collect additional data on the QoL Scale to increase sample sizes and review overall quality of life over longer time periods.

**RECOMMENDATION 9: CSC should review the Quality of Life Scale administration guidelines to ensure that guidelines for administration are practical and develop procedures to ensure that CMHI staff engage offenders in completing the assessment of quality of life as per the guidelines.**

### **Impact of CMHI on Reintegration to the Community**

**FINDING 16: The majority of offenders received either clinical discharge planning (CDP) or community mental health specialist (CMHS) services, but not both. Offenders receiving CMHS services were less likely to be suspended or revoked than the comparison group, after statistically controlling for pre-existing group differences. There was no evidence to suggest that the CDP group differed from the comparison group with respect to these outcomes. These preliminary findings should be interpreted with caution due to small sample sizes and short follow-up times.**

Three groups were included in correctional outcome analyses: (1) offenders who were accepted for CDP services, (2) those accepted for CMHS services, and (3) a comparison group. The demographic variables, criminal history, and risk information for these three groups are summarized earlier in the report (refer to Table 4). Generally, offenders in the CDP group had a lower reintegration potential and a higher number of prior convictions ( $M = 26.4$ ,  $SD = 17.5$ ) than the other two groups at release (significantly higher number of prior convictions than the CMHS group and marginally higher than the control group), which were quite similar in profile.

Release information for offenders in these three groups is presented in Table 28 (CSC, 2008d, p. 16). Within each group, the majority of the offenders were released on statutory release. None of the offenders in the CMHS group were released at warrant expiry, although 11.3% and 13.7% of the CDP and comparison groups were released at warrant expiry, respectively.

**Table 28: Release Types for the CDP, CMHS, and CMHI Comparison Groups**

	Frequency <i>n</i> (%)		
	CDP ( <i>n</i> = 53)	CMHS ( <i>n</i> = 79)	Comparison Group ( <i>n</i> = 95)
First Release Type <sup>1</sup>			
Day or Full Parole	8(15.1%) <sup>a</sup>	27(34.2%) <sup>b</sup>	25(26.3%)
Statutory Release	35(66.0%)	47(59.5%)	52(54.7%)
Warrant Expiry	6(11.3%)	--	13(13.7%)
Long Term Supervision	0(0%)	5(6.3%)	3(3.2%)
Resided in CRF/CCC <sup>2</sup>	17(39.5%)	31(39.2%)	42(52.5%)
Not Yet Released	4(7.5%)	--	2(2.1%)

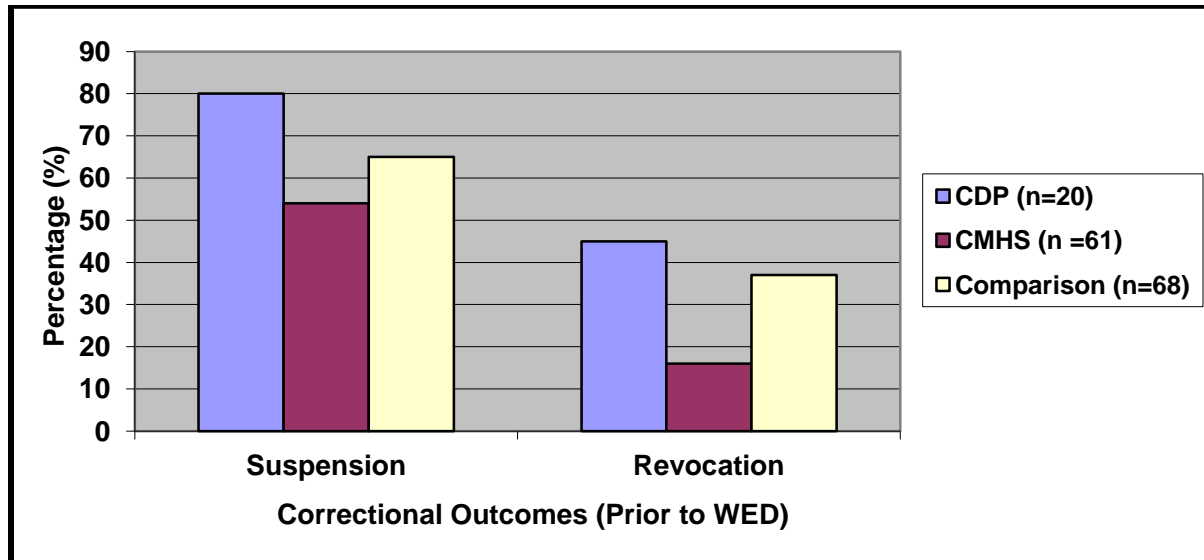
## Notes:

- 1) 1 1st releases are based on: 1) CDP group – 1st release following most recent referral to CDP, 2) CMHS group – closest release to referral date, 3) CMHI-Comp – 1st release following 2003-2005 eligibility.
- 2) 2 Percentages of those who resided in a CRF/CCC are reported out of the total number of offenders in that group on supervised release (i.e., the total *n* for that group minus the number of offenders released at warrant expiry or not yet released: 17/43 for CDP, 31/79 for CMHS and 42/80 for CMHI-Comparison Group).
- 3) CMHS services are not provided to offenders released at WED because CSC does not have jurisdiction over offenders beyond their warrant expiry dates.
- 4) Post-hoc comparisons between pairs of groups were completed, where the overall test was significant, to determine whether there were any differences among the three groups. Statistically significant differences between the groups are identified with an a, b at  $p < .05$ .

*Suspensions and Revocations*

Preliminary recidivism outcomes for the CDP, CMHS, and comparison groups were assessed. It is important to note that caution is needed in interpreting the results due to methodological limitations such as short follow-up periods for the CDP and CMHS groups and small sample sizes as well as pre-existing group differences in reintegration potential (a proximal measure of risk and need). Suspension and revocation outcomes for the three groups are presented in Figure 24 (see Appendix F for additional statistics).

**Figure 24: Suspension and Revocation Rates for CDP, CMHS, and Comparison Groups at the 6-Month Follow-Up**



Note: The values in parentheses represent the number of offenders who had at least 6-months of follow up for each group.

It is important to note that there were pre-existing differences between the groups on a number of demographic and risk-related variables and therefore the results in Figure 24 may be misleading. In addition, there were variable follow-up periods for each of the groups, with an average of 6.4 months for CDP, 8.4 months (CMHS), and 14.0 months for the CMHI Comparison Group (CSC, 2008d). In order to control for follow-up time and any potential pre-existing differences between the treatment and comparison groups, Cox regression analyses were conducted.

#### *Survival Analysis*

Pre-existing differences between the groups, particularly when the groups differ on variables that are related to risk of recidivism, may lead to difficulties in interpreting results, as any difference in recidivism between groups may be due to these pre-existing factors rather than the treatment (in this case, CMHI services). As such, Cox regression analysis was used to examine differences in survival rates after statistically controlling for pre-existing differences in age at release, reintegration potential, and functional impairment.

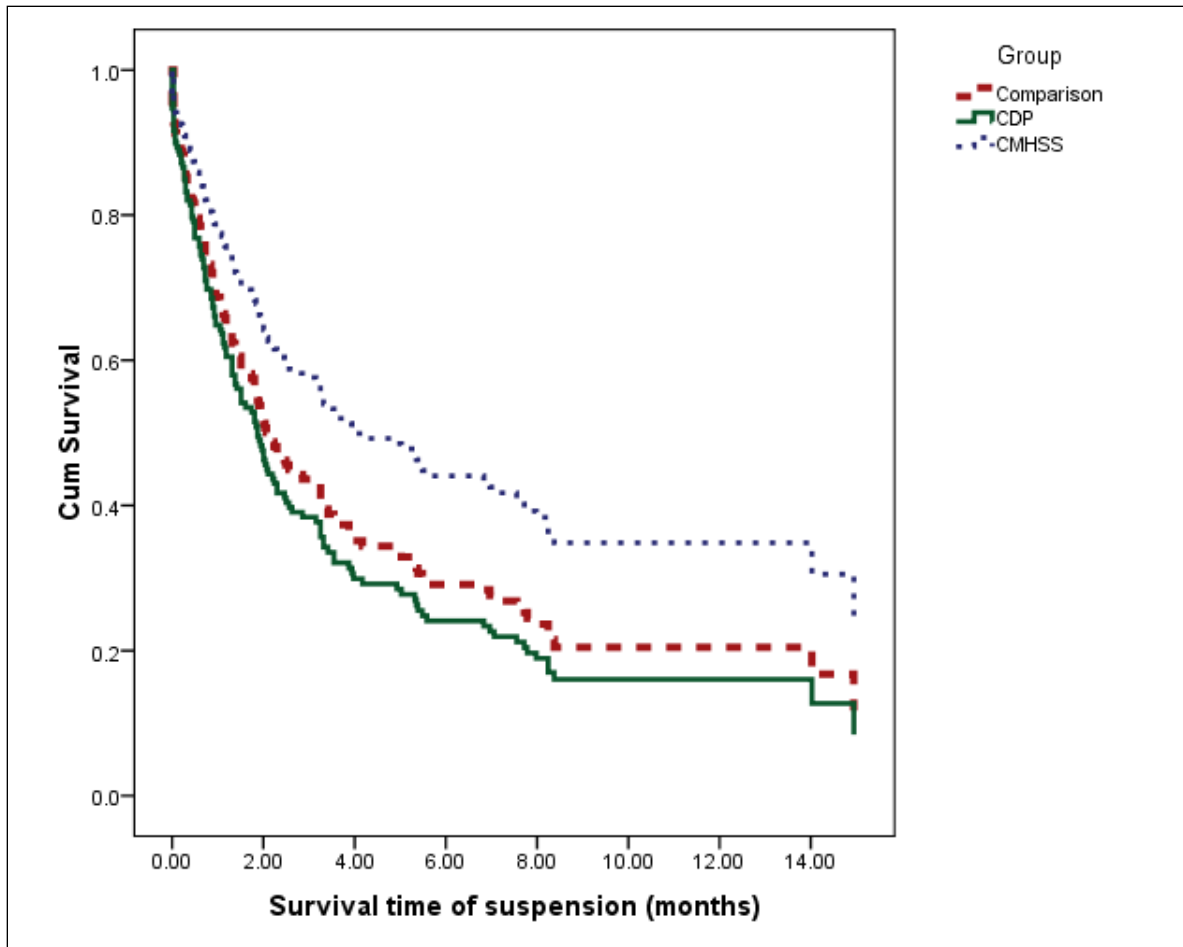
Two sets of Cox regression analyses were conducted to examine whether the likelihood of being suspended and revoked differ between three treatment groups (i.e., CDP, CMHS, and comparison) after controlling for age at release, functional impairment, and reintegration potential. For each analysis, age at release, functional impairment, and reintegration potential were entered into block 1, group was entered into block 2, and time at risk<sup>38</sup> was entered as the dependent variable. Offenders who “survived” were those who did not receive a suspension (or revocation) whereas offenders who “failed” were those who were suspended (or revoked).

*Suspension.* After controlling for pre-existing differences in age at release, functional impairment, and reintegration potential, there was a significant group effect on survival (refer to Figure 25). Specifically, the CMHS group was 34% less likely to be suspended than the comparison group (refer to Table e in Appendix F) and the CMHS group was 42% less likely to be suspended than the CDP group (refer to Table f in Appendix F). There was no significant difference between the CDP and comparison groups.

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<sup>38</sup> For suspensions, time at risk was the time between release into the community and date of suspension. For revocations, time at risk was the time between release and the date of revocation.

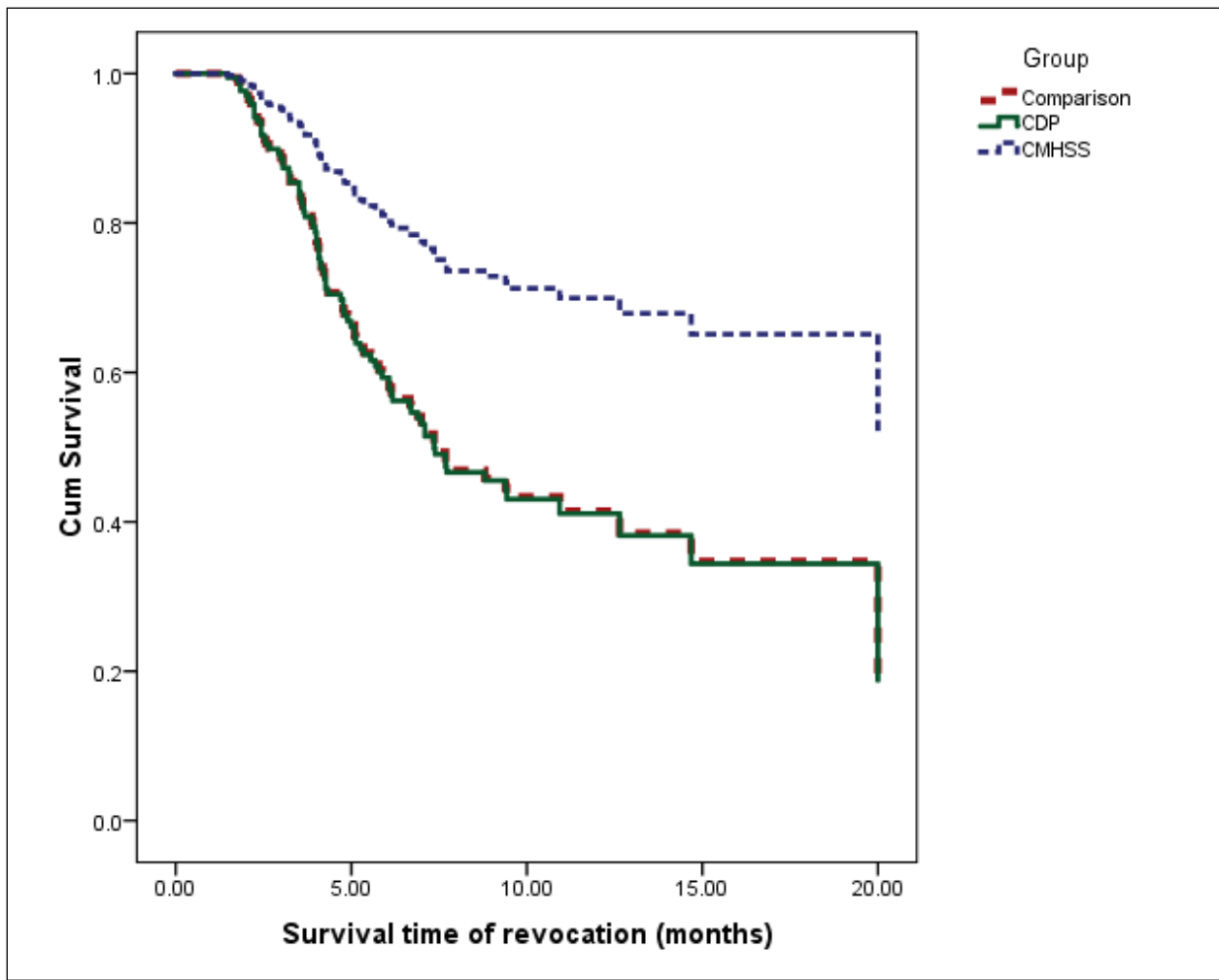
**Figure 25: Survival Function for the CDP, CMHS, and Comparison Groups (Suspensions)**



Note. Results indicate that CMHS group was suspended at a significantly lower rate than the CDP and CMHS groups. A point on the lines represents the proportion of offenders who have not been suspended at that point in time. Time 0 represents release date where 100% of the three groups have “survived” (i.e., not suspended). Note that results shown in the graph after 6 months should be interpreted with caution, as not all treatment group members were followed-up past that time.

*Revocation.* After controlling for pre-existing differences in age at release, functional impairment, and reintegration potential, there was a significant group effect on survival when examining likelihood of revocation of release (refer to Figure 26). Specifically, the CMHS group was 59% less likely to have their release revoked than the comparison group (refer to Table g in Appendix F), and the CMHS group was 60% less likely to be revoked than the CDP group (refer to Table h in Appendix F). There was no significant difference between the CDP and comparison groups on likelihood of revocation.

**Figure 26: Survival Function for the CDP, CMHS, and Comparison Groups (Revocations)**



Note. Results indicate that CMHS group was revoked at a significantly lower rate than the CDP and comparison groups. A point on the lines represents the proportion of offenders whose release has not been revoked at that point in time. Time 0 represents release date where 100% of the three groups have “survived” (i.e., not revoked). Note that results shown in the graph after 6 months should be interpreted with caution, as not all treatment group members were followed-up past that time.

Although caution is needed due to methodological limitations (e.g., short follow-up, small sample sizes), preliminary results suggest that CMHS is related to a reduction in rates of suspension and revocations whereas there is no evidence to suggest that CDP has an effect on these two outcomes when compared to the comparison group. The fact that the CDP group was also found to be different from the comparison group with respect to a number of factors (e.g., level of functioning, reintegration potential) should also be taken into account when interpreting these analyses. That, combined with the short follow-up times, indicates that it will be important

for these analyses to be conducted again in several years following full implementation and greater offender participation in the initiative.

Continuity of care in the community has frequently been identified as an important factor in the safe reintegration of offenders into the community. Whereas discharge planning may help to identify needs, it may not be sufficient if these plans are not followed through or implemented in the community. For those CDP offenders who did not receive CMHS services, there is no readily available information regarding any types of services that CDP offenders may have received in the community upon release. As of June 2008, only 23 offenders in CMHI databases had received both CDP and CMHS services. There may be various reasons for this, including the fact that CDP offenders may be released to non-CMHS sites, or that late implementation of discharge planning services or community specialist services may have resulted in a lack of continuity in services. Furthermore, results presented earlier indicated that discharge planning was not occurring within the suggested timelines (5 months rather than 9 months prior to anticipated release date). The delay in delivery of CDP services may have reduced the time available to coordinate community services for CDP offenders, ultimately having a negative impact on post-release outcomes. Although preliminary, the results thus far related to community outcomes for CDP offenders suggest that it will be important to ensure continuity of services for CDP offenders following release from CSC institutions, either through the provision of CMHS services (if CDP offenders are released to CMHS sites), or through links to other community services (if CDP offenders are not released to CMHS sites).

**RECOMMENDATION 10: CSC should review the possible reasons for lack of continuity from CDP services to CMHS services. Based on this review, CSC should develop strategies and procedures to better impact community reintegration for CDP offenders.**

#### **Evaluation Objective 4: Cost-Effectiveness**

Cost-effectiveness determines the relationship between the amount spent and the results achieved relative to alternative design and delivery approaches.
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**FINDING 17: Although the CMHI has demonstrated several positive short-term outcomes, limitations related to financial coding and the short implementation period precluded the ability to conduct a reliable cost-effectiveness analysis at this stage of the CMHI.**

In order to conduct cost-effectiveness analysis, cost-savings associated with decreased recidivism (i.e., reduced institutional costs because an offender is maintained in the community) would be compared to the program costs to determine overall dollar return on investment. For example, results indicated that CMHS participants were less likely than the comparison group to be revoked. Thus, the likelihood of remaining in the community without returning (technical revocation) would be converted to the number of days participants successfully remained in the community versus the comparison group in order to determine the cost savings due to CMHS participation. Specifically, the CMHS and CMHI comparison group would be compared, where calculations considered the daily cost to incarcerate an inmate, offset by the extended daily cost of supervising an offender in the community. Finally, cost savings (positive or negative) would be compared to the unit costs of delivering the CMHI, to calculate the overall dollar return per dollar invested (e.g., each \$1.00 spent results in a return of \$x).

However, there are several challenges associated with conducting a cost-effectiveness analysis at this stage of the CMHI implementation. In order to effectively conduct a cost-effectiveness analysis, a minimum of one full year of initiative implementation with associated financial data for that year would be necessary, as well as an adequate follow-up time (generally two years), to assess outcomes in the community. Currently the CMHI has only been fully operational for part of 2007/08, so a full year of implementation and associated financial data do not exist.

Furthermore, to conduct the cost-effectiveness analysis, the average length of time that treatment groups remain in the community longer than comparison groups would be assessed to determine the costs saved (i.e., because supervision costs less than institutionalization). Given the late implementation of the initiative, there are limited follow-up data. Specifically, only 20 CDP offenders and 61 CMHS offenders had six months of follow-up data related to the outcome analysis (i.e., suspensions, revocations), making any analyses conducted regarding community outcomes preliminary only. Such a short follow-up period would result in a truncated average time spent in the community which would impact upon the ability to detect differences between the groups with respect to survival time, and ultimately the ability to accurately determine any

potential cost savings of the initiative. At least several years of follow-up data should be available in order to adequately conduct a cost-effectiveness analysis of this nature.

In addition, it was noted in the previous section that the financial coding for the CMHI has varied somewhat over time and across regions, with some regions utilizing the specific financial codes to record financial expenditures for different types of treatment services (CDP and CMHS), and other regions appearing to utilize the more generic “Mental Health Community Strategy” to code this financial information.

The impact of these challenges, particularly the length of follow-up, on cost-effectiveness will become apparent after considering the following information. Given the current concerns regarding the length of follow-up time for outcome analysis, a different approach to cost-effectiveness analysis was taken, to determine the number of days that CMHS participants would need to remain in the community to offset program costs. In order to do so, it was necessary to provide estimates of program costs, the average daily cost of maintaining an offender in an institution, and the average daily cost of managing an offender in the community. Furthermore, since initial effectiveness was demonstrated by the CMHS group (in that the CMHS group was less likely to be suspended or revoked than the CMHI comparison group), the CMHS group was chosen to illustrate the hypothetical cost-analysis below.

The average cost of providing CMHS services in fiscal year 2007/08 was determined based on national CMHI expenditures (see Table 29).

**Table 29: National CMHI Operating and Salary Costs for 2007/08**

Actual Expenditure	210 - Salaries	240 - Operating
Mental Health Community Strategy	\$84,020	\$48,408
CDP	\$383,909	\$32,341
CMHS	\$700,161	\$48,819
Training	\$0	\$87,192
Contracts	\$0	\$876,779
Adjunctive Services	\$0	\$10,222
Evaluation and Research	\$115,794	\$1,521
Management and Coordination	\$608,328	\$222,263
Total	\$1,892,212	\$1,327,545

In order to calculate CMHS program costs, all national CMHS costs were included (but CDP costs – the other main treatment group - were excluded).<sup>39</sup> Valuation and research costs were excluded as they were not considered to be annual, fixed, ongoing costs for the initiative. Half of the dollar amount of all the other cost-centres (mental health community strategy, training, contracts, adjunctive services, management and coordination) was included in the CMHS program cost calculations (The remaining half of the cost for each of these cost-centres was presumed to be associated with the other main treatment group – CDP services).<sup>40</sup> The total cost associated with CMHS, based on these assumptions, is \$1,717,586. This total estimated value for CMHS services was then divided by the 79 CMHS treatment participants included in the outcome analysis to obtain the CMHS cost per person which was approximately \$21,742.

The daily savings associated with supervising an offender in the community is the difference between the average daily cost of maintaining an offender in an institution (\$241.28) and the average daily cost of managing an offender in the community (\$63.30), which equals \$177.98.<sup>41</sup>

In order to simply achieve cost-neutrality, CMHS participants would need to remain in the community approximately 122 days or approximately 4 months longer than the comparison

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<sup>39</sup> Note that there were two main treatment groups at the current time. Results have indicated that most offenders received either CDP or CMHS services. Aside from any costs directly attributed to either of these cost centres, other peripheral costs (e.g., management and coordination, training, etc.) might be presumed to be associated with either of these services. Therefore, half of these other costs were assumed to be associated with the cost of CMHS services (and included in the costs calculated here related to CMHS treatment outcomes), and the remaining costs were assumed to be associated with CDP services, and excluded from this analysis on CMHS outcomes.

<sup>40</sup> Note that there may be a number of limitations with this estimate of the CMHS cost analysis, including the fact that the CMHS services were not operational for a full year, the fact that financial data were not always coded consistently, and the fact that there may be other treatment groups/effects that may emerge after longer implementation. For example, there are a number of offenders who were receiving contract services. Currently, 5% of offenders who received contract services were CDP recipients, and 29% of those who received contract services were CMHS recipients. Given that most regions had contract services in place prior to the initiation of CDP and CMHS services, it is unclear whether these contract services will be utilized primarily by CMHS and CDP groups in the future (and costs should be attributed to these two treatment groups), or whether there may be other groups of offenders who might receive only contract services. If the latter is the case, it is possible that there may be a treatment effect attributed solely to the use of contract services, in which case financial costs associated with contract services should not be included in these CMHS service costs. However, this is something that cannot be determined at this time, and as such, cost calculations from CMHS services were calculated based on the two treatment groups that have been established and assessed to date, but could potentially be somewhat overestimated. In future years, following more extensive implementation time and more consistent financial coding, better estimates of CMHS costs should be possible.

<sup>41</sup> Note that these costs were reported based on the costs of maintaining an offender in 2005/06 as reported in the Corrections and Conditional Release Statistical Overview; Annual Report, 2007. The Annual Report for 2008 was not available at the time that this report was written, but more current financial data regarding the cost of maintaining an offender will need to be obtained when the cost effectiveness analysis of this program is conducted in the future.

group (program cost per offender divided by the daily cost-saving or \$21,742/\$177.98; refer to Table 30). In order to achieve a 50% return (e.g., \$1.50 for every \$1.00 spent), CMHS participants would need to remain in the community 183 days or approximately 6 months longer than the comparison group (122 days x 1.5).

**Table 30: Cost-Savings Analyses for CMHS Participants**

Return on CMHS Dollar Investment	Program Cost	Daily Savings (difference between costs of maintaining an offender in an institution and in the community)	Number of days that CMHS group would need to remain in the community beyond the comparison group
(A)	(B)	(C)	(A*B/C)
\$1.00	\$21,742	\$177.98	122 days
\$1.50	\$21,742	\$177.98	183 days

These results, although entirely achievable, demonstrate the limitations of trying to conduct a cost-effectiveness analysis at this stage of the CMHI implementation, when only approximately 6 months of follow-up data are available (i.e., even if there were significant cost savings, it is unlikely that they could be detected with such a truncated follow-up time in the community).<sup>42</sup>

The CMHI has demonstrated several benefits even at this early stage of implementation, including positive impacts on staff awareness and competency related to CMHI training, increased capacity building and access to services for offenders with mental health needs in the community, and reductions in suspensions and revocations for CMHS participants. However, given the current state of implementation (and resulting short follow-up period for long-term impacts), as well as issues related to recording of financial data, it is premature to conduct cost-effectiveness analysis at this time. It would be recommended to conduct this analysis after at least 2 more years, assuming that financial data are accurately recorded in the future.

<sup>42</sup> At the time of this evaluation, with 6 months of follow-up, a cost-effectiveness analysis cannot adequately be conducted. Results based on the data available to date indicates that the average number of days between release and revocation for the CMHS and comparison groups were 127 and 109 days, indicating that the CMHS group stayed in the community an average of 18 days longer than the comparison group.

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## Appendices

## Appendix A: Community Mental Health Initiative Evaluation Matrix

Evaluation Objective: Continued Relevance The extent to which the Initiative remains consistent with departmental and government-wide priorities, and realistically addresses actual needs.			
Evaluation Question	Performance Indicator	Source	Responsibility
1. What role does the enhancement of CSC's community mental health strategy play in accommodating and re-integrating offenders into the community?	<ul style="list-style-type: none"> <li>• Alignment of the Initiative to CSC's Program Activity Architecture (PAA) and Corporate Priorities</li> </ul>	<ul style="list-style-type: none"> <li>• Comparison of PAA, Corporate Priorities, Corporate Risk Profile, and Initiative objectives</li> <li>• Literature review</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluation Branch</li> </ul>
2. Does the strategy support the public policy objectives of the government?	<ul style="list-style-type: none"> <li>• Document review to identify government support for the initiative</li> </ul>	<ul style="list-style-type: none"> <li>• Key documents (e.g., 2007 Speech from the Throne, CCRA, Corporate Priorities, Corporate Risk Profile, Out of the Shadows at Last – the Kirby Report, Government of Canada's mental health strategy, Government of Canada budgets, World Health Organization documentation, CMHI key documents, CSC Panel Review)</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluation Branch</li> </ul>
3. Is there a need for the Initiative to continue?	<ul style="list-style-type: none"> <li>• Number of offenders who have benefited from the Initiative</li> <li>• Number and profile of offenders with mental health issues</li> </ul>	<ul style="list-style-type: none"> <li>• Documents (e.g., OIA, referrals for services, preliminary literature on intake screening tool pilot projects)</li> <li>• Review of Changing Offender Profile literature</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluation Branch</li> </ul>
4. Is the CMHI consistent with other jurisdictions' practices?	<ul style="list-style-type: none"> <li>• Comparison of costs between CSC and other jurisdictions who provide specific resources to community released offenders with mental disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Review of relevant literature</li> <li>• Review of Roundtable jurisdictions practices and provincial jurisdictions</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluation Branch</li> </ul>
Evaluation Objective: Implementation The extent to which the Initiative was organized or delivered in such a way that goals and objectives can be achieved. This involves appropriate and logical linkages between activities, outputs, outcomes and long-term outcomes.			

Evaluation Question	Performance Indicator	Source	Responsibility
1. Is the Initiative being delivered as designed?	<ul style="list-style-type: none"> <li>• A review of national implementation challenges and best practices (i.e. staffing, funding, etc.)</li> <li>• Key informant survey responses suggesting implementation issues and timeliness of service delivery</li> <li>• Establish implementation timeline with challenges and best practices identified with NHQ Health Services management</li> </ul>	<ul style="list-style-type: none"> <li>• Review of RPC Implementation Report</li> <li>• Review of Regional Implementation Model</li> <li>• Key informant survey</li> <li>• Consultation with NHQ Health Services management</li> </ul>	<ul style="list-style-type: none"> <li>• Regional Psychiatric Center/Health Services</li> <li>• Evaluation Branch</li> </ul>
2. Are there any operational constraints or implementation challenges that limit the ability of the Initiative to achieve the objectives or expected results and outcomes?	<ul style="list-style-type: none"> <li>• RPC Implementation Report reviews implementation dates, outputs, and timeliness of intervention</li> <li>• Staff that can provide details on the achievements of the initiative (i.e. discharge planning, community care plans, contracted services, and the timeliness of intervention)</li> <li>• Establish implementation timeline with challenges and best practices identified with NHQ Health Services management</li> </ul>	<ul style="list-style-type: none"> <li>• Review of RPC Implementation Report</li> <li>• Key informant survey</li> <li>• Consultation with NHQ Health Services management</li> </ul>	<ul style="list-style-type: none"> <li>• Regional Psychiatric Center/Health Services</li> <li>• Evaluation Branch</li> </ul>
3. Are the most appropriate offenders being identified and included in the Initiative?	<ul style="list-style-type: none"> <li>• Percentage of offenders who meet criteria for Initiative services targeted by the Initiative</li> <li>• Percentage of offenders who meet criteria for Initiative services not targeted by the Initiative</li> <li>• Perceptions of stakeholders regarding appropriate identification (i.e., are the referral criteria appropriate)</li> </ul>	<ul style="list-style-type: none"> <li>• Review of RPC Pre-Implementation and Implementation Reports</li> <li>• Survey of key informants</li> <li>• Interviews with offenders</li> </ul>	<ul style="list-style-type: none"> <li>• Regional Psychiatric Center/Health Services</li> <li>• Evaluation Branch</li> </ul>
4. Are the parole offices selected under the CMHI receiving the majority of offenders with mental	<ul style="list-style-type: none"> <li>• The 16 community sites selected had the highest percentages of offenders with the</li> </ul>	<ul style="list-style-type: none"> <li>• Geographical mapping of all offenders with mental disorders on community release</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluation Branch</li> </ul>

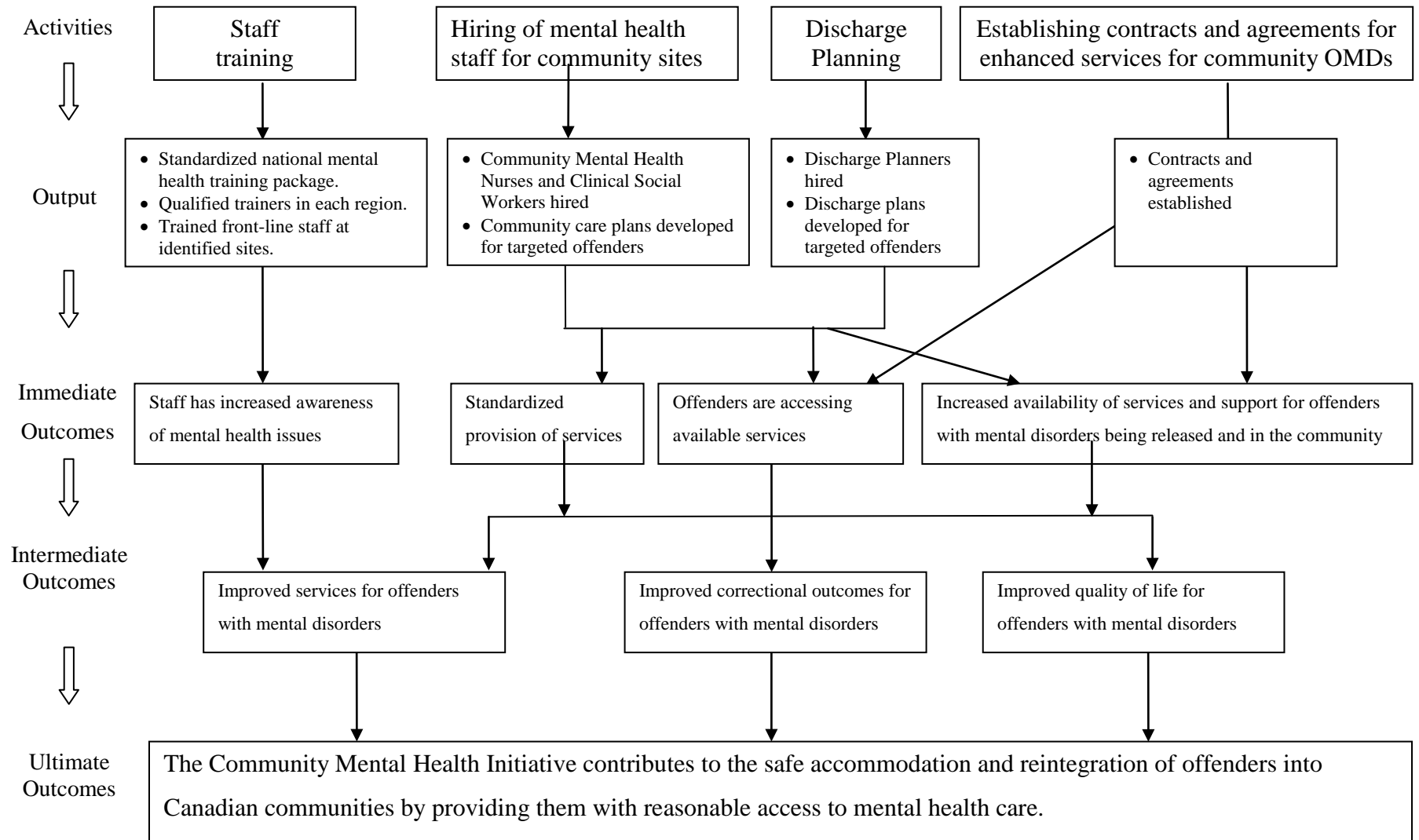
disorders on release?	OIA indicator “diagnosed as disordered currently” <ul style="list-style-type: none"> <li>● Examination of community released offenders with mental disorders in relation to where services are provided (i.e. offenders who received discharge planning services but were not released to CMHI parole offices)</li> </ul>		
5. Have the funds been spent as planned?	<ul style="list-style-type: none"> <li>● Establish implementation timeline with challenges and best practices identified with NHQ Health Services management</li> <li>● Financial documents and files, including the Regional Implementation Model and Integrated Financial and Material Management System (IFMMS) to identify any gaps, lapses, or reallocation in funding</li> <li>● Key stakeholder perceptions of reasons for gaps, lapses, or reallocation in funding</li> </ul>	<ul style="list-style-type: none"> <li>● Perceptions of senior management and stakeholders involved in the implementation of the initiative</li> <li>● Review of financial documents and files</li> <li>● Key informant interviews</li> </ul>	<ul style="list-style-type: none"> <li>● Evaluation Branch</li> </ul>
<p><b>Evaluation Objective: Success</b>  The extent to which the Initiative is the delivering the expected outputs, outcomes and objectives in relation to resources used.</p>			
Evaluation Question	Performance Indicator	Source	Responsibility
<b>Efficiency</b>			
1. To what extent has the CMHI been successful in achieving the following expected outputs in an efficient and timely manner: (1) training; (2) discharge planning; (3) services in the community?	<ul style="list-style-type: none"> <li>● Discharge plans have been created for all offenders who meet criteria and performed in a timely manner</li> <li>● Number and types of contracts with community agencies to provide services for offenders and performed in a timely manner</li> <li>● Number of CMHI staff hired is equal to number of positions originally allocated</li> </ul>	<ul style="list-style-type: none"> <li>● Review of RPC Implementation and Post-Implementation Reports</li> <li>● HS staff training report</li> <li>● Key informant interviews with staff and community contracts</li> </ul>	<ul style="list-style-type: none"> <li>● Evaluation Branch</li> </ul>

	<ul style="list-style-type: none"> <li>● Mental health awareness training has been conducted in all designated CMHS parole offices (number of staff trained, increased confidence to work with OMD following training)</li> <li>● Key informant interviews regarding improved confidence to work with OMD following staff training</li> </ul>		
<b>Effectiveness</b>			
1. To what extent is there an increased awareness amongst staff of mental health issues?	<ul style="list-style-type: none"> <li>● Staff report increased awareness of mental health issues following training and an increased ability/self-efficacy in managing the needs of OMDs in the community</li> </ul>	<ul style="list-style-type: none"> <li>● Pre/Post training questionnaires with staff members</li> <li>● Key informant survey results of those who participated in the training</li> </ul>	<ul style="list-style-type: none"> <li>● Health Services</li> <li>● Evaluation Branch</li> </ul>
2. To what extent is there an increased availability of services and offenders' access to these services?	<ul style="list-style-type: none"> <li>● Number of contracts and agreements established with community agencies as a result of the Initiative</li> <li>● Number of community capacity building records submitted as a result of the Initiative</li> <li>● Perceptions of offenders, staff, and stakeholders as to the ability to address offender needs</li> </ul>	<ul style="list-style-type: none"> <li>● Survey of staff and community stakeholder informants</li> <li>● Interviews with offenders</li> <li>● Review of RPC Implementation and Post-Implementation Reports</li> <li>● Alberta Continuity Services Scale for Mental Health administered after the interview with the Evaluation team</li> </ul>	<ul style="list-style-type: none"> <li>● Regional Psychiatric Center/Health Services</li> <li>● Evaluation Branch</li> </ul>
3. To what extent has there been an increased community capacity to deal with the needs of offenders with serious mental disorders?	<ul style="list-style-type: none"> <li>● Number of community capacity building records submitted as a result of the Initiative</li> <li>● Perceptions of offenders, staff, and stakeholders as to the ability to address offender needs</li> </ul>	<ul style="list-style-type: none"> <li>● Review of RPC Implementation and Post-Implementation Reports</li> <li>● Survey of staff and community stakeholder informants</li> </ul>	<ul style="list-style-type: none"> <li>● Regional Psychiatric Center/Health Services</li> <li>● Evaluation Branch</li> </ul>
4. To what extent has the Initiative resulted in improved immediate and intermediate correctional outcomes?	<ul style="list-style-type: none"> <li>● Decrease in revocation and recidivism rates</li> <li>● Decrease in offenders UAL</li> <li>● Increased length of time on community release</li> </ul>	<ul style="list-style-type: none"> <li>● Review of RPC Implementation and Post-Implementation Reports</li> <li>● OMS, CPIC</li> </ul>	<ul style="list-style-type: none"> <li>● Regional Psychiatric Center/Health Services</li> <li>● Evaluation Branch</li> </ul>

	<ul style="list-style-type: none"> <li>● Increase in discretionary releases (only applicable for those that received discharge planning service)</li> </ul>		
5. Has the Initiative resulted in improved quality of life for offenders with mental disorders?	<ul style="list-style-type: none"> <li>● Perceptions of offenders and staff as to whether or not the initiative has improved offenders' quality of life</li> <li>● Quality of Life instrument used at three-month intervals post-release to assess the offender's self perceived quality of life and after the interview</li> </ul>	<ul style="list-style-type: none"> <li>● Survey of key informants</li> <li>● Interviews with offenders</li> <li>● Quality of Life Scale repeated measures data from the RPC Post-Implementation Report</li> <li>● Quality of Life Scale administered after interview with Evaluation team</li> </ul>	<ul style="list-style-type: none"> <li>● Regional Psychiatric Center/Health Services</li> <li>● Evaluation Branch</li> </ul>
Evaluation Objective: Cost-Effectiveness The extent to which the initiative demonstrates value for money.			
Evaluation Question	Performance Indicator	Source	Responsibility
1. What evidence exists that the Initiative produces value for money?	<ul style="list-style-type: none"> <li>● Success of funded activities</li> <li>● Cost-savings of providing services to offenders through the Initiative compared to the cost of incarcerating these offenders in either regular institutions or RPC/RTC</li> </ul>	<ul style="list-style-type: none"> <li>● Review of RPC Implementation and Post-Implementation Reports</li> <li>● Review of financial data to examine costs of the Initiative</li> <li>● Cost of Maintaining Offenders (COMO) database</li> </ul>	<ul style="list-style-type: none"> <li>● Regional Psychiatric Center/Health Services</li> <li>● Evaluation Branch</li> </ul>
2. Is CSC providing cost effective interventions in relation to other jurisdictions (i.e., the provinces, other countries)?	<ul style="list-style-type: none"> <li>● Comparison of costs between CSC and other jurisdictions who provide specific resources to community released offenders with mental disorders</li> </ul>	<ul style="list-style-type: none"> <li>● Review of relevant literature</li> <li>● Review of Roundtable jurisdictions practices and provincial jurisdictions</li> </ul>	<ul style="list-style-type: none"> <li>● Evaluation Branch</li> </ul>
Evaluation Objective: Unintended Findings The extent to which the Initiative created any unintended positive and/or negative outcomes			
Evaluation Question	Performance Indicator	Source	Responsibility
1. Have there been any other impacts or effects resulting from the initiative?	<ul style="list-style-type: none"> <li>● Views of senior management, staff, offenders, community stakeholders regarding any unintended impacts</li> </ul>	<ul style="list-style-type: none"> <li>● Survey of staff and community stakeholders</li> <li>● Interviews with offenders</li> <li>● Review of documents and files</li> </ul>	<ul style="list-style-type: none"> <li>● Evaluation Branch</li> </ul>



## Appendix B: CSC's Community Mental Health Initiative Logic Model



## Appendix C: Themes from Open-Ended Questions Survey and Interview Questions

### General Notes:

- This Appendix provides information regarding themes from open-ended survey questions. Responses to dichotomous (yes-no) and rating scale questions are reported in the text of the document.
- Percentages were calculated using total number of respondents who had the opportunity to respond to the question.
- Note that total percentages may not sum to 100% since multiple themes were noted by individual respondents.
- Note that only responses to questions where clear themes emerged relevant to the evaluation questions are listed here. In some cases, few responses were generated by interviewees or survey respondents, or no clear themes emerged based on the responses that were generated. Thus, some questions may not be shown here due to lack of clear emerging themes.

### Themes from Staff Surveys

#### Design and Implementation

**If there were offenders who did not receive services (if you responded 2-4 in Question B2), why not (please indicate all that apply)? Other response.**

Theme	Staff ( <i>n</i> = 49)
Referrals for services were not being made/offenders not identified for services	18 (36.7%)
Referrals were made but services were not available (e.g., no staff in position)	9 (18.4%)
Staff members are unclear of roles and responsibilities of CMHI staff/unfamiliar with services offered through CMHI (e.g., had not received sufficient information about the CMHI to utilize the service)	5 (10.2%)

**Please explain why you feel offenders are not attending mental health interventions/services to which they were referred**

Theme	Staff ( <i>n</i> = 25)
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Offenders don't want services, don't think they need them, or refuse to participate in treatment	11 (44.0%)
Lack of supports/services in the community	5 (20.0%)

**Please explain why you feel offenders are not being referred to community-based services for mental health interventions**

Theme	Staff (n = 43)
Lack of services/resources in place for offenders	12 (27.9%)
Staff are unfamiliar with/not aware of the services of the CMHI	6 (14.0%)
Lack of communication/consultation with CMHI staff	4 (9.3%)
CMHI service is not available at the site/position not staffed so referrals cannot were not made	4 (9.3%)
Offenders not being identified/inclusion criteria excludes offenders who are not diagnosed	3 (7.0%)

**According to the guidelines, referral to discharge planners should occur within 9 months of offender's scheduled release. If you indicated that that 9- month target is not appropriate, please explain why.**

Theme	Staff (n = 71)
Timeframe too short (Total):	38 (55.5%)
a) General statement that timeframe is too short (k=11)	
b) Need more time to address/meet the needs (k=10)	
c) Waitlists for programs may be long (k=3)	
d) Need more time to build rapport (k=4)	
Timeframe too long (Total)	22 (31.0%)
a) General statement that timeframe is too long (k=9)	
b) Offenders' needs change over time (k=7)	
c) Services cannot be arranged so far in advance/opportunities or availability of services may change (k=6)	
Process should begin at institutional intake	8 (11.3%)

**How many months prior to release should referral for clinical discharge planning be initiated?**

Theme	Staff (n = 71)
0 – 4 months	18 (25.4%)
5 – 9 months	14 (19.7%)
10 -14 months	20 (28.2%)
15 or more months (max of 2 years)	9 (12.7%)

**According to the guidelines, referral to community mental health specialists by Community Parole Officers should occur within 24 hours of the offender’s release. If you feel this timeframe is not appropriate, please explain why.**

Theme	Staff (n = 133)
More work needs to be completed prior to release/referral should occur prior to release	49 (36.8%)
More time is needed for PO to complete the necessary work (e.g., to ensure continuum of care, improve integration, build rapport; insufficient time)	36 (27.1%)
Staff scheduling conflicts that do not permit referral within the timeframe (e.g., releases on Friday/pre-weekend; PO away)	14 (10.5%)
General comment indicating timeline is unrealistic or unreasonable	10 (7.5%)
Shortage of services; backlogs/waitlists for services or appointments	9 (6.8%)

**When should referrals to the community mental health specialists occur (e.g., 1 week prior to release, at release, within 1 week of release)?**

Theme	Staff (n = 133)
Prior to release	59 (44.4%)
1 week before (k=25)	
From 1 to 4 weeks (k=17)	
Over 4 weeks (k = 5)	
Non-specific (k= 12)	
Within 1 week after release	27 (20.3%)
Between 1 week after release and 1 month	11 (8.3%)

**If you are aware of mechanisms/procedures in place for Community Mental Health Specialists to facilitate the continuity of care/services for offenders after sentence completion (i.e., after WED), please describe them and indicate whether they are adequate**

Theme	Staff (n = 65)
Contact with/refer to non-governmental community-based providers (e.g., Canadian Mental Health Association, psychiatrists, hospitals) before WED to ensure services will be available after WED	29 (44.6%)
Contact/refer to government agencies/departments (e.g., provincial health, Social Services)	10 (15.4%)

**Please describe any suggestions that you have to facilitate continuity of care/services after sentence completion**

Theme	Staff (n = 218)
Refer offenders to service providers who can provide services after WED (e.g., provincial mental health) or arrange appointments/case conferences with agencies involved in post-WED care	46 (21.1%)
CSC/CMHI staff provide follow-up for a short-term/long-term/temporary basis or as needed	19 (8.7%)
Pre-WED planning (non-specific)	12 (5.5%)
Develop partnerships/MOU/agreement/information sharing with service providers (government or non-government) to provide services beyond WED	11 (5.0%)

**Unintended Outcomes**

**Is there anything about the Community Mental Health Initiative that you feel could be changed to improve the correctional outcomes for offenders participating in the initiative? If yes, briefly describe.**

Theme	Staff (n = 212)
Staffing issues:	46 (21.7%)
a) General comment to increase staff (k=9)	
b) Hire more discharge planners (k=9)	
c) Hire more community mental health specialists (i.e., nurses and clinical social workers) (k=8)	
d) Hire more psychologists/psychiatrists (k=7)	
e) Improve recruitment and retention of qualified personnel (e.g., permanent positions rather than contract; competitive salary) (k=13)	

Improve communication, information-sharing, and collaboration between institutional staff and community staff (e.g., correctional and mental health staff)	43 (20.3%)
Increase services	31 (14.6%)
a) Increase funding/resources (non-specific) (k=19)	
b) Expand CMHI services into other/rural areas (k=12)	
Provide/increase general mental health training to CSC staff members (e.g., so that staff members can recognize mental health symptoms; reduce stigma; increase awareness)	29 (13.7%)
Develop partnerships/establish contracts with community mental health care providers and other service agencies	23 (10.8%)
Provide training/information session/workshops about the CMHI (e.g., CMHI staff roles and responsibilities)	18 (8.5%)
Inclusion criteria is too restrictive; OMDs without diagnoses but nonetheless require mental health services cannot access the needed services/resources	12 (5.7%)
There is a need for post-WED planning to ensure that offenders have access to services beyond WED	12 (5.7%)
More timely referrals/earlier referrals to discharge planning services	12 (5.7%)
Changes to reporting practices (e.g., reduce paperwork, reduce repetition in reports)	7 (3.3%)

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**Please describe lessons learned and best practices in the implementation of the Community Mental Health Initiative**

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Theme	Staff ( <i>n</i> = 526)
Increase communication and collaboration among the parties involved in offender case management	32 (6.1%)
Staffing was a challenging process (e.g., timely staffing, clear roles and job descriptions)	15 (2.9%)
Services for special populations (e.g., women and Aboriginal offenders and offenders with FASD) and in rural areas need to be improved/increased	13 (2.5%)
Discharge planning needs to start early in the process and should include community staff	12 (2.3%)
Provide training/workshops about the CMHI (e.g., services provided, roles and responsibilities)	11 (2.1%)
Training and education on mental health issues is important/needs to be provided to staff	11 (2.1%)
Need to build community capacity/networks	9 (1.7%)
Consult with frontline staff on program design	6 (1.1%)
Too much paperwork; paperwork is repetitive/takes time away from provision of services; revise reporting format to facilitate case management/communication	6 (1.1%)
Importance of providing follow up	6 (1.1%)
Develop relationship with offender (e.g., advocacy, rapport)	5 (1.0%)

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**Is there anything else you would like to add?**

Theme	Staff ( <i>n</i> = 526)
Information sharing/communication among stakeholders involved in the management of offenders with mental disorders (e.g., POs, IMHT, CMHI, service providers); case conference/team approach	24 (4.6%)
Mental health education/training for CSC staff (k=17)	23 (4.4%)
a) Correctional officers (k=1)	
b) Other institutional staff (k=1)	
c) Cross-training (k=4)	
Increase funding/resources in the community (including Community Mental Health Specialists); increase community capacity/collaboration with community service providers	19 (3.6%)
Program needs to be continued/funded/expanded/increased to other sites	18 (3.4%)
Difficulties in staffing (e.g., positions not staffed, delay, permanent positions)	13 (2.5%)
Increase mental health resources and services in the institutions	13(2.5%)
Training/workshop on the CMHI (e.g., services provided, roles and responsibilities, procedures)	9 (1.7%)

## Themes from Offender Interviews

### Overall Experience

**In your opinion, do you think the services you have received within the Community Mental Health Initiative have helped you to be able to live successfully in the community?**

Theme	Offenders (n=33)
Negative	
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Positive	
Staff help me to gain access to specific services (e.g., housing, counselling, programs)	4 (12.1%)
Staff provide support/monitoring (non-specific)	9 (27.3%)

**What was the most helpful aspect of the Community Mental Health Initiative?**

Theme	Offenders (n=33)
Staff provided support (non-specific)	18 (54.5%)
Staff members helped me get access to medication/medication information	7 (21.2%)
Staff members helped me obtain basic necessities (e.g., housing, transportation, identification)	6 (18.2%)

**Overall, to what extent do you feel that you have all the needed services in place for you once you reach the end of your sentence?**

Theme	Offenders (n=33)
Needed services are in place	7 (21.2%)
Concerned about having access to services after warrant expiry (WED)	5 (15.2%)

**Would you recommend the services you have received within the Community Mental Health Initiative to a friend?**

Theme	Offenders (n=33)
Yes	
Can be beneficial/helpful (non-specific)	15 (45.5%)
CMHI facilitates access to services (e.g., faster, less stressful)	5 (15.2%)

## Themes from Community-Based Service Provider Surveys

### Relevance

#### Specify other need addresses by your organization

Theme	Community Service Providers ( <i>n</i> = 6)
Personal support (e.g., provide assistance in personal management skills and personal care)	4 (67%)

### Design and Implementation

#### Explain why you feel the right offenders are not being identified

Theme	Community Service Providers ( <i>n</i> = 3)
Criteria for inclusion/requirement of diagnosis excludes offenders who still require help	3 (100%)

#### Describe strategies that may be useful in overcoming these implementation challenges

Theme	Community Service Providers ( <i>n</i> = 14)
Increase communication between case management staff and community service providers (e.g., include providers in case management meetings)	4 (29%)

## Success

### Describe the process involved in continuing services to federal offenders after WED

Theme	Community Service Providers ( <i>n</i> = 10)
Request as needed/apply	6 (60%)
Refer to other service providers	2 (20%)

### Describe changes to services provided to federal offenders after they have completed their community supervision

Theme	Community Service Providers ( <i>n</i> = 5)
CSC does not fund services beyond WED	3 (60%)

## Unintended Outcomes

### Describe changes to the CMHI that could improve correctional outcomes of offenders

Theme	Community Service Providers ( <i>n</i> = 14)
Increase funding/services	4 (29%)
Ensure services are available after WED	2 (14%)

### Describe changes to CMHI that could improve the mental health outcomes of CMHI offenders

Theme	Community Service Providers ( <i>n</i> = 14)
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Increase funding/services	3 (21%)
Increase participation of community service provider in case management meetings	2 (14%)

**Describe lessons learned and best practices in the implementation of the CMHI**

Theme	Community Service Providers ( <i>n</i> = 14)
Team approach to managing these offenders	6 (43%)

## Appendix D: Referral Profiles from RPC Implementation Report #2

**Table D1: Profile of all offenders referred for CDP service by Region**

	National (N = 242)	Atlantic (N = 55)	Ontario (N = 9)	Pacific (N = 38)	Prairies (N = 125)	Quebec (N = 15)
<b>Demographic Variables</b>						
Age at Referral – Years	33.8	33.2	40.7	36.2	32.3	37.4
% (n) Gender – Male	86 (208)	75 (41)	100 (9)	87 (33)	89 (111)	93 (14)
% (n) Race – Aboriginal	35 (85)	9 (5)	11 (1)	40 (15)	50 (63)	7 (1)
% (n) Missing	1 (3)	2 (1)	0	0	2 (2)	0
<b>Criminal History &amp; Risk Variables</b>						
% (n) Alerts/Flags/Needs – Yes	71 (172)	76 (42)	100 (9)	53 (20)	74 (92)	60 (9)
% (n) Missing	13 (32)	9 (5)	0	11 (4)	16 (20)	20 (3)
<b>Reintegration Potential</b>						
% (n) High	10 (25)	20 (11)	0	3 (1)	9 (11)	13 (2)
% (n) Medium	31 (74)	38 (21)	56 (5)	26 (10)	29 (36)	13 (2)
% (n) Low	48 (115)	35 (19)	33 (3)	61 (23)	50 (62)	53 (8)
% (n) Missing Data	12 (28)	7 (4)	11 (1)	11 (4)	13 (16)	20 (3)
<b>Type of Offence</b>						
% (n) Schedule I	66 (159)	62 (34)	67 (6)	68 (26)	66 (82)	73 (11)
Provincial	0.4 (1)	2 (1)	0	0	0	0
% (n) Schedule II	7 (16)	11 (6)	0	3 (1)	6 (8)	7(1)
Provincial	0.4 (1)	2 (1)	0	0	0	0
% (n) Other	27 (65)	24 (13)	33 (3)	29 (11)	28 (35)	20 (3)
% (n) Dangerous Offender or Lifer	14 (34)	0	0	0	27 (34)	0
Mean Sentence Length – Years	3.9	3.9	3.7	4.3	3.8	3.7
<b>Offender Security Level</b>						
% (n) Maximum	23 (55)	26 (14)	0	50 (19)	15 (19)	20 (3)
% (n) Medium	54 (130)	53 (29)	100 (9)	50 (19)	52 (65)	53 (8)

% (n) Minimum	13 (31)	18 (10)	0	0	16 (20)	7 (1)
% (n) Missing Data	11 (26)	4 (2)	0	0	17 (21)	20 (3)
CMHI Referral Criteria						
% (n) Major Mental Disorders (MMD)*	62 (149)	67 (37)	78 (7)	66 (25)	63 (79)	7 (1)
% (n) Schizophrenia/Other Psychotic Disorder	18 (44)	7 (4)	22 (2)	13 (5)	26 (33)	0
% (n) Mood Disorders	36 (86)	27 (15)	56 (5)	53 (20)	36 (45)	7 (1)
% (n) Other (e.g., PTSD, OCD)	19 (46)	42 (23)	0	13 (5)	14 (18)	0
% (n) PD with Functional Impairment	18 (44)	27 (15)	11 (1)	50 (19)	6 (8)	7 (1)
% (n) Acquired Brain Injury/Organic Brain Dysfunction	16 (39)	9 (5)	0	21 (8)	21 (26)	0
% (n) Developmental Disability/Intellectual Impairment	9 (21)	11 (6)	11 (1)	5 (2)	10 (12)	0
% (n) History of Substance Abuse	69 (166)	55 (30)	67 (6)	79 (30)	79 (99)	7 (1)

\*Note: The categories of MMD do not add up to 100% due to co-morbidity.

**Table D2: Profile of all offenders referred for CMHS services by region**

	National (N = 288)	Atlantic (N = 76)	Ontario (N = 53)	Pacific (N = 59)	Prairies (N = 86)	Quebec (N = 14)
<b>Demographic Variables</b>						
Age at Referral – Years	36.5	35.6	40.2	36.5	34.7	38.0
% (n) Gender – Male	85 (246)	78 (59)	98 (52)	85 (50)	85 (73)	86 (12)
% (n) Race – Aboriginal	23 (66)	3 (2)	25 (13)	29 (17)	40 (34)	0
<b>Criminal History &amp; Risk Variables</b>						
% (n) Alerts/Flags/Needs – Yes	71 (203)	68 (52)	81 (43)	78 (46)	59 (51)	79 (11)
% (n) Missing	9 (25)	8 (6)	13 (7)	2 (1)	9 (8)	21 (3)
<b>Reintegration Potential</b>						
% (n) High	17 (49)	22 (17)	4 (2)	17 (10)	22 (19)	7 (1)
% (n) Medium	41 (117)	42 (32)	23 (12)	51 (30)	42 (36)	50 (7)
% (n) Low	36 (103)	30 (23)	74 (39)	29 (17)	22 (19)	36 (5)
% (n) Missing Data	7 (19)	5 (4)	0	3 (2)	14 (12)	7 (1)
<b>Type of Offence</b>						
% (n) Schedule I	63 (182)	63 (48)	77 (41)	54 (32)	56 (48)	93 (13)
Provincial	1 (3)	0	0	5 (3)	0	0
% (n) Schedule II	7 (19)	5 (4)	0	8 (5)	11 (9)	7 (1)
% (n) Other	28 (80)	32 (24)	23 (12)	32 (19)	29 (25)	0
% (n) Missing Data	1 (4)	0	0	0	5 (4)	0
% (n) Dangerous Offender or Lifer	8 (24)	0	0	12 (7)	19 (16)	7 (1)
Mean Sentence Length – Years	5.1	3.8	3.6	6.9	5.6	6.3
<b>Offender Security Level</b>						
% (n) Maximum	12 (35)	18 (14)	19 (10)	10 (6)	5 (4)	7 (1)
% (n) Medium	61 (175)	50 (38)	70 (37)	64 (38)	61 (52)	71 (10)
% (n) Minimum	19 (55)	26 (20)	8 (4)	15 (9)	22 (19)	21 (3)
% (n) Provincial	1 (3)	1 (1)	0	3 (2)	0	0
% (n) Missing Data	7 (20)	4 (3)	4 (2)	7 (4)	13 (11)	0
<b>CMHI Referral Criteria</b>						
% (n) Major Mental Disorders (MMD)	60 (174)	70 (53)	47 (25)	61 (36)	59 (51)	64 (9)
% (n) Schizophrenia/Other Psychotic Disorder	18 (51)	5 (4)	25 (13)	24 (14)	19 (16)	29 (4)

% (n) Mood Disorders	29 (84)	41 (31)	19 (10)	31 (18)	26 (22)	21 (3)
% (n) Other (e.g., PTSD,OCD)	21 (60)	34 (26)	6 (3)	14 (8)	24 (21)	14 (2)
% (n) PD with Functional Impairment	15 (42)	17 (13)	15 (8)	12 (7)	15 (13)	7 (1)
% (n) Missing Data	0.3 (1)	0	0	0	0	7 (1)
% (n) Acquired Brain Injury/Organic Brain Dysfunction	15 (43)	12 (9)	8 (4)	25 (15)	17 (15)	0
% (n) Developmental Disability/ Intellectual Impairment	10 (29)	13 (10)	17 (9)	7 (4)	7 (6)	0
% (n) History of Substance Abuse	74 (213)	80 (61)	62 (33)	78 (46)	76 (65)	57 (8)

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**Table D3: Number, status and timeliness of CMHI referrals for CDP services by race and gender**

	Total	By Race			By Gender	
		Aboriginal	Non-Aboriginal	Missing Data	Male	Female
Total # Referrals	530	151	376	3	454	76
Clinical Discharge Planning (CDP)						
# Referrals	242	85	154	3	208	34
% (n) Accepted	73 (176)	78 (66)	70 (108)	67 (2)	72 (149)	79 (27)
% (n) Commence 1 Month*	80 (141)	79 (52)	81 (88)	50 (1)	78 (116)	93 (25)
% (n) Waitlist	14 (25)	18 (12)	11 (12)	50 (1)	16 (24)	4 (1)
% (n) Missing Data	6 (10)	3 (2)	7 (8)	0	6 (9)	4 (1)
% (n) Not Accepted	14 (34)	12 (10)	15 (23)	33 (1)	15 (31)	9 (3)
% (n) Does Not Meet Criteria	47 (16)	60 (6)	39 (9)	100 (1)	52 (16)	0
% (n) Offender Refused	12 (4)	20 (2)	9 (2)	0	13 (4)	0
% (n) Resources Available at Destination	3 (1)	0	4 (1)	0	3 (1)	0
% (n) Short Turnaround	32 (11)	10 (1)	43 (10)	0	26 (8)	100 (3)
% (n) Supports Available in Community	3 (1)	0	4 (1)	0	3 (1)	0
% (n) Remanded to Custody on Release	3 (1)	10 (1)	0	0	3 (1)	0
% (n) Missing Data	13 (32)	11 (9)	15 (23)	0	14 (28)	12 (4)
Mean Time to Anticipated Release When Referred – Months (n)	5.0 (239)	5.6 (84)	4.7 (152)	4.9 (3)	5.3 (205)	3.6 (34)

\*Includes categories ‘commence as soon as possible’, ‘commenced’, and ‘plan to commence within one month’.

**Table D4: Number and status of CMHI referrals for CMHS services by race and gender**

	Total	By Race		By Gender	
		Aboriginal	Non-Aboriginal	Male	Female
<b>Community Mental Health Specialist (CMHS) Services</b>					
# Referrals	288	66	222	246	42
% (n) Accepted	66 (190)	68 (45)	65 (145)	66 (162)	67 (28)
% (n) Commence 1 Month	75 (143)	71 (32)	77 (111)	74 (120)	82 (23)
% (n) Waitlist	5 (9)	2 (1)	6 (8)	5 (8)	4 (1)
% (n) Offender UAL	0.5 (1)	2 (1)	0	1 (1)	0
% (n) Missing Data	20 (37)	24 (11)	18 (26)	20 (33)	14 (4)
% (n) Not Accepted	20 (57)	24 (16)	18 (41)	21 (51)	14 (6)
% (n) Does not Meet Criteria	42 (24)	31 (5)	46 (19)	45 (23)	17 (1)
% (n) Offender Refused Services	14 (8)	25 (4)	10 (4)	16 (8)	0
% (n) Offender UAL	7 (4)	19 (3)	2 (1)	4 (2)	33 (2)
% (n) Other	33 (19)	25 (4)	37 (15)	33 (17)	33 (2)
% (n) Missing Data	4 (2)	0	5 (2)	2 (1)	17 (1)
% (n) Pending	0.3 (1)	0	0.5 (1)	0.4 (1)	0
% (n) Missing Data	14 (40)	8 (5)	16 (35)	13 (32)	19 (8)

## Appendix E: Mental Health Training and Results

**Table a: Percentage of participants with relative improvement from the post-quiz relative to the pre-quiz.**

	Same score on post (Improvement Possible)	Same score on post (Improvement Not Possible)	Better score on post
Axis I of the DSM IV is used to classify which area of conditions? (1 point)	4.87% ( <i>n</i> = 30)	69.48% ( <i>n</i> = 428)	19.8% ( <i>n</i> = 122)
List three positive symptoms of Schizophrenia. (3 points)	4.55% ( <i>n</i> = 28)	16.23% ( <i>n</i> = 100)	76.3% ( <i>n</i> = 470)
In general, offenders with mental disorders are more violent than offenders without mental disorders. (1 point)	1.95% ( <i>n</i> = 12)	81.01% ( <i>n</i> = 499)	14.0% ( <i>n</i> = 86)
Identify how the Recovery Model is different from the Medical Model. (1 point)	16.23% ( <i>n</i> = 100)	25.97% ( <i>n</i> = 160)	55.5% ( <i>n</i> = 342)
List two treatments for Bi Polar Disorder. (2 points)	2.27% ( <i>n</i> = 14)	58.76% ( <i>n</i> = 362)	33.2% ( <i>n</i> = 204)
In North America, mental disorders are categorized in a manual called the _____. (1 point)	3.41% ( <i>n</i> = 21)	71.75% ( <i>n</i> = 442)	24.7% ( <i>n</i> = 152)
A fear of abandonment, impulsiveness, and reactive mood are key characteristics of which personality disorder? (1 point)	7.80% ( <i>n</i> = 48)	65.20% ( <i>n</i> = 401)	23.1% ( <i>n</i> = 142)
Name three key potential side effects of psychotropic medications. (3 points)	8.12% ( <i>n</i> = 50)	28.08% ( <i>n</i> = 173)	55.5% ( <i>n</i> = 342)
Name three effective strategies for working with an offender with FASD. (3 points)	10.88% ( <i>n</i> = 67)	18.83% ( <i>n</i> = 116)	65.8% ( <i>n</i> = 405)
Suicide rates for offenders are similar to those of the general population. (1 points)	1.79% ( <i>n</i> = 11)	76.62% ( <i>n</i> = 472)	17.2% ( <i>n</i> = 106)
Total Score	3.73% ( <i>n</i> = 23)	0.16% ( <i>n</i> = 1)	93.18% ( <i>n</i> = 574)

Note: The percentage of participants who received a lower score on the post-quiz relative to the pre-quiz was also calculated. The following values correspond to each question respectively: 5.4% (*n* = 29), 2.8% (*n* = 16), 3.0% (*n* = 16), 2.0% (*n* = 11), 6.5% (*n* = 35), 0.2% (*n* = 1), 3.9% (*n* = 21), 8.9% (*n* = 48), 5.0% (*n* = 27), 3.7% (*n* = 20). It should be noted that there may be several explanations for lower post-quiz scores including the stringent scoring criteria used to maintain consistency in data; the marking scheme was derived from the selection of responses within the participant manual and is not all inclusive. The tests were marked by non-clinical staff at NHQ (and not the trainers), who would not be aware of other “correct” responses discussed during training but not included within the scoring guide.

**Table b: Average pre-and post-training self perceived competency ratings**

Question	Training Package	Pre mean score	Post mean score	Difference
I have the knowledge to work effectively with offenders with mental disorders.	All ( <i>n</i> = 588)	3.74	5.13	1.39**
	Generic ( <i>n</i> = 396)	3.60	5.01	1.41**
	Women's ( <i>n</i> = 133)	3.77	5.20	1.43**
	TtT ( <i>n</i> = 59)	4.54	5.76	1.22**
I have the skills and abilities to work effectively with offenders with mental disorders.	All ( <i>n</i> = 587)	3.92	5.04	1.12**
	Generic ( <i>n</i> = 395)	3.79	4.94	1.15**
	Women's ( <i>n</i> = 133)	3.99	5.08	1.08**
	TtT ( <i>n</i> = 59)	4.64	5.59	0.95**
I am confident that my approach to working with offenders with mental disorders is based on "realities" of mental disorders rather than "myths".	All ( <i>n</i> = 585)	4.36	5.56	1.20**
	Generic ( <i>n</i> = 394)	4.24	5.41	1.17**
	Women's ( <i>n</i> = 132)	4.45	5.75	1.30**
	TtT ( <i>n</i> = 59)	5.00	6.12	1.12**
I have the received the necessary training to prepare me to work in my position with offenders with mental disorders.	All ( <i>n</i> = 586)	3.29	5.09	1.80**
	Generic ( <i>n</i> = 394)	3.13	4.98	1.85**
	Women's ( <i>n</i> = 133)	3.41	5.14	1.74**
	TtT ( <i>n</i> = 59)	4.10	5.73	1.63**
I am informed about legislation and CSC initiatives that impact my ability to work with offenders with mental disorders.	All ( <i>n</i> = 579)	3.45	5.27	1.82**
	Generic ( <i>n</i> = 388)	3.37	5.30	1.93**
	Women's ( <i>n</i> = 132)	3.33	5.10	1.77**
	TtT ( <i>n</i> = 59)	4.25	5.42	1.17**
I am aware of specific considerations for working with special populations (women offenders, Aboriginal offenders).	All ( <i>n</i> = 583)	4.17	5.15	0.98**
	Generic ( <i>n</i> = 393)	4.07	5.03	0.96**
	Women's ( <i>n</i> = 132)	4.35	5.47	1.12**
	TtT ( <i>n</i> = 58)	4.47	5.28	0.81*
I have the skills to recognize symptoms suggestive of the need for intervention by a mental health professional.	All ( <i>n</i> = 585)	4.46	5.47	1.01**
	Generic ( <i>n</i> = 393)	4.29	5.32	1.03**
	Women's ( <i>n</i> = 133)	4.71	5.66	0.95**
	TtT ( <i>n</i> = 59)	4.97	6.03	1.07**
I am able to support offenders with mental disorders by consulting and collaborating with mental health professionals, community resources, and families.	All ( <i>n</i> = 582)	4.91	5.59	0.67**
	Generic ( <i>n</i> = 390)	4.81	5.47	0.66**
	Women's ( <i>n</i> = 133)	4.98	5.70	0.72**
	TtT ( <i>n</i> = 59)	5.46	6.12	0.66*

\**p* < .01, \*\* *p* < .001

## Appendix F: Recidivism - Additional Data and Analyses

### Descriptive Statistics

**Table a: Suspension and Revocation Summary Statistics**

Suspensions and Revocations	CDP (n =53)	CMHS (n = 79)	Comparison Group (n =95)
	Mean (SD)		
Length of Supervised Follow-Up Time (months) <sup>a</sup>	6.4 (2.9)*	8.4 (3.8)*	14.0 (9.9)
Time to 1st Suspension (months) <sup>b</sup>	0.9 (1.1)	2.5 (2.2)	2.4 (3.3)
Time to 1st Revocation (months) <sup>b</sup>	3.8 (1.5)	5.1 (1.8)	5.5 (3.6)
	n (%)		
Number of offenders released to community supervision <sup>a</sup>	43	79	80
Suspended	31 (72.1%)	46 (58.2%)	58 (72.5%)
Revoked	20 (46.5%)	19 (24.1%)	45 (56.2%)
Revocation without Chrg/Off <sup>c</sup>	14 (70.0%)	14 (73.7%)	34 (75.6%)
Revocation with Chrg/Off <sup>c</sup>	6 (30.0%)	5 (26.3%)	11 (24.4%)

Notes:

- 1) Table reproduced from CSC (2008, October), Community Mental Health Initiative (CMHI) Outcome Evaluations: Preliminary Post-Implementation Report, p. 19.
- 2) <sup>a</sup> Outcome follow up is based on: (1) CDP group – 1st release following most recent referral to CDP, (2) CMHS group – closest release to referral date, if the release is prior to the referral date, the referral date is used, (3) CMHI-Comp – 1st release following 1st eligibility date between 2003 and 2005.
- 3) <sup>b</sup> Mean for time to first suspension and revocation is based on the number of individuals suspended or revoked.
- 4) <sup>c</sup> Percentage calculated based on the number of offenders revoked.

**Table b: Correctional Outcomes for the CDP, CMHS and CMHI Comparison Groups by Gender**

Suspensions and Revocations	CDP Accepted Referrals (n =53)		CMHS Accepted Referrals (n = 79)		CMHI Comparison Group (n =95)	
	Male (n= 42)	Female (n =11)	Male (n =64)	Female (n =15)	Male (n =85)	Female (n =10)
Supervised Follow-Up Time (months) ‡	6.1(3.0)	7.9(2.2)	8.5(3.9)	7.9(3.6)	14.4(10.4)	11.3(5.1)
Time to 1st Suspension (months)†	0.9(1.1)	1.3(1.0)	2.5(2.4)	2.7(1.4)	2.6(3.5)	1.1(1.1)
Time to 1st Revocation (months)†	3.7(1.6)	4.2(0.7)	5.0(1.9)	5.8(0.9)	5.5(3.8)	5.3(1.7)

	Number (%)					
	35	8	64	15	71	9
# on Any Supervised Release during Follow-Up‡:						
Suspended	26(74.3%)	5(62.5%)	38(59.4%)	8(53.3%)	50(70.4%)	8(88.9%)
Revoked	18(51.4%)	2(25.0%)	16(25.0%)	3(20.0%)	39(54.9%)	6(66.7%)
Revocation without Chrg/Off††	12(66.7%)	2(100%)	12(75.0%)	2(66.7%)	29(74.4%)	5(83.3%)
Revocation with Chrg/Off††	6(33.3%)	0(0%)	4(25.0%)	1(33.3%)	10(25.6%)	1(16.7%)

Notes:

1) Table reproduced from Table 3 of CSC (2008, October), Community Mental Health Initiative (CMHI) outcome evaluations: Preliminary post-implementation report

2) ‡Outcome follow-up is based on: 1) CDP group – 1<sup>st</sup> release following most recent referral to CDP, 2) CMHS group – closest release to referral date, if the release is prior to the referral date, the referral date is used, 3) CMHI-Comp – 1<sup>st</sup> release following 1<sup>st</sup> eligibility date between 2003 and 2005. †Mean for time to first suspension and revocation is based on the number of individuals suspended or revoked. ††Percentage calculated based on the number of offenders revoked.

**Table c: Correctional Outcomes for the CDP, CMHS and CMHI Comparison Groups by Race**

	CDP Accepted Referrals (n =53)		CMHS Accepted Referrals (n = 79)		CMHI Comparison Group (n =95)	
	Non- Aboriginal (n=30)	Aboriginal (n=23)	Non- Aboriginal (n=61)	Aboriginal (n=18)	Non- Aboriginal (n=79)	Aboriginal (n=16)
Suspensions and Revocations						
Supervised Follow-Up Time (months) ‡	5.8(3.0)	7.1(2.6)	8.4(3.8)	8.4(4.0)	13.7(8.5)	16.3(16.8)
Time to 1st Suspension (months) †	1.2(1.4)	0.7(0.7)	2.7(2.1)	2.1(2.6)	2.7(3.5)	1.0(1.3)
Time to 1st Revocation (months) †	4.0(1.6)	3.7(1.6)	5.5(1.7)	4.4(2.0)	5.9(3.9)	3.7(1.6)
	n (%)					
# on Any Supervised Release in Sentence‡:	24	19	61	18	69	11
Suspended	15(62.5%)	16(84.2%)	33(54.1%)	13(72.2%)	49(71.1%)	9(81.8%)
Revoked	8(33.3%)	12(63.2%)	13(21.3%)	6(33.3%)	36(52.2%)	9(81.8%)
Revocation without Chrg/Off††	5(62.5%)	9(75.0%)	9(69.2%)	5(83.3%)	28(77.8%)	6(66.7%)
Revocation with Chrg/Off††	3(37.5%)	3(25.0%)	4(30.8%)	1(16.7%)	8(22.2%)	3(33.3%)

Notes:

1) Table reproduced from Table 3 of CSC (2008, October), Community Mental Health Initiative (CMHI) outcome evaluations: Preliminary post-implementation report

2) ‡ Outcome follow-up is based on: 1) CDP group – 1<sup>st</sup> release following most recent referral to CDP, 2) CMHS group – closest release to referral date, if the release is prior to the referral date, the referral date is used, 3) CMHI-Comp – 1<sup>st</sup> release following 1<sup>st</sup> eligibility date between 2003 and 2005. † Mean for time to first suspension and revocation is based on the number of individuals suspended or revoked. †† Percentage calculated based on the number of offenders revoked.

**Table d: Mean Follow-up Times to Suspensions and Revocations for the Comparison, CDP, and CMHS Groups (only offenders with 6-month or shorter follow-up)**

	<i>N</i>	Mean in Months (SD)
Suspension		
Comparison	50	1.31a (1.39)
CDP	31	0.93a (1.12)
CMHS	42	2.01b (1.55)
Revocation		
Comparison	30	3.59 (1.19)
CDP	18	3.40 (1.05)
CMHS	13	4.18 (1.17)

Notes:

- 1) Post-hoc analyses using LSD.
- 2) For suspensions, comparison vs. CMHS group: mean difference = -0.70, standard error = 0.29,  $p = .017$ ; CDP vs. CMHS group: mean difference = -1.08, standard error = 0.33,  $p = .001$ .
- 3) For revocation, CDP vs. CMHS group: mean difference = -0.77, standard error = 0.42,  $p = .07$ .

## Cox Regression Analyses

### Suspension

**Table e. Cox regression analysis to examine whether survival is a function of group (CMHS, CDP, and comparison groups)**

	$\beta$	SE	Wald	df	Sig.	Odds ratio
Block 1						
Age at Release	-0.044	0.009	21.516	1	.000	0.957
Functional Impairment	0.059	0.040	2.216	1	.137	1.061
Reintegration Potential (high)	-	-	-	2	-	-
Reintegration Potential (low vs. high)	1.118	0.292	14.642	1	.000	3.060
Reintegration Potential (medium vs. high)	0.772	0.282	7.502	1	.006	2.165
Block 2						

Comparison	-	-	-	2	-	-
CDP vs. Comparison	0.143	0.229	0.391	1	.532	1.154
CMHS vs. Comparison	-0.409	0.202	4.085	1	.043	0.664

Note: The omnibus test of model coefficients found that group added significantly to the model after controlling for age at release, functional impairment, and reintegration potential,  $-2 \log \text{likelihood} = 1217.795$ , total model  $\chi^2(6) = 58.151$ ,  $p < .001$ . Change in  $\chi^2(2) = 6.756$ ,  $p = .034$ .

**Table f. Cox regression analysis to examine whether survival is a function of group (CDP and CMHS groups)**

	$\beta$	SE	Wald	df	Sig.	Odds ratio
Block 1						
Age at Release	-0.057	0.013	19.047	1	.000	0.945
Functional Impairment	0.062	0.051	1.490	1	.222	1.064
Reintegration Potential (high)	-	-	-	2	-	-
Reintegration Potential (low)	1.228	0.379	10.486	1	.001	3.414
Reintegration Potential (medium)	0.716	0.368	3.775	1	.052	2.046
Block 2						
Group a	0.550	0.239	5.300	1	.021	1.734

Note. a Group: 0 = CMHS and 1 = CDP

The odds ratio of 1.734 indicates that the CDP group is at a 1.734 odds of being suspended compared to the CMHS group. This means that the odds of the CMHS group being suspended compared to the CDP group is 0.577 (i.e.,  $1/1.734 = 0.577$ ). Therefore, the CMHS group is associated with a 42% (i.e.,  $1-0.577$ ) reduction in odds of suspension compared to the CDP group.

## Revocation

**Table g. Cox regression analysis to examine whether survival is a function of group (CMHS, CDP, and comparison groups)**

	$\beta$	SE	Wald	df	Sig.	Odds ratio
Block 1						
Age at Release	-0.031	0.012	6.491	1	.011	0.970
Functional Impairment	0.014	0.051	0.072	1	.788	1.014
Reintegration Potential	-	-	-	2	-	-

(high)						
Reintegration Potential	1.250	0.420	8.876	1	.003	3.490
(low)						
Reintegration Potential	1.143	0.405	7.958	1	.005	3.137
(medium)						
Block 2						
Comparison	-	-	-	2	-	-
CDP vs. Comparison	0.009	0.278	0.001	1	.975	1.009
CMHS vs. Comparison	-0.903	0.278	10.530	1	.001	0.406

Note: The omnibus test of model coefficients found that group added significantly to the model after controlling for age at release, functional impairment, and reintegration potential,  $-2 \log \text{likelihood} = 763.301$ , total model  $\chi^2(6) = 35.233$ ,  $p < .001$ . Change in  $\chi^2(2) = 13.379$ ,  $p = .001$ .

**Table h. Cox regression analysis to examine whether survival is a function of group (CDP and CMHS)**

	$\beta$	SE	Wald	df	Sig.	Odds ratio
Block 1						
Age at Release	-0.052	0.019	7.098	1	.008	0.950
Functional Impairment	0.081	0.075	1.144	1	.285	1.084
Reintegration Potential	-	-	-	2	-	-
(high)						
Reintegration Potential	0.769	0.580	1.760	1	.185	2.159
(low)						
Reintegration Potential	0.889	0.558	2.535	1	.111	2.432
(medium)						
Block 2						
Group a	0.907	0.333	7.394	1	.007	2.476

Note. a Group: 0 = CMHS and 1 = CDP.

The odds ratio of 2.476 indicates that the CDP group is at a 2.476 odds of being revoked compared to the CMHS group. This means that the odds of the CMHS group being revoked compared to the CDP group is 0.404 (i.e.,  $1/2.476 = 0.404$ ). Therefore, the CMHS group is associated with a 60% (i.e.,  $1-0.404$ ) reduction in odds of revocation compared to the CDP group.