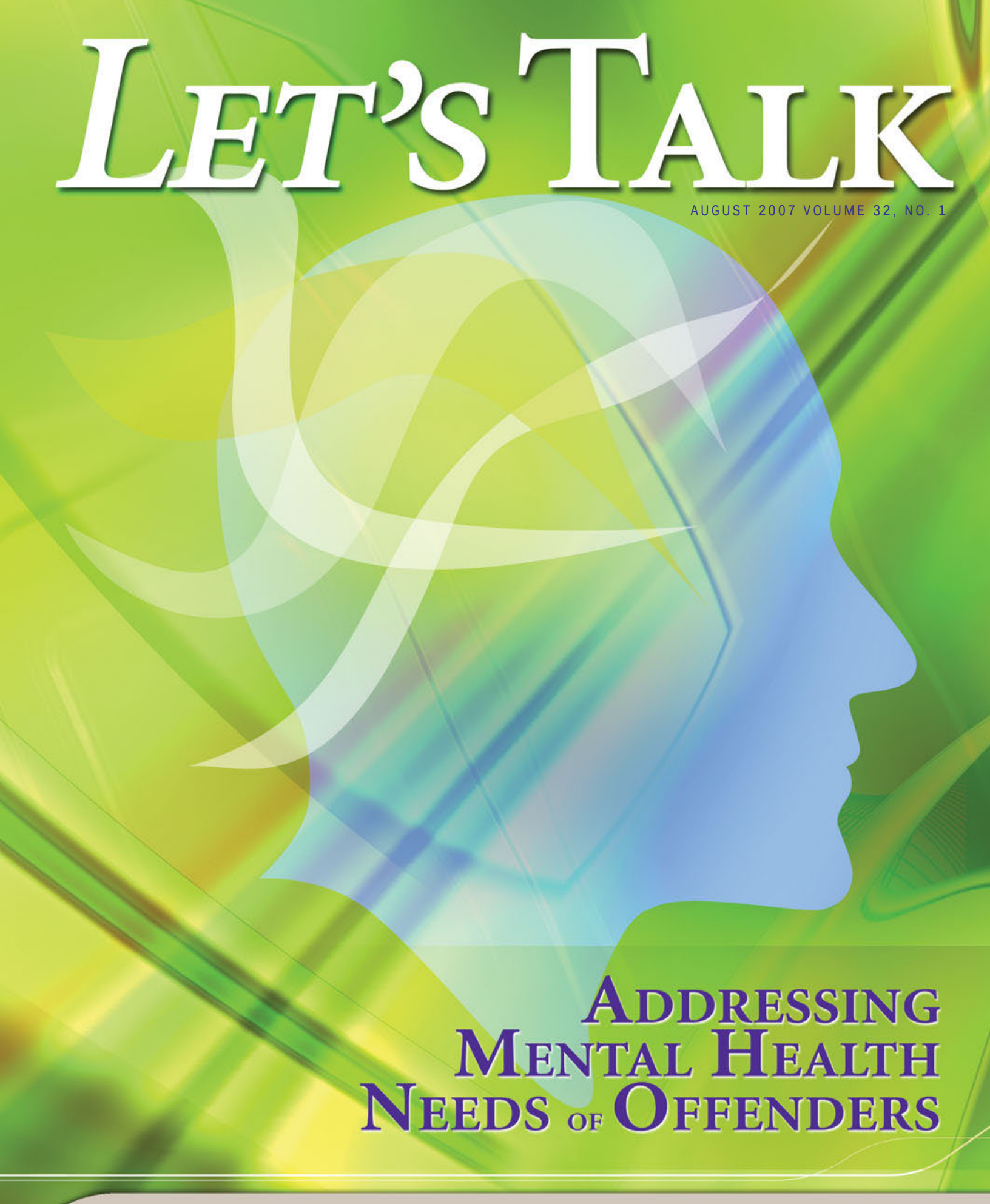
LET'S TALK

AUGUST 2007 VOLUME 32, NO. 1



ADDRESSING MENTAL HEALTH NEEDS OF OFFENDERS

Correctional Service Canada
Service correctionnel Canada

Canada

Contents

Let's Talk

AUGUST 2007 VOLUME 32, NO. 1

COVER

Illustration created by Gisele Richard and Doug Jackson from Accurate Design, to depict the complexity of the human mind and the ray of hope in unlocking its mysteries.

Over the last few years, CSC has witnessed an increase in the number of offenders with diagnosed mental disorders. As a result of this trend, CSC made it a priority to improve its capacity to provide a full-spectrum response to the broad and multidimensional mental health needs of offenders.

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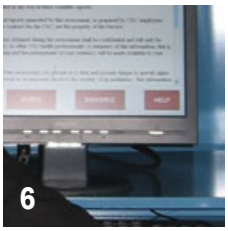

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Opinions expressed in the following articles do not necessarily reflect the views of the Commissioner.

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Addressing Mental Health Needs of Offenders

The key theme of this *Let's Talk* edition is CSC's work, and our results, in dealing with offenders who have mental health problems. The stark reality is that within only a decade, the increase in this offender population has escalated: a dramatic increase of 71 percent. And what that means for our organization and partners is that 12 percent of federal male offenders, and one in four federal women offenders have mental disorders.

That's why one of CSC's key priorities is to improve our capacity to address this issue. We are taking decisive action to implement a comprehensive mental health strategy that you'll read more about in this publication. You'll also get a closer look at some new tools to screen offenders when they first come into our system, so we can develop correctional plans that better meet their needs.

Having the right CSC people in the right places is another key element to meeting the challenges of offenders with mental health problems, so we are moving to implement a new internal governance structure that is needed to support and continually improve the quality of health services provided to inmates. The new structure will also help ensure that policies are applied consistently and that standardized practices will provide greater integration of physical and mental health services.

There is a direct link between how well we respond to the needs of offenders with mental disorders and keeping Canadian communities safe. Our dedicated and professional staff, as well as our many partners in corrections, make a real difference in helping these individuals, and thus in contributing to the public safety interests of all Canadians.

I hope you enjoy this important issue of *Let's Talk*, which I know will also help you to see how strongly linked this priority is to our other business priorities of safe transition to the community, staff and offender safety in our institutions, and working to narrow the gap of re-offending between Aboriginal and non-Aboriginal offenders.

Keith Coulter
Commissioner
Correctional Service of Canada

A Continuum of Care

CSC Launches a Comprehensive Mental Health Strategy

ADDRESSING MENTAL HEALTH NEEDS OF OFFENDERS

What happens when the criminal justice system becomes, by default, the health care system? For many offenders with mental health disorders, this is what has been happening in Canada over the past 10 years, due in large part to gaps in community-based mental health services.

In 1997, seven percent of male offenders coming into the federal correctional system were diagnosed as having a mental health problem. By 2007, the proportion had jumped to one in eight—a 71 percent increase. A similar rate of increase has been seen for women offenders, at least 25 percent of whom are now diagnosed as having mental health problems at the time they're admitted to federal institutions.

"In our communities, we have significant mental health needs that are not being met," says Dr. Françoise Bouchard, CSC's Director General of Health Services. "The result is a population that cannot adjust to society. Often, they end up breaking the law and being sent to prison."

The Challenge

But Dr. Bouchard notes that, once incarcerated, many offenders with mental health problems fail to receive the treatment they need because the system is not equipped to cope with the sheer numbers.

"Nevertheless, we have a legal obligation to provide essential health services to a professional standard for all offenders under our jurisdiction," she emphasizes.

"The other important element is that most of these offenders are released back into the community once they serve their sentence. If their mental health problems have not been addressed, either in the institution or in the community, they are more likely to breach their release conditions and end up back in prison."

Support for Change

A way out of this dilemma came two years ago, spurred by testimony, including CSC submissions, at the Kirby Senate Committee on mental health. The Committee's report, which devoted a chapter to offenders with mental health problems, galvanized support for a wide-ranging, five-pronged mental health strategy and substantial funding.

Dr. Françoise Bouchard, Director General of Health Services, CSC

The strategy, developed by Health Services in consultation with the regions, proposes a continuum of mental health services, from the time offenders arrive at an institution, to their release into the community.

Intake Screening and Assessment

The first element of the mental health strategy will involve voluntary screening of all offenders when they arrive at a regional reception centre. At present, the centres don't have the means to administer a battery of psychological tests to all new inmates. But this will soon change with the introduction of a standardized approach to screening at intake. (See article on p. 6.)

"Often, some people, if not being identified at intake, end up later being placed in segregation or in the special handling unit because of their underlying mental health condition," explains Dr. Bouchard. "Now, with the computerized mental health screening tool, we will have a way of assessing everyone who comes in, and be able to intervene earlier, so that offenders do not suffer needlessly from their illness and are better able to pursue their correctional plan."

Increased safety for prison staff, volunteers and other inmates is another expected benefit, she adds.

Systematic computerized screening is also expected to yield more accurate data on overall mental health needs, helping CSC make system-wide programming decisions.

Primary Care

The second element of the strategy is primary, or basic, mental health care in each institution. In principle, all CSC institutions are supposed to have mental health teams comprised of psychologists, psychiatric nurses, social workers and other professionals, such as psychiatrists or occupational therapists.

"The reality," says Dr. Bouchard, "is that we don't have these teams functioning on a regular basis in all our institutions because the staff is overwhelmed with crisis management. And often, our psychologists are busy with risk assessments — managing the risk that offenders present as opposed to their mental health condition."

This, too, will change with the creation of full-fledged mental health teams in a number of maximum and medium-security institutions.

"We don't want a situation where the only way one can access mental health services is by being referred to a treatment centre," says Dr. Bouchard. "We want to have the services right in the institution, as close as possible to the offender."

Making this happen will require training for the newly constituted teams, to orient them to best practices in correctional mental health. Correctional officers will also be trained to better understand signs and symptoms of mental illness so they can better interact with the inmates and know the signs whereby the best response would be a referral to the mental health team.

Intermediate Care

The third component of the strategy recognizes the fact that some mentally disordered offenders, while not requiring hospitalization in a treatment centre, need more structure than that offered by a regular institution. They need an accommodation unit, where they can still work on their correctional plan, but have the treatment and support they need to manage their illness.

"At present, many offenders with mental health disorders are mixed in with the general prison population, which exposes them to certain risks and does not allow the provision of more structured interventions," says Dr. Bouchard. "So, in each region, we're planning to establish intermediate health care units in some of our institutions."

Intensive Care — Regional Treatment Centres

The Regional Treatment Centres, designed to provide intensive care for offenders with acute mental disorders, such as schizophrenia, will also receive new resources under the mental health strategy, to help all five facilities either earn or maintain their accreditation as psychiatric hospitals, with standards comparable to those found in the community.

"In many cases, the staff-to-patient ratio is not up to par," says Dr. Bouchard. "So we need to standardize that, along with ensuring proper training of staff, consistent standards of care, and use of force that is adapted to mentally ill offenders."

With comprehensive screening of all offenders coming into the correctional system, CSC will also be better able to develop uniform criteria for admission to the treatment centres.

"We have never established standardized admission criteria," says Jane Laishes, Senior Manager, Mental Health Services, CSC national headquarters. "We need something that's consistent right across the country, so that an inmate can't say, 'Well, I was able to get that treatment out West and now I'm in Ontario and it's not available.'"

Transitional Care — Back into the Community

The fifth element of the strategy, CSC's Community Mental Health Initiative, is well under way, having been launched in 2005, with nearly $30 million in funding for a five-year period. (See *Let's Talk*, Vol. 30, No. 4 and this issue, p. 19.)

"What we had observed," says Ms. Laishes, "is that offenders who had mental health problems were the least likely to be released on parole. Often, we were unable to ensure continuity of care once they left the institution, which meant that these offenders would be on their own, with no community support."

"Better discharge planning, starting nine months before the offender's release date, along with specialized mental health staff in selected district parole offices, should make for a smoother and safer transition back into the community," says Ms. Laishes. The other key element will be CSC partnering with community service providers, to ensure mentally ill offenders continue to get the help they need when they are no longer on parole.

"Hopefully, we will end up with offenders who follow their treatment plan and there will be fewer problems in terms of breach of parole or behavioural dysfunction and safety issues within the community," says Ms. Laishes.

Setting Priorities: A Two-year Pilot

In 2006, Dr. Bouchard and her team consulted with the regions on the first four components of the strategy, to see if it reflected their needs. There was wide endorsement, and general agreement that the initial focus should be on intake assessment and primary mental health care.

CSC now has $21 million in funding for the next two years. The money will be directed towards the computerized screening project, recruitment, training, provision of services by primary care mental health teams, training correctional officers and improving in-patient care at the treatment centres.

With universal screening, it's estimated that up to 25 percent of new inmates will be flagged for further assessment and follow-up. Dr. Bouchard is confident that the organization will be able to address the predicted increase in demand for services.

"We have the resources. What we need to change now is our recognition of the problem and the way we treat mentally ill offenders," she says. "The mental health strategy has given us a direction for quite a few years. It shows we can do something right and do it well. Ultimately, everybody benefits if we can reduce the human suffering caused by mental illness — our staff and volunteers, offenders and their families, and the community at large."♦

Jane Laishes, Senior Manager, Mental Health Services, CSC National Headquarters

Senior Research Manager Dr. Andrew Harris

CSC to Launch Computerized Mental Health Screening

According to the 2006 Corrections and Conditional Release Statistical Overview, *10 percent of offenders are diagnosed as having a mental health disorder upon entering the federal correctional system. The same report shows that 20 percent of federal offenders are on prescribed psychiatric medication at the time of admission. "The discrepancy suggests that the system does not reliably count and follow individuals with mental health challenges," says Senior Research Manager Dr. Andrew Harris.*

Due to the stigma attached to mental illness throughout society, many inmates feel they have to hide their mental health problems upon admission. Offenders who are not screened and flagged for treatment can become disruptive, can be a threat to themselves and others, or, because they are left to cope on their own, in the regular prison population, they can be preyed on by other inmates.

"Finding out who has mental health problems at intake, so we can better respond to their needs, has always been a goal for CSC," says Dr. Harris. "But until recently, we didn't have the tools or the resources to screen everyone."

"Administering mental health assessments is a very time-consuming and expensive process, which makes it impractical for daily screening of large numbers of inmates," he explains.

Extensive consultations with regional staff led to Dr. Harris and his team developing a computerized mental health screening tool, to be pilot-tested in reception centres, over the next two years.

How It Works

All federal offenders arriving at a regional reception centre will be asked to sit down at a private computer station and spend 30 to 40 minutes completing a series of true or false and scale ("not at all", "a bit", "moderately", "a lot") questions. Participation is voluntary.

The tests have been used in correctional settings for some years and include what's known as the Brief Symptom Inventory of mental health indicators such as depression, anxiety, hostility, obsessive-compulsive disorder and paranoia, along with a depression, hopelessness and

suicide scale, developed within CSC. A third test, the Paulus Deception Scale, is a safeguard against faked responses.

Offenders who are unable to read the grade six-level questions can have them read aloud by the computer, in French or English. Plans are under way to add major Aboriginal and immigrant languages down the road, along with tests for personality disorders, Fetal Alcohol Spectrum Disorder and Attention Deficit Hyperactivity Disorder.

Project Manager Dr. Ron Frey, a clinical psychologist hired to oversee implementation of the screening tool, emphasizes there are checks and balances built into the process, to allow offenders to take a break when they need to or ask questions. "They're not just alone in a room with a computer," he says. "There will always be a clinician standing by, in case a question is disturbing to an inmate or brings back painful memories that might trigger a safety risk."

Further human contact will come in the form of a face-to-face interview with a psychologist, if necessary, after offenders complete the computerized tests. "In deciding whether an offender requires follow-up assessment, you cannot make decisions on test results alone," says Dr. Frey. "For example, in the case of Aboriginal offenders, you need to have a clinician who understands the culture of the individual sitting across from them so they can properly interpret the psychological tests results."

Results

Once offenders complete the screening process, the data will generate a report that goes to their confidential medical file. If the score exceeds a certain threshold, there will be an automatic referral to a psychologist for a full-blown assessment and therapy, if needed, including placement in a Regional Treatment Centre or other specialized facility.

"It's a more efficient use of our resources," says Dr. Frey, "to do customized assessments only on those offenders who have been flagged. On a system-wide level, the data we gather will also give us regional profiles of mental health needs and help us do a better job of treatment planning, including the right type of follow-up once a person is discharged into the community."

Having all the test results online also gets around the massive problem of data entry and the possibility of human error when punching in the data.

All test results will be uploaded to National Headquarters Research Branch, to be analyzed and will be used to inform programming decisions at all levels, as well as used in making the case for increased mental health resources. "Year-to-year variations in screening results will also allow CSC to respond to future needs," says Dr. Harris.

Similar screening tests are currently being piloted in the Pacific Region, with the difference that they are manually administered in the presence of a psychiatric nurse. Results from that project will be helpful in terms of estimating the nationwide need for hiring more mental health staff.

Benefits

"To date, 25 to 30 percent of new offenders coming into the Pacific Region have been identified as having some sort of mental disorder, with admissions to the psychiatric hospital and rehabilitation unit going up accordingly," says Executive Director Art Gordon. "What we've noticed," he comments, "is that simply attending to people by a mental health professional, right at the outset, makes a huge difference to the smooth operation of the entire unit."

"The screening doesn't diagnose anybody," Dr. Harris points out, "but it checks for problems. The big issue here is, if somebody's coming in and they've got a problem, we'll be able to respond proactively and support them as opposed to waiting for them to have a crisis."

"We don't want offenders who are holding it together well enough to get past the reception stage to then be sitting in a cell dealing with mental illness by themselves. It's hard to treat a hidden problem and it's very hard to argue for effective resources for a problem that's difficult to count or where you know your counts are under-estimated."

Apart from the benefits to offenders, CSC staff and management, universal screening also has a wider, societal impact, notes Dr. Harris, with the potential to ease offenders' return to and acceptance into the community.

"We want people to get the most out of their correctional experience so that they don't come back. We can help them best when we have valid, reliable data. It's all about public safety." ♦

Project Manager Dr. Ron Frey, a clinical psychologist hired to oversee implementation of the screening tool.

Ambulatory Services at the Ontario Regional Treatment Centre

The Ambulatory Services Program at the Ontario Regional Treatment Centre RTC(O), was the first of its kind in CSC. The program was established in 1987, following publication of a groundbreaking report, The Mental Health Disorders Needs Identification Study. *The research confirmed what wardens had long suspected — that treatment services for mentally ill offenders were seriously inadequate.*

BY **Jean Folsom**, Director of Psychology and Rehabilitation Services, **Pat Onysko**, **Louise Kennedy**, and **Carolyn Kirkup**, Ambulatory Services Nurses

At first, the program focused on providing routine follow-up mental health care with a view to reducing the number of admissions and readmissions to the RTC(O) from the offenders' parent institutions. It was, and still is, staffed with certified psychiatric nurses who go out to the institutions and also, occasionally, to the Community Correctional Centres.

Over the years, the focus has changed to that of maintaining offenders with mental health problems in their regular institutions. The program consists of four main activities:

- mental health teaching to both offenders and the non-mental health care staff who work with them;
- monitoring the effectiveness of psychotropic medication to

Jean Folsom, Director of Psychology and Rehabilitation Services

Photo: Bill Rankin

Psychiatric Mental Health Nursing

Carolyn Kirkup

Dr. Hildegard E. Peplau, who died in 1999 at age 89, is considered by nurses worldwide to be the founder of psychiatric nursing. For her, the key question was: "What do nurses know and how do they use that knowledge to benefit people?"

BY **Carolyn Kirkup**, Registered Nurse, Psychiatric Mental Health Nurse, Ambulatory Services Program, Ontario Regional Treatment Centre

Photos: Philip Gordanier

determine whether the offender also needs to be seen by the psychiatrist;
- making referrals to the psychiatrist when warranted; and
- mental health discharge planning for offenders who are getting ready for release.

At some sites, all newly admitted offenders who are flagged as having mental health needs on the Offender Management System are screened by the Ambulatory Services nurse to see if those needs are current and whether further assessment or intervention is required. At other sites, the nurse provides a variety of services at the psychiatric clinics such as prioritizing referrals and attending the clinic along with the psychiatrist.

As active members of institutional mental health teams, the psychiatric nurses liaise between the RTC(O) and the institutions. They also act as a bridge between psychology departments and health care centres within institutions, to ensure smooth communication channels. Their own internal network allows them to have a good overall picture of offenders with mental health needs across the region.

In short, the Ambulatory Services nurses are the "glue" that holds mental health services together in Ontario Region. They provide a continuum of care from admission to release and on into the community. Feedback from both offenders and institutional staff has been extremely positive about the usefulness and effective of this unique service. ♦

Dr. Peplau's scope of influence goes far beyond the field of psychiatric mental health nursing. She advanced nursing professional, educational, and practice standards and stressed the importance of professional self-regulation through credentialing. Peplau challenged psychiatric nursing to thrive in the new millennium in four central areas:
- the nurse-patient relationship;
- engagement in evidence-based practice;
- competence in information technology; and
- leadership in shifting the health care paradigm to community-based delivery.

Today, psychiatric mental health content is part of all diploma and baccalaureate nursing programs on an international scale. Specialization can occur at the graduate level. Sub-specialties include child, adolescent, adult, geriatric, consultation/liaison, addictions/substance abuse, eating disorders and forensic psychiatry. Psychiatric mental health nursing in the area of corrections is also a sub-specialty.

What do nurses know?

We know the number of offenders with mental disorders is increasing in Canadian federal prisons. Many offenders have serious and chronic physical and mental illnesses requiring substantial health care efforts. Institutional factors, inmate vulnerabilities, poor coping skills and conditions of confinement, such as segregation, all make caring for these offenders extremely challenging for nurses who work in a correctional setting.

According to the Canadian Nurses Association, psychiatric nurses must be knowledgeable in the areas of biological and psychological theories of mental health and mental illness, psychotherapy, substance abuse, care of populations at risk, the community as a therapeutic milieu, cultural and spiritual implications of nursing care, psychopharmacology and documentation specific to the care of the mentally ill. Skill competency stresses comprehensive bio-psychosocial assessment, interdisciplinary collaboration, identification and coordination of resources for offenders and families, the use of psychiatric diagnostic classification systems, therapeutic communication, establishing therapeutic relationships, therapeutic use of self, psycho-education with clients and administering and monitoring psychopharmacologic agents.

Both registered nurses and registered practical nurses provide psychiatric mental health nursing care at the Ontario Regional Treatment Centre. Nurse coordinators are responsible for management, leadership, education and training. Nurses work with offenders to meet their goals for recovery. Nurses with specialty certification in psychiatric mental health nursing with the Canadian Nurses Association work with offenders as part of the Ambulatory Services Program.

How do nurses use their knowledge to benefit offenders?

The Registered Nurses Association of Ontario (RNAO) has evidence-based nursing best practice guidelines such as client-centered care, establishing therapeutic relationships and crisis intervention that assist psychiatric nurses

working in correctional institutions, where self-knowledge and boundary setting is imperative when responding to offenders in crisis.

This year, RNAO is holding the first International Conference on Evidence-based Practice Guidelines. New partnerships are being formed to evaluate clinical practice guidelines in Canada and worldwide. Collaboration, sharing, working with researchers, academic institutions and health care providers will translate evidence into practice. Networks where psychiatric nurses and health care organizations come together to share dramatic improvements result in positive clinical outcomes for our patients and our offenders.

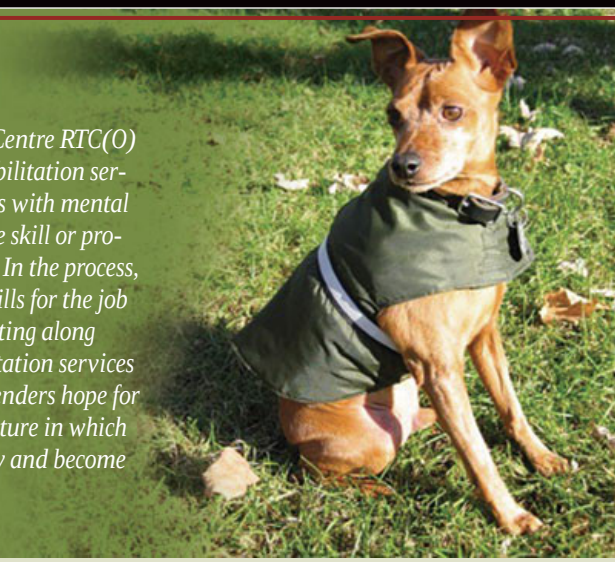
The following Canadian Nurses Association domains of practice for psychiatric mental health nursing are applied to the correctional setting:

- the helping role;
- the diagnostic and monitoring function;
- the teaching-coaching function;
- administering and monitoring therapeutic interventions;
- effective management of rapidly changing situations;
- organizational and work-role competencies;
- monitoring and ensuring the quality of health care practices. ♦

Pat Onysko, Louise Kennedy and Carolyn Kirkup, Ambulatory Services Nurses

Rehabilitation Services at the Ontario Regional Treatment Centre

Skills for the Job of Living



The Ontario Regional Treatment Centre RTC(O) offers a variety of innovative rehabilitation services, all designed to help offenders with mental disorders by teaching them a marketable skill or providing them with a meaningful activity. In the process, they also learn many of the essential "skills for the job of living," like following instructions, getting along with others and self-discipline. Rehabilitation services like the ones profiled here, give these offenders hope for a future beyond the prison walls — a future in which they may safely return to the community and become a contributing member.

Old Blue Jeans Heal, Restore

Inmates find self-worth and a way to give back

BY The Free Spirit Affirmative Business Associates and **Tracey Davidson**, Occupational Therapist, RTC(O) and Chaplain **Fergy Wilson**, RTC(O)

Photo: Mark Hauser

Rocco models a dog jacket made by Free Spirit. The olive-green apparel is crafted out of recycled correctional officer jackets.

They're federal offenders. They have mental illnesses. They serve long or even indeterminate sentences. But they're producing beautiful, saleable, practical items. They make their creations out of old stuff. It's hard to imagine their sturdy, attractive and fashionable tote bags or dog jackets began as blue jeans or guards' uniforms headed for the landfill.

The Free Spirit Affirmative Business at the Ontario Regional Treatment Centre fosters recovery from mental illness. It combats stigma and helps its 14 workers be a part of the community.

The workers, or Business Associates, named it "Free Spirit" themselves. They're proud of their handiwork, which is sold locally. Every two months, 60 percent of the profits go into the men's personal accounts, according to the number of hours they have worked. Of the rest, 25 percent buys equipment and raw materials and 15 percent is kept for emergency business expenses. The associates

donate 15 percent of their profits or items "in kind" to charitable organizations such as the United Way.

After eight years of operation, the business associates say Free Spirit is successful because of its simple structure, its philosophy of consensus and its democracy. They also like the challenge of "making something from nothing." In their own words:

- "I learn a lot from others. There is a sense of mutual respect."
- "I like coming to work. It has helped me develop a healthy routine."
- "You acquire wisdom, faith, understanding and discipline."
- "Working gives you a sense of belonging to something."
- "The business gives me hope for a better future."
- "The business gave me new ideas to start making chemo-wraps for cancer patients on a voluntary basis. I've learned independence which I will use to start my own business."

Tracey Davidson, a registered occupational therapist, helps each associate obtain productive, meaningful employment through ongoing assessment, employment support and workplace accommodations. Chaplain Fergy Wilson assists through creative community marketing.

A version of this article first appeared in the Anglican Diocese of Ontario publication *Dialogue*, January 2007.♦

From left to right: Dave Farnsworth, Psychologist; Tracey Davidson, Occupational Therapist; Chaplain Fergy Wilson; Kim Bennett, Behavioural Technologist; Danny Offord, Job Coach-Housekeeping Services; and Donna Stickles, Behavioural Technologist

Job Coaching Program

BY **Danny Offord**, Job Coach-Housekeeping Services and **Dave Farnsworth**, Psychologist, RTC(O)

Job coaching at the Ontario Regional Treatment Centre is a cleaning program, designed to teach industry standards for a hospital setting. The result is a cleaner, healthier environment for inmates, staff and visitors. The goal is rehabilitation through meaningful work. Vocational therapy is one facet of the patient's treatment plan, complemented by counseling, medication and correctional programming.

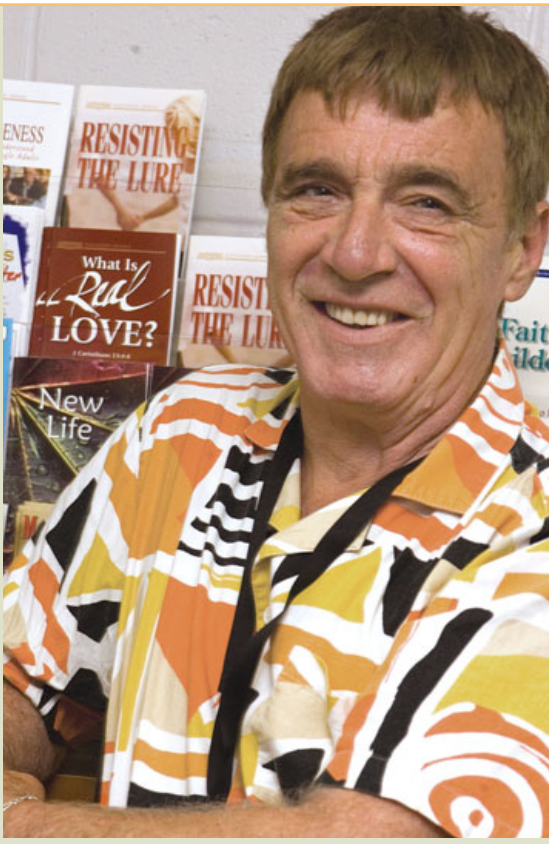
The cleaning program was created in 1999 by Occupational Therapist Tracey Davidson and Psychologist Dave Farnsworth. It remains part of the Psychology Department, offering supported employment to inmates with severe and persistent mental disorders, emotional concerns, learning disabilities and little or no previous work history. To quote a former parole officer: "It motivates inmates who spend most of their day sitting on the window sill or sleeping to do something constructive."

Job coach duties include supervising the worksite, scheduling work detail, obtaining equipment and providing cleaning and sanitizing services for restricted areas. The coach works alongside inmate-patients, offering encouragement, role modeling and feedback. Evaluations are also shared with the multidisciplinary team — medical staff, psychologists, parole officers, case workers and the National Parole Board.

Results

In 2002, five program participants were released. Of these, three are still employed. Currently, the following has been achieved:

- five participants have successfully completed the 72-hour Cleaning Program. Of these, two are employed full-time as cleaners;
- 13 have completed Health and Safety training and shown their ability to use it;
- 13 have completed training towards the Workplace Hazardous Materials Information Systems (WHMIS) certification;



Danny Offord, Job Coach-Housekeeping Services

- 12 have completed training on industry-accepted cleaning procedures for Biohazard and Blood-borne Pathogens;
- five have received additional training in Industrial Cleaning Procedures for a hospital environment and the correct use of cleaning chemicals and equipment;
- three have been trained in writing cover letters and resumes.

The benefits are evident in the following comments by participants:

- "When I am working I don't hear the voices."
- "Working has helped me develop people skills. I am less argumentative with others."
- "The program has increased my sense of knowledge and safety."
- "It adds structure to my day."
- "Working got me motivated. I don't feel as depressed when I'm working. People need to work."♦

Kitchen Worker Program

BY **Kim Bennett**, Behavioural Technologist, RTC(O)

The Kitchen Worker Program began in 2005, when Kingston Penitentiary (KP) staff approached the Ontario Regional Treatment Centre RTC(O) to see if patients could take on the job of putting together bags of condiments and cutlery for their Segregation Unit and the Acute Range. The bags are needed for kitchen staff to serve meals to the offender population. RTC(O) agreed and two behavioural technologists adopted the project.

The program runs three half-days a week and can employ five to six patients per session. The group works in assembly line fashion with each person doing a specific job. In one section, four patients put together bags containing a day's worth of cutlery and condiments for KP and RTC(O) units. During each session, patients can complete two days worth of bags, or 420 sets. The other section puts together the weekend cutlery-condiment bags for the entire offender population at KP.

In contrast to other programs, participants do not lose pay if they are unable to work due to mental health problems. Casual workers can be called in at the last minute if a participant is not feeling well. When he is ready, he returns to the program.

Patients who suffer from a major mental illness find the program a welcome distraction that gives them something to do outside their unit. One man said that when he is working in the group, he seems to "get a break" from the voices he hears.

Since 2005, 23 patients have been involved in the program. It is highly successful in terms of offering meaningful and productive work to offenders who are unable to do other jobs and in meeting a constant need of the KP kitchen. ♦

Kim Bennett and Donna Stickles, Behavioural Technologists supervise RTC(O) patients who assemble hundreds of condiment and cutlery bags for the Kingston Penitentiary kitchen every week.

Mental Health Services for Women Offenders Continuing to Create Choices

Dr. Allister Webster

ADDRESSING MENTAL HEALTH NEEDS OF OFFENDERS

Statistics may vary from one year to the next, but one thing is certain: women offenders are twice as likely to suffer from mental illness as male inmates, with major depression and schizophrenia heading the list. Latest figures show that 25 percent of women in federal custody were diagnosed as having a mental health problem at the time of intake, compared with 12 percent of male offenders.

Photo: Paul Pollard

Though there is no typical profile of women offenders with mental health disorders, an expert committee, commenting on CSC's *10-year Status Report on Women's Corrections 1996-2006*, agreed that women with mental health issues "are among the most vulnerable of the imprisoned population," due to harmful life experiences. These experiences include a history of poverty, family violence, physical and sexual abuse, trauma and addiction.

A Women-centred Approach

A series of studies carried out in the late 1990s, confirmed that mentally ill women offenders had special needs, and that their best hope lay in the provision of intensive programming in a structured environment, removed from the general prison population.

By this time, a women's mental health strategy had been developed by CSC, and most women offenders had been moved into separate institutions, including the Okimaw Ohci Healing Lodge, in Saskatchewan, for incarcerated Aboriginal women. Still lacking were dedicated treatment units.

Following the closure in 2000 of the Kingston Prison for Women, a major step forward was taken with the creation of Structured Living Environment houses in each region for minimum and medium-security women with mental health disorders and Secure Units for those classified as maximum security.

Having these facilities region-wide makes it easier for the women to preserve community and family ties, especially with their children. Two thirds of incarcerated women have children under the age of five.

"The bond between federal women offenders and their children is important," says Dr. Allister Webster, a psychologist at Nova Institution for Women in Truro, Nova Scotia. "Providing opportunities for the women to maintain a connection with their families/children can greatly contribute to a woman's success in reaching her reintegration goals. CSC has placed the women facilities as closely as possible to the women's home communities so they can maintain valued familial relationships, and build towards a successful reintegration," he adds.

Structured Living Environment Houses (SLEs)

The SLEs, with a total of 40 beds (8 per region), offer around-the-clock support. The layout includes a living space, a program area, two therapeutic quiet spaces and staff offices. All staff members have specialized training in mental health issues and work as a multidisciplinary team, providing correctional and rehabilitation programming as well. Placement in the SLE is voluntary and only occurs after a thorough assessment by a case management team. Overall, the SLEs operate as a therapeutic environment incorporating the principles and practices of Dialectical Behaviour Therapy and Psychosocial Rehabilitation.

Dialectical Behaviour Therapy (DBT)

"DBT is a psychological treatment designed to assist individuals develop adaptive skills and strategies targeting problematic behaviours that interfere with effectively coping in one's environment and that prevent an individual from feeling she has a "life worth living". The notion of "a life worth living" is based on the woman's perspective," says Dr. Webster, who also acts as national clinical advisor for DBT. "This isn't about what you or I might suggest as appropriate."

"It rather allows a woman to define it for herself. This is significant," Dr. Webster notes. "For many women, their needs focus on personal empowerment, to be able to take control over the direction of their lives and to develop a sense of ownership."

"Adapted to the realities of prison life, DBT is a combination of individual psychotherapy and groups skills training sessions, backed up by coaching support and team consultations. The goal is to assist the women to develop and utilize adaptive coping strategies. As the woman integrates adaptive skills and strategies, she is less likely to engage in maladaptive coping strategies that sometimes include self-destructive patterns of thoughts, feelings, and behaviours."

"The bond between federal women offenders and their children is important," says Dr. Allister Webster, a psychologist at Nova Institution for Women in Truro, Nova Scotia.

It is particularly suitable for those suffering from high levels of distress, suicidal behaviour, low self-image and cognitive distortion. By working through a series of skill development modules, the women learn to practise mindfulness (similar to the Buddhist notion of living fully in the moment), build greater tolerance for distressing events, gain control over their emotions and improve their interpersonal skills — for example, learning how to ask for what you need and how to say "no" tactfully.

Psychosocial Rehabilitation (PSR)

PSR focuses on those with severe and persistent mental illness. It helps the women identify their needs, build on their strengths and develop basic skills for everyday living, to the point where they may once again be able to function in the community.

Intensive Treatment

For women who require intensive, psychiatric treatment, there are two facilities, one in Saskatchewan and the other in Quebec. The Women's Mental Health Treatment Unit, at the Regional Psychiatric Centre in Saskatoon, provides emergency and ongoing psychiatric care, along with other specialized treatments, including DBT. Aboriginal programming is also offered and there is a sweat lodge on the grounds.

L'Institut Philippe-Pinel de Montréal offers a similar range of services to women in need of psychiatric inpatient treatment. The bilingual institution, though separate from CSC, provides a certain number of beds on a contract basis.

In both cases, a stringent referral process is in place, to ensure the woman's needs are fully understood and that all other options have been thoroughly explored.

Primary and Transitional Care

Within each regular institution, women offenders in need of psychological services may request one-on-one service with a psychologist, or they might be provided with access to a group. "Waiting times can vary", says Dr. Webster, "depending upon treatment availability, but we try to maintain community standards." Primary care can include anger and stress management, coping with eating disorders, substance abuse, adjustment issues, self-esteem issues and other mental health related challenges. Psychological support is available to women returning to the general prison population from treatment facilities to assist in transition and to assist in the prevention of relapses. Access to Native Elders and traditional healing practices is also available to the women.

Transitional care involves discharge planning months in advance of the release date and connecting the women with community agencies and other supports. Under the new Community Mental Health Initiative, psychiatric nurses and social workers in each district parole office are already helping them access the services they need to make a safe and successful return to their home communities. ♦

ADDRESSING MENTAL HEALTH NEEDS OF OFFENDERS

Beyond the Drive

Accompaniment Support at

From July 2006 to July 2007, Veronica Felizardo and David Champagne accompanied 28 offenders from the RTC(O) to the community.

A typical day for an offender being released on warrant expiry:

07:00 Meet in the parking lot at Kingston Penitentiary, the site of the Ontario Regional Treatment Centre RTC(O).

07:05 Bring the RTC van through the south gate; let the correctional officer at the gate know an offender is being released today.

07:10 Proceed to the main security post; pick up the gate clearance that will allow the offender to be released.

07:15 Head to the offender's range; pick up discharge medication from nursing staff and confirm that offender has taken his a.m. medication; pick up offender along with his cell effects.

07:35 Escort offender to Admissions and Discharge Department to obtain his discharge clothing, personal effects (including ID), and CSC identification.

07:50 Escort offender to Finance Department to withdraw his institutional funds.

08:00 Drive to the south gate; hand the legal paperwork to a correctional officer to allow for offender's release.

The gate opens. Lake Ontario appears. Accompaniment support into the community begins…

Given the stigma that is still attached to mental illness, offenders with mental disorders face more than the usual hurdles upon their release into the community. First steps that are difficult enough, like finding housing, or accessing health services or applying for welfare benefits, or engaging in a lengthy round of appointments and interviews, may loom as insurmountable in the offender's mind.

BY **David Champagne**, Master of Social Work, Registered Social Worker and **Veronica Felizardo**, Master of Social Work, Registered Social Worker and PhD c.

Deemed especially vulnerable because of their illness, these offenders typically have a short attention span, low tolerance to change, cognitive impairment and little understanding of how to navigate through the system and make it work on their behalf — all of which can jeopardize their safe transition back into society.

Recognizing the need for advocacy and in the interest of public safety, RTC(O) clinical staff have been providing an Accompaniment Support Service since the late 1980s, currently championed by clinical social workers. In essence, two staff members, including at least one health care professional, accompany offenders being released into the community (i.e. conditional and warrant expiry releases) through their first, critical day out of prison, making sure appointments are kept, paperwork completed and the men connected with essential services (for example, housing, finances, health care and counseling).

Clinical Discharge Planning Services

Accompaniment support is a key component of the clinical discharge planning process. Based on the principle of "continuity of care," the goal is to develop a comprehensive, individualized plan to identify transitional and longer-term discharge needs of offenders with a mental disorder. Social workers at RTC(O), as a primary responsibility, develop release plans by consulting with offenders, family/community support systems and multidisciplinary teams, including representation from health and parole services.

Accompaniment Support

Accompaniment support is a voluntary clinical service that requires the offender's informed consent. Despite common perception, accompaniment support is not a "taxi service" and is much more than "a drive." It should not be confused with situations where an offender may require a security escort, nor is it the only possible option for an assisted release. On occasion, a family member or representative from a community agency may arrange to pick up the offender at the institution and accompany him on his release date. Such cases are rare, though,

A typical day continued:

08:15 Stop at coffee shop on the way out of Kingston. (This is the offender's first encounter with the public after his release.)

11:00 Arrive at court to address a section 810 application by community police services.

11:40 Doctor's appointment scheduled for 11:30 has to be cancelled due to delays at court.

11:45 Help offender replace his birth certificate at Office of Registrar General; unsuccessful due to lengthy line up.

12:00 Pick up a letter at a community agency to allow offender's health card to be replaced without a birth certificate.

12:15 Help offender replace health card at the Ministry of Health and Long-Term Care office.

12:45 Stop at McDonald's to pick up take out and head to next scheduled appointment.

13:00 Accompany offender to appointment for short-term housing with the Mental Health and Justice Program; complete housing intake interview; view the offender's new apartment; obtain document to confirm address required for Ontario Works (welfare) appointment.

13:30 Arrive just in time for Ontario Works (welfare) appointment; appointment begins late; complete lengthy intake interview; obtain drug benefit medications, bus tickets, and emergency financial aid.

16:00 Return to the offender's new apartment, now stocked with food, blankets, sheets, and other essential items.

17:00 Spend time with the offender to help him prepare a schedule for his many appointments the following week; review Ontario Works paperwork, his medication schedule and police-imposed conditions.

18:15 Wish offender success in the community; review relapse prevention plan with him; encourage occasional contact to report on progress. Offender states that he is very grateful for the assistance and says that throughout his life, no one has ever helped him in this way. He's particularly grateful for accompaniment support on his release date.

the Ontario Regional Treatment Centre

since these offenders are often alienated from family and community supports. In addition, the men frequently require more time and attention on their release date than members of their support system are willing or able to provide.

Accompaniment support plans are developed in consultation with institutional and community parole services to ensure a good fit with the community strategy and identified release conditions. Consultation with health care colleagues, including other social workers, nurses, psychiatrists, psychologists and occupational therapists, ensures that an offender's unique community integration needs are identified and factored into the plan.

There are numerous variables that influence the clinical discharge planning process. Intrinsic factors, such as the offender's motivation, cooperation, and symptoms of their disorder, must be carefully assessed and reviewed on a regular basis. Extrinsic factors, such as family and community supports, conditions of release and availability of resources, also have to be monitored, allowing for modification as required.

On the Day of Release

En route to the offender's release destination, those providing the accompaniment support, have an opportunity to talk to the offender about his prioritized discharge needs and to encourage him to follow through with his relapse prevention plan. During this time, offenders tend to be more forthcoming and receptive to intervention. Time spent together also provides the opportunity to observe offenders interacting with the public and to provide feedback on their interpersonal skills. For men who have served lengthy sentences or those who have had a "rough ride" inside, this is often an important transitional step in shedding their inmate label.

Staff providing accompaniment support must remain flexible, professional and compassionate when dealing with unexpected events where the release plan has to be modified. These situations, often upsetting to the offender, may arise prior to release (for example, incomplete paperwork, missing personal effects, complications with discharge medication) or throughout the day in the form of traffic jams, court delays, last-minute changes to pre-scheduled appointments or denial of services.

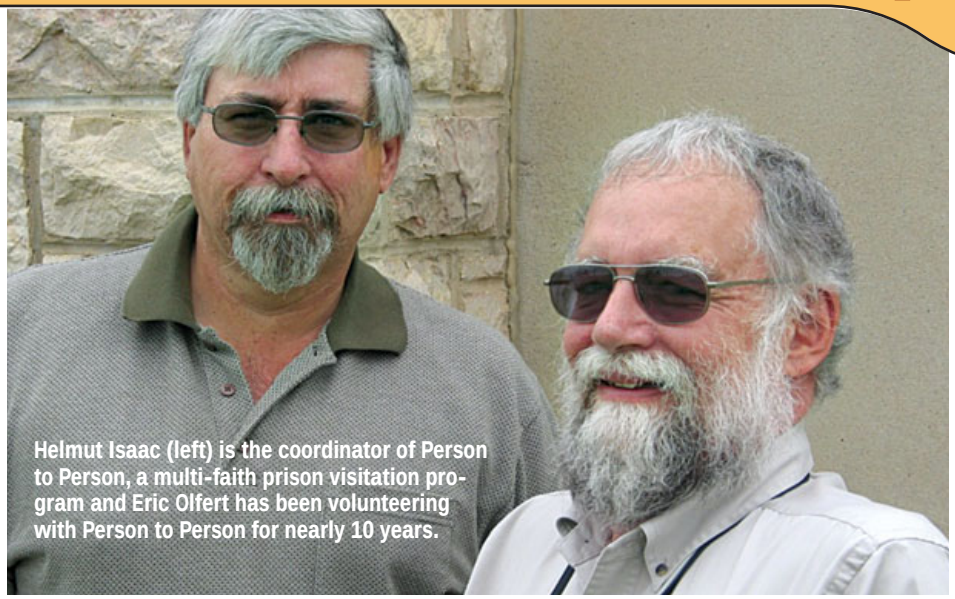
Having a professional at their side to help them navigate through the system enables offenders to access essential services at their first, crucial appointments in the community, often including housing, financial services, identification replacement and health care follow-up. In the case of a conditional release, there is an additional need to support the offender in complying with their legal obligation to report to community parole services and, if required, to complete an initial police report on their release date.

Above all, accompaniment support ensures the safe and timely travel of offenders with mental disorders from the institution to the community where they will be trying to make a fresh start. For those who are committed to making significant changes in their lives, accompaniment support as part of the clinical discharge planning process, is invaluable in empowering them to become responsible, law-abiding citizens. ♦

Part of the accompaniment support plans is to find, with the offender, a place to relocate where he will have access to appropriate services.

Visiting Mentally Ill Offenders
The Healing Power of Friendship

"I was in prison and you visited me." These simple words from the Book of Matthew *in the* New Testament *lie behind Helmut Isaac's commitment to befriend those whom society has turned its back on.*



Helmut Isaac (left) is the coordinator of Person to Person, a multi-faith prison visitation program and Eric Olfert has been volunteering with Person to Person for nearly 10 years.

While farming in northern Saskatchewan in the 1980s, Isaac began visiting inmates at the Prince Albert Penitentiary. Following a disabling farm accident, he and his wife moved to Saskatoon, where he became coordinator of Person to Person, a multi-faith prison visitation program that largely serves mentally ill male offenders at CSC's Regional Psychiatric Centre (RPC) in the Prairie Region.

"We're not coming in there to fix anything," he emphasizes. "We're there to offer friendship. Many of these guys have come through the foster care system and have no family to connect with anymore. Others have been abandoned by their family because of their offences. We provide visits for those who would not otherwise get one."

The team of 35 Person to Person volunteers offers companionship — talking, listening, maybe playing cards, maybe just sitting together, but most of all communicating caring, respect and acceptance to lonely and isolated men.

As coordinator, Isaac matches volunteers up with inmates who have applied to be in the program, but only after RPC staff has put them through a risk assessment. "They don't let guys who are having an acute episode of mental illness come to the visitors' area," he says. "If they're not stable on their meds, or if they're causing problems on the units, they're not allowed to participate."

Benefits Both Ways

Volunteers are expected to form long-term relationships with the men and help lay the groundwork for the offenders' eventual return to society. It works, he says, because of the depth of relationship and trust that builds up over the years.

Eric Olfert has been volunteering with Person to Person for nearly 10 years. One of the biggest benefits of the program, he says, is that "it helps the men to begin restoring their sense of self-worth, and gives them a head start on what it all means when they are out on the street again."

"There are safety benefits as well," he adds. "One of the guys I visit said to me: 'I trust you. I value your visits and I'm finding it more and more important that I learn not to re-offend when I come out because that would jeopardize our friendship.'"

For Olfert, the personal reward is that "I get to meet some really interesting people. I find it a fascinating and powerful experience to spend time with these folks. Sometimes we can have wide-ranging conversations. Sometimes they can only talk about what happened that day and it takes careful work to get them to think in a bit more depth. But we get a lot of feedback from the people we visit, that just being treated like a human being who has some worth is a huge boost for them."

In his contacts with sex offenders, Olfert's non-judgmental approach can lead to barriers coming down. He recalls an inmate he'd been visiting for about three months. "Then, all of a sudden I got a note which said 'I imagine you wonder what I'm in for? Well, I abused small children. If you never want to see me again that's OK.'" Olfert wrote back to the offender, assuring him that he wanted to continue with the visits. "From that point on, our conversations were at a whole different level of honesty and openness."

Helmut Isaac also finds that the RPC benefits from the volunteers' presence. "Sometimes you're like a sponge. I remember one of the chaplains saying the volunteers don't realize how much tension they take out of the institution. The patients don't often get a chance to talk to anybody who isn't part of the system."

Safety Concerns

Not being part of the correctional system doesn't mean there are no boundaries. Volunteers soon learn how to recognize when offenders are trying to manipulate them or overstep the limits. This becomes easier as the relationship deepens and mutual trust develops. Potential volunteers are also required to attend training provided by the RPC, as well as Person to Person's orientation before they begin visiting.

Although conversations are kept confidential, offenders are told, up-front, that any threats of self-harm, or harm to others, or escape plans will be promptly reported.

When Eric Olfert first started doing prison visits, "it was a new experience to have the big doors clang behind you and to know that you were 'inside.' But the sense that there was any

real danger was very small. When you start following patients out and relating to them on the street, then it becomes a bit more real." One of the men he's befriended is now in the community. "We trust each other," he says, "but he does have a mental illness and I always keep an eye on how things are for him."

Return to the Community

Although Person to Person began as a prison visitation program, the community component came about in response to the realization that patients were leaving the RPC with no friends, family or community supports.

Both Olfert and Isaac participate in the local Circles of Support and Accountability group, helping released sex offenders stay on their medication, find their place in the community and avoid re-offending. To ensure continuity, Helmut Isaac tries to have the volunteer who's been visiting with the offender on the inside be part of the circle as well.

Volunteers also get involved in driving the men to mental health appointments or accompanying them to support group meetings, such as Alcoholics Anonymous or Narcotics Anonymous, and helping to connect them with community resources.

Person to Person is all about creating a sense of community for offenders who never had one to start with, providing a group of people who care about them, regardless of their mental illness or what they have done, and helping them make a fresh start. ♦

For more information about volunteer programs within CSC please visit http://www.csc-scc.gc.ca/text/portals/volunteers/index_e.shtml

ADDRESSING MENTAL HEALTH NEEDS OF OFFENDERS

The Meaning Comes in Moments

Reverend Helen Tervo had never considered prison work early on in her career as an Anglican priest. She was out of a job and looking for a new congregation, when an opening came up at CSC in the Prairie Region. "Within two weeks of working at the institution," she says, "I knew this was where I was called to be."

She remembers the first day she was on her own in the institution. A young inmate walked into her office, just to talk. "And he said, 'There's somewhere in the Bible about this son, who takes all his money and goes and wastes it.'"

"I told him it was the story of the prodigal son and asked if he wanted me to read it to him. When I finished, he said 'That's my story.' It was like God had given me this moment to say 'You belong here.'"

Now based at the Pacific Institution / Regional Treatment Centre, in Abbotsford, British Columbia, Reverend Tervo, along with Father Joe Ostopowich, a Catholic chaplain, is part of a multidisciplinary team of psychiatric nurses, psychologists, psychotherapists and other health care professionals within the almost 400-bed facility, which includes a reception and assessment unit, a medical hospital, a psychiatric hospital and a rehabilitation unit.

As full-time institutional chaplains, dealing with diversity is a major consideration for Reverend Tervo and her Catholic counterpart. "We have people from all the major ethnic and religious communities. So you need to understand the cultural assumptions that different individuals have, and to work within that."

Other faith groups have their spiritual needs attended to by visiting Aboriginal Elders, as well as Muslim, Sikh, Jewish, Buddhist and Wiccan chaplains.

A Day in the Institution

Reverend Tervo maintains there is no such thing as a typical day. After attending the team meeting, she spends most of her mornings going to where the men are, either in the hospitals or the rehabilitation unit, since many are unable to leave their unit.

"And if there's someone who wants to talk, I'll stop and talk to them. There's a huge range of conversations we can have, just at the drop of a hat, like 'How come God let me do such terrible things?' or 'Where can I find forgiveness?'"

Afternoons may be spent in one-on-one counseling, planning the weekly chapel service, talking to volunteers, acting as a go-between for the men, liaising with their family members, escorting offenders on temporary absences and ministering to the spiritual needs of staff members who may be going through a rough time.

"Whether someone is religious or not, the most important thing in all of this is that chaplains are about relationships. People with mental illness aren't any different from people without mental illness in terms of trying to connect or to find some meaning in their lives," she says.

Striking a Balance

Though she considers herself to be an integral part of the treatment team, Reverend Tervo tries to strike a balance between the demands of the correctional system and her role as spiritual advisor.

"As chaplains, we're *in* but not *of* Corrections," she emphasizes. "It's easy to begin to talk the language and get pulled in, but I've had to learn that I'm here for spiritual purposes. That's my place on the team — to raise some of those issues around forgiveness and compassion and meaning."

Maintaining the balance can be challenging, when offenders speak with Reverend Tervo in confidence. She often has to make a judgment call about sharing the information, especially where health and safety are concerned.

"Confidentiality is important, but my understanding of confidentiality is not secrecy," she says, "and I make this clear to the men." For example, if an offender discloses a past history of sexual abuse, her first reaction is to see whether he has tried to get professional help and, if not, to connect him with the right services.

"The same thing with suicide," she says. "Anytime someone talks to me about suicide, I say 'Who can we talk to about this, right now?' I don't leave the men with me being the only person they've spoken to."

Working with Families

As Reverend Tervo points out, inmates who are mentally ill are often estranged from their families, especially in cases where the family has been the victim, or simply because they are worn out from years spent on an emotional roller-coaster.

She has to tread carefully, to avoid working towards reconciliation before all parties are ready for it. "You want to build a solid relationship that may not be one of those Oprah Winfrey moments, but something that gets both sides involved," she says.

"Amazingly, there are families who do stay in contact," she adds. "In lots of ways, when someone is mentally ill and in prison, the family can finally relax and know they're safe. They don't have to worry about their brother, or son or father living on the street somewhere in downtown Vancouver."

The Frustrations

One of the biggest frustrations for Reverend Tervo is to work with an inmate for several months, to see him make progress, and then lapse back into familiar patterns.

"You can have a direct result in someone's life, but it can disappear very quickly, like a decision not to stay on their medication," she says. "With mental illness, it's not something that they can just think away. Just because they have an insight one day, it doesn't mean that's going to hold them six months down the road. One of the frustrations with chaplaincy and doing spiritual work in a place like Corrections is that we're eager to measure. But our job is to step back from measurements, to know that we can have an impact on somebody that may not show up right away."

The Rewards

For Reverend Tervo, it comes down to a question of faith and trust that broken lives can be rebuilt, that showing kindness and compassion to those who least expect it can make a big difference, even if the results aren't immediately visible.

"I can't tell you the number of men who sit in my office and tell me about a correctional officer who said something encouraging to them 20 years ago or gave them a break. They still remember these things. So, we have to trust that the good we do is good, that there are some people who are able to turn their lives around and leave prison to lead a rewarding life. But we don't see that every day," she adds. "It comes in moments, not in great plans."

She observes that being a chaplain isn't mainstream pastoral care. "This is going into people's lives at a very dark time, and reminding them that they are more than whatever dreadful things have been done to them or that they've done to others, that they are more than the mental illness they've got. They can then start to see themselves the way God would see them. And they can see some hope," she says. "When I get a chance to be part of that, it makes it all worthwhile." ♦

Community Supervision of Offenders with Mental Disorders

Forging Steps Towards Safer Reintegration

ADDRESSING MENTAL HEALTH NEEDS OF OFFENDERS

In the past decade, the Correctional Service of Canada (CSC) has seen a substantial increase in the number of offenders coming into the federal correctional system who are suffering from mental disorders. Since 1997, the number of male offenders presenting a mental disorder at intake increased from seven to 12 percent. In addition, 25 percent of woman offenders are currently presenting with mental health issues at intake.

Above: Dr. Andrea Moser, Manager of Community Mental Health Initiatives in CSC's Health Services Branch, National Headquarters

BY **G. Chartier**, Communications Officer, Communications and Citizen Engagement Sector

To meet this challenge efficiently and effectively and to ensure the safety of communities across Canada, parole offices and Community Correctional Centre (CCC) staff have worked at developing local community partnerships while nationally, CSC is working to provide new staff and training.

The result is a nationwide initiative with positive local results.

Increase in the Population of Offenders with Mental Disorders

The term "offenders with mental disorders" includes not only mental illnesses such as bipolar disorder or schizophrenia but also disorders such as Fetal Alcohol Spectrum Disorders, Alzheimer's Disorder, Attention Deficit Hyperactivity Disorder (ADHD), personality disorders, as well as problems resulting from head injuries and other disorders that influence the functioning of an individual. This group of offenders is the population in CSC custody that has shown such a dramatic increase in numbers over the past decade.

"This increase puts the pressure on CSC to provide services," says Dr. Andrea Moser, Manager of Community Mental Health Initiative in CSC's Health Services Branch. A psychologist by training, she has worked as a Manager in the Reintegration Programs and Health Services Branches at National Headquarters for the past 10 years, but started her career at the Regional Treatment Centre in the Ontario Region of CSC providing psychological services to offenders with mental disorders.

"We are legislated to provide health services to offenders and to promote the safe reintegration of offenders into the community. We have to keep in mind their mental health needs because that can certainly contribute to their reintegration back into society and in several cases may be related to how they ended up in the correctional system initially," Dr. Moser says.

Forging Steps to the Community

One of the people reaching out to offenders with mental disorders is Parole Officer Sue Bruff at the St. John's Parole Office in Newfoundland and Labrador. Because that province doesn't have a federal penitentiary, Bruff often travels to the mainland CSC institutions in the Atlantic Region to meet offenders with mental disorders who will be discharged back into the community.

Ms. Bruff is part of a multidisciplinary case management team that is comprised of other staff from CSC, including a senior parole officer, a contract psychologist, psychiatric nurses from Ambulatory Services, as well as a team of community mental health professionals from Stella Burry Community Services (SBCS), a local community organization with deep ties in Newfoundland and Labrador.

Named after a pioneering teacher and social worker from Newfoundland, SBCS provides housing, counseling, education and employment services. It is a vital community partner in the safe reintegration of offenders with mental disorders in communities throughout the province.

One of the services provided is in the form of support workers who provide the one-on-one service to help offenders enhance their basic living skills, such as cooking, budgeting, shopping, medication management, attending appointments and advocacy.

Left: Clara Rendell, Director of the St. John's Parole Office and CCC Newfoundland, in the Atlantic Region

Right: Parole Officer Sue Bruff at the St. John's Parole Office in Newfoundland and Labrador

"When their sentence ends, the SBCS continues to work with them over the long term," Sue Bruff says. "So there's a reduction in psychiatric admissions and jail admissions once they've got the supports in place."

Community partnerships such as Stella Burry and Waterford Psychiatric Hospital, and provincial government departments in St. John's as well as the John Howard Society, St. Leonard's Society, Salvation Army and other community organizations across Canada, help to meet the mental health needs of offenders in the community.

"The Waterford Hospital staff know the kind of work we do and have developed a short-term stay strategy within their overall planning. We know we can go through their emergency system and get someone to see the offenders quickly. A short-term stay might be all a particular offender needs. The person might just need his medication adjusted a little bit," says Clara Rendell, Director of the St. John's Parole Office and CCC Newfoundland, in the Atlantic Region of CSC.

Community Mental Health Initiative (CMHI) Funds New Positions Across Canada

One of the primary components of the Community Mental Health Initiative (CMHI), launched in 2005, is enhanced discharge planning for offenders with mental disorders when they leave CSC institutions. Fourteen Clinical Social Workers (Discharge Planners) are being hired across the country to provide comprehensive discharge planning services to offenders being released from the regional treatment centres as well as regular men's and women's institutions. In addition, 15 Clinical Social Workers and 15 Community Health Nurses are being hired to provide mental health services to offenders with mental disorders on supervised release. This will help offenders to connect with community support and lay the groundwork for services that offenders will need when they are released.

"The in-depth discharge planning work done by the Clinical Social Workers complements and does not replace what the Parole Officer is doing in that case," says Dr. Moser. "Better discharge planning will assist their reintegration into the community," she says. "At the same time, we have to look at what is available in the community in terms of services."

"The Clinical Social Work and Community Mental Health Nursing positions work directly with offenders with mental health issues who are released," says Dr. Moser. "There will be a dialogue between the discharge planners, the institutions and the community site to which they will be released to promote a smooth transition between the institution and the community."

Clara Rendell says that because of the CMHI, the St. John's Parole Office has been able to hire a full-time community mental health nurse and a full-time social worker. She adds that the CMHI is also providing funding for a contract psychiatrist who holds clinics once a month.

St. John's Parole Office Working with the Community

However appropriate and effective the services to offenders with mental disorders may be during their incarceration, additional challenges are faced during reintegration back to the community.

Having started work as a Parole Officer in St. John's, Ms. Rendell has seen the efforts made over the years while working in the community with mental health offenders.

"We started out — it must be eight or nine years ago — identifying a particular need," she says.

Ms. Rendell and her colleagues saw a gap in services when offenders with mental disorders were going back into the community. "These were the individuals who had a number of agencies involved with them prior to their sentencing — five or six very likely," she says.

"It is also important, she says, to recognize that offenders with mental health problems will need service in the community beyond the end of their sentence. By the time they are off their federal sentence, they may have gained supports needed beyond their sentence."

To meet this challenge, CSC has partnered with local agencies to ensure that after an offender is discharged or the sentence ends, supports remain for that individual.

"We have said that this is a continuum," says Ms. Rendell, "that you have to start while the person is still in the institution."

Training an Important Factor for Front-line Staff

Training is an important factor for CSC front-line staff who work with the new community health specialists to provide information and effective tools for dealing with offenders with mental disorders.

To that end, CSC has piloted a two-day training for front-line community staff that will be rolled out over the next year.

"The hope is that we can provide training to more staff," says Dr. Moser. "Staff can benefit from greater understanding of mental health issues and how to work effectively with offenders with mental health issues."

Building Capacity in the Community

"One thing we want to do with this initiative when we place new staff in the community is capacity building," says Dr. Moser, "to build the bridges between CSC and the other organizations that provide mental health services in the community."

"So that kind of link to the community when you work with a mental health population is really important," says Ms. Rendell. "It's making those connections."

"It's having an understanding that we're all working toward the same goal here — how can we work on it together?"

"We're getting there," she says. ♦