Court File No. T-539-20

FEDERAL COURT

BETWEEN:

CANADIAN CIVIL LIBERTIES ASSOCIATION,
CANADIAN PRISON LAW ASSOCIATION,
HIV & AIDS LEGAL CLINIC ONTARIO,
HIV LEGAL NETWORK,
& SEAN JOHNSTON

Applicants

– and –

THE ATTORNEY GENERAL OF CANADA

Respondent

APPLICATION RECORD
VOLUME 4 OF 5

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VOLUME 1

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AFFIDAVIT OF HOWARD SAPERS

I, HOWARD SAPERS, of the City of Ottawa, in the Province of Ontario, AFFIRM:

1. I have been asked to provide an affidavit on the how the COVID-19 pandemic affects institutional corrections, why it is particularly dangerous in the context of institutional corrections and what can be done to manage and mitigate the risks of the virus inside prisons and jails. My affidavit will focus on three inter-related questions regarding the response of correctional services to the COVID-19 pandemic.

   i. Why is it important to implement release policies and practices as part of the penal response to COVID-19?

   ii. What release policies and practices have correctional services, aside from the Correctional Service of Canada (CSC), put in place since the outset of the pandemic, and what have been the results of theses policies and practices, including the impact on public safety?

iii. How does CSC's response to the COVID-19 pandemic compare to the response of other jurisdictions, and are there steps CSC should be taking to ensure that the living and working conditions inside Canada's penitentiaries are safe and healthy?

My Qualifications

2. The opinions expressed in this affidavit are my own, informed by the authorities cited and nearly 40 years of experience working in the justice sector.

3. My qualifications include an undergraduate degree in Criminology and the completion of graduate course work, both at the Simon Fraser University Department of Criminology, followed by a lengthy career in corrections and the broader justice sector. I currently consult domestically and internationally on oversight, ombudsmanship and correctional policy and practice.

4. Between January 01, 2017 and December 31, 2018, I served as the Independent Advisor on Corrections Reform for the province of Ontario. In May 2017, I released my first report to Ontario, *Segregation in Ontario*, which provided the Ministry of Community and Correctional Services with advice and recommendations on ways to reduce the use of segregation, improve conditions of confinement for those segregated and enhance accountability and transparency in the segregation process. A second report, *Corrections in Ontario: Directions for Reform*, was released in October 2017 and called for transformative change in numerous areas of correctional operation. In December 2018 I provided my final report, on Institutional Violence, to the provincial government. In total, the three reports contained 167 recommendations. Based upon my work, a new principle-based correctional law for the province was drafted and received Royal Assent.

5. Between 2004 and 2016 I was the Correctional Investigator of Canada. Appointed by the Governor in Council, the Correctional Investigator is the statutory Ombudsman for federal offenders. As Head of this independent agency, I acted as the designated Accounting Officer. I represented the Office to the public, within the Public Safety portfolio and across government. The primary function of the Office is to investigate and bring resolution to individual prisoner concerns and to identify systemic issues. Annual and Special Reports are made to Parliament through the Minister of Public Safety. For 11 of the 12 years I held this office the number one concern investigated was access to and quality of health care.

6. Other professional roles have included serving as the Executive Director of the John Howard Society of Alberta, Director of Canada's National Crime Prevention Centre Investment Fund and Vice Chairperson (Prairie Region) of the Parole Board Canada. Between 1993 and 2001 I served two terms as an elected member of the Legislative Assembly of Alberta representing Edmonton Glenora. I am a Past President of the Canadian Criminal Justice Association, was a member of the Board of Directors of the Forum of Canadian Ombudsman and between 2012 and 2016 was a North American Regional representative to the International Ombudsman Institute. I represented the community of small federal departments and agencies on the Government of Canada Small Department Audit Committee and was Chairman of the Department of National Defence/Canadian Forces Ombudsman Advisory Committee.

7. My work as Correctional Investigator was recognized in the cover story of the Fall 2016 edition of *Power & Influence* magazine and have received the President's Commendation from the Canadian Psychiatric Association. I am an Adjunct Professor at Simon Fraser University's School of Criminology, a Visiting Professor in the University of Ottawa Department of Criminology and have been awarded a Honourary Doctor of Laws from the University of Ottawa. I am currently a member of the Ryerson University Department of Criminology Advisory Council, on the Board of Trustees at the Centre for Addiction and Mental Health and a member of the Legal Aid Ontario Prison Law Advisory Committee.

8. A more detailed curriculum vitae is attached as **Exhibit "A"** to my affidavit.

9. The opinions expressed in this report are those of the author, informed by the authorities cited and nearly 40 years of experience working in the justice sector.

Why is it important to implement release policies and practices as part of the penal response to COVID-19?

10. The Correctional Service of Canada (CSC) operates 43 institutions in 5 regions across the country. There are 6 institutions rated maximum security, 9 medium security, 5 minimum security, 12 multi-level institutions and 11 clustered sites (multiple buildings on one site operating at different security levels). According to the Corrections and Conditional Release Statistical Overview (**Exhibit "B"**), last year 24.2% of the prisoner population was being held in minimum security, 61.1% at medium and 14.7% at maximum.

11. The combined capacity of all institutions is 16,354. CSC institutions employ a variety of accommodation styles and housing options. While single-cell occupancy is the policy standard, there are cells built for shared occupancy (typically in lower security institutions or units) and communal living spaces (usually in women's institutions.). Many institutions have been retro-fitted to provide for double bunking – the placement of two prisoners in a cell originally designed for single occupancy. Current policy calls for a minimum cell size in new and renovated housing units of 7 metres square, however, the policy also allows double bunking in cells as small as 5 metres square. The Commissioner's Directive on Inmate Accommodation (CD550) states: "Any increase in double occupancy above 20% of the overall regional rated capacity will require the Commissioner's approval". This policy allows for individual institutions to exceed 120% of rated capacity as long as total double bunking within the region does not exceed 120% (**Exhibit "C"**).

12. On May 5, 2020 there were 13,754 men and women in federal custody, or 84.1% of stated capacity. In correctional accommodation planning terms, many jurisdictions consider 85% - 90% cell utilization as optimal. The CSC targets for utilization are the limit or exceed this norm. The CSC target for minimum security is 90%, for medium security 95%, and 90% for maximum security. Aggregate cell utilization numbers do not reveal a full picture of accommodation pressures. As important as the number of cells and the number of prisoners is the distribution of cells across the security spectrum and within each region. Crowding may occur at specific sites even when aggregate numbers suggest excess capacity. Crowding is typical in CSC reception centres (where new prisoners are placed for assessment), in women's institutions, and in medium security institutions within the Ontario region.

13. The CSC reports that in the community, the Service operates 92 parole offices and 14 community correctional centres that support offenders on conditional or statutory release. The CSC has an operating budget of $2.65 Billion for the current fiscal year and employs over 18,000 people.

14. The profile of those in custody suggests a vulnerable and high needs population. Pre-existing physical and mental health issues, history of substance abuse, history of sexual and physical abuse, low educational attainment, chronic under or unemployment, unstable housing

and social relationships are typical. The demographics are also troubling. A growing proportion of prisoners are aged over 50 (now more than 1 in 4), 30% of prisoners are Indigenous (this grows to over 40% for women), and 8% are Black. The over representation of Indigenous and Black Canadians, as well as those with histories of substance misuse and mental illness and those who are aging and dying in prison are long-standing trends. The needs they have for support, care and safety do not fade away during a public health emergency. (Office of the Correctional Investigator, *Indigenous Peoples in the Federal Correctional System*, Presentation to the First Nations Policing and Indigenous Justice National Symposium, November 5th, 2019, **Exhibit "D"**).

15. Correctional facilities are by design closed institutions. The Prison Policy Initiative has stated "Prisons and jails are amplifiers of infectious diseases such as COVID-19, because the conditions that can keep diseases from spreading – such as social distancing – are nearly impossible to achieve in correctional facilities" (**Exhibit "E"**).

16. In 2016, while Correctional Investigator of Canada, I published a summary of health care concerns in federal penitentiaries (**Exhibit "F"**) which noted the following:

> The federal correctional system faces serious capacity, accessibility, quality of care and health service delivery challenges and constraints:
>
> Bed space at the five regional treatment centres (psychiatric hospitals)
>
> Aging and inappropriate infrastructure
>
> Lack of "intermediate" mental health care units
>
> Management of self-injurious offenders
>
> Recruitment and retention of mental health care professionals
>
> Sharing of information between health care and front-line staff.
>
> Meeting the needs of aging inmates
>
> Operational dilemmas - prison vs. hospital, inmate vs. patient, security vs. treatment
>
> Infectious diseases, drugs in prison and harm reduction

Informed consent and involuntary treatment.

17. In a presentation to correctional nurses in October 2013 (**Exhibit "G"**), I made the following observations regarding the provision of healthcare in a correctional setting:

- Unlike most of us when we need physical or mental health care, prisoners are offenders first and patients second.
- While in custody, prisoners have little practical choice over who attends to their health needs, how or where that care is administered or what constitutes an "essential" health care item, service or need
- Persons under federal custody are excluded from the *Canada Health Act* and they are not covered by provincial health care systems.
- The CSC is obligated to consider an offender's state of health and health care needs in all decisions, including placements, transfer, segregation, discipline and community release and supervision.
- A high standard of care is required, even if for no other reason than good prison health is good public health.

18. In a *Canadian Family Physician* article published in March 2016 (**Exhibit "H"**), Fiona Kouyoumdjian concluded:

> Canadians in correctional facilities have poor health across a range of health status indicators, a finding that is consistent with international data on persons who experience imprisonment. This information is relevant to physicians who assess and treat persons while in custody or after release, as it might inform history taking, counseling regarding pretest probability, investigations, and management strategies.
>
> Information on health status is also important for defining areas of focus for improving health and health care. Health care in correctional facilities is largely delivered by government authorities in Canada, which makes the lack of data on some key indicators of health striking, including on mortality after release, chronic diseases, injury, and health care access and quality. Among other measures, the implementation of electronic medical records, which are still not available in correctional facilities in many jurisdictions, could facilitate the collection and management of data on many health status indicators.

19. According to research published by the CSC, "The correctional health literature suggests that offenders generally report poorer health than individuals in the community. Furthermore, some studies suggest that women offenders may have poorer health than men offenders" (**Exhibit "I"**).

20. In 2015, the Canadian Medical Association published an article by Lynn Stewart, a Senior Research Manager at CSC, that included the following observations:

> There is reason to be concerned that rates of chronic health conditions of federal inmates may be increasing because of demographic shifts in the incarcerated population. For example, the proportion of incoming offenders aged 50 years or older has grown over the last 10 years, from 7.5% in 2003/04 to 13.3% in 2012/13. Among incarcerated offenders in 2012/13, 21.5% were 50 years or older. Older inmates generally require more health care services than younger inmates because they are more likely to have chronic diseases and disabilities and consequently have more specialized needs for care and assistance with mobility and daily living. Despite the increase in the proportion of older inmates, the overall inmate population is younger than the general Canadian population: based on the latest census, 15% of the general population is 65 years and older, as compared with 3.5% of federal inmates.
>
> Another factor that could affect the overall prevalence of health conditions among federal inmates is the increased proportion of inmates who are of self-reported Aboriginal ancestry. From 2003/04 to 2012/13, the Aboriginal federal inmate population increased by 47.2%, and in 2012/13, 23% of federal inmates were of self-reported Aboriginal ancestry. Overall, Aboriginal populations in Canada face a higher prevalence of health conditions and a lower life expectancy than the non-Aboriginal population. Evidence suggests that many of the health conditions seen in the general population of Aboriginal Canadians (e.g., diabetes, obesity, and drug and alcohol abuse) are more prevalent in Aboriginal inmate populations. Other areas that affect the relatively lower life expectancy of Aboriginal inmates are the higher rates of suicide and injury from violence (**Exhibit "J"**).

21. The above area small sample of the expert opinion regarding the challenges and significance of prison health care, and how the CSC struggles to meet these challenges. Based upon my knowledge of correctional operations, I believe these issues are extremely relevant today as CSC deals with COVID-19.

22. Correctional Service of Canada efforts to reduce risk of infection within its facilities include the cancellation of most activities and programs, increased time in cell, restrictions on access to non-urgent health and dental care, staff reductions which result in significant service limitations, and focusing remaining capacity on older and vulnerable prisoners at the expense of the planned ongoing treatment of others. In a published statement (**Exhibit "K"**), the CSC notes the following COVID-19 responses with specific impact on those in custody:

- CSC has suspended visits to offenders, temporary absences (except for medical escorts) and work releases. CSC is supporting inmates staying connected to family and community by video visitation or telephone, as well as looking at additional measures to maintain the calm in institutions.
- CSC has waived telephone, accommodation and food deductions for inmates, and has provided additional minutes on their phone accounts. This will help them to continue connecting with family, friends, and support networks.
- All inter-regional and international transfers of inmates have been suspended.
- CSC is increasing supply of medication for offenders on release to reduce the burden of the health care system and provide offenders with more time before visiting a pharmacy or seeing their physician.
- CSC is actively screening offenders in CSC institutions upon arrival.
- CSC has asked legal counsel to postpone visiting institutions and maintain access by telephone. Case-by-case accommodation will be facilitated, where essential.

23. In my opinion these efforts should be considered only first steps. Making custody less humane, less focused on activities that aid reintegration and less likely to be rehabilitative is contrary to CSC's purpose and duty of care. Actions taken during this pandemic, including policy revisions, should have preservation of life as a focus while working to maintain the integrity of CSC's overall mission.

24. Taken together, prisoner demographics in federal penitentiaries (an aging population with generally poorer health than people outside of prison, a high proportion of vulnerable and marginalized populations heavily negatively impacted by the social determinants of health, a high prevalence of substance misuse and mental health issues), security driven infrastructure not well suited to responding to the provision of health promotion, prevention and treatment, challenges in recruiting and retaining health professionals, and a lack of data and analysis to help shape CSC health care strategies, planning and provision make Canada's federal prisons dangerous places for those in custody during this pandemic.

25. It is clear to me that there are too many structural and operational barriers to overcome before current levels of incarceration can be safely maintained. The dual purpose of prisons is to protect the public and prepare those who are incarcerated for safe and timely return to the community. Both goals are undermined by the pandemic. Public safety and public health both

suffer when prison conditions threaten the health and well being of those in custody and those who are responsible for their care.

What release policies and practices have correctional services, aside from the Correctional Service of Canada (CSC), put in place since the outset of the pandemic, and what have been the results of theses policies and practices, including the impact on public safety?

26. Correctional services around the globe have been adapting to the pandemic. Most are changing policy and practice while some jurisdictions have altered corrections legislation and regulation. The intent is to decrease the number of people in custody and reduce the likelihood of infection for those who remain.

27. A Lancet article published May 2, 2020 (**Exhibit "L"**) provides a sobering international overview. Unsafe, unsanitary, and crowded conditions of confinement, inadequate access to health services, poor nutrition, and a health-compromised prisoner population characterize the jurisdiction reviewed in the article. Specific to COVID-19, the author reports the following:

> In the UK, COVID-19 has been detected in the majority of prisons.
>
> The Marion Correctional Institution in Ohio, USA, holds around 2500 detainees. As *The Lancet* went to press, more than 2000 of them had tested positive for COVID-19.
>
> According to the New York City Board of Correction, there are currently 378 cases of COVID-19 among inmates in the city jails, equating to an infection rate of around 10% (based upon acknowledged inadequate testing).

28. The key conclusion is that decarceration is the "only answer" to meeting the threat of COVID-19 and that several jurisdictions have in fact prioritized release as their response.

29. On April 28, 2020, the U.S based Prison Policy initiative reported 49 separate local, county and state initiatives reducing custody populations in response to COVID-19. These include a 44% drop in the Hennepin County, Minnesota jail population and a 41% decrease in Denver, Colorado following the release of those over 60, those who are pregnant, those with health vulnerabilities and those with less than 60 days remaining in their sentence. Dallas County, Texas released 1000 prisoners to help reduce transmission and Los Angles County Sheriff's Department is releasing people with less than 30 days remaining on their sentences (**Exhibit "E"**).

30. Some U.S. jurisdictions are taking proactive measures, others are responding to court orders. Some state governors (including Tom Wolf in Pennsylvania, Jay Inslee in Washington, and Phil Murphy in New Jersey) have signed executive orders to facilitate the early release of sentenced, non-violent prisoners. The press release announcing the Washington State initiative is explicit that the purpose of accelerated release is to affect physical distancing:

> The Washington State Department of Corrections is planning for the transfer of incarcerated individuals back to their communities. The goal in transferring a limited number of individuals to the community is to provide more physical distancing within the state's correctional facilities. (**Exhibit "M"**)

31. There are at least two legislative proposals before the United States House of Representatives (H.R. 6400: A bill to require the release of certain individuals in custody in the United States because of their risk of exposure during a national emergency and for other purposes (**Exhibit "N"**); H.R. 6414: A bill to amend the Omnibus Crime Control and Safe Streets Act of 1968 to establish the Pandemic Jail and Prison Emergency Response grant programs and for other purposes (**Exhibit "O"**)) that, if passed, will mitigate the risks associated with COVID-19 through depopulation.

32. The issues and challenges driving concern and action internationally are not dissimilar to the those faced in Canada. Canada's provinces and territories have implemented initiatives to both reduce intake and to mitigate health risks. Common elements of the response to COVID-19 by correctional services across the country include enhanced personal protection measures for staff that follow general public health advice, provision of written infection management information to employees, provision of personal protective equipment, and screening and temperature checking of people entering facilities. Movement in and out of, as well as within, correctional facilities has been significantly restricted. Programs, activities, and other forms of association have been cancelled or curtailed. In-person visits are almost uniformly forbidden, and telephone and video contact has been enhanced. Testing of prisoners with flu-like symptoms is commonplace. These announced measures have yet to be evaluated or audited. After 12 years of serving as the oversight agent for the CSC, I know that without external monitoring and reporting, we will never know how robustly these initiatives are being implemented or what their impact is on prison population and staff health.

33. Between March 12, 2020 and April 15, 2020 Ontario reduced its custody population by 29%. This has been achieved through regulatory changes and collaborative efforts between ministries, police and other agencies to increase the use of video court appearances, encourage the use of non-custodial sentences, permit longer-term temporary absences, conduct remote parole hearings and reduce the number of bail hearings. Ontario Corrections now proactively performs a temporary absence review for all prisoners with less than 30 days remaining on their sentence and is granting temporary absences to those serving intermittent sentences. (**Exhibit "P"**).

34. British Columbia released nearly 6% of its in-custody population between March 1, 2020 and April 1, 2020. Most of those released were serving intermittent sentences. Their release followed individual risk assessments prompted by a desire to reduce the potential for an outbreak within correctional facilities. Pre-trial intake has also declined, further reducing the in-custody population. B.C Corrections has initiated daily pandemic planning meetings within all its jails.

35. Manitoba has used Unescorted Temporary Absences to reduce its custody population and to allow those sentenced to intermittent incarceration to serve their sentences at home. The "count" as of April 27, 2020 was 1638, down from an average daily "count" of 2144 during the fiscal ending March 31, 2020.

36. As of April 22. 2020, Nova Scotia had reduced its custody population by nearly 50% (from 452 to 251). Temporary Absences for those serving intermittent sentences and those within 30 days of their sentence ending, public health focused case reviews and the use of video bail hearings on weekends and over Easter contributed to the reduction. Between March 1, 2020 and March 23, 2020, Newfoundland and Labrador released 17 prisoners from custody who were within 30 days of their sentence end. An increase in bail hearings has led to a reduction of the remand population.

37. Clearly, provincial and territorial governments are aware of the risks to the health of custodial populations during a pandemic and are engaged in mitigation initiatives. While some jurisdictions are reporting few or no cases of COVID-19, all are taking preventative measures, including early release. The use of temporary absences, identification of at-risk individuals, enhanced case work and assessment and working with community partners have contributed to

reduced custody populations and the potential spread of disease. In my opinion, these measures, while reflecting good correctional practice at any time, are particularly important during a pandemic.

38. Concerns have been expressed that early release initiatives will compromise public safety. There is no evidence to support this concern. There is evidence that incarceration rates and crime rates are predominately independent of each other (see articles attached as **Exhibit "Q"** and **Exhibit "R"**). As Andrew Coyle, the founder of the International Center for Prison Studies, has said "…we can safely say that the difference in rates of imprisonment between the United States and neighbouring Canada, between England & Wales and Germany, between New Zealand and Australia and between the other countries which I have mentioned cannot be explained by differences in levels of crime" (**Exhibit "S"**).

39. The Prison Policy Initiative has documented 14 examples of large scale decarceration in the United States, Finland, Czech Republic, Israel, Italy, and Russia (**Exhibit "T"**). What all these examples share is no documented increase in crime rates or seriousness.

40. A Canadian example of safe decarceration took place in Alberta between 1993 and 1997. During that period, Alberta saw its use of incarceration drop by 32% (**Exhibit "U"**). This drop was not because of a sudden decrease in arrests, charges, or prosecutions, but the result of fiscal policy driving all provincial government departments to cut budgets and reduce spending. Once again, there is no evidence of a crime wave following the decarceration.

41. Parole success rates in Canada are high. The successful completion rate for federal day parole releases in 2017-18 was 92.2%. Most day parole breaches result from violation of conditions of release, not new crimes. Over the last five years, the rate of violent re-offending for federal prisoners released on day parole averaged 0.1%. The success rate for federal prisoners released on full parole has increased to 90.5% while the rate of violent re-offending for those in the community on full parole has been decreasing over the last five years, averaging 0.5% (**Exhibit "B"**).

42. The topic of a January 2020 gathering of justice sector leaders in Montreal was Alternatives to Short Term Custody. Our deliberations were informed by presentations from

Scotland, Denmark, and Norway – jurisdictions that have made efforts to reduce or eliminate short-term sentences to custody. While the agenda and presentations remain privileged, there will be a report shared with Federal/Provincial/Territorial justice sector ministries. The report will include advice regarding safe alternatives to custody based in part on the evidence that short sentences are not effective deterrents and may in fact contribute to criminality. These conclusions are broadly supported in published criminal justice and corrections research. The clear policy implications are that Canada should avoid short periods of incarceration and pay rigorous attention to the principle of restraint that requires incarceration to be used as a last resort.

How does CSC's response to the COVID-19 pandemic compare to the response of other jurisdictions, and are there steps CSC should be taking to ensure that the living and working conditions inside Canada's penitentiaries are safe and healthy?

43. The Correctional Service of Canada last renewed its Public Health Strategy in 2010. The strategy was to be implemented over five years. The Strategy recognizes both the compromised health status of the prisoner population and the high risk of disease transmission within prisons.

> The penitentiary environment inherently presents the potential for the transmission of diseases, given the high number of persons in close confinement and the daily movement of staff, visitors and others from the community in and out of the penitentiary.
>
> The potential for transmission of air-borne, sexually transmitted and blood-borne pathogens is heightened by the generally poorer levels of health among inmates, many of whom also have a history of high-risk behaviours such as injection drug use, sex work, and unprotected sex with high-risk partners, and by the compromised health of those with chronic diseases (**Exhibit "V"**).

44. The Strategy identifies seven strategic areas: Infectious disease prevention, control and management, Health promotion and health education, Surveillance and knowledge sharing, Aboriginal and women offender health, Healthy environments, Public health competencies, and Visibility and accountability. The Public Health Program that implemented the Strategy was to be evaluated in in 2014. While CSC did release an evaluation of its health services in March 2017, the Public Health Strategy is not mentioned (**Exhibit "W"**). I am not aware of any specific evaluation, audit or monitoring of the Public Health Strategy. Over the last decade, some of CSC's Reports on Plans and Priorities have included statements regarding infectious disease

screening and monitoring and specifically mention hepatitis C, HIV and tuberculosis. The Service's 2019-20 Department Plan (**Exhibit "X"**) makes a single reference to infectious diseases, but no mention of the Public Health Strategy. It is my opinion there has been inadequate implementation of the Public Health Strategy and no meaningful follow-up or assessment. This has left CSC poorly informed regarding the effectiveness of its strategy and its ability to identify health needs of prisoners, plan and deliver necessary public health activities and respond swiftly to emerging public health concerns.

45. The CSC has announced it is taking steps to reduce harm and risk during the pandemic, including increasing supplies of medication and cleaning supplies, screening all people entering institutions, and enhancing governance and information sharing practices and activities related to the health emergency. The stated focus of all these activities (detailed at **Exhibit "C"**) is to minimize the risk of introducing COVID-19 to institutions. This is laudable and these measures are necessary, but not sufficient. They fall short of recognizing that reducing the in-custody population is the safest practice during the pandemic. These initiatives do not reflect the content of the Service's Public Health Strategy, nor do they reflect the totality of good practices instituted in other jurisdictions.

46. A recent update issued by the Office of the Correctional Investigator (**Exhibit "Y"**) includes the following observations:

> There appears to be an overall spike in incidents involving unusual or non-compliant inmate behavior at a number of sites, including disciplinary problems, protests, threats against staff, assaults on inmates, hunger strikes and other disturbances.
>
> Prison gyms and libraries are closed and access to yard and fresh air has been extremely curtailed.
>
> Communal eating and serving have been halted in most facilities.
>
> Out of cell time is has been limited to 2 – 4 hours.
>
> Despite these efforts to limit movement and association, practising safe physical distancing is to expect the impossible.
>
> It is remarkable the spread of COVID-19 has been limited to only 5 institutions.

47. It is important to note that inadequate health planning and provision also puts staff at risk. While CSC addresses staff well being in its stated COVID-19 response, it is impossible to separate health and safety concerns of staff from those of prisoners.

48. On April 9, 2020 CSC reported the that number of positive COVID-19 cases among the prisoner population was less than 0.5%. With a custody population of approximately 13,800, this suggests we could expect a few less than 70 cases. On the same date, the Public Health Agency of Canada reported that Canada had 20,748 confirmed COVID-19 cases. Based on an estimated population of 37,700,000, if Canada had the same infection rate as CSC, there would be over 188,000 confirmed cases. Clearly a rate of 0.5% for those in federal prisons is not good news and is dramatically higher than the rate in the community.

49. During an April 20, 2020 news briefing on Canada's response to COVID-19, Public Safety Minister Bill Blair remarked "[Corrections officials] have been working hard to make sure those individuals are considered for early release, and literally hundreds of people have, in fact, been placed back into the community" (**Exhibit "Z"**). While it is technically true that hundreds of people had been released during the previous few weeks, there is no evidence the releases were the result of COVID-19 related activities. During 2017-18, the average number of combined day parole, full parole and statutory releases was 139 per week. Over a three-week period, we could expect that over 400 people would be released from federal penitentiaries without resorting to extraordinary measures.

50. An analysis done by the Office of the Correctional Investigator (**Exhibit "AA"**) confirms that release from federal penitentiaries has not accelerated during the pandemic. The analysis leads to four key conclusions:

- The population of federal prisoner has declined by 338 (2.4%) since its peak 2020-03-01
- The community population has increased by 61 (0.7%) offenders since 2020-03-01
- This appears to have resulted from a significant drop in warrant of committal admissions and a smaller drop in conditional release revocations

- There has been no increase in overall releases although day paroles have increased in the last two weeks

51. According to the Corrections and Conditional Release Statistical Overview 2017-18 (**Exhibit "B"**):

> 49.4% of federal prisoners are serving a sentence of less than 5 years.
>
> 23.3% of federal prisoners are serving a sentence of less than 3 years.
>
> On average 36.7% of the sentence is served prior to first day parole release.
>
> 24.2% of prisoners are classified at minimum security

52. The CSC has reported that nearly 1/3 (31%) of prisoners in 2017-18 were sentenced for non-violent or drug related offences (**Exhibit "BB"**). The above suggest there is a large pool of non-violent, low risk prisoners who could be considered for accelerated release. This was also true during my tenure as Correctional Investigator of Canada and was compounded by the number of prisoners who remained in custody well beyond their first parole eligibility date, even when they were housed in minimum security. In my opinion, given the current circumstance, the status quo is not defensible.

53. COVID-19 poses a threat so serious that governments have all but shut down our economy and mandated physical distancing. It is difficult to reconcile why CSC has not responded to the pandemic in kind.

54. I believe CSC has the ability to dedicate more resources to case review that would identify every prisoner with health vulnerabilities and other personal circumstances that could be addressed through early release. At the same time, increased efforts are possible to expedite release planning and identify community supports for those returned to their communities. Based upon my experience, it is a reasonable expectation that the Service would explore all forms of release and to amend any operational policies (Commissioner's Directives) that are contrary to this initiative. As a priority, CSC could ensure that cases are referred to the Parole Board Canada in advance of the first eligibility for consideration of conditional release.

55. Having been a Regional Vice-Chair, I am familiar with the operations of the Parole Board Canada. I am confident the Board could review and adjudicate Parole by Exception

requests made pursuant to s121(1) of the *Corrections and Conditional Release Act* (*CCRA*) on an urgent basis if it was provided additional resources targeted to this task. The Board could also increase capacity to process applications for clemency under the Royal Prerogative Mercy when the applications are clearly based on the undue hardship resulting from the presence of COVID-19 in the applicants place of custody.

56. Commissioner's Directives (CDs) regarding security classification (particularly CD705 (initial classification), CD710-6 (classification review) and CD081 (appeal of initial classification)) are important operational polices that could be amended to better support the goal of moving people as expeditiously as possible to lower security classifications and closer to community release.

57. Based upon my knowledge of the general importance and positive effect of Temporary Absences (TA), I believe their use has been unreasonably curtailed. The language and definitions in Commissioner's Directive 710-3, along with related CDs, could be more liberally interpreted or even amended to broaden the availability of TA and remove arbitrary restrictions. As has been done in other jurisdictions, the Government of Canada could propose amendments to the legal framework governing corrections. For example, the *CCRA* could be amended to ensure that risk of exposure to COVID-19 is considered grounds for an indefinite medical temporary absence.

58. I do not find that the Service is using its full authority granted by the CCRA. For example, sections of the *CCRA* that allow a Warden to refuse to receive a person into prison without medical certification stating whether or not the person appears to be suffering from a dangerous, infectious or contagious disease (s13), granting the authority to release a prisoner five days ahead of statutory or sentence expiration release (s93(2)), or giving the Commissioner the ability to designate alternate places of custody to be penitentiaries (s7) do not appear to be part of the current discussion. Importantly, the authority to designate other places to be penitentiaries does not mean that persons housed in such places are not in custody, only that their place of custody has changed. It is my opinion that health status should be considered appropriate grounds for alternative custody arrangements.

59. When people are sentenced to prison, they are not sentenced to further punishment that may arise from the circumstances of imprisonment. Correctional services are not supposed to add to the sentence of the court through unreasonably harsh, punitive, or dangerous conditions of confinement. The threat of COVID-19 in prison posses a grave risk to health. Death can come suddenly after exposure, particularly if health treatment is not immediately available. I believe this is above and beyond what could be considered as the inherent pains of imprisonment.

60. I make this affidavit in support of this Application, and for no other or improper purpose.

AFFIRMED BEFORE ME by
videoconference in the City of Ottawa,
in the Province of Ontario,
this 19th day of June, 2020

A Commissioner for taking affidavits, etc.

ADRIEL WEAVER
LSO 54173D

Howard Sapers

This is **Exhibit "A"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

_____

A Commissioner, etc

Howard Sapers 2020-05-10

323 SUMMIT AVENUE, OTTAWA ONTARIO K1H 5Z7
HOWARD.SAPERS@GMAIL.COM 613-731-5652

- **Ombudsman, oversight, and accountability expertise**
- **Justice Sector program, policy, and operations expertise**
- **Recognized leadership skills**
- **Track record of management excellence**
- **Trusted advisor**
- **Significant experience in managing complex investigations**
- **Demonstrated ability in interpreting and applying law and policy**
- **Effective multi-level communication skills – internal, public and media**
- **Proven opportunity assessment / critical analyses / options formulation abilities**
- **Demonstrated ability in financial administration and human resources management**
- **Collaborative, Innovative, and adaptable**

- ***EXPERIENCE:***

Current ***Consultant and Subject Matter Expert***

Working with a variety of government and non-governmental clients, I provide policy and operational advice on accountability, oversight, and correctional services. I provide keynote and workshop presentations, advise on matters related to correctional practices and offer instruction on the role and function of ombudsman.

Current *Simon Fraser University School of Criminology*
Adjunct Professor

Current *University of Ottawa Department of Criminology*
Visiting Professor

2017 - 2018: *Independent Advisor on Corrections Reform*
Government of Ontario

On January 1, 2017 I was appointed by the Government of Ontario to review the province's corrections system and provide advice to improve operations and outcomes. My mandate was to build a review team and produce three reports with recommendations that would reduce the use of segregation, provide alternative strategies and capacities for vulnerable populations including those with acute mental health issues, improve the conditions of confinement for those who must be housed separately from others, and ensure there are robust accountability and oversight mechanisms. My reviews also addressed Indigenous issues in corrections, staff recruitment and training, infrastructure concerns, information management and analysis, and institutional violence. My work has resulted in significant policy renewal, operational changes and new corrections legislation for the province.

2004 – 2016: *Office of the Correctional Investigator*
Correctional Investigator

Appointed by the Governor in Council, the Correctional Investigator is the Ombudsman for federal offenders. As Head of this independent agency, I acted as the designated Accounting Officer. The Office is a separate employer and I had delegated authority for all human resource matters. I represented the Office to the public, within the Public Safety portfolio and across government. The primary function of the Office is to investigate and bring resolution to individual concerns and to identify systemic issues. Annual and Special Reports are made to Parliament through the Minister of Public Safety. The Office is located in Ottawa. The Office responds to well over 20,000 contacts per year and conducts hundreds of investigations and statutory reviews of serious incidents.

As Correctional Investigator I determined the nature of investigations, formulated recommendations and served as the primary spokesperson for the work of the Office. The legal authority for the Office is the *Corrections and Conditional Release Act*. Recent focus has been on mental illness, preparation for release and reintegration, deaths in custody, Indigenous offenders, vulnerable sub-populations and the use of force in corrections. By the end of my tenure, the Office had built a solid reputation as a primary source of unbiased information and was well respected for the quality of its work and the positive impact achieved.

Between 2011 – 2013 my office engaged in a bilateral consultation and technical training exchange with the Ministry of Public Security of the People's Republic of China. This 2.5 year project focused on use of force and involved leading a delegation to China to meet with officials and conduct site visits to jails and police lock-ups, host two Chinese delegations to Canada and deliver a final seminar summarizing findings and offering advice to improve operations and oversight.

2003-2004 *National Parole Board*
Vice Chairperson, Prairies Region

I was appointed to a five-year term by Governor in Council. As Vice Chair, I was not only responsible for decisions regarding the conditional release of Federal and Provincial offenders, but also for supporting all full and part-time Board Members in the Region and serving on the Board's Executive Committee. This leadership position included both operational and management responsibilities. Success required full knowledge of the *Corrections and Conditional Release Act* and a deep understanding of administrative law principles. My role included involvement in policy development and significant horizontal initiatives. Together with the Regional Manager, I had responsibility for both the Edmonton and Saskatoon offices. This included budget development, inter-agency and inter-governmental relationships and community engagement regarding Board activities. Skills utilized in this position included applying law and policy to decision making, following the principles of natural justice and plain language decision writing.

2001-2003 *National Crime Prevention Centre (Department of Justice)*
Director, Crime Prevention Investment Fund

While located in Edmonton, this was a national program and required that an Executive Office be established under my direction. I was responsible for managing a national program to fund Crime Prevention Through Social Development demonstration projects; making funding recommendations to the Minister of Justice; directing staff activities in six offices across Canada; and administering over 30 projects with combined budgets in excess of $45 million. Achievements included creating a management structure for a nationally delivered contribution fund; providing input into the renewal of Canada's Drug Strategy; helping to establish Drug Treatment Courts in Canada; reviewing and recommending on over 600 applications for funding. Funded projects included early intervention, capacity building and primary prevention initiatives across Canada. I acted as the liaison between the Centre and the Federation of Canadian Municipalities and the Canadian Association of Chiefs of Police.

1993-2001 *Legislative Assembly of Alberta*
Member, Edmonton Glenora

I served as Health Critic and was a Member, Select Committee on Privacy and Freedom of Information; Member, Standing Committee on Privileges and Elections; Member, Standing Committee on Heritage Savings Trust Fund; Member, Opposition Task Force on Young Offenders; and Chair, Caucus Strategy Committee. Achievements during tenure as an MLA included managing the political response to budget reductions for publicly-funded health services; direct involvement in the hiring of a Chief Electoral Officer and an Ombudsman for the Province of Alberta; introducing the Non-smokers Health Act as a Private Member's Bill which directly led to the current law; negotiating the schedule and timing of debate in the Chamber as well as in Committee. During my second term I served as Acting Leader, Official Opposition, Treasury Critic; Innovation and Science Critic; Advanced Education Critic; Official Opposition House Leader; Member, Standing Committee on Public Accounts; and Member, Standing Committee on Legislative Offices. My duties including meeting with federal, municipal, health and school board elected officials. Serving as an elected Member provided a firsthand opportunity to be involved in the review and crafting of legislation, the review of public accounts and to gaining a broad understanding of a vast array of public services.

1982-1993 *John Howard Society of Alberta*
Provincial Executive Director (1986-1993)
Director, Program Development and Research (1984-1986)
Executive Director, Grande Prairie District (1982-1984)

Responsible for leading and managing this non-profit agency providing crime prevention programs for offenders and their families, ex-offenders, young persons, and the public; and providing programs and assistance for the reintegration of offenders into society. I gained significant and direct experience in reporting to and working with a volunteer Board of Directors. I managed a professional staff and was the primary liaison between the agency and government, media and the public.
Achievements included developing a research capacity for the Society, creating a monthly newsletter for members, developing a national direct-mail fundraising effort, creating and editing a series of four children's books explaining corrections, negotiating new Terms of Association with the six district offices leading to the establishment of the districts as separately incorporated Societies and moving from a hierarchical organization to a federated organization. Lessons learned about the importance of inclusion, the value of multiple points of view and the management of competing interests have had lasting impact.

1986-1993 *Grant MacEwan College, Correctional Services Program*
Sessional Instructor (Part Time)

- ***POST-SECONDARY EDUCATION:***

1976-1980 *Simon Fraser University – Burnaby, BC*
Bachelor of Arts Degree (Criminology)

1981 ***Master of Arts – course requirements completed/degree not obtained***

- ***ADDITIONAL AFFILIATIONS AND RESPONSIBILITIES:***

- **Centre for Addiction and Mental Health (CAMH) Board of Trustees, Member (Current)**
  The Board has overall responsibility for governance and providing strategic leadership in furthering the vision, mission, goals and values of Canada's largest mental health teaching hospital.

- **Ryerson University Department of Criminology Advisory Committee, Member (Current)**
  Provides feedback on course offerings and participates in setting strategic direction for the department.

- **Legal Aid Ontario Prison Law Advisory Committee, Member (Current)**
  Provides advice and strategic direction regarding how to best serve incarcerated clients through both policy development and direct service.

- **Department of National Defence/Canadian Forces Ombudsman Advisory Committee, Chair (2009- 2016)**
  Appointed by the Minister of National Defence as the sole external member and Chair, this committee provides advice to the National Defence and Canadian Forces Ombudsman regarding the discharge of his duties.

- **Government of Canada Small Departments Audit Committee, Member (2008– 2015)**
  Appointed by the Secretary of the Treasury Board upon the advice of the Comptroller General of Canada, this committee serves as the Internal Audit Committee for the community of small federal departments and agencies.

- **Centre for Public Legal Education, Member of the Board of Directors, Member (2009 – 2015)**
  This not-for-profit organization has a mandate to contribute to, advance and promote the legal knowledge and education of the people of Canada.

- **International Ombudsman Institute, North American Board Member (2013 – 2016)**
  Established in 1978, the Institute is committed to promoting and developing the Ombudsman concept through research, training, information exchange and dialogue.

- **Canadian Criminal Justice Association, Past President and Member (1985 – 1998)**
  The Association is an independent national voluntary organization working for an improved criminal justice system in Canada.

- **Forum of Canadian Ombudsman, Member of the Board of Directors, Member (2005 – 2016)**
  The Forum is a voluntary association that promotes the Ombudsman role in all sectors by encouraging and sharing ideas, finding innovative solutions and best practices and developing professional standards.

- **Heads of Federal Agencies Steering Committee, Member (2013 – 2016)**
  This committee facilitates the open exchange of information between federal agencies and central authorities and represents the community of small departments and agencies to government.

PROFESSIONAL DEVELOPMENT HIGHLIGHTS:

2020 San'yas Indigenous Cultural Safety Online Training Program
2010 Management Control Frameworks – Office of the Comptroller General – Ottawa
2009 Systemic Investigations – The Workplace Institute
2009 Risk Based Audit Plans – Office of the Comptroller General - Ottawa
2006 Accountabilities for Heads of Federal Agencies – Canada School of Public Service – Ottawa
2006 What Constitutes Effective Prison Oversight – LBJ School of Public Service – Austin, TX.
2006 ICMS@Work – Federal Conflict Resolution Network – Gatineau, PQ
2002 The Power of a Progressive Workplace – Department of Justice Canada – Kelowna, B.C.
2002 Aboriginal Cultural Awareness – National Crime Prevention Centre – Vancouver, B.C.
1997 Achieving Satisfying Justice: A Symposium on Implementing Restorative Models – Vancouver, B.C.
1996 Israeli Forum: Preparing for the Palestinian Elections – Jerusalem, Israel – Invited Participant
1987 Helping Adults Learn – Grant MacEwan Community College In-Service Training – Edmonton, AB

- ***ACCREDITATIONS:***

- University of Ottawa Honorary Doctorate (conferred Spring Convocation 2016)
- Native Counselling Services of Alberta Outstanding Contributions Award 2015
- Simon Fraser University Outstanding Alumni Award (Public Service) 2014
- Queen Elizabeth II Diamond Jubilee Medal for Exemplary Service 2012
- President's Commendation Canadian Psychiatric Association 2010
- Champion of Mental Health Award Canadian Alliance on Mental Health and Mental Illness 2010
- Canadian Council on Social Development Weiler Award for outstanding commitment to the pursuit of social justice and social development 2003
- Queen Elizabeth II Golden Jubilee Medal recognizing significant contributions to Canadians 2003
- Canadian Criminal Justice Association Achievement Award 1997
- City of Edmonton Recognition Certificate for excellent service to the Action Group on Prostitution 1994
- John Howard Society of Canada Outstanding Service Award 1993
- City of Edmonton Salute to Excellence Award for contributions to Health & Social Services 1993
- Government of Canada 125th Anniversary of Confederation Commemorative Medal 1992

- ***SELECTED PUBLICATIONS:***

Sapers, H. (2006). "The Ombudsman as a Monitor of Human rights in Community Corrections." *An Introduction to Community Corrections in Canada and China.* The International Centre for Criminal Law Reform and Criminal Justice Policy / China Prison Society.

Sapers, H. (2006). "The Correctional Investigator." *Law Now,* 30(5).

Sapers, H. (Summer 2010). "Safer Custody: What Canada can learn from the United Kingdom." *Justice Report, 25*(3), 4-8.

Sapers, H. & Zinger, I. (Fall 2010). "The Ombudsman as a Monitor of Human Rights in Canadian Federal Corrections." *Pace Law Review, 30*(5), 1512-1528.

Sapers, H. & Hurst, C. (2013). "Oversight and Accountability in Federal Corrections: The Office of the Correctional Investigator." In J. Winterdyk & M. Weinrath (Eds.). *Adult Corrections in Canada.* Whitby, Ontario: DeSitter Publications.

Sapers, H. (Summer 2014). "A Decade of Correctional Oversight: 2004-2014." *Justice Report*, 29(3).

Murphy, Yoko, Andrea Monteiro & Howard Sapers (Winter 2019) "The Challenges of an Aging Population in Ontario Correctional Facilities". *Justice Report*, 34(4)

Sapers, H. & Murphy, Y. (April 2020) "Prison Health as Public Health in Ontario Corrections". *Journal of Community Safety and Well Being,* 5(1)

- ***SELECTED PRESENTATIONS:***

May 26, 2005 "Parole and Conditional Release at the Crossroads" Ting Forum Morris J. Work Centre, Vancouver, B.C.

June 21, 2005 "Prison Drugs Use and Public Health" Lockdown: Drug, Prisons and Disease in our Communities Morris J. Work Centre, Vancouver B.C.

February 7, 2006 "Human Rights and Corrections: A Prison Ombudsman's Perspective" Australian and New Zealand Society of Criminology Hobart, Australia

February 24, 2007 "Good Corrections = Public Safety" Safe is a Big Word Crime Prevention Conference Grande Prairie Regional College, Grande Prairie, Alberta

March 17, 2007 "The Ombudsman as a Model of Prison Oversight" Academy of Criminal Justice Sciences Seattle, Washington

March 28, 2007 "Disordered Offenders" BCCJA/Justice Institute of British Columbia New Westminster, British Columbia

June 12, 2008 "Human Rights and Corrections: A Prison Ombudsman's Perspective." Madness, Citizenship and Social Justice: A Human Rights Conference Simon Fraser University, Vancouver, British Columbia

October 29, 2008 "Preventing In-Custody Deaths" International Corrections and Prisons Association Prague, Czech Republic

October 30, 2009 "Moving the Monolith: Attempting to Make Change in the Justice System CCJA Congress on Criminal Justice Halifax, Nova Scotia

Sept. 21, 2010 "Getting Started: Planning an Investigation." Forum of Canadian Ombudsman: Ombuds Fundamentals Workshop Toronto, Ontario

October 15, 2010 "Sentencing and Corrections" Canadian Institute for the Administration of Justice Seminar Vancouver, British Columbia

Nov. 16, 2010 "Some Reflections on the Discourse on Crime and Punishment in Canada" 2010 Law Foundation of Saskatchewan Lecture University of Regina, Regina, Saskatchewan

May 5, 2011 "Key Challenges in Federal Corrections and the Role of the Specialized Prison Ombudsman." Presentation to the Manitoba Provincial Judges Court Education Seminar Winnipeg, Manitoba

10 August 2011 "Oversight in Corrections." 2011 Globalization of Crime – Criminal Justice Responses Conference Access to Justice – Rights of the Imprisoned Plenary Session Ottawa, Ontario

September 8, 2011 "Mental Health Challenges in Canadian Corrections." International Corrections and Prisons Association 13th Annual Conference Singapore

October 14, 2011	"Impact of Large Investigations on Ombudsman Offices: The Ashley Smith Case." Federation of Canadian Ombudsmen (FCO) Corrections Seminar Halifax, Nova Scotia
June 8, 2012	"The Canadian Federal Prison Ombudsman and Human Rights: Addressing the needs of mentally disordered, women and Aboriginal offenders in Canada." John Jay College 10th Biennial International Conference NYC, New York
April 4, 2013	"Findings of A Systemic Investigation into the Operation of Aboriginal Corrections" National Forum on Community Safety and Ending Violence Edmonton, Alberta
April 17, 2013	"Respecting Rights in Canadian Prisons" British House of Lords London, United Kingdom
Dec. 10, 2013	"Corrections and Human Rights" Gall Conference 2013 Keynote Address. John Humphrey Centre for Peace and Human Rights Edmonton, Alberta
February 21, 2014	"Chronic Disease and Premature Deaths in Canadian Correctional Facilities" Collaborating Centre for Prison Health and Education University of British Columbia, Vancouver, B.C.
May 23, 2014	"Post-Sentence Issues in the Federal Correctional System" Nova Scotia Criminal Lawyers Association Halifax, Nova Scotia
Sept. 15, 2014	"Reintegration in Canadian Federal Corrections: Challenges and Opportunities" 22nd Annual International Research Conference of the International Community Corrections Association Cleveland, Ohio
April 11, 2015	"Aboriginal People and Corrections" Osgoode Hall Law School Centre for Professional Development Toronto, Ontario
Sept. 11, 2015	"State of Incarceration – Prevention, Prison and Popcorn Film and Forum Evening with Howard Sapers" Waterloo Regional Crime Prevention Council Kitchener, Ontario
Sept. 28. 2015	"Reflections on the Broad Impact of Correctional Policy" Maclean Lecture, University of Victoria Law School Victoria, British Columbia
April 8, 2016	"Fetal Alcohol Spectrum Disorder and Federal Corrections" 7th National Biennial Conference on Adolescents and Adults with FASD Vancouver, British Columbia
May 12, 2016	"Federal Inmate Complaint Resolution" Ombudsmen Behind Bars Seminar Dublin, Ireland
Sept. 15, 2016	"Key Challenges and Directions for Reform" Maddison Chair Lecture in Northern Justice Whitehorse, Yukon
May 5, 2017	"Mental Health and Segregation in Ontario" Ontario Review Board Annual Meeting Toronto, Ontario
Nov. 24, 2017	"Meeting the Needs of Indigenous People in Custody" Alberta Restorative Justice Association Edmonton Alberta
May 1, 2018	"Addressing the Unique Needs of Older Offenders in Canada" National Initiative for the Care of the Elderly Toronto, Ontario
April 17, 2019	"There Are No Sacred Cows (or Ombuds)" FCO/ACCUO 2019 Biennial Conference Toronto, Ontario

This is **Exhibit "B"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

_____

A Commissioner, etc

Public Safety Canada
Sécurité publique Canada

Corrections and Conditional Release Statistical Overview

Canada

Ce rapport est disponible en français sous le titre : *Aperçu statistique : Le système correctionnel et la mise en liberté sous condition.*

This report is also available on the Public Safety Canada website: http://www.publicsafety.gc.ca

August 2019

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ISSN: 1713-1081

Corrections and Conditional Release Statistical Overview

2018

This document was produced by the Public Safety Canada Portfolio Corrections Statistics Committee which is composed of representatives of Public Safety Canada, Correctional Service Canada, Parole Board of Canada, the Office of the Correctional Investigator and the Canadian Centre for Justice Statistics (Statistics Canada).

PREFACE

This document provides a statistical overview of corrections and conditional release within a context of trends in crime and criminal justice. A primary consideration in producing this overview was to present general statistical information in a "user friendly" way that will facilitate understanding by a broad audience. Accordingly, there are a number of features of this document that make it different from typical statistical reports.

- First, the visual representation of the statistics is simple and uncluttered, and under each chart there are a few key points that will assist the reader in extracting the information from the chart.

- Second, for each chart there is a table of numbers corresponding to the visual representation. In some instances, the table includes additional numbers, e.g., a five-year series, even though the chart depicts the data for the most recent year (e.g., Figure A2).

- Third, rather than using the conventional headings for statistics (e.g., "Police-reported crime rate by year by type of crime") the titles for each chart and table inform the reader about the matter at hand (e.g., "Police-reported crime rate has decreased since 1998").

- Fourth, notes have been kept to a minimum, that is, only where they were judged to be essential for the reader to understand the statistics.

- Finally, the source of the statistics is indicated under each chart so that the interested reader can easily access more information if desired.

The *Corrections and Conditional Release Statistical Overview* (CCRSO) has been published annually since 1998. Readers are advised that in some instances figures have been revised from earlier publications. Also, the total number of offenders will vary slightly depending on the characteristics of the data set.

It is hoped that this document will serve as a useful source of statistical information on corrections and conditional release and assist the public in gaining a better understanding of these important components of the criminal justice system.

PREFACE (CONTINUED)

Regarding police crime data from Statistics Canada, until the late 1980s, the *Uniform Crime Reporting* (UCR) survey provided aggregate counts of the number of incidents reported to police and the number of persons charged by type of offence. With the advent of microdata reporting, the UCR has become an "incident-based" survey (UCR2), collecting in-depth information about each criminal incident. The update to this new survey, as well as revisions to the definitions of violent crime, property crime, and other *Criminal Code* offences has resulted in data only being available from 1998 to the present. It is worth noting that the Total Crime Rates presented in the CCRSO differ from those reported by Statistics Canada in their publications. The Total Crime Rates reported in the CCRSO include offences (i.e., traffic offences in the Canadian *Criminal Code* and violations of federal statutes) that are excluded in the rates published by Statistics Canada.

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CONTRIBUTING PARTNERS

Public Safety Canada

Public Safety Canada is Canada's lead federal department for public safety, which includes emergency management, national security and community safety. Its many responsibilities include developing legislation and policies that govern corrections, implementing innovative approaches to community justice, and providing research expertise and resources to the corrections community.

Correctional Service Canada

The Correctional Service of Canada (CSC) is the federal government agency responsible for administering sentences of a term of two years or more, as imposed by the courts. CSC is responsible for managing institutions of various security levels and supervising offenders under conditional release in the community.

Parole Board of Canada

The Parole Board of Canada is an independent administrative tribunal responsible for making decisions about the timing and conditions of release of offenders into the community on various forms of conditional release. The Board also makes pardon decisions and recommendations respecting clemency through the Royal Prerogative of Mercy.

Office of the Correctional Investigator

The Office of the Correctional Investigator is an ombudsman for federal offenders. It conducts investigations into the problems of offenders related to decisions, recommendations, acts or omissions of the Correctional Service of Canada that affect offenders individually or as a group.

Canadian Centre for Justice Statistics (Statistics Canada)

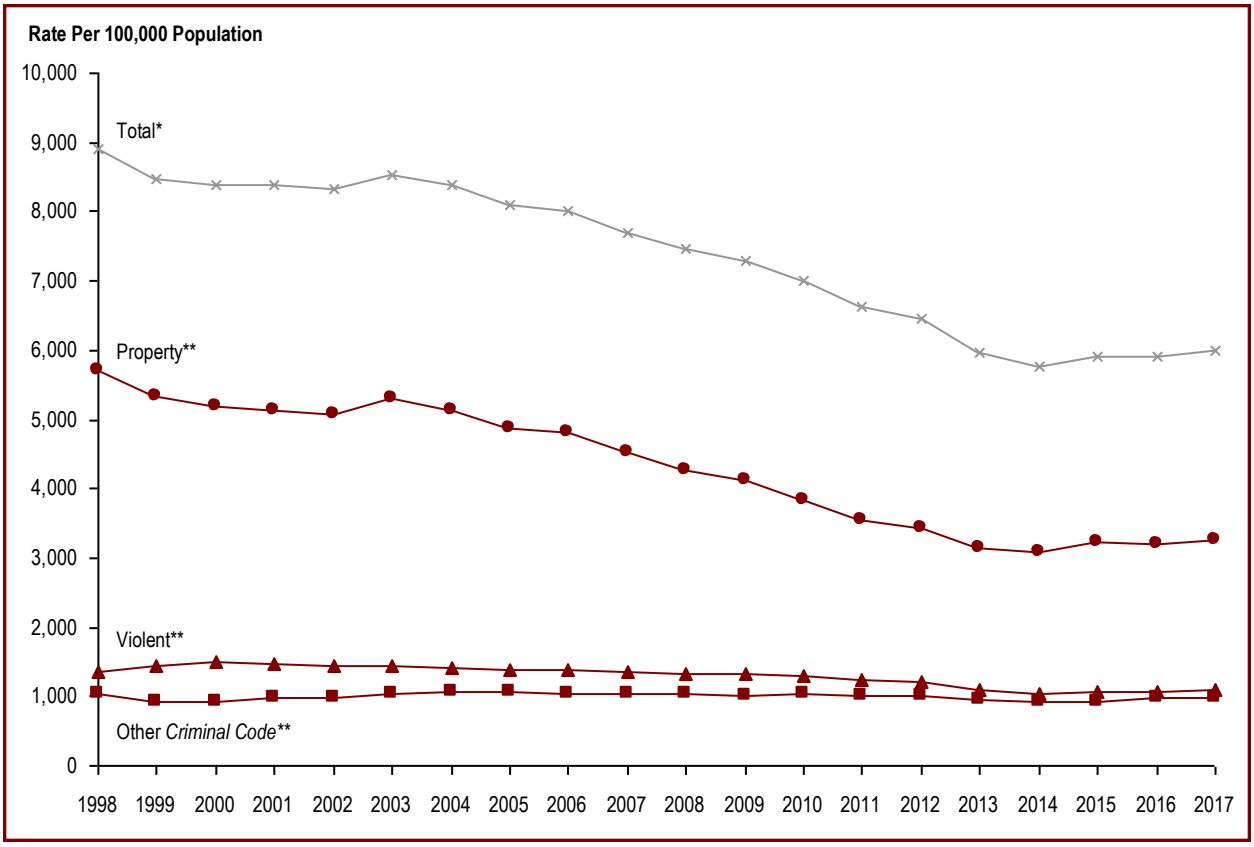
The Canadian Centre for Justice Statistics (CCJS) is a division of Statistics Canada. The CCJS is the focal point of a federal-provincial-territorial partnership, known as the National Justice Statistics Initiative, for the collection of information on the nature and extent of crime and the administration of civil and criminal justice in Canada.

SECTION A

CONTEXT - CRIME AND THE CRIMINAL JUSTICE SYSTEM

POLICE-REPORTED CRIME RATE HAS BEEN DECREASING SINCE 1998

Figure A1



Source: Table 35-10-0177-01, Uniform Crime Reporting Survey, Canadian Centre for Justice Statistics, Statistics Canada.

- The overall crime rate has decreased 36.3% since 1998, from 8,915 per 100,000 to 6,006 in 2017.
- Over the same period, there was a 43.0% decrease in the property crime rate, from 5,696 per 100,000 to 3,245 in 2017. In contrast, the crime rate for drug offences has increased 5.1% since 1998, from 235 per 100,000 population to 247.
- The rate of violent crime has fluctuated over the last 19 years, peaking in 2000 at 1,494 per 100,000 population. Since 2000, the rate of violent crimes had decreased by 26.5% to 1,098 in 2017.
- In general, the crime rates for traffic offences and other *Criminal Code* offences have fluctuated since 1998.

Note:
*Unlike Statistics Canada, the Total Crime Rate in the *Corrections and Conditional Release Statistical Overview* **includes** traffic offences and violations of federal statutes to provide a measure of all criminal offences. As a result, the Total Crime Rate reported here is higher than that reported by Statistics Canada.
**The definitions for Violent, Property and Other *Criminal Code* offences have been revised by Statistics Canada to better reflect definitions used by the policing community. As a result of these changes, comparable data are only available starting in 1998 and the data presented in this year's report are not comparable to the data reported in previous versions of the *Corrections and Conditional Release Statistical Overview*.
These crime statistics are based on crimes that are reported to the police. Since not all crimes are reported to the police, these figures underestimate actual crime. See Figure F1 for rates based on victimization surveys (drawn from the *General Social Survey*), an alternative method of measuring crime.

POLICE-REPORTED CRIME RATE HAS BEEN DECREASING SINCE 1998

Table A1

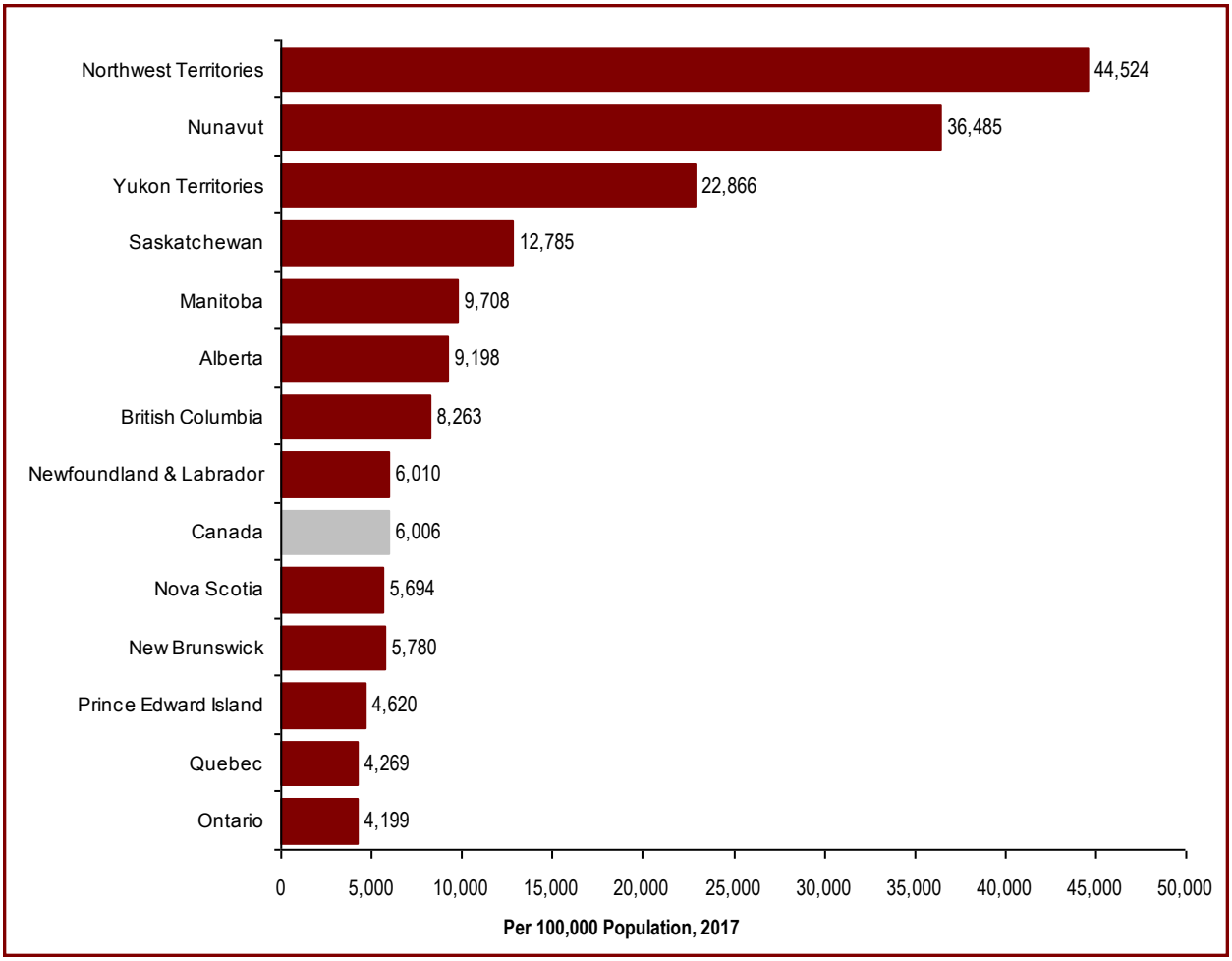
Year	Type of Offence						
	Violent**	Property**	Traffic	Other *CC***	Drugs	Total Other Fed. Stat-	**Total***
1998	1,345	5,696	496	1,051	235	40	**8,915**
1999	1,440	5,345	388	910	264	44	**8,474**
2000	1,494	5,189	370	924	287	43	**8,376**
2001	1,473	5,124	393	989	288	62	**8,390**
2002	1,441	5,080	379	991	296	55	**8,315**
2003	1,435	5,299	373	1,037	274	46	**8,532**
2004	1,404	5,123	379	1,072	306	50	**8,391**
2005	1,389	4,884	378	1,052	290	60	**8,090**
2006	1,387	4,809	376	1,050	295	57	**8,004**
2007	1,354	4,525	402	1,029	308	59	**7,707**
2008	1,334	4,258	437	1,039	308	67	**7,475**
2009	1,322	4,122	435	1,017	291	57	**7,281**
2010	1,292	3,838	420	1,029	321	62	**6,996**
2011	1,236	3,536	424	1,008	330	60	**6,627**
2012	1,198	3,435	406	1,000	317	67	**6,459**
2013	1,093	3,147	386	954	310	52	**5,971**
2014	1,041	3,090	364	915	294	49	**5,777**
2015	1,066	3,218	351	926	278	50	**5,913**
2016	1,052	3,207	345	965	263	59	**5,962**
2017	1,098	3,245	342	991	247	69	**6,006**

Source: Table 35-10-0177-01, Uniform Crime Reporting Survey, Canadian Centre for Justice Statistics, Statistics Canada.

Note:
*Unlike Statistics Canada, the Total Crime Rate in the *Corrections and Conditional Release Statistical Overview* **includes** traffic offences and violations of federal statutes to provide a measure of all criminal offences. As a result, the Total Crime Rate reported here is higher than that reported by Statistics Canada.
**The definitions for Violent, Property, Other *Criminal Code* offences, and Total Other Federal Statutes have been revised by Statistics Canada to better reflect definitions used by the policing community. As a result of these changes, comparable data are only available starting in 1998 and the data presented in this year's report are not comparable to the data reported in previous versions of the *Corrections and Conditional Release Statistical Overview*.
Rates are based on incidents reported per 100,000 population.
Due to rounding, rates may not add up to totals.

CRIME RATES ARE HIGHER IN THE WEST AND HIGHEST IN THE NORTH

Figure A2



Source: Table 35-10-0177-01, Uniform Crime Reporting Survey, Canadian Centre for Justice Statistics, Statistics Canada.

- Crime rates are higher in the west and highest in the territories. This general pattern has been stable over time.
- The Canadian crime rate* slightly increased from 5,970 in 2013 to 6,006 in 2017.

Note:
*Rates are based on 100,000 population.
Unlike Statistics Canada, the Crime Rate in the *Corrections and Conditional Release Statistical Overview* **includes** traffic offences and violations of federal statutes to provide a measure of all criminal offences. As a result, the Crime Rate reported here is higher than that reported by Statistics Canada. In addition, the definitions for Violent, Property and Other *Criminal Code* offences have been revised by Statistics Canada to better reflect definitions used by the policing community. As a result of these changes, comparable data are only available starting in 1998 and the data presented in this year's report are not comparable to the data reported in previous versions of the *Corrections and Conditional Release Statistical Overview*.

CRIME RATES ARE HIGHER IN THE WEST AND HIGHEST IN THE NORTH

Table A2

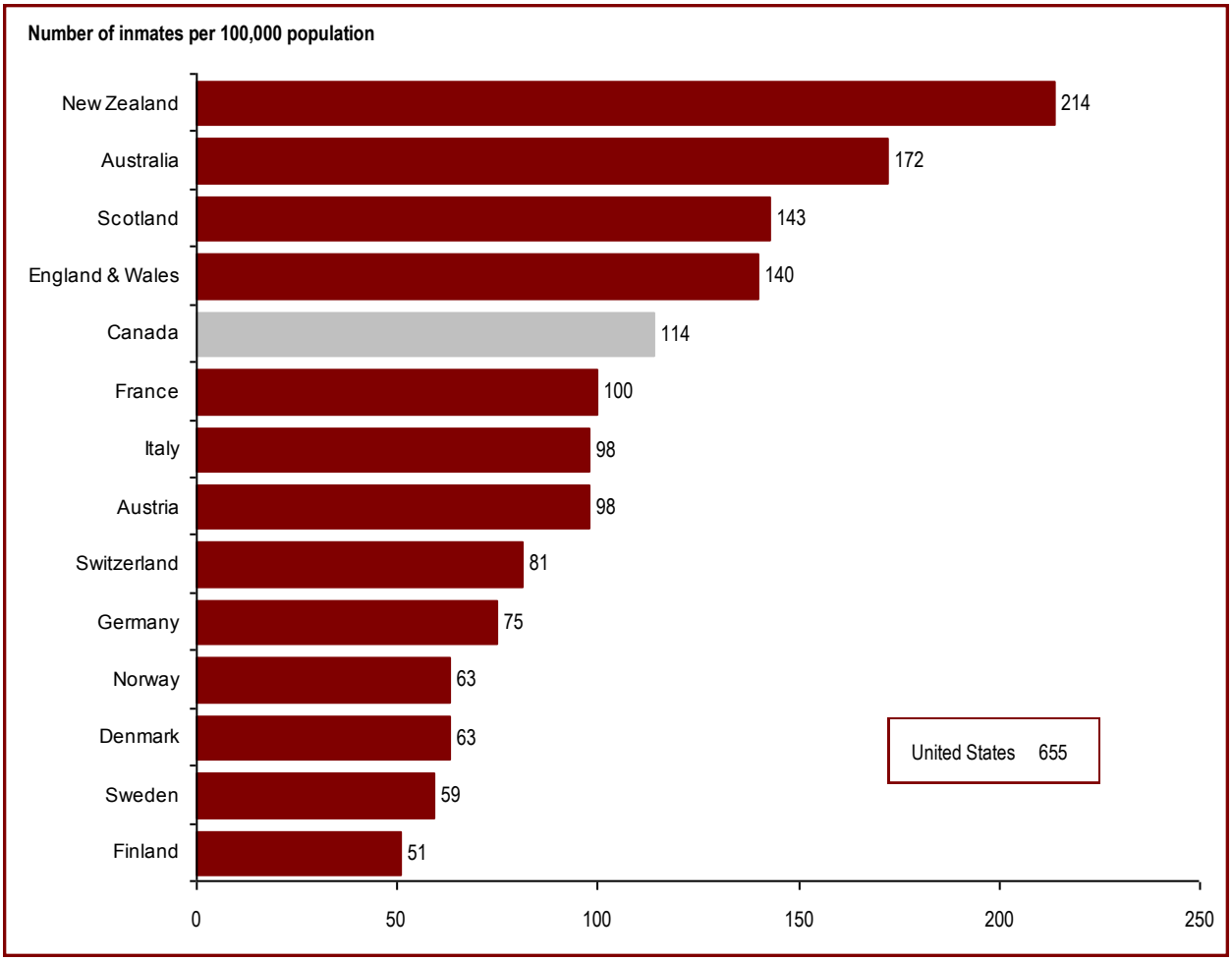
Province/Territory	Crime Rate*				
	2013	2014	2015	2016	2017
Newfoundland & Labrador	6,677	6,216	6,362	6,490	6,010
Prince Edward Island	6,541	5,304	4,677	4,929	4,620
Nova Scotia	6,414	6,229	5,697	5,555	5,694
New Brunswick	5,476	5,072	5,514	5,318	5,780
Quebec	4,701	4,317	4,212	4,184	4,269
Ontario	4,182	4,003	3,998	4,061	4,119
Manitoba	8,720	8,399	8,904	9,479	9,708
Saskatchewan	12,545	12,138	12,803	13,362	12,785
Alberta	7,962	7,986	8,846	8,940	9,198
British Columbia	8,535	8,602	8,758	8,670	8,263
Yukon Territories	26,150	26,430	26,072	23,828	22,866
Northwest Territories	48,550	46,677	47,254	43,351	44,524
Nunavut	34,650	32,628	34,370	35,740	36,485
Canada	**5,970**	**5,777**	**5,913**	**5,961**	**6,006**

Source: Table 35-10-0177-01, Uniform Crime Reporting Survey, Canadian Centre for Justice Statistics, Statistics Canada.

Note:
*Rates are based on 100,000 population.
Unlike Statistics Canada, the Crime Rate in the *Corrections and Conditional Release Statistical Overview* **includes** traffic offences and violations of federal statutes to provide a measure of all criminal offences. As a result, the Crime Rate reported here is higher than that reported by Statistics Canada. In addition, the definitions for Violent, Property and Other *Criminal Code* offences have been revised by Statistics Canada to better reflect definitions used by the policing community. As a result of these changes, comparable data are only available starting in 1998 and the data presented in this year's report are not comparable to the data reported in previous versions of the *Corrections and Conditional Release Statistical Overview*.

CANADA'S INCARCERATION RATE RELATIVE TO OTHER WESTERN EUROPEAN COUNTRIES

Figure A3



Source: World Prison Population List online (retrieved February 12, 2019 at www.prisonstudies.org/highest-to-lowest/prison-population-total.

- Canada's incarceration rate is higher than the rates in most western European countries but much lower than the United States, where the most recent incarceration rate was 655 per 100,000 general population.
- Based on the most up-to-date information available from the International Centre for Prison Studies, Canada's incarceration rate was 114 per 100,000. When ranked from highest to lowest, Canada's prison population rate was ranked 138 of 223 countries.

Note:
The incarceration rate, in this figure, is a measure of the number of people (i.e., adults and youth) in custody per 100,000 people in the general population. Incarceration rates from the *World Prison Population List* are based on the most recently available data at the time the list was compiled. Due to variations in the availability of information, the 2006 and 2008 dates reported in Figure A3 refer to when the *World Prison Population Lists (Seventh and Eighth Editions* respectively) were published, but may not necessarily correspond to the date the data were obtained. For 2018, the data was retrieved online on February 12, 2019 from http://www.prisonstudies.org which contains the most up-to-date information available. These data reflect incarceration rates based on the country's population. Additionally, different practices and variations in measurement in different countries limit the comparability of these figures.

CANADA'S INCARCERATION RATE RELATIVE TO OTHER WESTERN EUROPEAN COUNTRIES

Table A3

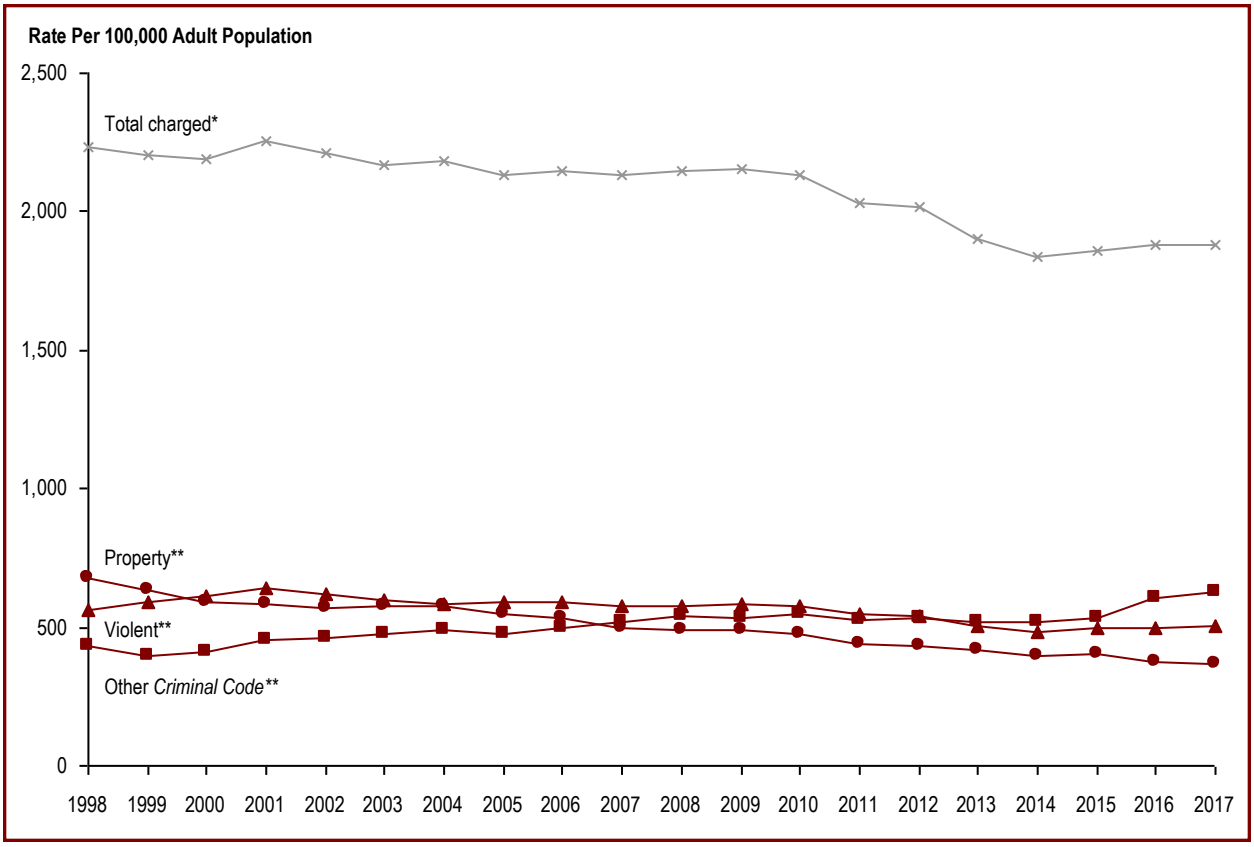
	2006[1*]	2008[2*]	2011[3*]	2012[4*]	2013[5*]	2014[6*]	2015[7*]	2016[8*]	2017[9*]	2018[10*]
United States	738	756	743	730	716	707	698	693	666	655
New Zealand	186	185	199	194	192	190	190	203	214	214
England & Wales	148	153	155	154	148	149	148	147	146	140
Scotland	139	152	155	151	147	144	144	142	138	143
Australia	126	129	133	129	130	143	151	152	168	172
Canada	**107**	**116**	**117**	**114**	**118**	**118**	**106**	**114**	**114**	**114**
Italy	104	92	110	109	106	88	86	90	95	98
Austria	105	95	104	104	98	99	95	93	94	98
France	85	96	102	102	101	102	100	103	103	100
Germany	95	89	87	83	79	81	78	78	77	75
Switzerland	83	76	79	76	82	87	84	83	82	81
Sweden	82	74	78	70	67	57	60	53	57	59
Denmark	77	63	74	74	73	67	61	58	59	63
Norway	66	69	73	73	72	75	71	74	74	63
Finland	75	64	59	59	58	55	57	55	57	51

Source: International Centre for Prison Studies: [1]World Prison Population List (Seventh Edition); [2]World Prison Population List (Eighth Edition); [3]World Prison Population List online (retrieved October 7, 2011 at www.prisonstudies.org/info/worldbrief/index.php), [4]World Prison Population List online (retrieved October 15, 2012 at www.prisonstudies.org/info/worldbrief/index.php).[5]World Prison Population List online (retrieved November 20, 2013 at www.prisonstudies.org/info/worldbrief/index.php). [6]World Prison Population List online (retrieved December 8, 2014 at www.prisonstudies.org/world-prison-brief). [7]*World Prison Population List* (retrieved November 20, 2015 at www.prisonstudies.org/highest-to-lowest/prison-population-total). [8]World Prison Population List online (retrieved December 6, 2016 at www.prisonstudies.org/highest-to-lowest/prison-population-total). [9]World Prison Population List online (retrieved November 10, 2017 at www.prisonstudies.org/highest-to-lowest/prison-population-total). [10]World Prison Population List (Twelfth Edition) online (retrieved February 12, 2019 at www.prisonstudies.org/highest-to-lowest/prison-population-total).

Note:
*Incarceration rates from the *World Prison Population List* are based on the most recently available data at the time the list was compiled. Due to variations in the availability of information, the 2006 and 2008 dates reported in Table A3 refer to when the *World Prison Population Lists (Seventh and Eighth Editions* respectively) were published, but may not necessarily correspond to the date the data were obtained. For 2018, the data was retrieved online on February 12, 2019 at www.prisonstudies.org which contains the most up to date information available. Additionally, different practices and variations in measurement in different countries limit the comparability of these figures. Rates are based on 100,000 population.

THE RATE OF ADULTS CHARGED HAS DECLINED

Figure A4



Source: Table 35-10-0177-01, Uniform Crime Reporting Survey, Canadian Centre for Justice Statistics, Statistics Canada.

- Since 1998, the rate of adults charged has decreased from 2,236 adults per 100,000 to 1,881 in 2017, a decrease of 15.9%.
- Over the same period, the rate of adults charged with violent crimes decreased by 10.1%, such that in 2017, 506 adults were charged per 100,000, whereas the rate of adults charged for property offences decreased by 45.2% from 677 adults per 100,000 to 371 in 2017.

Note:
*Unlike Statistics Canada, the Total Crime Rate in the *Corrections and Conditional Release Statistical Overview* **includes** traffic offences and violations of federal statutes to provide a measure of all criminal offences. As a result, the Total Crime Rate reported here is higher than that reported by Statistics Canada.
**The definitions for Violent, Property and Other *Criminal Code* offences have been revised by Statistics Canada to better reflect definitions used by the policing community. As a result of these changes, comparable data are only available starting in 1998 and the data presented in this year's report are not comparable to the data reported in previous versions of the *Corrections and Conditional Release Statistical Overview*.
Violent crimes include homicide, attempted murder, assault, sexual offences, abduction, extortion, robbery, firearms, and other violent offences such as uttering threats and criminal harassment.
Property crimes include break and enter, motor vehicle thefts, other thefts, possession of stolen property, fraud, mischief and arson.

THE RATE OF ADULTS CHARGED HAS DECLINED

Table A4

Year	Type of Offence						
	Violent**	Property**	Traffic	Other *CCC***	Drugs	Total Other Fed. Stat-	**Total Charged***
1998	563	677	374	430	168	12	**2,236**
1999	590	632	371	396	185	18	**2,203**
2000	615	591	349	411	198	16	**2,190**
2001	641	584	349	451	202	18	**2,256**
2002	617	569	336	460	199	18	**2,211**
2003	598	573	326	476	172	15	**2,168**
2004	584	573	314	490	187	22	**2,180**
2005	589	550	299	479	185	22	**2,131**
2006	594	533	300	498	198	20	**2,150**
2007	577	499	298	521	208	20	**2,132**
2008	576	487	307	540	207	22	**2,149**
2009	585	490	311	532	201	20	**2,152**
2010	576	473	295	545	211	22	**2,132**
2011	548	441	271	527	213	23	**2,034**
2012	540	434	268	535	202	25	**2,016**
2013	504	415	242	518	200	18	**1,904**
2014	486	397	232	518	190	13	**1,840**
2015	498	401	228	531	180	15	**1,859**
2016	506	378	220	603	169	17	**1,900**
2017	506	371	206	636	155	12	**1,881**

Source: Table 35-10-0177-01, Uniform Crime Reporting Survey, Canadian Centre for Justice Statistics, Statistics Canada.

Note:

*Unlike Statistics Canada, the Total Crime Rate in the *Corrections and Conditional Release Statistical Overview* **includes** traffic offences and violations of federal statutes to provide a measure of all criminal offences. As a result, the Total Crime Rate reported here is higher than that reported by Statistics Canada.

**The definitions for Violent, Property, Other *Criminal Code* offences, and Total Other Federal Statutes have been revised by Statistics Canada to better reflect definitions used by the policing community. As a result of these changes, comparable data are only available starting in 1998 and the data presented in this year's report are not comparable to the data reported in previous versions of the *Corrections and Conditional Release Statistical Overview*.

Rates are based on 100,000 population, 18 years of age and older.

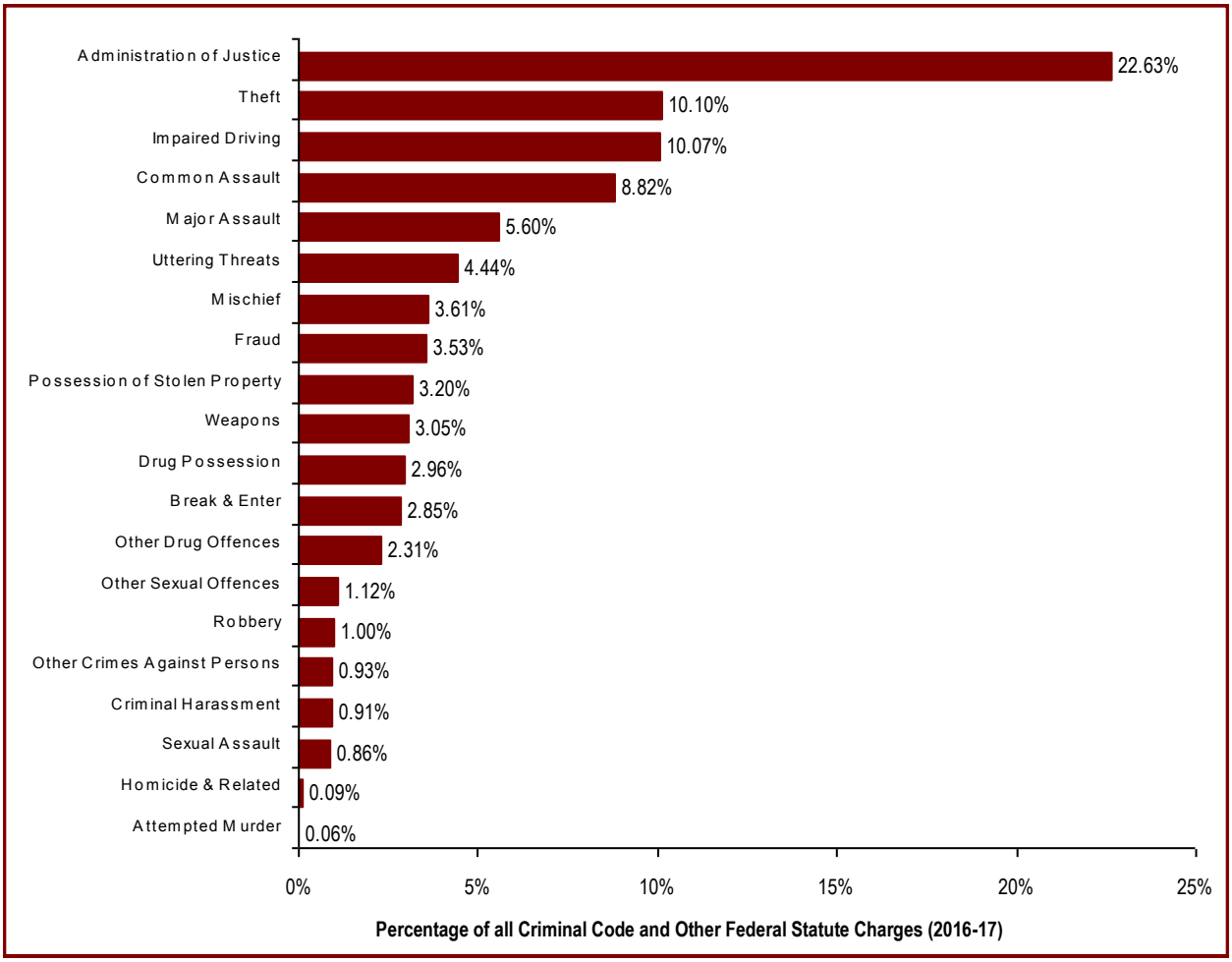
Due to rounding, rates may not add up to totals.

Violent crimes include homicide, attempted murder, assault, sexual offences, abduction, extortion, robbery, firearms, and other violent offences such as uttering threats and criminal harassment.

Property crimes include break and enter, motor vehicle theft, other theft, possession of stolen property, fraud, mischief and arson.

ADMINISTRATION OF JUSTICE CASES, CRIMES AGAINST THE PERSON CASES AND CRIMES AGAINST PROPERTY CASES EACH ACCOUNT FOR 23% OF CASES* IN ADULT COURTS

Figure A5



Source: Table 35-10-0027-01, Integrated Criminal Court Survey, Canadian Centre for Justice Statistics, Statistics Canada.

- Administration of justice cases (offences related to case proceedings such as failure to appear in court, failure to comply with a court order, breach of probation, and unlawfully at large) account for more than one fifth of cases completed in adult criminal courts.
- Apart from administration of justice cases, theft and impaired driving are the most frequent cases in adult courts.

Note:
*Cases completed in adult criminal courts.
The concept of a case has changed to more closely reflect court processing. Statistics from the *Integrated Criminal Court Survey* used in this report should not be compared to editions of the *Corrections and Conditional Release Statistical Overview* prior to 2007. A case is one or more charges against an accused person or corporation, processed by the courts at the same time, and where all of the charges in the case received a final disposition. Where a case has more than one charge, it is necessary to select a charge to represent the case. An offence is selected by applying two rules. First, the "most serious decision" rule is applied. In cases where two or more offences have the same decision, the "most serious offence" rule is applied. All charges are ranked according to an offence seriousness scale.
Superior Court data are not reported to the *Integrated Criminal Court Survey* for Prince Edward Island, Quebec, Ontario, Manitoba and Saskatchewan. In addition, information from Quebec's municipal courts is not collected.
The Canadian Centre for Justice Statistics continues to make updates to the offence library used to classify offence data sent by the provinces and territories. These improvements have resulted in minor changes in the counts of charges and cases as well as the distributions by type of offence. Data presented have been revised to account for these updates.
Due to rounding, percentages may not add up to 100 percent.

ADMINISTRATION OF JUSTICE CASES, CRIMES AGAINST THE PERSON CASES AND CRIMES AGAINST PROPERTY CASES EACH ACCOUNT FOR 23% OF CASES* IN ADULT COURTS

Table A5

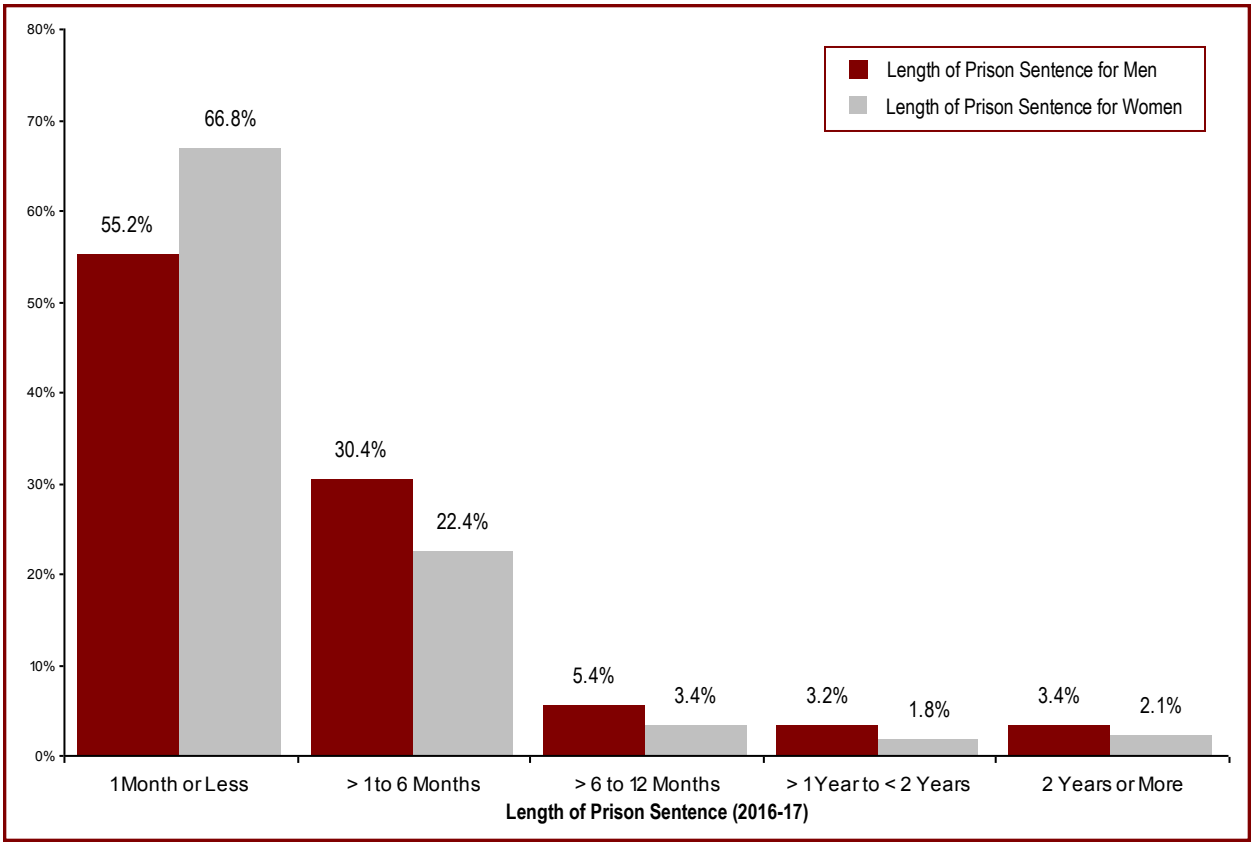
Type of Charge	*Criminal Code* and Other Federal Statute Charges					
	2014-15		2015-16		2016-17	
	#	%	#	%		
Crimes Against the Person	**80,994**	**23.01**	**82,387**	**23.47**	**85,270**	**23.84**
Homicide and Related	262	0.07	247	0.07	328	0.09
Attempted Murder	158	0.04	195	0.06	197	0.06
Robbery	3,318	0.94	3,512	1.00	3,594	1.00
Sexual Assault	2,753	0.78	2,925	0.83	3,086	0.86
Other Sexual Offences	3,564	1.01	3,823	1.09	4,015	1.12
Major Assault (Levels 2 & 3)	18,644	5.30	19,164	5.46	20,034	5.60
Common Assault (Level 1)	30,517	8.67	30,748	8.76	31,554	8.82
Uttering Threats	15,849	4.50	15,677	4.47	15,897	4.44
Criminal Harassment	3,006	0.85	3,114	0.89	3,251	0.91
Other Crimes Against Persons	2,923	0.83	2,982	0.85	3,314	0.93
Crimes Against Property	**80,467**	**22.86**	**81,959**	**23.35**	**85,125**	**23.80**
Theft	35,195	10.00	35,537	10.12	36,112	10.10
Break and Enter	9,458	2.69	9,830	2.80	10,207	2.85
Fraud	11,371	3.23	11,623	3.31	12,634	3.53
Mischief	12,418	3.53	12,471	3.55	12,921	3.61
Possession of Stolen Property	10,441	2.97	10,872	3.10	11,460	3.20
Other Property Crimes	1,584	0.45	1,626	0.46	1,791	0.50
Administration of Justice	**78,365**	**22.26**	**79,312**	**22.59**	**80,950**	**22.63**
Fail to Appear	3,892	1.11	4,111	1.17	4,305	1.20
Breach of Probation	30,716	8.73	31,047	8.84	31,337	8.76
Unlawfully at Large	2,616	0.74	2,607	0.74	2,734	0.76
Fail to Comply with Order	33,159	9.42	33,546	9.56	34,341	9.60
Other Admin. Justice	7,982	2.27	8,001	2.28	8,233	2.30
Other *Criminal Code*	**15,419**	**4.38**	**16,162**	**4.60**	**16,590**	**4.64**
Weapons	9,693	2.75	10,545	3.00	10,906	3.05
Prostitution	388	0.11	198	0.06	425	0.12
Disturbing the Peace	1,136	0.32	1,056	0.30	938	0.26
Residual *Criminal Code*	4,202	1.19	4,363	1.24	4,321	1.21
***Criminal Code* Traffic**	**49,346**	**14.02**	**46,728**	**13.31**	**45,812**	**12.81**
Impaired Driving	39,585	11.25	36,825	10.49	36,000	10.07
Other *CC* Traffic	9,761	2.77	9,903	2.82	9,812	2.74
Other Federal Statutes	**47,428**	**13.47**	**44,513**	**12.68**	**43,895**	**12.27**
Drug Possession	13,677	3.89	12,515	3.56	10,571	2.96
Other Drug Offences	9,228	2.62	8,547	2.43	8,273	2.31
Residual Federal Statutes	23,621	6.71	22,554	6.42	24,330	6.80
Total Offences	**352,019**	**100.00**	**351,061**	**100.00**	**357,642**	**100.00**

Source: Table 35-10-0027-01, Integrated Criminal Court Survey, Canadian Centre for Justice Statistics, Statistics Canada.

Note:
*Cases completed in adult criminal courts.
The concept of a case has changed to more closely reflect court processing. Statistics from the *Integrated Criminal Court Survey* used in this report should not be compared to editions of the *Corrections and Conditional Release Statistical Overview* prior to 2007. Superior Court data are not reported to the *Integrated Criminal Court Survey* for Prince Edward Island, Quebec, Ontario, Manitoba and Saskatchewan. In addition, information from Quebec's municipal courts is not collected. The Canadian Centre for Justice Statistics continues to make updates to the offence library used to classify offence data sent by the provinces and territories. These improvements have resulted in minor changes in the counts of charges and cases as well as the distributions by type of offence. Data presented have been revised to account for these updates. Due to rounding, percentages may not add up to 100 percent.

MOST ADULT CUSTODIAL SENTENCES ORDERED BY THE COURT ARE SHORT

Figure A6



Source: Table 35-10-0032-01, Integrated Criminal Court Survey, Canadian Centre for Justice Statistics, Statistics Canada.

- Over half (52.6%) of all custodial sentences imposed by adult criminal courts are one month or less.
- Prison sentences for men tend to be longer than for women. About two-thirds (66.8%) of women and just over half of men (55.2%) who are incarcerated following a guilty* finding receive a sentence of one month or less, and 89.2% of women and 85.6% of men receive a sentence of six months or less.
- Of all guilty findings that result in custody, only 3.1% result in federal jurisdiction (i.e., a sentence of two years or more).

Note:
*The decision type "guilty" includes guilty of the offence, of an included offence, of an attempt of the offence, or of an attempt of an included offence. This category also includes cases where an absolute or conditional discharge has been imposed.
The concept of a case has changed to more closely reflect court processing. Statistics from the *Integrated Criminal Court Survey* used in this report should not be compared to editions of the *Corrections and Conditional Release Statistical Overview* prior to 2007.
Excludes cases where length of prison sentence and/or sex was not known, data for Manitoba as information on sentence length was not available.
Superior Court data are not reported to the *Integrated Criminal Court Survey* for Prince Edward Island, Quebec, Ontario, Manitoba and Saskatchewan. In addition, information from Quebec's municipal courts is not collected.
The Canadian Centre for Justice Statistics continues to make updates to the offence library used to classify offence data sent by the provinces and territories. These improvements have resulted in minor changes in the counts of charges and cases as well as the distributions by type of offence. Data presented have been revised to account for these updates.
Due to rounding, totals may not add up to 100 percent.

MOST ADULT CUSTODIAL SENTENCES ORDERED BY THE COURT ARE SHORT

Table A6

Length of Prison Sentence	2012-13	2013-14	2014-15	2015-16	2016-17
	%	%	%	%	%
1 Month or Less					
Women	67.1	65.4	65.4	66.6	66.8
Men	52.9	52.6	53.8	54.2	55.2
Total	**50.6**	**50.0**	**51.1**	**51.6**	**52.6**
More Than 1 Month up to 6 Months					
Women	23.9	24.9	24.1	25.0	22.4
Men	32.4	32.6	31.5	30.9	30.4
Total	**29.5**	**29.6**	**28.8**	**28.2**	**27.7**
More Than 6 Months up to 12 Months					
Women	4.2	4.1	4.0	4.0	3.4
Men	6.3	6.2	6.2	5.8	5.4
Total	**5.8**	**5.7**	**5.6**	**5.3**	**4.9**
More Than 1 Year up to Less Than 2 Years					
Women	2.0	2.2	2.1	2.1	1.8
Men	3.9	3.9	3.6	3.6	3.2
Total	**3.6**	**3.6**	**3.3**	**3.2**	**3.0**
2 Years or More					
Women	1.8	2.0	2.2	2.5	2.1
Men	3.8	3.9	3.6	3.7	3.4
Total	**3.4**	**3.4**	**3.2**	**3.3**	**3.1**

Source: Table 35-10-0032-01, Integrated Criminal Court Survey, Canadian Centre for Justice Statistics, Statistics Canada.

Note:
The concept of a case has changed to more closely reflect court processing. Statistics from the *Integrated Criminal Court Survey* used in this report should not be compared to editions of the *Corrections and Conditional Release Statistical Overview* prior to 2007.
Excludes cases where length of prison sentence and/or sex was not known, data for Manitoba as information on both sentence length was not available.
Superior Court data are not reported to the *Integrated Criminal Court Survey* for Prince Edward Island, Quebec, Ontario, Manitoba and Saskatchewan. In addition, information from Quebec's municipal courts is not collected.
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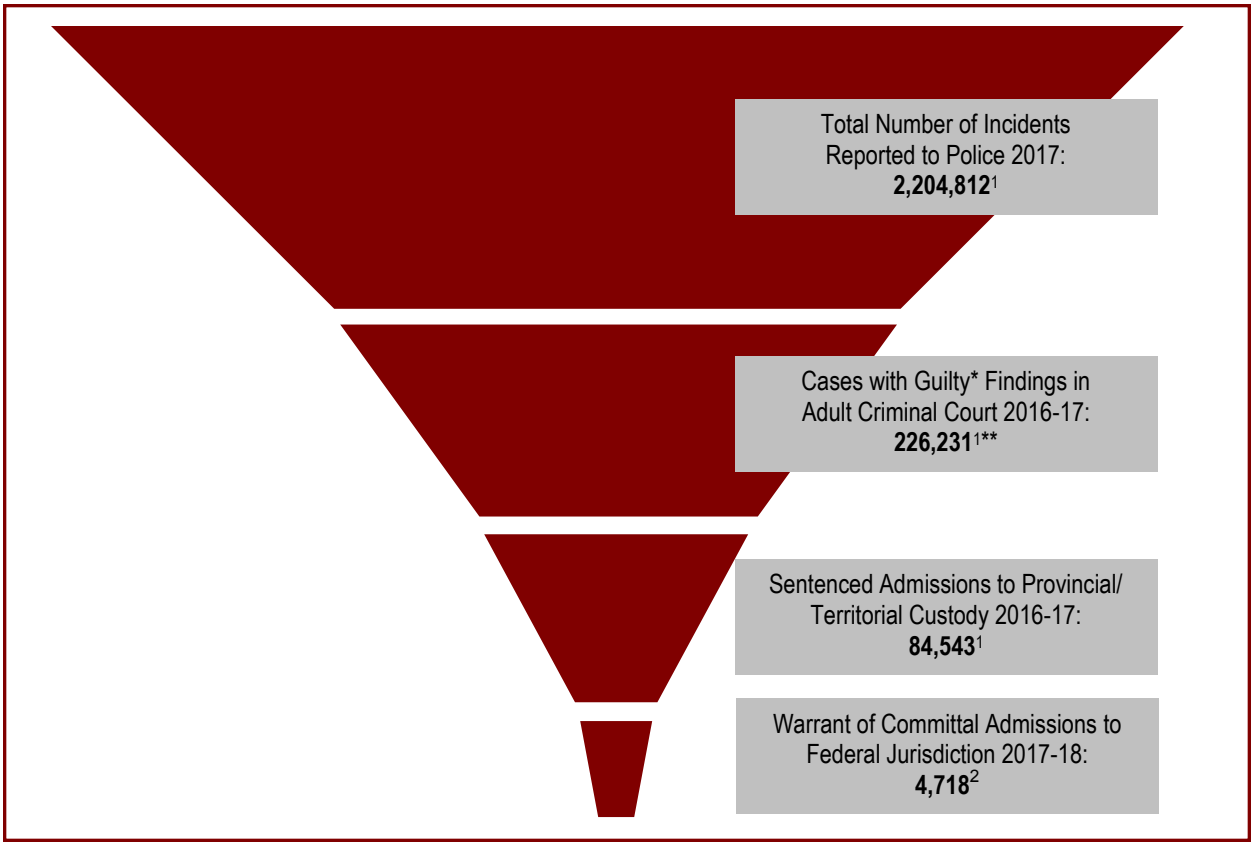
Due to rounding, totals may not add up to 100 percent.

RELATIVELY FEW CRIMES RESULT IN SENTENCES TO FEDERAL PENITENTIARIES

Figure A7



Source: [1]Table 35-10-0177-01, Uniform Crime Reporting Survey-2; Table 35-10-0027-01, Integrated Criminal Court Survey; and Table 35-10-0018-01, Adult Correctional Services Survey, all Canadian Centre for Justice Statistics, Statistics Canada; [2]Correctional Service Canada.

- There were about 2.2 million incidents reported to police in 2017.
- In 2017-18, there were 4,718 warrant of committal admissions for offenders sentenced to a federal institution or Healing Lodge.

Note:
*The decision type "guilty" includes guilty of the offence, of an included offence, of an attempt of the offence, or of an attempt of an included offence. This category also includes cases where an absolute or conditional discharge has been imposed.
**This figure only includes cases in provincial court and partial data from Superior Court. Superior Court data are not reported to the *Integrated Criminal Court Survey* for Prince Edward Island, Quebec, Ontario, Manitoba and Saskatchewan. Information from Quebec's municipal courts is not collected.
The concept of a case has changed to more closely reflect court processing. Statistics from the *Integrated Criminal Court Survey* used in this report should not be compared to editions of the *Corrections and Conditional Release Statistical Overview* prior to 2007. A case is one or more charges against an accused person or corporation, processed by the courts at the same time, and where all of the charges in the case received a final disposition.
Police data are reported on a calendar year basis whereas court and prison data are reported on a fiscal year basis (April 1 through March 31).

RELATIVELY FEW CRIMES RESULT IN SENTENCES TO FEDERAL PENITENTIARIES

Table A7

	2013-14	2014-15	2015-16	2016-17	2017-18
Total Number of Incidents Reported to Police[1]	2,098,776	2,052,925	2,118,681	2,161,927	2,204,812
Cases With Guilty* Findings in Adult Criminal Court[1**]	244,742	227,031	227,279	226,231	Not available***
Sentenced Admissions to Provincial/ Territorial Custody[1]	64,604	62,279	62,771	84,543	Not available***
Warrant of Committal Admissions to Federal Facilities[2]	5,071	4,818	4,891	4,908	4,718

Source: [1]Table 35-10-0177-01, Uniform Crime Reporting Survey-2; Table 35-10-0027-01, Integrated Criminal Court Survey; and Table 35-10-0018-01, Adult Correctional Services Survey, all Canadian Centre for Justice Statistics, Statistics Canada; [2]Correctional Service Canada.

Note:

*The decision type "guilty" includes guilty of the offence, of an included offence, of an attempt of the offence, or of an attempt of an included offence. This category also includes cases where an absolute or conditional discharge has been imposed.

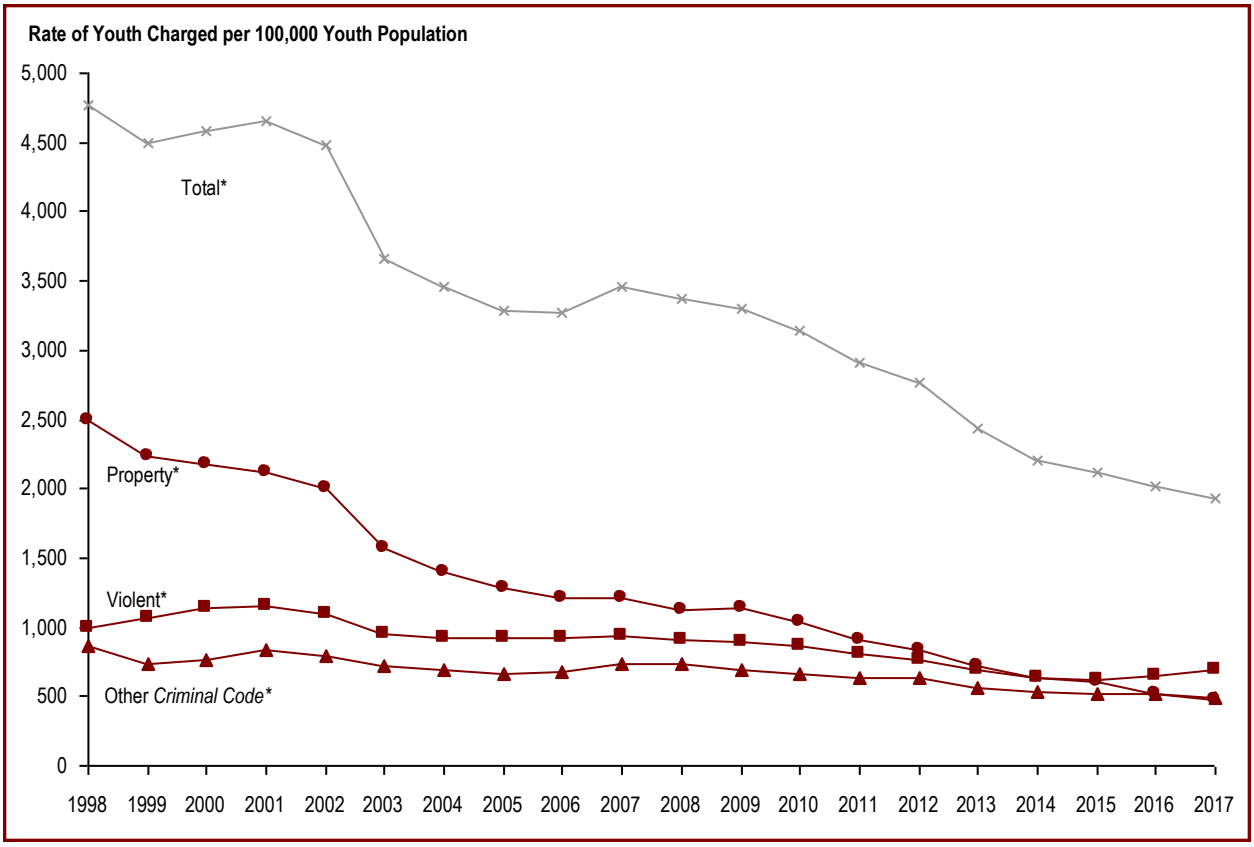
**This figure only includes cases convicted in provincial court and partial data from Superior Court. Superior Court data are not reported to the *Integrated Criminal Court Survey* for Prince Edward Island, Quebec, Ontario, Manitoba and Saskatchewan. Information from Quebec's municipal courts is not collected. The concept of a case has changed to more closely reflect court processing. Statistics from the *Integrated Criminal Court Survey* used in this report should not be compared to editions of the *Corrections and Conditional Release Statistical Overview* prior to 2007. A case is one or more charges against an accused person or corporation, processed by the courts at the same time, and where all of the charges in the case received a final disposition.

Police data are reported on a calendar year basis whereas court and prison data are reported on a fiscal year basis (April 1 through March 31).

***Data from 2017-2018 were not yet released during the preparation of this report.

THE RATE OF YOUTH CHARGED HAS DECLINED OVER THE PAST TEN YEARS

Figure A8



Source: Table 35-10-0177-01, Uniform Crime Reporting Survey, Canadian Centre for Justice Statistics, Statistics Canada.

- The rate of youth** charged has declined over the past ten years.
- In 2003, there was a notable decrease in all major crime categories, in part attributable to the implementation of the *Youth Criminal Justice Act* (YCJA) in April 2003, which places greater emphasis on diversion.
- The rate of youth charged with property crimes has decreased since 1998 by 81.0%, dropping from 2,500 per 100,000 youth to 474 in 2017.
- The rate of youth charged with violent crimes has decreased by 40.7% since reaching its peak in 2001, dropping from 1,157 per 100,000 youth to 686 in 2017.

Note:
*Unlike Statistics Canada, the Total Crime Rate in the *Corrections and Conditional Release Statistical Overview* **includes** traffic offences and violations of federal statutes to provide a measure of all criminal offences. As a result, the Total Crime Rate reported here is higher than that reported by Statistics Canada. In addition, the definitions for Violent, Property and Other *Criminal Code* offences have been revised by Statistics Canada to better reflect definitions used by the policing community. As a result of these changes, comparable data are only available starting in 1998 and the data presented in this year's report are not comparable to the data reported in previous versions of the *Corrections and Conditional Release Statistical Overview*.
**For criminal justice purposes, youth are defined under Canadian law as persons age 12 to 17.
Rates are based on 100,000 youth population (12 to 17 years old).
Violent crimes include homicide, attempted murder, assault, sexual offences, abduction, extortion, robbery, firearms, and other violent offences such as uttering threats and criminal harassment.
Property crimes include break and enter, motor vehicle theft, other theft, possession of stolen property, fraud, mischief and arson.

THE RATE OF YOUTH CHARGED HAS DECLINED OVER THE PAST TEN YEARS

Table A8

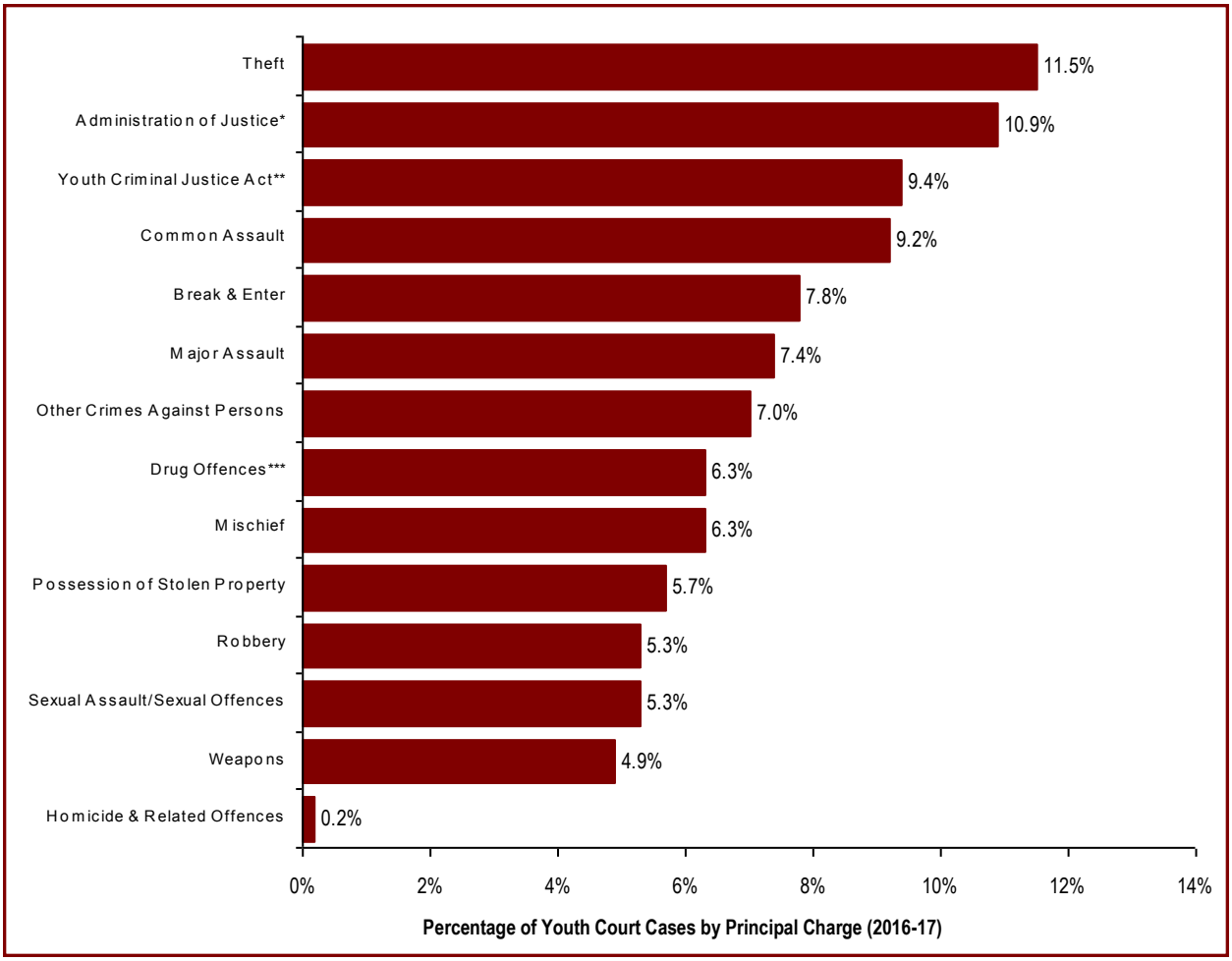
Year	Type of Offence						
	Violent*	Property*	Traffic**	Other *CCC**	Drugs	Total Other Fed. Stat-	**Total Charged***
1998	994	2,500	--	870	226	4	**4,775**
1999	1,060	2,237	--	728	266	2	**4,500**
2000	1,136	2,177	--	760	317	4	**4,589**
2001	1,157	2,119	--	840	343	6	**4,656**
2002	1,102	2,009	--	793	337	6	**4,476**
2003	953	1,570	--	726	208	5	**3,662**
2004	918	1,395	--	691	230	5	**3,457**
2005	924	1,276	--	660	214	10	**3,287**
2006	917	1,216	--	680	240	16	**3,269**
2007	943	1,211	75	732	260	17	**3,461**
2008	909	1,130	74	730	267	19	**3,369**
2009	888	1,143	68	698	238	30	**3,294**
2010	860	1,035	62	669	255	31	**3,147**
2011	805	903	58	635	263	31	**2,915**
2012	764	841	58	629	240	20	**2,768**
2013	692	723	45	555	229	10	**2,437**
2014	629	629	43	530	200	6	**2,199**
2015	623	612	44	525	161	10	**2,125**
2016	648	514	41	523	138	12	**2,003**
2017	686	474	37	492	121	6	**1,930**

Source: Table 35-10-0177-01, Uniform Crime Reporting Survey, Canadian Centre for Justice Statistics, Statistics Canada.

Note:
*Unlike Statistics Canada, the Total Crime Rate in the *Corrections and Conditional Release Statistical Overview* **includes** traffic offences and violations of federal statutes to provide a measure of all criminal offences. As a result, the Total Crime Rate reported here is higher than that reported by Statistics Canada. In addition, the definitions for Violent, Property, Other *Criminal Code* offences, and Total Other Federal Statutes have been revised by Statistics Canada to better reflect definitions used by the policing community. As a result of these changes, comparable data are only available starting in 1998 and the data presented in this year's report are not comparable to the data reported in previous versions of the *Corrections and Conditional Release Statistical Overview*.
**Data for Youth Charged and Youth Not Charged for Impaired Driving are not available prior to 2007. As a result, comparisons to Total Charged and Other *CCC* (including traffic) over time should be made with caution.
For criminal justice purposes, youth are defined under Canadian law as persons age 12 to 17.
Rates are based on 100,000 youth population (12 to 17 years old).
Violent crimes include homicide, attempted murder, assault, sexual offences, abduction, extortion, robbery, firearms, and other violent offences such as uttering threats and criminal harassment.

THE MOST COMMON YOUTH COURT CASE IS THEFT

Figure A9



Source: Table 35-10-0038-01, Integrated Criminal Court Survey, Canadian Centre for Justice Statistics, Statistics Canada.

- Following the enactment of the *Youth Criminal Justice Act* in 2003, fewer youth appear in court.
- Theft is the most common case in youth court.
- Homicides and related offences account for 0.2% of all youth cases.
- Females account for 20% of all cases, but they account for 33% of common assaults.

Note:
*"Administration of Justice" includes the offences failure to appear, failure to comply, and breach of recognizance.
**_Youth Criminal Justice Act_ offences include failure to comply with a disposition or undertaking, contempt against youth court, assisting a youth to leave a place of custody and harbouring a youth unlawfully at large. Also included are similar offences under the _Young Offenders Act_, which preceded the _Youth Criminal Justice Act_.
***"Drug Offences" includes possession and other drug offences.
The concept of a case has changed to more closely reflect court processing. Statistics from the _Integrated Criminal Court Survey_ used in this report should not be compared to editions of the _Corrections and Conditional Release Statistical Overview_ prior to 2007. A case is one or more charges against an accused person or corporation, processed by the courts at the same time, and where all of the charges in the case received a final disposition. Where a case has more than one charge, it is necessary to select a charge to represent the case. An offence is selected by applying two rules. First, the "most serious decision" rule is applied. In cases where two or more offences have the same decision, the "most serious offence" rule is applied. All charges are ranked according to an offence seriousness scale.
The Canadian Centre for Justice Statistics continues to make updates to the offence library used to classify offence data sent by the provinces and territories. These improvements have resulted in minor changes in the counts of charges and cases as well as the distributions by type of offence. Data presented have been revised to account for these updates.

THE MOST COMMON YOUTH COURT CASE IS THEFT

Table A9

Type of Case	Number of Youth Court Cases				
	2012-13	2013-14	2014-15	2015-16	2016-17
Crimes Against the Person	**12,792**	**11,883**	**9,959**	**9,635**	**9,709**
Homicide and Attempted Murder	52	53	49	55	54
Robbery	2,336	1,937	1,487	1,482	1,498
Sexual Assault/Other Sexual Offences	1,331	1,449	1,325	1,440	1,489
Major Assault	2,715	2,427	2,128	2,084	2,096
Common Assault	3,878	3,637	2,771	2,567	2,593
Other Crimes Against the Person*	2,480	2,380	2,199	2,007	1,979
Crimes Against Property	**15,723**	**13,526**	**11,014**	**10,654**	**9,482**
Theft	5,476	4,692	3,660	3,658	3,234
Break and Enter	3,606	3,153	2,603	2,419	2,200
Fraud	474	470	377	380	418
Mischief	2,948	2,514	2,155	2,087	1,788
Possession of Stolen Property	2,779	2,322	1,913	1,832	1,600
Other Crimes Against Property	440	375	306	278	242
Administration of Justice	**4,893**	**4,336**	**3,659**	**3,421**	**3,065**
Failure to Comply With Order	3,230	2,902	2,414	2,229	2,039
Other Administration of Justice**	1,357	1,172	1,028	983	822
Other *Criminal Code*	**2,424**	**2,193**	**2,078**	**1,933**	**1,834**
Weapons/Firearms	1,555	1,463	1,421	1,401	1,368
Prostitution	6	11	17	8	19
Disturbing the Peace	132	86	64	65	49
Residual *Criminal Code*	731	633	576	459	398
***Criminal Code* Traffic**	**828**	**656**	**569**	**570**	**550**
Other Federal Statutes	**8,781**	**7,780**	**6,395**	**5,505**	**4,532**
Drug Possession	1,840	1,571	1,784	1,551	1,122
Other Drug Offences	710	666	917	724	640
*Youth Criminal Justice Act****	4,542	3,870	3,524	3,096	2,648
Residual Federal Statutes	163	150	170	134	122
Total	**45,441**	**40,374**	**33,674**	**31,718**	**28,172**

Source: Table 35-10-0038-01, Integrated Criminal Court Survey, Canadian Centre for Justice Statistics, Statistics Canada.

Note:

*"Other Crimes Against the Person" includes the offences uttering threats and criminal harassment.

**"Other Administration of Justice" includes the offences failure to appear and breach of recognizance.

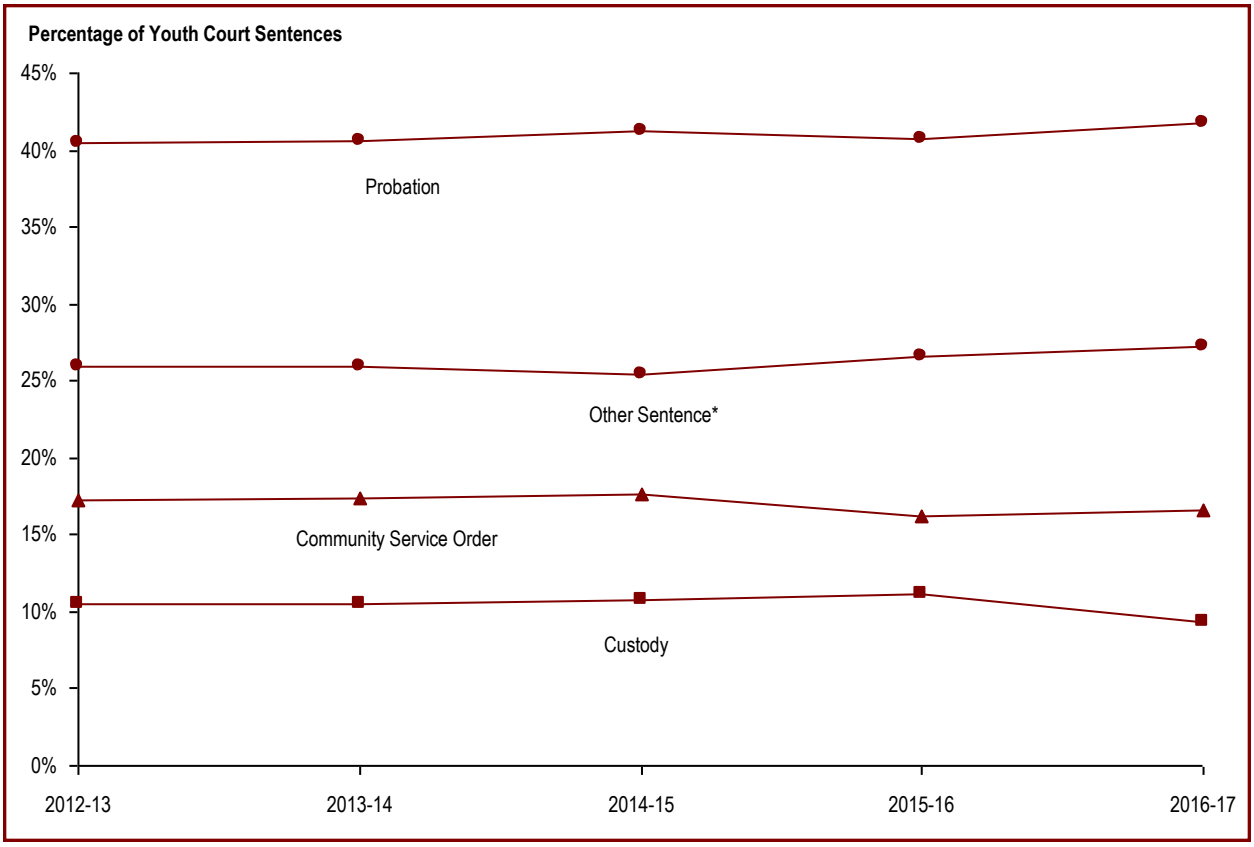
***_Youth Criminal Justice Act_ offences include failure to comply with a disposition or undertaking, contempt against youth court, assisting a youth to leave a place of custody and harbouring a youth unlawfully at large. Also included are similar offences under the _Young Offenders Act_, which preceded the _Youth Criminal Justice Act_.

The concept of a case has changed to more closely reflect court processing. Statistics from the _Integrated Criminal Court Survey_ used in this report should not be compared to editions of the _Corrections and Conditional Release Statistical Overview_ prior to 2007. A case is one or more charges against an accused person or corporation, processed by the courts at the same time, and where all of the charges in the case received a final disposition. Where a case has more than one charge, it is necessary to select a charge to represent the case. An offence is selected by applying two rules. First, the "most serious decision" rule is applied. In cases where two or more offences have the same decision, the "most serious offence" rule is applied. All charges are ranked according to an offence seriousness scale.

The Canadian Centre for Justice Statistics continues to make updates to the offence library used to classify offence data sent by the provinces and territories. These improvements have resulted in minor changes in the counts of charges and cases as well as the distributions by type of offence. Data presented have been revised to account for these updates.

THE MOST COMMON SENTENCE FOR YOUTH IS PROBATION

Figure A10



Source: Table 35-10-0041-01, Integrated Criminal Court Survey, Canadian Centre for Justice Statistics, Statistics Canada.

- Consistent with the objectives of the *YCJA*, fewer youth are sentenced to custody. In 2016-17, 12.9% of all guilty cases resulted in the youth being sentenced to custody.
- In 2016-17, 57.2% of youth found guilty were given probation as the most serious sentence. This rate has remained relatively stable since the implementation of the *YCJA* in April 2003.
- Of the new *YCJA* sentences, deferred custody and supervision orders were handed down least frequently. In 2016-17, 4.5% of all guilty cases received such an order as the most serious sentence.

Note:
*"Other Sentence" includes absolute discharge, restitution, prohibition, seizure, forfeiture, compensation, pay purchaser, essays, apologies, counselling programs and conditional discharge, conditional sentence, intensive support and supervision, attendance at non-residential program(s) and reprimand. This category also includes deferred custody and supervision, intensive support and supervision, attendance at non-residential program(s) and reprimand where sentencing data under the *Youth Criminal Justice Act* (YCJA) are not available.
Unlike previous years, this data represents the most serious sentence and therefore, sanctions are mutually exclusive. However, each case may receive more than one sentence.
The concept of a case has changed to more closely reflect court processing. Statistics from the *Integrated Criminal Court Survey* used in this report should not be compared to editions of the *Corrections and Conditional Release Statistical Overview* prior to 2007.

THE MOST COMMON SENTENCE FOR YOUTH IS PROBATION

Table A10

Type of Sentence	Gender	Year				
		2012-13	2013-14	2014-15	2015-16	2016-17
		%	%	%	%	%
Probation	Female	41.9	41.4	41.1	41.2	42.6
	Male	39.2	39.4	40.1	40.0	40.9
	Total	40.4	40.6	41.2	40.7	41.7
Custody	Female	8.4	8.0	9.0	9.0	5.8
	Male	10.9	10.8	10.8	11.2	9.3
	Total	10.5	10.5	10.8	11.2	9.4
Community Service Order	Female	18.0	17.6	18.0	15.9	17.0
	Male	17.4	17.9	18.3	16.6	17.0
	Total	17.2	17.4	17.6	16.2	16.6
Fine	Female	2.0	2.0	2.2	2.2	1.9
	Male	2.7	2.2	1.9	2.0	1.8
	Total	2.6	2.2	2.0	2.1	1.8
Deferred Custody and Supervision	Female	3.0	3.3	2.5	3.0	2.6
	Male	3.3	3.2	2.9	3.2	3.3
	Total	3.3	3.3	3.0	3.2	3.3
Other Sentence*	Female	26.7	27.6	27.2	28.7	30.1
	Male	26.5	26.5	25.9	27.0	27.8
	Total	26.0	25.9	25.4	26.6	27.2

Source: Table 35-10-0041-01, Integrated Criminal Court Survey, Canadian Centre for Justice Statistics, Statistics Canada.

Note:

*"Other Sentence" includes absolute discharge, restitution, prohibition, seizure, forfeiture, compensation, pay purchaser, essays, apologies, counselling programs and conditional discharge, conditional sentence, intensive support and supervision, attendance at non-residential program(s) and reprimand. This category also includes deferred custody and supervision, intensive support and supervision, attendance at non-residential program(s) and reprimand where sentencing data under the *Youth Criminal Justice Act* (YCJA) are not available.

Unlike previous years, this data represents the most serious sentence and therefore, sanctions are mutually exclusive. However, each case may receive more than one sentence.

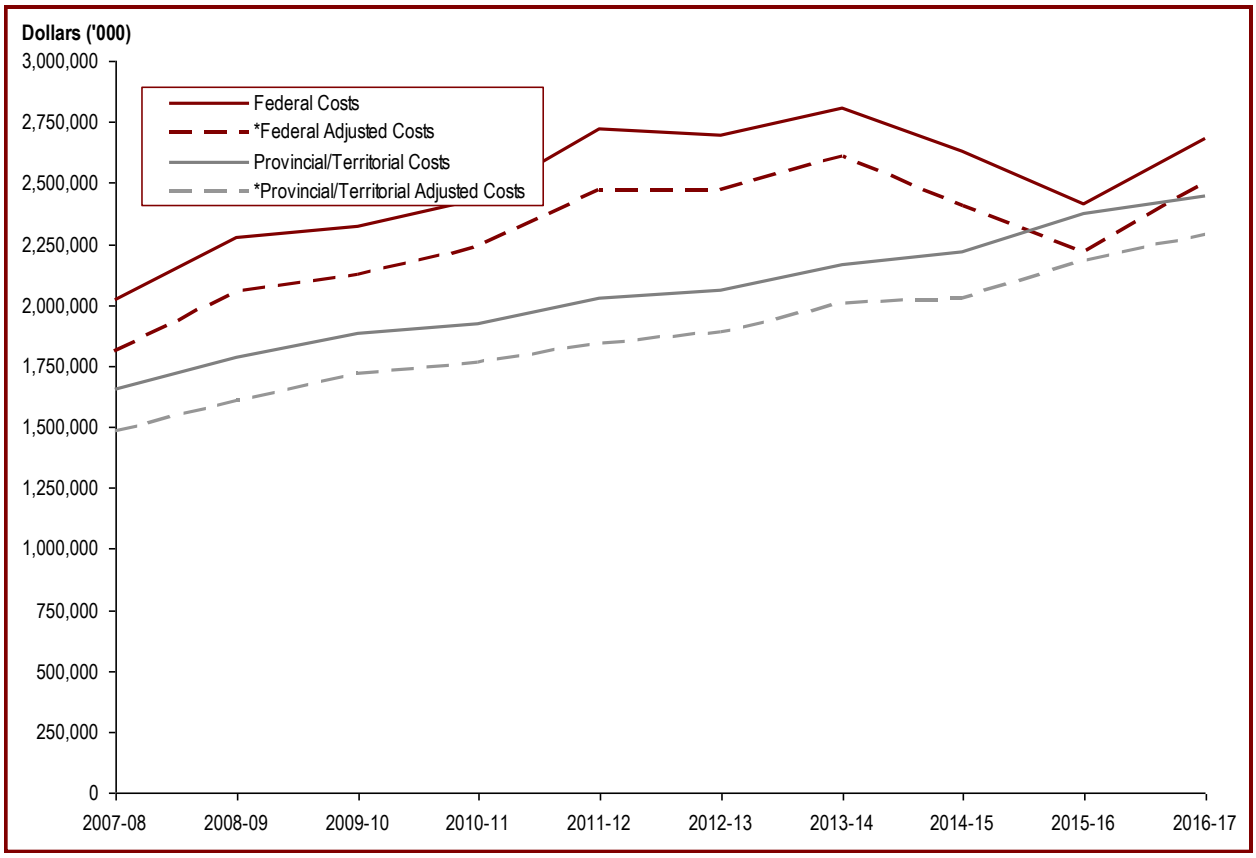
The concept of a case has changed to more closely reflect court processing. Statistics from the *Integrated Criminal Court Survey* used in this report should not be compared to editions of the *Corrections and Conditional Release Statistical Overview* prior to 2007.

SECTION B

CORRECTIONS ADMINISTRATION

EXPENDITURES ON CORRECTIONS

Figure B1



Source: Correctional Service Canada; Parole Board of Canada; Office of the Correctional Investigator; Statistics Canada Consumer Price Index. Provincial figures derived from the Adult Correctional Services Survey, Canadian Center for Justice Statistics, Statistics Canada.

- In 2016-17, expenditures on federal corrections in Canada totaled approximately $2.41 billion, an 0.2% increase from 2015-16.
- Provincial/territorial expenditures totaled about $2.45 billion in 2016-17, an increase of 3.2% from 2015-16.
- Since 2007-08, expenditures on federal corrections have increased by 19.8%, from $2.02 billion to $2.41 billion. In constant dollars, this represents an increase of 24.8%.
- Over the same time period, provincial/territorial expenditures increased by 48.5% from $1.65 billion to $2.45 billion. In constant dollars, this represents an increase of 54.6%.

Note:
*Adjusted costs are reported in constant dollars. Constant dollars (2002) represent dollar amounts calculated on a one-year base that adjusts for inflation, allowing the yearly amounts to be directly comparable. Changes in the Consumer Price Index were used to calculate constant dollars.
Federal expenditures on corrections include spending by Correctional Service Canada (CSC), the Parole Board of Canada (PBC), and the Office of the Correctional Investigator (OCI). Total expenditures represent gross expenditures and exclude revenues. Operating costs include Employee benefit Plan expenditures. CSC expenditures exclude CORCAN (a Special Operating Agency that conducts industrial operations within penitentiaries). Provincial/Territorial expenditures do not include capital costs.

EXPENDITURES ON CORRECTIONS

Table B1

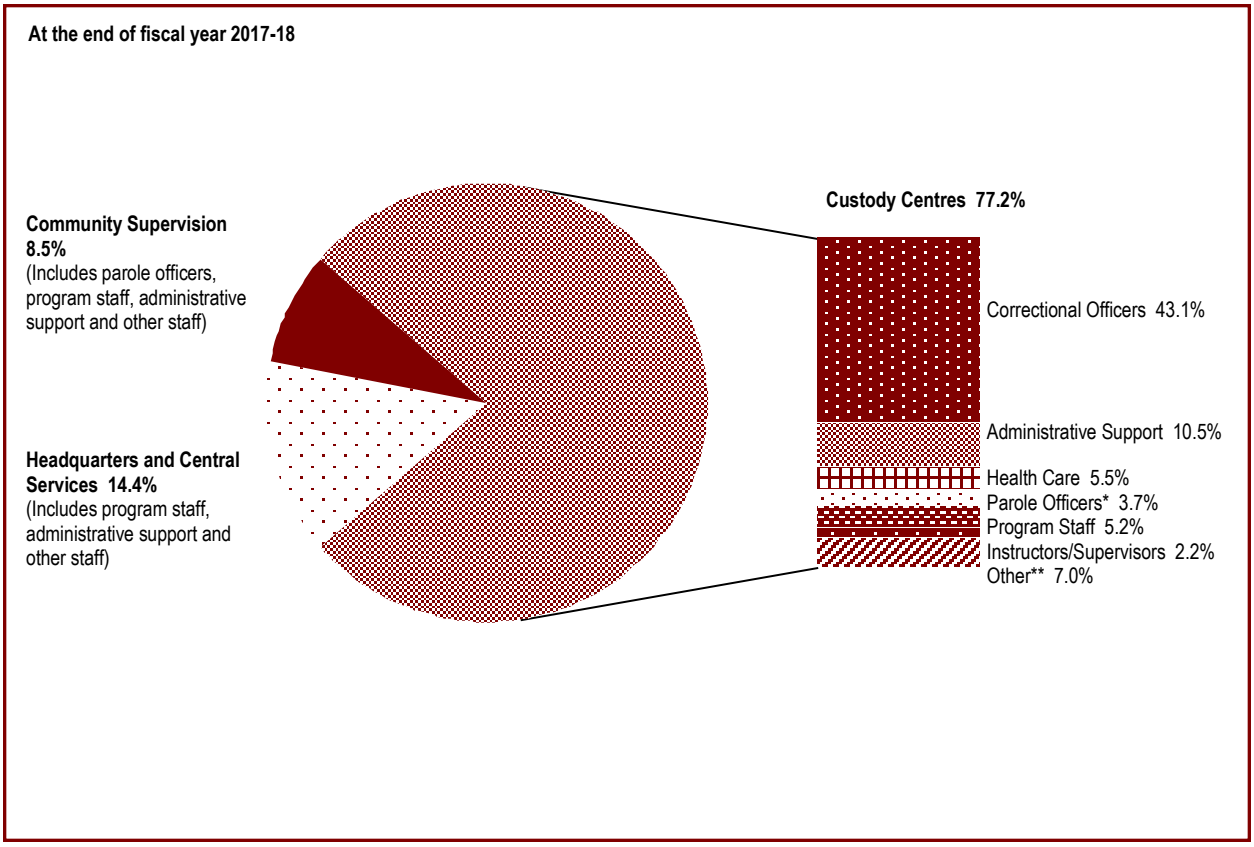
Year	Current Dollars				Constant 2002 Dollars			
	Operating	Capital	Total	Per capita	Operating	Capital	Total	Per capita
	$'000			$	$'000			$
2012-13								
CSC	2,204,005	437,736	2,641,742	76.01	2,019,281	401,048	2,420,331	69.64
PBC	46,500	- -	46,500	1.34	42,603	- -	42,603	1.23
OCI	4,801	- -	4,801	0.14	4,399	- -	4,399	0.13
Total	2,255,306	437,736	2,693,043	77.49	2,066,283	401,048	2,467,332	70.99
2013-14								
CSC	2,371,700	378,372	2,750,072	78.22	2,203,672	351,566	2,555,238	72.68
PBC	50,400	- -	50,400	1.43	46,829	- -	46,829	1.33
OCI	4,946	- -	4,946	0.14	4,596	- -	4,596	0.13
Total	2,427,046	378,372	2,805,418	79.79	2,255,097	351,566	2,606,663	74.14
2014-15								
CSC	2,373,604	200,606	2,574,210	72.42	2,168,852	183,301	2,352,154	66.17
PBC	50,100	- -	50,100	1.41	45,778	- -	45,778	1.29
OCI	4,659	- -	4,659	0.13	4,257	- -	4,257	0.12
Total	2,428,363	200,606	2,628,969	73.96	2,218,888	183,301	2,402,189	67.58
2015-16								
CSC	2,189,101	168,684	2,357,785	65.77	2,014,457	155,227	2,169,684	60.52
PBC	46,300	- -	46,300	1.29	42,606	- -	42,606	1.19
OCI	4,656	- -	4,656	0.13	4,285	- -	4,285	0.12
Total	2,240,057	168,684	2,408,741	67.19	2,061,348	155,227	2,216,574	61.83
2016-17								
CSC	2,209,048	153,757	2,362,804	65.12	2,062,810	143,578	2,206,388	60.80
PBC	46,800	- -	46,800	1.29	43,702	- -	43,702	1.20
OCI	4,693	- -	4,693	0.13	4,382	- -	4,382	0.12
Total	2,260,541	153,757	2,414,297	66.53	2,110,895	143,578	2,254,472	62.13

Source: Correctional Service Canada; Parole Board of Canada; Office of the Correctional Investigator; Statistics Canada Consumer Price Index.

Note:
Due to rounding, constant dollar amounts may not add up to "Total".
Per capita cost is calculated by dividing the total expenditures by the total Canadian population and thus represents the cost per Canadian for federal correctional services.
Constant dollars represent dollar amounts calculated on a one-year base (2002) that adjusts for inflation allowing the yearly amounts to be directly comparable. Changes in the Consumer Price Index were used to calculate constant dollars.

CSC EMPLOYEES ARE CONCENTRATED IN CUSTODY CENTRES

Figure B2



Source: Correctional Service Canada.

- Correctional Service Canada (CSC) has a total of 16,898 staff.***
- Approximately 77% of CSC staff work in institutions.
- Staff employed in community supervision account for 9% of the total.

Note:
Due to changes in policy, Correctional Officers no longer occupy positions in the community.
*These parole officers are situated within institutions, with the responsibility of preparing offenders for release.
** The "Other" category represents job classifications such as trades and food services.
***CSC has changed its definition of employee. Previously the total number of employees included casual employees, employees on leave without pay and suspended employees. These categories have been removed from the total as of 2005-06. These numbers represent Indeterminate and Term equal to, or more than 3 months substantive employment; and Employee Status of Active and Paid Leave current up to March 31, 2018.
Due to rounding, percentage may not add to 100.

CSC EMPLOYEES ARE CONCENTRATED IN CUSTODY CENTRES

Table B2

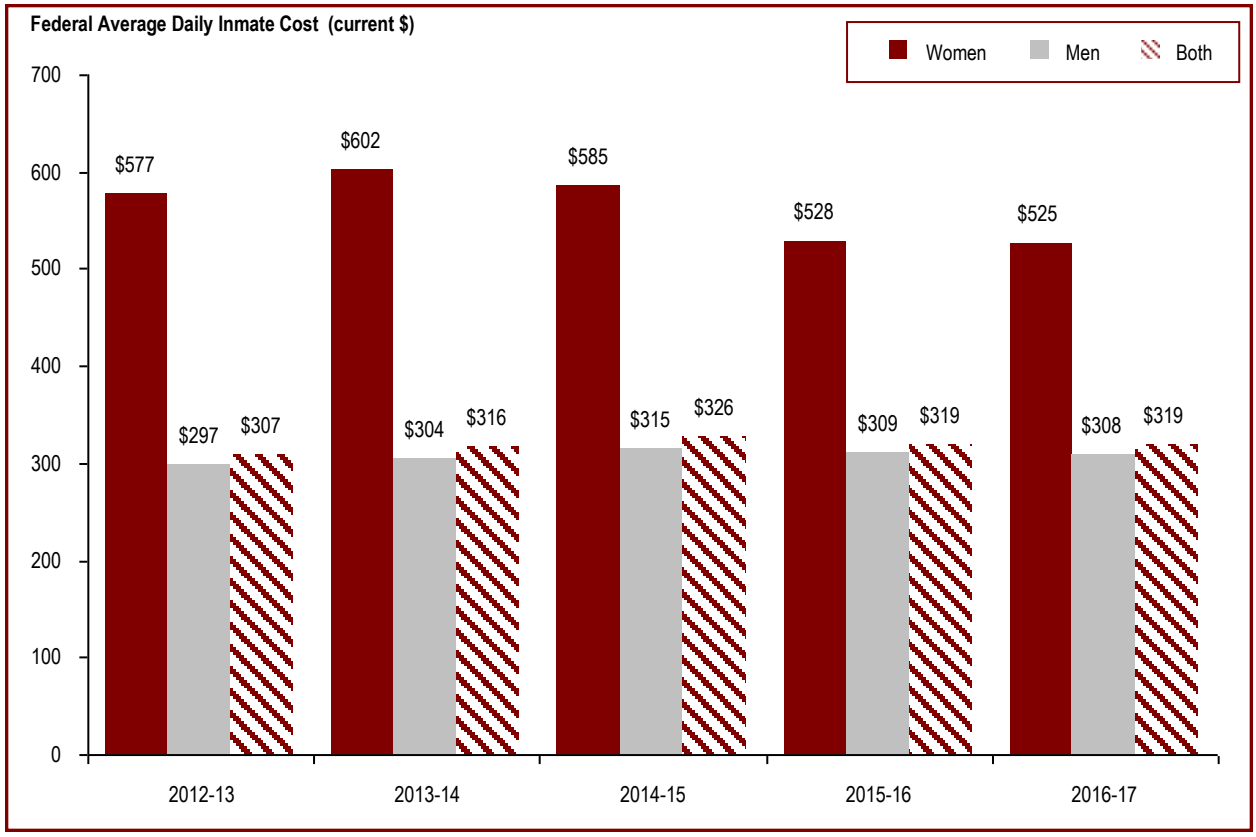
Service Area	March 31, 2006		March 31, 2018	
	#	%	#	%
Headquarters and Central Services	**2,087**	**14.5**	**2,427**	**14.4**
Administration	1,699	11.8	2,065	12.2
Health Care	111	0.8	80	0.5
Program Staff	120	0.8	62	0.4
Correctional Officers	28	0.2	39	0.2
Instructors/Supervisors	10	0.1	10	0.1
Parole Officers/Parole Supervisors			1	<0.1
Other**	119	0.8	170	1.0
Custody Centres	**11,229**	**77.8**	**13,039**	**77.2**
Correctional Officers	5,965	41.3	7,285	43.1
Administration	1,914	13.3	1,771	10.5
Health Care	779	5.4	921	5.5
Program Staff	534	3.7	875	5.2
Parole Officers/Parole Supervisors*	648	4.5	619	3.7
Instructors/Supervisors	387	2.7	377	2.2
Other**	1,002	6.9	1,191	7.0
Community Supervision	**1,125**	**7.8**	**1,432**	**8.5**
Parole Officers/Parole Supervisors	581	4.0	715	4.2
Administration	315	2.2	354	2.1
Program Staff	172	1.2	273	1.6
Health Care	34	0.2	87	0.5
Correctional Officers	22	0.2	0	0.0
Other**	1	<0.1	3	<0.1
Total* **	**14,441**	**100.0**	**16,898**	**100.0**

Source: Correctional Service Canada.

Note:
Due to changes in policy, Correctional Officers no longer occupy positions in the community.
*These parole officers are situated within institutions, with the responsibility of preparing offenders for release.
** The "Other" category represents job classifications such as trades and food services.
***CSC has changed its definition of employee. Previously the total number of employees included casual employees, employees on leave without pay and suspended employees. These categories have been removed from the total as of 2005-06. These numbers represent Indeterminate and Term equal to, or more than 3 months substantive employment; and Employee Status of Active and Paid Leave current up to March 31, 2018.
Due to rounding, percentage may not add to 100.

THE COST OF KEEPING AN INMATE INCARCERATED

Figure B3



Source: Correctional Service Canada.

- The federal average daily inmate cost has increased from $307 in 2012-13 to $319 in 2016-17.
- In 2016-17, the annual average cost of keeping an inmate incarcerated was $116,473 per year, an increase from $112,197 per year in 2012-13. In 2016-17, the annual average cost of keeping a man incarcerated was $112,640 per year, whereas the annual average cost for incarcerating a woman was $191,843.
- The cost associated with maintaining an offender in the community is 74% less than the costs of maintaining an offender in custody ($30,639 per year versus $116,473 per year).

Note:
The average daily inmate cost includes those costs associated with the operation of the institutions such as salaries and employee benefit plan contributions, but excludes capital expenditures and expenditures related to CORCAN (a Special Operating Agency that conducts industrial operations within federal institutions). Total incarcerated and community includes additional NHQ & RHQ administrative costs which are not part of the Institutional and/or Community calculations. Offenders in the Community includes: Offenders on conditional release, statutory release or with Long-Term Supervision Order, under CSC supervision. Figures may not add due to rounding.

THE COST OF KEEPING AN INMATE INCARCERATED

Table B3

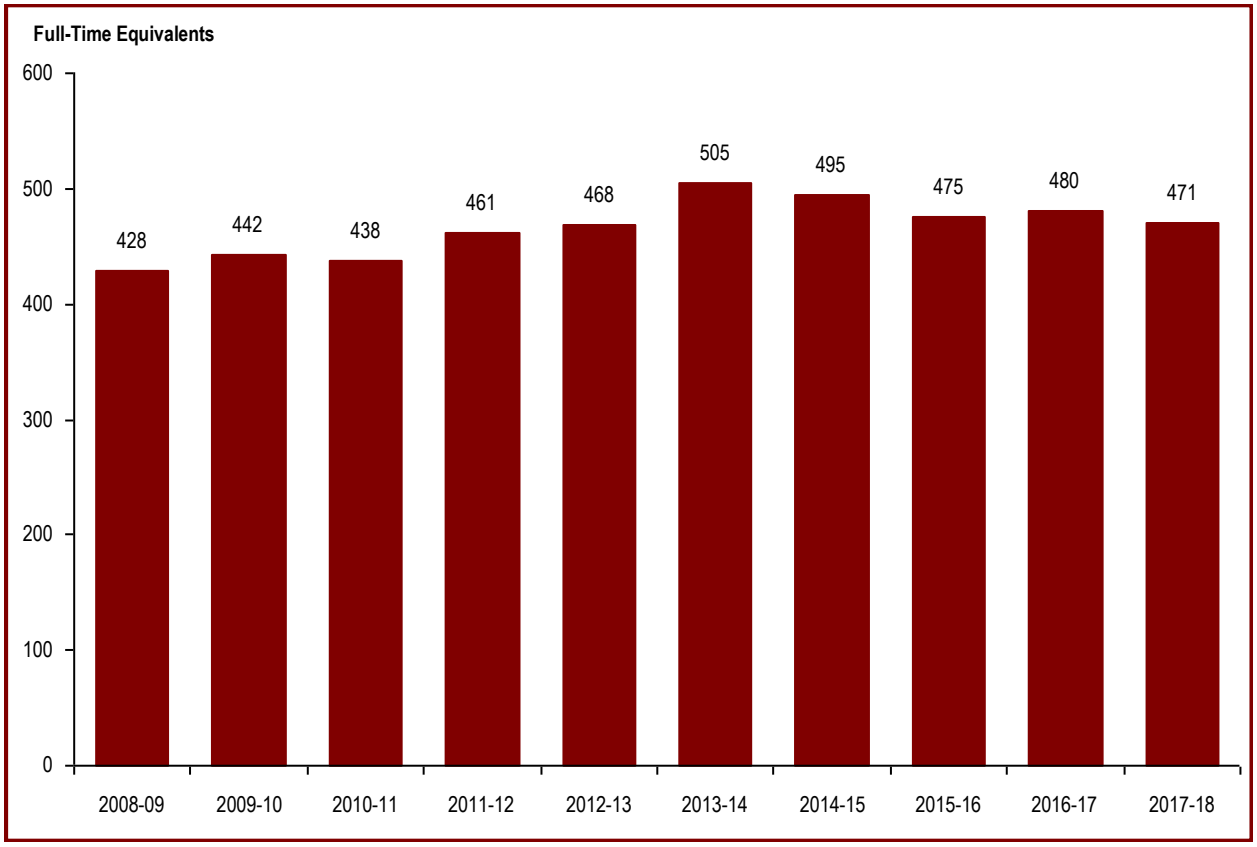
Categories	Annual Average Costs per Offender (current $)				
	2012-13	2013-14	2014-15	2015-16	2016-17
Incarcerated Offenders					
Maximum Security (men only)	148,330	156,768	160,094	155,848	158,113
Medium Security (men only)	99,207	101,583	105,750	106,868	105,349
Minimum Security (men only)	83,910	83,182	86,613	81,528	83,450
Women's Facilities	210,695	219,884	213,800	192,742	191,843
*Exchange of Services Agreements (both)	104,828	108,388	111,839	114,974	122,998
Incarcerated Average	**112,197**	**115,310**	**119,152**	**116,364**	**116,473**
Offenders in the Community	33,799	34,432	33,067	31,052	30,639
Total Incarcerated and Community	**95,504**	**99,923**	**99,982**	**94,545**	**95,654**

Source: Correctional Service Canada.

Note:
*The intent of an Exchange of Service Agreement is to detail the roles and responsibilities of each jurisdiction and include specific protocols regarding per diem rates, offender information sharing, and invoicing pertaining to the reciprocal exchange of offenders between jurisdictions.
The average daily inmate cost includes those costs associated with the operation of the institutions such as salaries and employee benefit plan contributions, but excludes capital expenditures and expenditures related to CORCAN (a Special Operating Agency that conducts industrial operations within federal institutions). Total incarcerated and community includes additional NHQ & RHQ administrative costs which are not part of the Institutional and/or Community calculations. Offenders in the Community includes: Offenders on conditional release, statutory release or with Long-Term Supervision Order, under CSC supervision. Figures may not add due to rounding.

THE NUMBER OF PAROLE BOARD OF CANADA EMPLOYEES

Figure B4



Source: Parole Board of Canada.

- The higher number of full-time equivalents used by the Parole Board of Canada in 2013-14 and 2014-15 were related to temporary human resources hired to work on clearing the Pardons backlog which accumulated prior to the application fee increase.

Note:
A full-time equivalent is a measure of the extent to which an employee represents a full person-year charge against a departmental budget. Section 103 of the *Corrections and Conditional Release Act* limits the Parole Board of Canada to 60 full-time members.

THE NUMBER OF PAROLE BOARD OF CANADA EMPLOYEES

Table B4

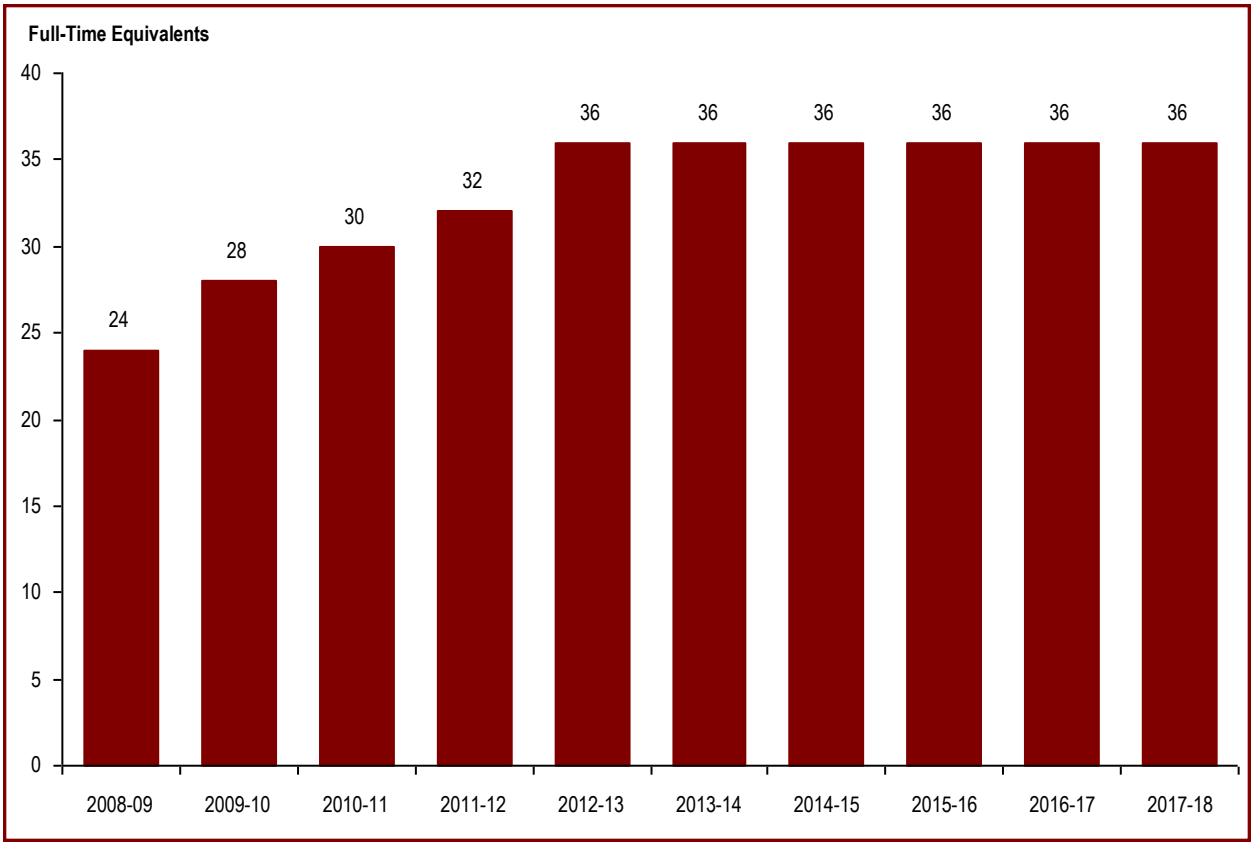
	Full-Time Equivalents				
	2013-14	2014-15	2015-16	2016-17	2017-18
Program Activity					
Conditional Release Decisions	325	325	322	321	317
Conditional Release Openness and Accountability	53	54	42	44	42
Record Suspension and Clemency Recommendations	79	69	52	59	48
Internal Services	48	47	59	56	64
Total	**505**	**495**	**475**	**480**	**471**
Types of Employees					
Full-time Board Members	42	42	41	39	38
Part-time Board Members	20	18	18	17	20
Staff	443	435	416	424	413
Total	**505**	**495**	**475**	**480**	**471**

Source: Parole Board of Canada.

Note:
A full-time equivalent is a measure of the extent to which an employee represents a full person-year charge against a departmental budget.
Section 103 of the *Corrections and Conditional Release Act* limits the Parole Board of Canada to 60 full-time members.

THE NUMBER OF EMPLOYEES IN THE OFFICE OF THE CORRECTIONAL INVESTIGATOR

Figure B5



Source: Office of the Correctional Investigator.

- The total number of full-time equivalents at the Office of the Correctional Investigator has been stable over the last six years.

Note:
*The Office of the Correctional Investigator (OCI) may commence an investigation on receipt of a complaint by or on behalf of an offender or on its own initiative. Complaints are made by telephone, letter and during interviews with the OCI's investigative staff at federal correctional facilities. The dispositions in response to complaints involve a combination of internal responses (where the information or assistance sought by the offender can generally be provided by the OCI's investigative staff) and investigations (where, further to a review/analysis of law, policies and documentation, OCI investigative staff make an inquiry or several interventions with Correctional Service Canada and submit recommendations to address the complaint). Investigations vary considerably in terms of scope, complexity, duration and resources required.

THE NUMBER OF EMPLOYEES IN THE OFFICE OF THE CORRECTIONAL INVESTIGATOR

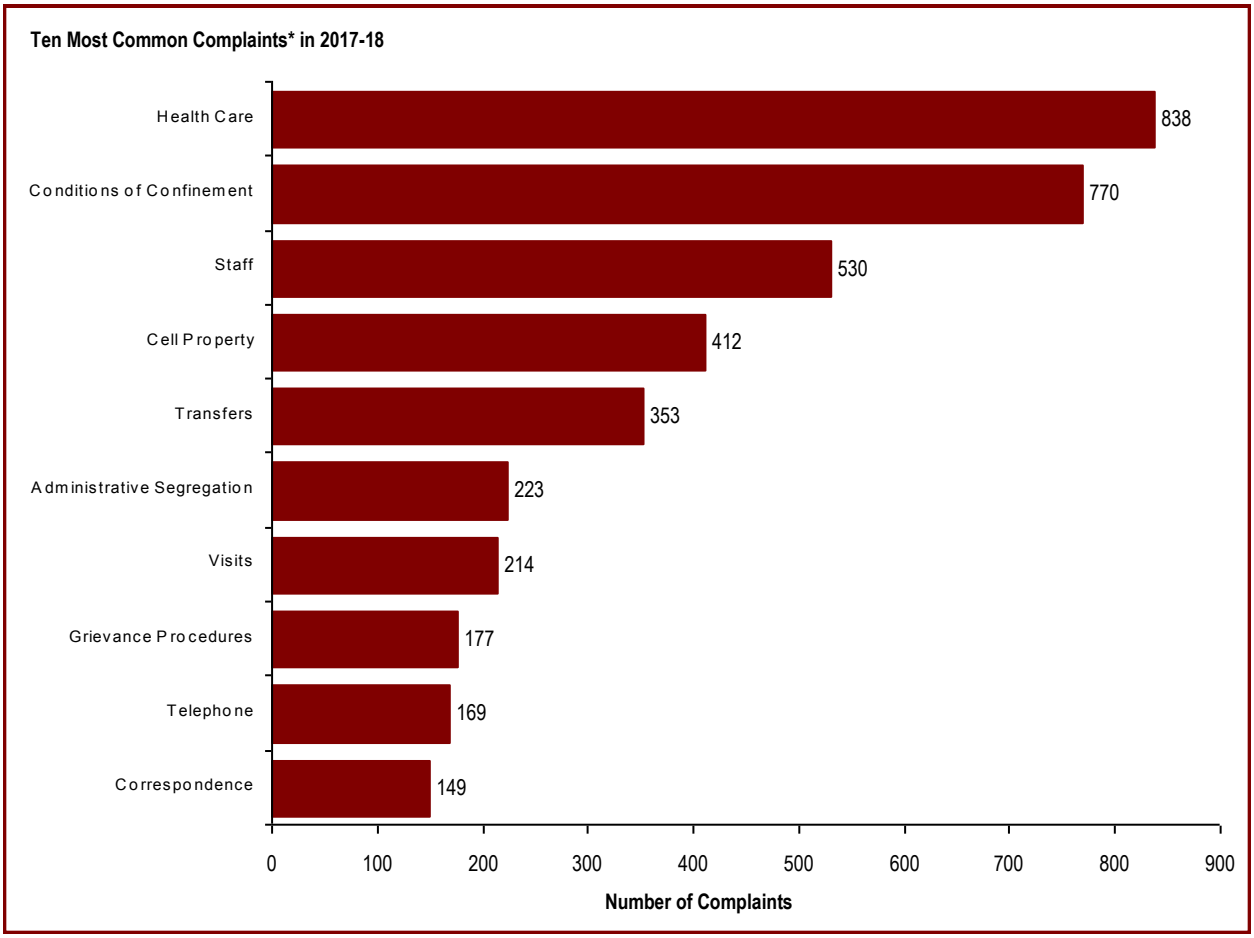
Table B5

	Full-Time Equivalents				
	2013-14	2014-15	2015-16	2016-17	2017-18
Type of Employees					
Correctional Investigator	1	1	1	1	1
Senior Management and Legal Counsel/Advisor	5	5	5	5	5
Investigative Services	25	25	25	26	26
Administrative Services	5	5	5	4	4
Total	**36**	**36**	**36**	**36**	**36**

Source: Office of the Correctional Investigator.

HEALTH CARE IS THE MOST COMMON AREA OF OFFENDER COMPLAINT RECEIVED BY THE OFFICE OF THE CORRECTIONAL INVESTIGATOR

Figure B6



Source: Office of the Correctional Investigator.

- There were 5,846 complaints/enquiries received at the Office of the Correctional Investigator (OCI) in 2017-18.
- Health care (14.3%), conditions of confinement (13.1%), staff (9.0%), and cell effects (7.0%), accounted for 43.5% of all complaints.

Note:
*Excludes complaints received on issues outside the OCIs jurisdiction.
The Office of the Correctional Investigator (OCI) may commence an investigation on receipt of a complaint by or on behalf of an offender or on its own initiative. Complaints are made by telephone, letter and during interviews with the OCI's investigative staff at federal correctional facilities. The dispositions in response to complaints involve a combination of internal responses (where the information or assistance sought by the offender can generally be provided by the OCI's investigative staff) and investigations (where, further to a review/analysis of law, policies and documentation, OCI investigative staff make an inquiry or several interventions with Correctional Service Canada and submit recommendations to address the complaint). Investigations vary considerably in terms of scope, complexity, duration and resources required.

HEALTH CARE IS THE MOST COMMON AREA OF OFFENDER COMPLAINT RECEIVED BY THE OFFICE OF THE CORRECTIONAL INVESTIGATOR

Table B6

Category of Complaint*	Number of Complaints				
	2013-14	2014-15	2015-16	2016-17	2017-18
Health Care	649	816	911	903	838
Conditions of Confinement	699	616	808	761	770
Staff	427	422	429	408	530
Cell Property	335	360	426	497	412
Transfers	409	474	370	439	353
Administrative Segregation	369	383	272	269	223
Visits	236	244	290	285	214
Outside OCI Jurisdiction	270	238	245	259	193
Telephone	245	278	224	187	169
Grievance Procedures	163	195	188	173	177
Request for Information	147	181	152	213	126
Financial Matters	139	143	197	208	127
Safety/Security of Offender(s)	98	180	199	170	107
Correspondence	88	149	165	167	149
Security Classification	100	104	49	35	31
Programs / Services	93	145	143	135	129
Decisions (General)	95	101	117	170	128
Case Preparation	75	137	102	115	55
Temporary Absence	90	98	100	93	74
Mental Health	51	77	133	122	76
Total of all Categories**	**5,557**	**6,382**	**6,651**	**6,844**	**5,846**

Source: Office of the Correctional Investigator.

Note:

*These top categories of complaints are based on the sum totals for the five reported fiscal years between 2013-14 and 2017-18. The remaining categories, in order of total complaints received between 2013-14 and 2017-18, are as follows: Employment, Release Procedures, Food Services, Search and Seizure, Harassment, UNCATEGORIZED, Use of Force, Discipline, Legal Counsel, Claims, Cell Placement, Diets, Other, Religious/spiritual, Community Programs/Supervision, Inmate Requests, Programmes/Services, Operation/Decisions of the OCI, Sentence Administration, Death or Serious Injury, Discrimination, and Conditional Release.

**These totals represent all complaint categories.

The Office of the Correctional Investigator (OCI) may commence an investigation on receipt of a complaint by or on behalf of an offender or on its own initiative. Complaints are made by telephone, letter and during interviews with the OCI's investigative staff at federal correctional facilities. The dispositions in response to complaints involve a combination of internal responses (where the information or assistance sought by the offender can generally be provided by the OCI's investigative staff) and investigations (where, further to a review/analysis of law, policies and documentation, OCI investigative staff make an inquiry or several interventions with Correctional Service Canada and submit recommendations to address the complaint). Investigations vary considerably in terms of scope, complexity, duration and resources required.

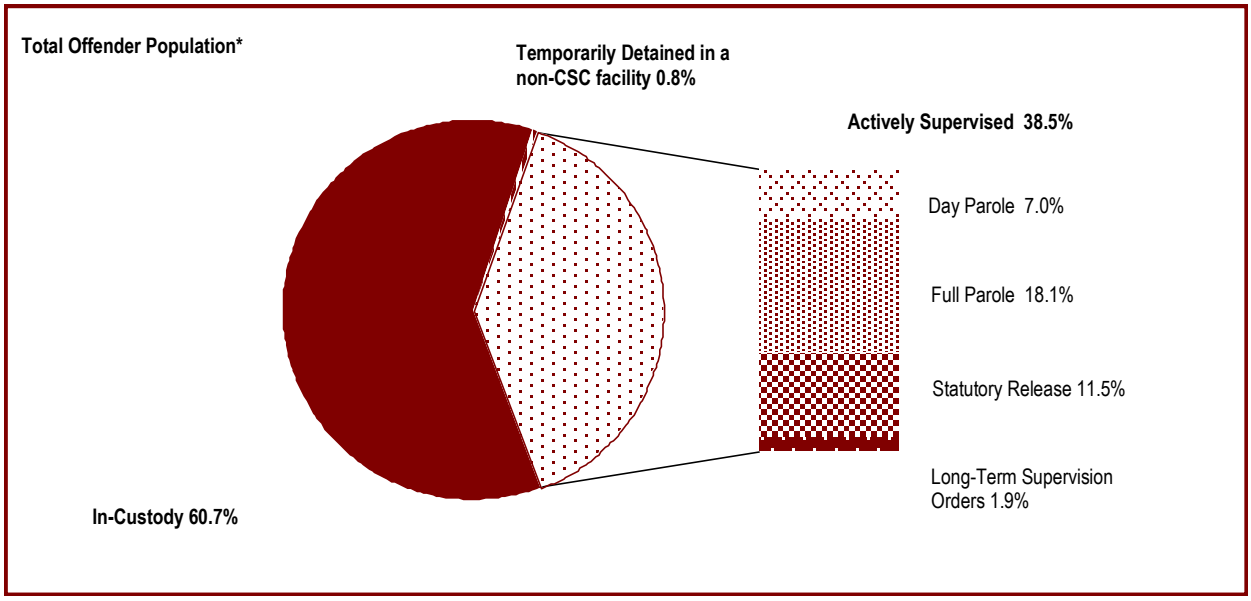
Due to ongoing efforts at the OCI to streamline our administrative database and ensure accuracy in reporting, the numbers in this table will not always match those of past *Corrections and Conditional Release Statistical Overviews,* or OCI Annual Reports.

SECTION C

OFFENDER POPULATION

OFFENDERS UNDER THE RESPONSIBILITY OF CORRECTIONAL SERVICE CANADA

Figure C1



Source: Correctional Service Canada.

Definitions:

CSC Facilities include all federal institutions, federally funded healing lodges, and healing lodges operated under Section 81 of the *Corrections and Conditional Release Act*.

Total Offender Population includes all active offenders, who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised and offenders who are unlawfully at large for less than 90 days.

In-Custody includes all active offenders incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained in a CSC facility and offenders on remand in a CSC facility.

Temporarily Detained includes offenders who are physically held in a CSC facility or a non-CSC facility after being suspended for a breach of a parole condition or to prevent a breach of parole conditions.

Actively Supervised includes all active offenders on day parole, full parole or statutory release, as well as those who are in the community on long-term supervision orders.

In Community Under Supervision includes all active offenders on day parole, full parole, or statutory release, or in the community supervised on a long-term supervision order, offenders who are temporarily detained in a non-CSC facility, offenders who are unlawfully at large for less than 90 days, offenders on remand in a non-CSC facility, and offenders supervised and subject to an immigration hold by the Canada Border Services Agency.

In addition to Total Offender Population, there are excluded groups such as:

Federal jurisdiction offenders incarcerated in a Community Correctional Centre or in a non-CSC facility. Federal jurisdiction offenders deported/extradited including offenders for whom a deportation order has been enforced by the Canada Border Services Agency. Federal offenders on bail which includes offenders on judicial interim release; they have appealed their conviction or sentence and have been released to await results of a new trial. Escaped includes offenders who have absconded from either a correctional facility or while on a temporary absence and whose whereabouts are unknown. Unlawfully at Large for 90 days or more. This includes offenders who have been released to the community on day parole, full parole, statutory release, or a long-term supervision order for whom a warrant of suspension has been issued at least 90 days ago but has not yet been executed.

Note:

*In addition to this total offender population, 224 offenders were on bail, 126 offenders had escaped, 230 offenders serving a federal sentence were in custody in a non-CSC facility, 336 offenders were unlawfully at large for 90 days or more, and 422 offenders were deported. The definition of "Offender Population" changed from previous editions of the Corrections and Conditional Release Statistical Overview (CCRSO). As such, comparisons to editions of the CCRSO prior to 2016 should be done with caution.

OFFENDERS UNDER THE RESPONSIBILITY OF CORRECTIONAL SERVICE CANADA

Table C1

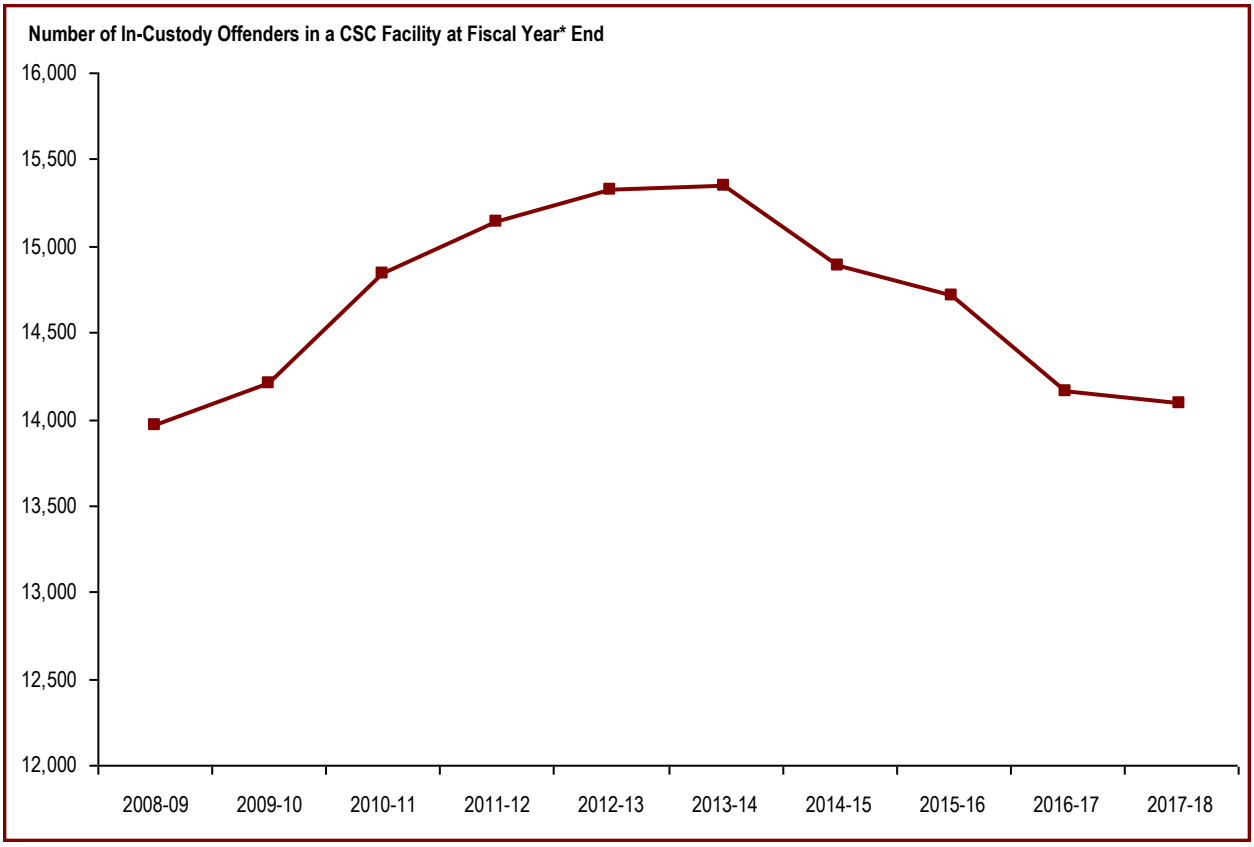
Status	Offenders under the responsibility of Correctional Service Canada					
	#	#	#	%	%	%
In-Custody Population (CSC Facility)	**14,092**					**60.7**
Incarcerated in CSC Facility		13,264			57.1	
Temporarily Detained in CSC Facility		828			3.6	
In Community under Supervision	**9,131**					**39.3**
Temporarily Detained in Non-CSC Facility		192			0.8	
Actively Supervised		8,939			38.5	
Day Parole			1,615	7.0		
Full Parole			4,209	18.1		
Statutory Release			2,672	11.5		
Long-Term Supervision Order			443	1.9		
Total	**23,223***					**100.0**

Source: Correctional Service Canada.

Note:
*In addition to this total offender population, 224 offenders were on bail, 126 offenders had escaped, 230 offenders serving a federal sentence were in custody in a non-CSC facility, 336 offenders were unlawfully at large for 90 days or more, and 422 offenders were deported. The definition of "Offender Population" changed from previous editions of the Corrections and Conditional Release Statistical Overview (CCRSO). As such, comparisons to editions of the CCRSO prior to 2016 should be done with caution.

THE NUMBER OF OFFENDERS IN CUSTODY IN A CSC FACILITY DECREASED IN THE LAST FOUR YEARS

Figure C2



Source: Correctional Service Canada.

- From 2008-2009 to 2013-2014, the in-custody population increased consistently but started to decline in 2014-2015 and has been declining since then.
- From 2013-14 to 2015-16, the average provincial/territorial in-custody offender population increased by 4.1% from 24,455 to 25,448. The remand population increased by 13.0%, from 13,650 to 15,417 during this period. Since 2006-07, the number of remanded inmates has exceeded the number of sentenced inmates in provincial/territorial custody.**

Note:
*The data reflect the number of offenders in custody at the end of each fiscal year. A fiscal year runs from April 1 to March 31 of the following year.
The term "In Custody in a CSC Facility" includes all active offenders incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained in a CSC facility and offenders on remand in a CSC facility.
**Source: *Corrections Key Indicator Report for Adults and Youth,* Canadian Centre for Justice Statistics, Statistics Canada

THE NUMBER OF OFFENDERS IN CUSTODY IN A CSC FACILITY DECREASED IN THE LAST FOUR YEARS

Table C2

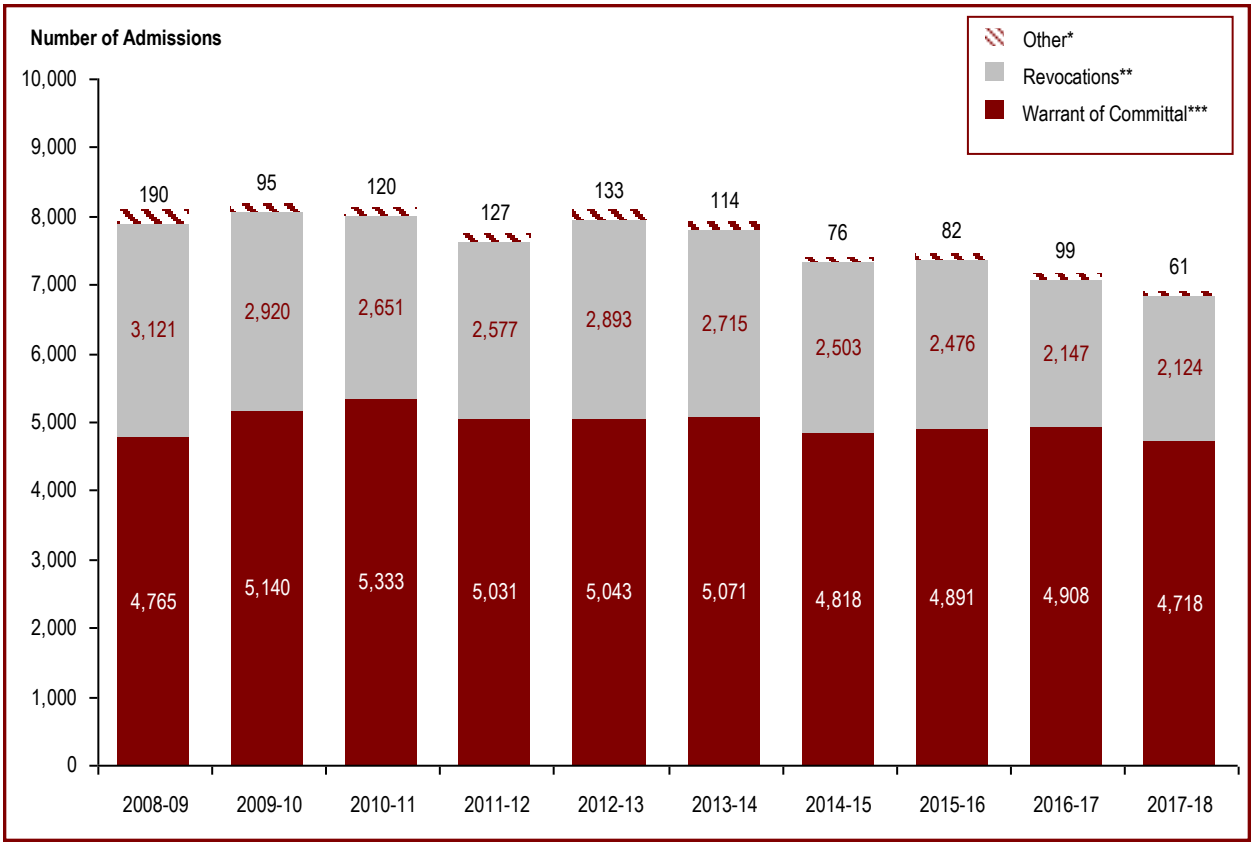
Year	In Custody Offenders					
		Provincial/Territorial[2]				
	In-Custody in a CSC Facility*[1]	Sentenced	Remand	Other/ Temporary Detention	Total	**Total**
2008-09	13,960	9,931	13,548	311	23,790	**37,750**
2009-10	14,197	10,045	13,739	308	24,092	**38,289**
2010-11	14,840	10,922	13,086	427	24,435	**39,275**
2011-12	15,131	11,138	13,369	308	24,814	**39,945**
2012-13	15,318	11,138	13,739	308	25,185	**40,503**
2013-14	15,342	9,888	11,494	322	21,704	**37,046**
2014-15	14,886	10,364	13,650	441	24,455	**39,341**
2015-16	14,712	10,091	14,899	415	25,405	**40,117**
2016-17	14,159	9,710	15,417	321	25,448	**39,607**
2017-18	14,092	--	--	--	--	--

Source: [1]Correctional Service Canada.; [2]Table 35-10-0154-01, Corrections Key Indicator Report for Adults and Youth, Canadian Centre for Justice Statistics, Statistics Canada

Note:
*The data reflect the number of offenders in custody at the end of each fiscal year. A fiscal year runs from April 1 to March 31 of the following year.
The term "In Custody in a CSC Facility" includes all active offenders incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained in a CSC facility and offenders on remand in a CSC facility.
The figures for provincial and territorial offenders reflect annual average counts.
-- Data not available.

THE NUMBER OF ADMISSIONS TO FEDERAL JURISDICTION HAS DECREASED

Figure C3



Source: Correctional Service Canada.

- After peaking at 8,155 in 2009-10, the number of admissions has decreased by 15.4% to 6,903 in 2017-18.
- The number of warrant of committal admissions has fluctuated over the past decade but has declined by 11.5% compared to the highest point which occurred in fiscal year 2010-11.
- The number of women admitted to federal jurisdiction under warrants of committal increased 14.1% from 312 in 2013-14 to 356 in 2017-18.

Note:
*"Other" includes transfers from other jurisdictions (exchange of services), terminations, transfers from foreign countries, and admissions where a release is interrupted as a consequence of a new conviction.
These numbers refer to the total number of admissions to a federal institution or Healing Lodge during each fiscal year and may be greater than the actual number of offenders admitted, since an individual offender may be admitted more than once in a given year. A fiscal year runs from April 1 to March 31 of the following year.
**Revocation is when an offender is admitted to federal custody after conditional release and before reaching warrant expiry.
***Warrant of Committal is a new admission to federal jurisdiction from the courts.

THE NUMBER OF ADMISSIONS TO FEDERAL JURISDICTION HAS DECREASED

Table C3

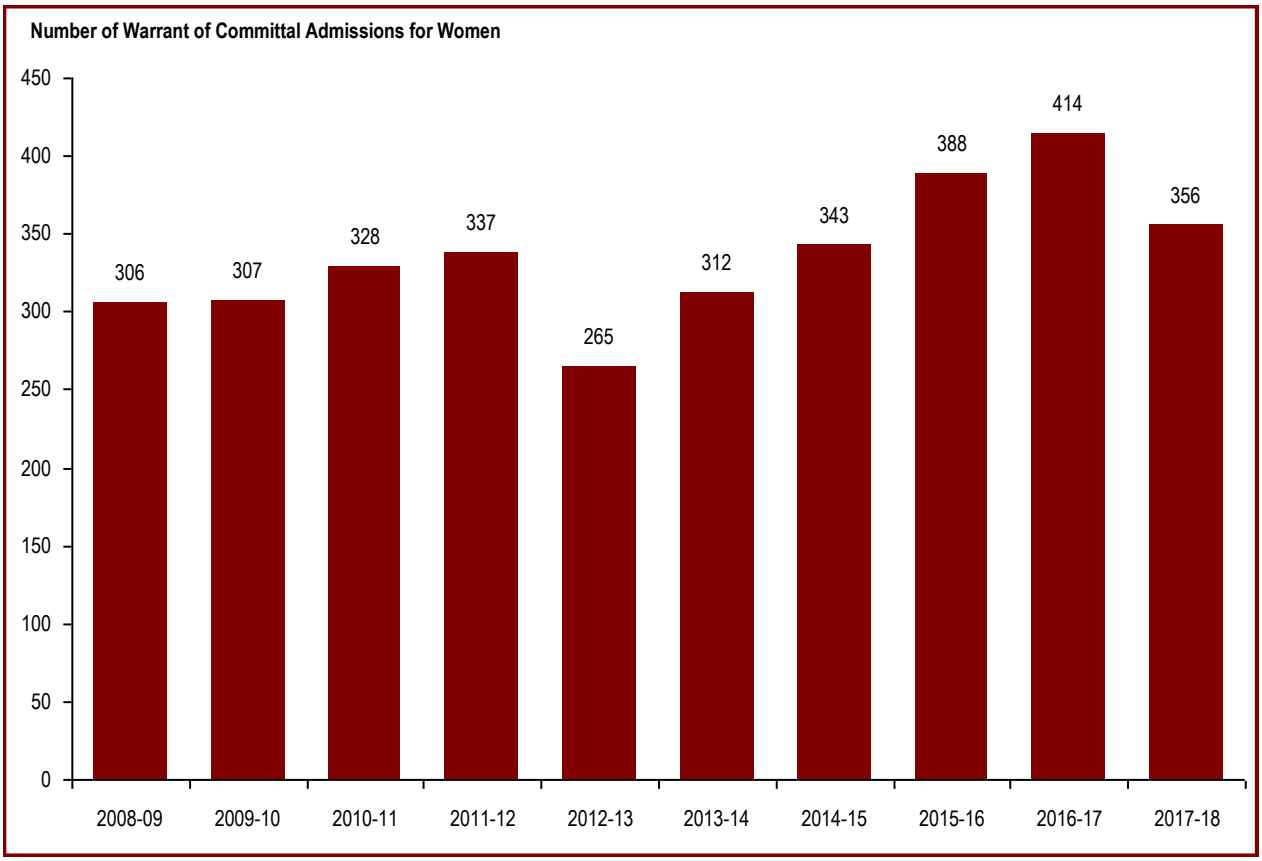
	2013-14		2014-15		2015-16		2016-17		2017-18	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
Warrant of Committal										
1st Federal Sentence	273	3,467	302	3,309	348	3,321	378	3,357	315	3,186
2nd or Subsequent Federal Sentence	38	1,269	41	1,153	39	1,176	36	1,130	41	1,172
Provincial Sentence	1	23	0	13	1	6	0	7	0	4
Subtotal	312	4,759	343	4,475	388	4,503	414	4,494	356	4,362
Total	5,071		4,818		4,891		4,908		4,718	
Revocations	111	2,604	124	2,379	149	2,327	132	2,015	148	1,976
Total	2,715		2,503		2,476		2,147		2,124	
Other*	6	108	5	71	4	78	3	96	7	54
Total	114		76		82		99		61	
	429	**7,471**	**472**	**6,925**	**541**	**6,908**	**549**	**6,605**	**511**	**6,392**
Total Admissions	**7,900**		**7,397**		**7,449**		**7,154**		**6,903**	

Source: Correctional Service Canada.

Note:
*"Other" includes transfers from other jurisdictions (exchange of services), terminations, transfers from foreign countries, and admissions where a release is interrupted as a consequence of a new conviction.
These numbers refer to the total number of admissions to a federal institution or Healing Lodge during each fiscal year and may be greater than the actual number of offenders admitted, since an individual offender may be admitted more than once in a given year. A fiscal year runs from April 1 to March 31 of the following year.

THE NUMBER OF WOMEN ADMITTED FROM THE COURTS TO FEDERAL JURISDICTION DECREASED

Figure C4



Source: Correctional Service Canada.

- In the last ten years, the number of women admitted to federal jurisdiction on a warrant of committal increased 16.3% from 306 in 2008-09 to 356 in 2017-18. During the same time period, there was a small decrease in the number of men admitted to federal jurisdiction on a warrant of committal from 4,459 in 2008-09 to 4,362 in 2017-18.
- Overall, women continue to represent a small proportion of the total number of warrant of committal admissions (i.e., 7.5% in 2017-18).
- At the end of fiscal year 2017-18, there were 676 women in custody within Correctional Service Canada facilities.

Note:
A warrant of committal is a new admission to federal jurisdiction from the courts.

THE NUMBER OF WOMEN ADMITTED FROM THE COURTS TO FEDERAL JURISDICTION DECREASED

Table C4

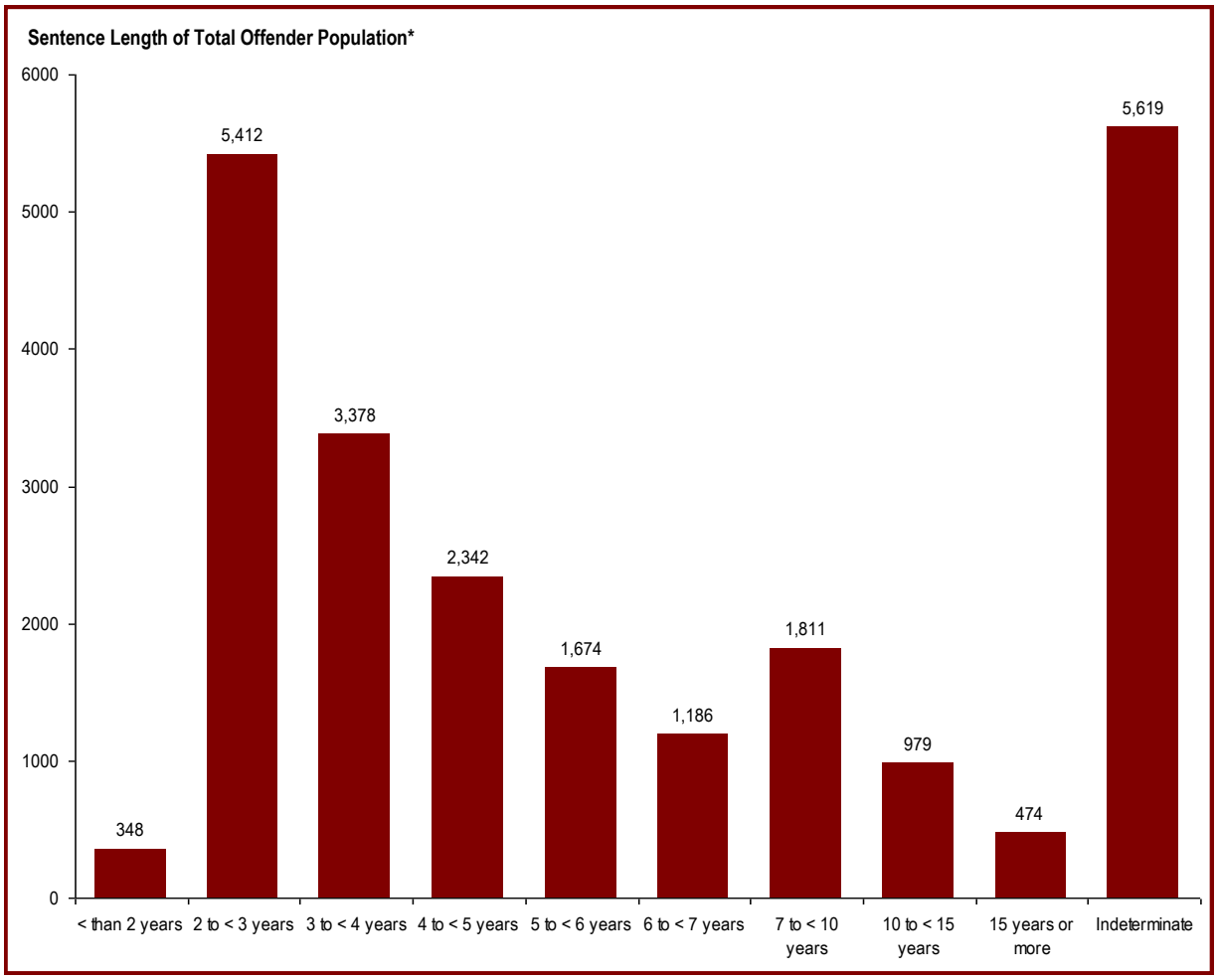
Year	Warrant of Committal Admissions				**Total**
	Women		Men		
	#	%	#	%	
2008-09	306	6.4	4,459	93.6	**4,765**
2009-10	307	6.0	4,833	94.0	**5,140**
2010-11	328	6.2	5,005	93.8	**5,333**
2011-12	337	6.7	4,694	93.3	**5,031**
2012-13	265	5.3	4,778	94.7	**5,043**
2013-14	312	6.2	4,759	93.8	**5,071**
2014-15	343	7.1	4,475	92.9	**4,818**
2015-16	388	7.9	4,503	92.1	**4,891**
2016-17	414	8.4	4,494	91.6	**4,908**
2017-18	356	7.5	4,362	92.5	**4,718**

Source: Correctional Service Canada.

Note:
A warrant of committal is a new admission to federal jurisdiction from the courts.

ABOUT HALF OF THE TOTAL OFFENDER POPULATION IN CSC FACILITIES IS SERVING A SENTENCE OF LESS THAN FIVE YEARS

Figure C5



Source: Correctional Service Canada.

- In 2017-18, almost half (49.4%) of the total offender population was serving a sentence of less than 5 years with 23.3% serving a sentence between two years and less than three years.
- Almost one quarter (24.2%) of the total offender population was serving an indeterminate sentence. The total number of offenders with indeterminate sentences** has increased 7.0% since 2013-14 from 5,253 to 5,619 in 2017-18.

Note:
**Total Offender Population* includes all active offenders who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised, and offenders who are unlawfully at large for less than 90 days.
Offenders serving a sentence less than two years includes offenders transferred from foreign countries or offenders under a long-term supervision order who received a new sentence of less than two years.
** Indeterminate means that the offender's term of imprisonment does not have an end date. The Parole Board of Canada reviews the case after seven years and every two years after that.

ABOUT HALF OF THE TOTAL OFFENDER POPULATION IN CSC FACILITIES IS SERVING A SENTENCE OF LESS THAN FIVE YEARS

Table C5

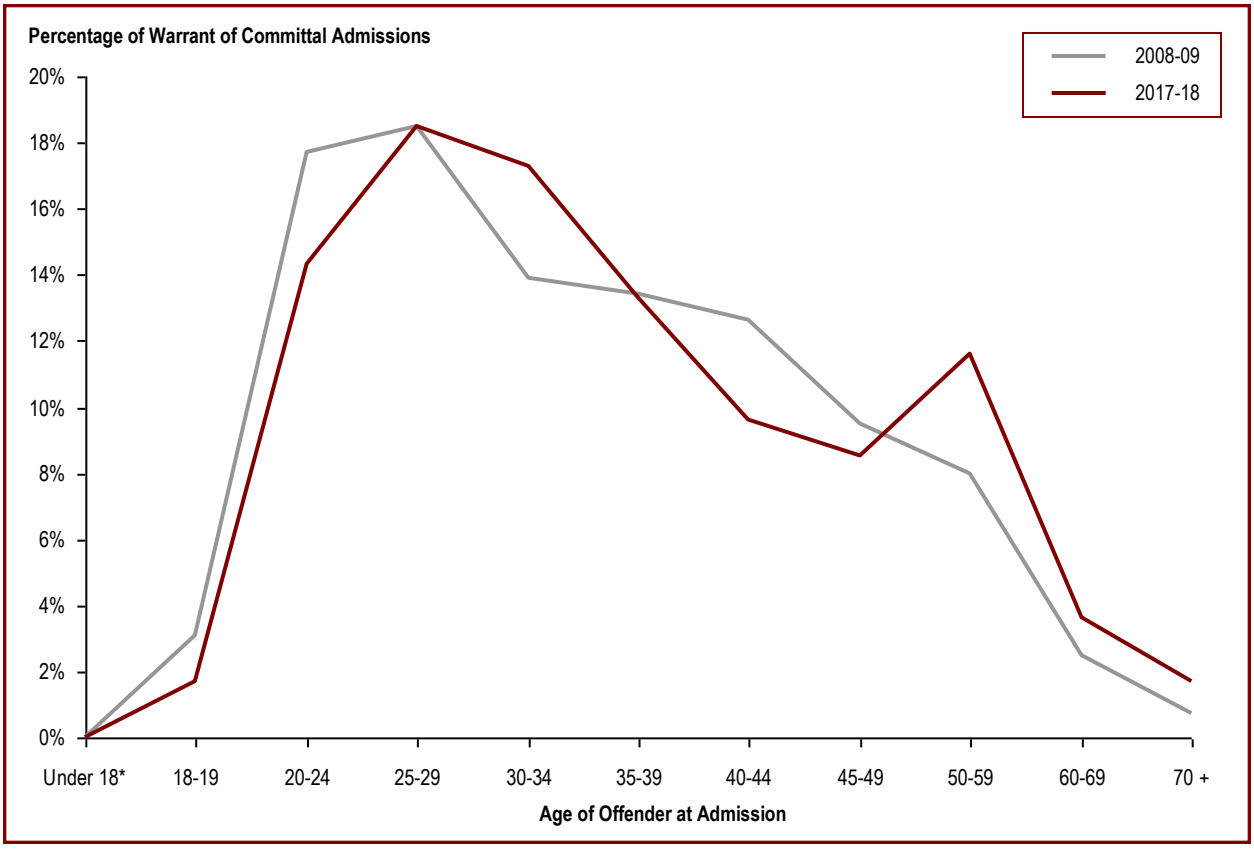
Sentence Length	2013-14		2014-15		2015-16		2016-17		2017-18	
	#	%	#	%	#	%	#	%	#	%
< than 2 years	291	1.3	287	1.2	306	1.3	307	1.3	348	1.5
2 years to < 3 years	5,296	22.9	5,241	22.8	5,367	23.3	5,391	23.4	5,412	23.3
3 years to < 4 years	3,771	16.3	3,631	15.8	3,503	15.2	3,377	14.7	3,378	14.5
4 years to < 5 years	2,447	10.6	2,422	10.5	2,393	10.4	2,382	10.3	2,342	10.1
5 years to < 6 years	1,638	7.1	1,672	7.3	1,692	7.3	1,691	7.3	1,674	7.2
6 years to < 7 years	1,100	4.8	1,104	4.8	1,136	4.9	1,143	5.0	1,186	5.1
7 years to < 10 years	1,793	7.7	1,788	7.8	1,805	7.8	1,810	7.9	1,811	7.8
10 years to < 15 years	954	4.1	936	4.1	940	4.1	951	4.1	979	4.2
15 years or more	612	2.6	564	2.5	522	2.3	501	2.2	474	2.0
Indeterminate	5,253	22.7	5,316	23.2	5,393	23.4	5,492	23.8	5,619	24.2
Total	**23,155**	**100**	**22,961**	**100**	**23,057**	**100**	**23,045**	**100**	**23,223**	**100**

Source: Correctional Service Canada.

Note:
Total Offender Population includes all active offenders, who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised, and offenders who are unlawfully at large for less than 90 days.
The group of offenders serving a sentence less than 2 years includes offenders transferred from foreign countries or offenders under a long-term supervision order who received a new sentence of less than 2 years.

ADMISSION OF OLDER OFFENDERS TO FEDERAL JURISDICTION IS INCREASING

Figure C6



Source: Correctional Service Canada.

- In 2017-18, 32.8% of offenders admitted on a warrant of committal to federal jurisdiction were between the ages of 20 and 29, and 30.6% were between 30 and 39 years of age.
- The distribution of age upon admission is similar for both men and women.
- The median age of the population upon admission in 2017-18 was 34, compared to a median age of 33 in 2008-09.
- The number of offenders between the ages of 40 and 49 at admission decreased from 1,055 in 2008-09 to 850 in 2017-18, representing a 19.4% decrease.
- The number of offenders between the ages of 50 and 59 at admission increased from 382 in 2008-09 to 548 in 2017-18 representing a 43.5% increase.

Note:
*This offender was admitted to a youth correctional centre.
A warrant of committal is a new admission to federal jurisdiction from the courts.
Due to rounding, percentages may not add up to 100 percent.

ADMISSION OF OLDER OFFENDERS TO FEDERAL JURISDICTION IS INCREASING

Table C6

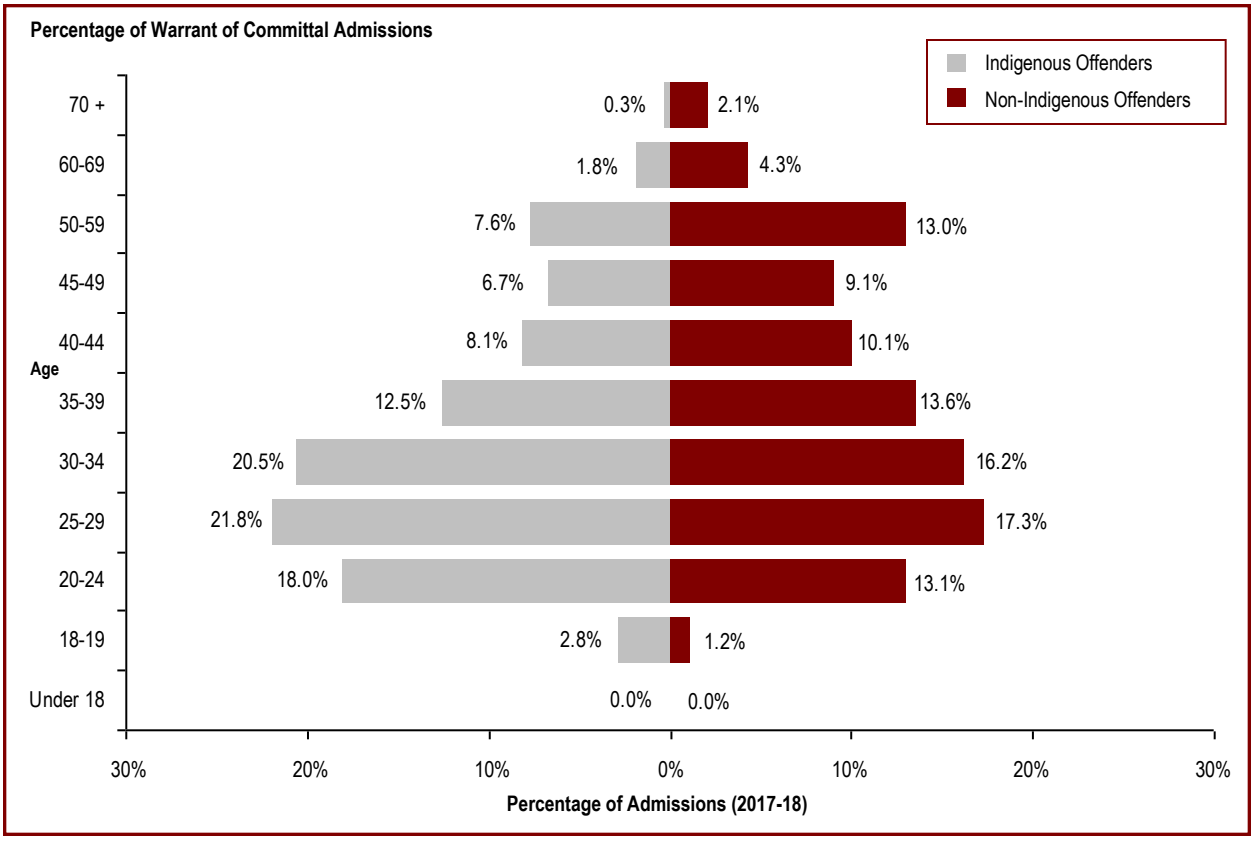
Age at Admission	2008-09						2017-18					
	Women		Men		Total		Women		Men		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Under 18	0	0.0	1*	0.0	1*	0.0	0	0.0	0	0.0	0	0.0
18 and 19	10	3.3	139	3.1	149	3.1	4	1.1	74	1.7	78	1.7
20 to 24	39	12.7	804	18.0	843	17.7	49	13.8	628	14.4	677	14.3
25 to 29	47	15.4	834	18.7	881	18.5	76	21.3	795	18.2	871	18.5
30 to 34	60	19.6	602	13.5	662	13.9	68	19.1	750	17.2	818	17.3
35 to 39	42	13.7	598	13.4	640	13.4	50	14.0	576	13.2	626	13.3
40 to 44	51	16.7	551	12.4	602	12.6	38	10.7	413	9.5	451	9.6
45 to 49	27	8.8	426	9.6	453	9.5	26	7.3	373	8.6	399	8.5
50 to 59	26	8.5	356	8.0	382	8.0	35	9.8	513	11.8	548	11.6
60 to 69	4	1.3	115	2.6	119	2.5	9	2.5	163	3.7	172	3.6
70 and over	0	0.0	33	0.7	33	0.7	1	0.3	77	1.8	78	1.7
Total	**306**		**4,459**		**4,765**		**356**		**4,362**		**4,718**	

Source: Correctional Service Canada.

Note:
*This offender was admitted to a youth correctional centre.
A warrant of committal is a new admission to federal jurisdiction from the courts.
Due to rounding, percentages may not add to 100 percent.

THE AVERAGE AGE AT ADMISSION IS LOWER FOR INDIGENOUS OFFENDERS THAN FOR NON-INDIGENOUS OFFENDERS

Figure C7



Source: Correctional Service Canada.

- Of those offenders admitted on a warrant of committal to federal jurisdiction in 2017-18, 42.6% of Indigenous offenders were under the age of 30, compared to 31.6% of non-Indigenous offenders.
- The median age of Indigenous offenders at admission was 31, compared to a median age of 35 for non-Indigenous offenders.
- The median age of Indigenous women offenders at admission was 30, compared to a median age of 35 for non-Indigenous women offenders.

Note:
A warrant of committal is a new admission to federal jurisdiction from the courts.
Due to rounding, percentages may not add to 100 percent.

THE AVERAGE AGE AT ADMISSION IS LOWER FOR INDIGENOUS OFFENDERS THAN FOR NON-INDIGENOUS OFFENDERS

Table C7

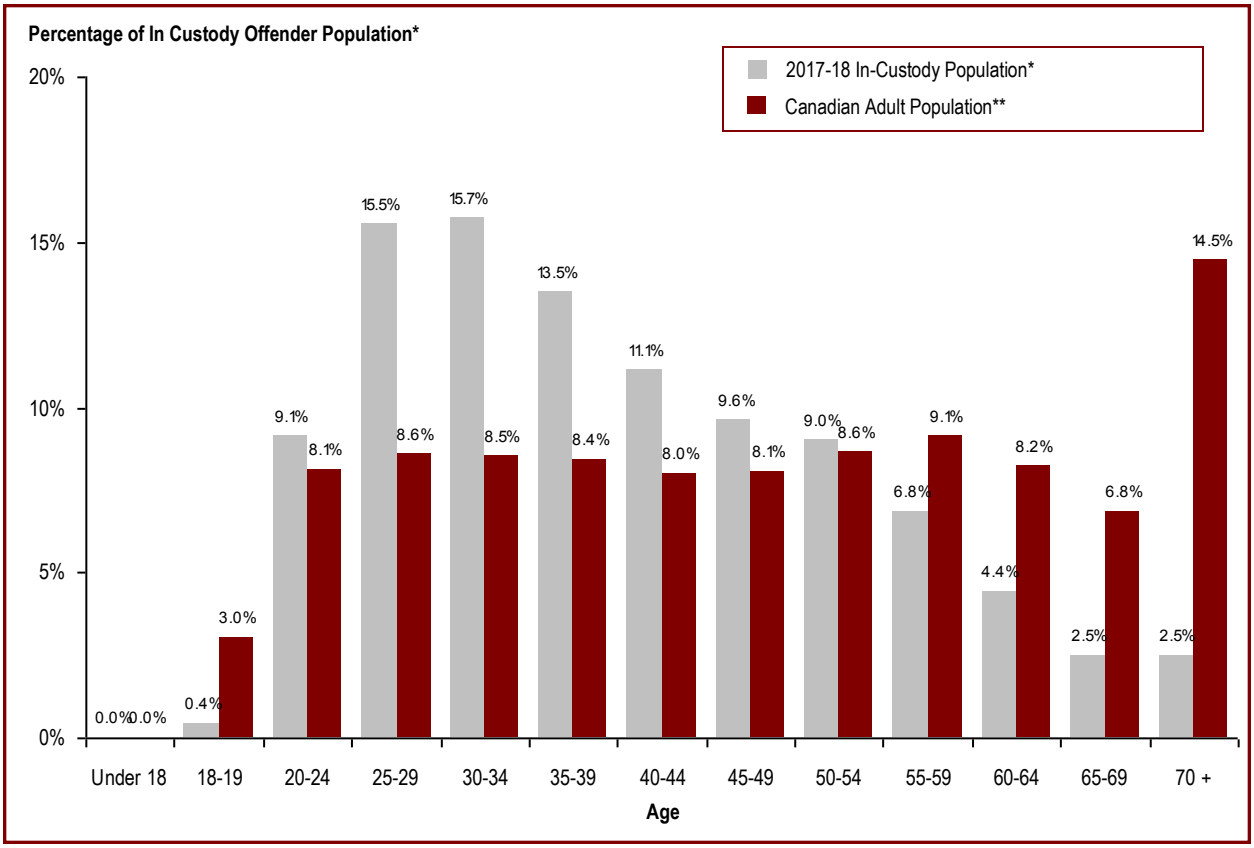
Age at Admission	2008-09						2017-18					
	Indigenous		Non-Indigenous		Total		Indigenous		Non-Indigenous		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Under 18	1*	0.1	0	0.0	1*	0.0	0	0.0	0	0.0	0	0.0
18 and 19	43	4.5	106	2.8	149	3.1	35	2.8	43	1.2	78	1.7
20 to 24	199	20.7	644	16.9	843	17.7	223	18.0	454	13.1	677	14.3
25 to 29	187	19.4	694	18.3	881	18.5	271	21.8	600	17.3	871	18.5
30 to 34	164	17.0	498	13.1	662	13.9	254	20.5	564	16.2	818	17.3
35 to 39	124	12.9	516	13.6	640	13.4	155	12.5	471	13.6	626	13.3
40 to 44	113	11.7	489	12.9	602	12.6	100	8.1	351	10.1	451	9.6
45 to 49	78	8.1	375	9.9	453	9.5	83	6.7	316	9.1	399	8.5
50 to 59	47	4.9	335	8.8	382	8.0	95	7.6	453	13.0	548	11.6
60 to 69	6	0.6	113	3.0	119	2.5	22	1.8	150	4.3	172	3.6
70 and over	1	0.1	32	0.8	33	0.7	4	0.3	74	2.1	78	1.7
Total	**963**		**3,802**		**4,765**		**1,242**		**3,476**		**4,718**	

Source: Correctional Service Canada.

Note:
*This offender was admitted to a youth correctional centre.
A warrant of committal is a new admission to federal jurisdiction from the courts.
Due to rounding, percentages may not add to 100 percent.

25% OF THE IN-CUSTODY OFFENDER POPULATION IS AGE 50 OR OVER

Figure C8



Source: Correctional Service Canada; Statistics Canada.

- In 2017-18, 54.1% of in-custody offenders were under the age of 40.
- In 2017-18, 25.2% of the in-custody offender population was age 50 and over.
- ***The community offender population was older than the in-custody population; 38.0% of offenders in the community were age 50 and over, compared to 25.2% of the in-custody offenders in this age group.

Note:
*In-custody population includes all active offenders incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained in a CSC facility, and offenders on remand in a CSC facility.
**2014 Postcensal Estimates, Demography Division, and Statistics Canada include only those age 18 and older.
***In community under supervision includes all active offenders on day parole, full parole, statutory release, or in the community supervised on a long-term supervision order, offenders who are temporarily detained in a non-CSC facility, offenders who are unlawfully at large for less than 90 days, offenders on remand in a non-CSC facility, and offenders supervised and subject to an immigration hold by the Canada Border Services Agency.
Due to rounding, percentage may not add up to 100 percent.

25% OF THE IN-CUSTODY OFFENDER POPULATION IS AGE 50 OR OVER

Table C8

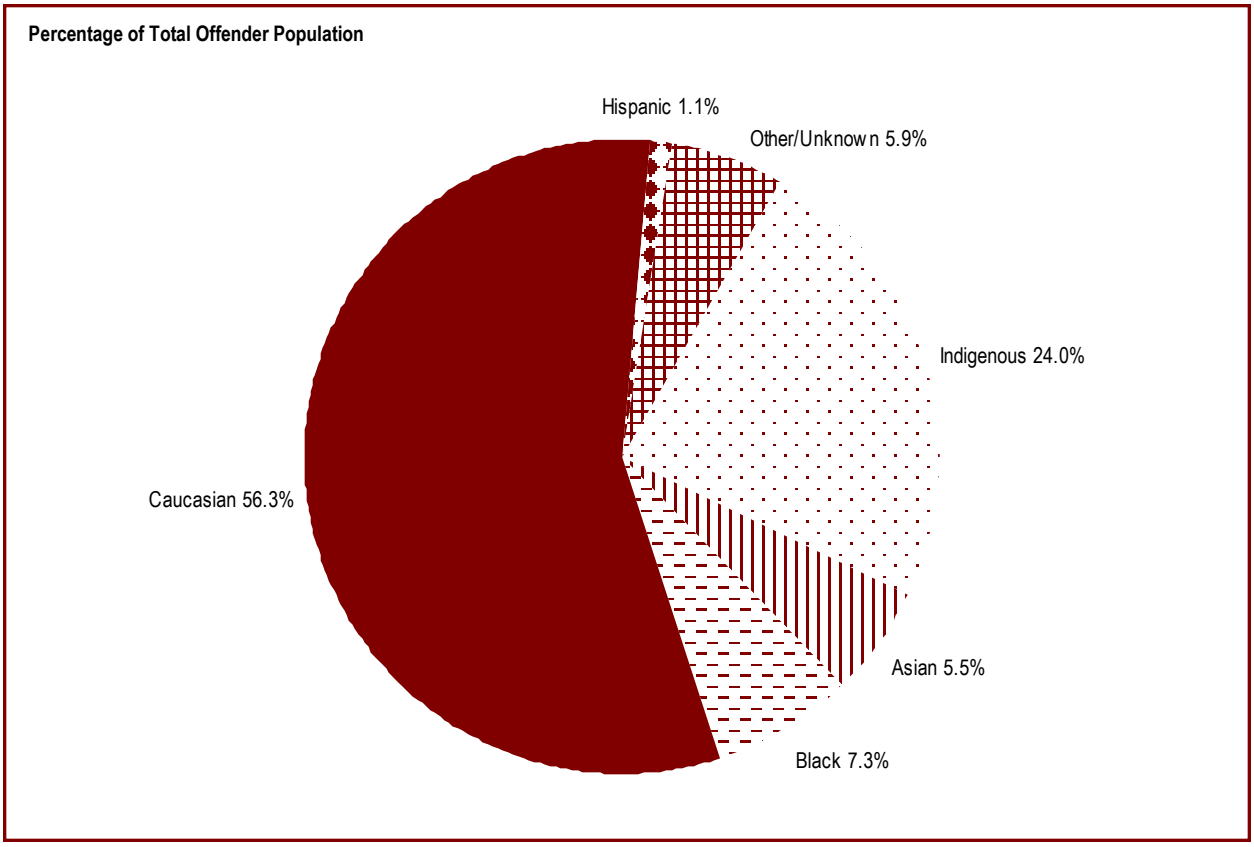
Age	In-Custody*		In Community Under Supervision**		Total		% of Canadian Adult Population***
	#	%	#	%	#	%	%
Under 18	0	0.0	0	0.0	0	0.0	0.0
18 and 19	55	0.4	5	0.1	60	0.3	3.0
20 to 24	1,282	9.1	462	5.1	1,744	7.5	8.1
25 to 29	2,179	15.5	1,030	11.3	3,209	13.8	8.6
30 to 34	2,211	15.7	1,156	12.7	3,367	14.5	8.5
35 to 39	1,900	13.5	1,145	12.5	3,045	13.1	8.4
40 to 44	1,560	11.1	930	10.2	2,490	10.7	8.0
45 to 49	1,357	9.6	935	10.2	2,292	9.9	8.1
50 to 54	1,275	9.0	900	9.9	2,175	9.4	8.6
55 to 59	961	6.8	810	8.9	1,771	7.6	9.1
60 to 64	615	4.4	646	7.1	1,261	5.4	8.2
65 to 69	349	2.5	472	5.2	821	3.5	6.8
70 and over	348	2.5	640	7.0	988	4.3	14.5
Total	**14,092**	**100.0**	**9,131**	**100.0**	**23,223**	**100.0**	**100.0**

Source: Correctional Service Canada; Statistics Canada.

Note:
*In-custody population includes all active offenders incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained in a CSC facility, and offenders on remand in a CSC facility.
**In community under supervision includes all active offenders on day parole, full parole, statutory release, or in the community supervised on a long-term supervision order, offenders who are temporarily detained in a non-CSC facility, offenders who are unlawfully at large for less than 90 days, offenders on remand in a non-CSC facility, and offenders supervised and subject to an immigration hold by the Canada Border Services Agency.
Due to rounding, percentage may not add up to 100 percent.
***2014 Postcensal Estimates, Demography Division, and Statistics Canada include only those age 18 and older.

56% OF OFFENDERS ARE CAUCASIAN

Figure C9



Source: Correctional Service Canada.

- The federal offender population is becoming more diverse, as evidenced by the decrease in the proportion of Caucasian offenders (from 60.8% in 2013-14 to 56.3% in 2017-18).
- Between 2013-14 and 2017-18, the Indigenous population has increased by 14.7% (from 4,856 to 5,572).
- Indigenous offenders represented 24.0% of the 2017-18 total federal offender population and 26.3% of 2017-18 warrant of committal admissions to federal jurisdiction.

Note:
The offenders themselves identify to which race they belong. The list of categories may not fully account for all races and the race groupings information has changed starting in 2012-13; therefore, the comparisons before and after 2012-13 should be done with caution.
According to Correctional Service of Canada, "Indigenous" includes offenders who are Inuit, Innu, Métis and North American Indian. "Asian" includes offenders who are Arab, Arab/West Asian, Asian-East and Southeast, Asian-South, Asian West, Asiatic, Chinese, East Indian, Filipino, Japanese, Korean, South Asian, South East Asian. "Asiatic" includes offenders who are Asian-East and Southeast, Asian-South, Asian West, and Asiatic. "Hispanic" includes offenders who are Hispanic and Latin American. "Black" includes offenders who are Black. "Other/Unknown" includes offenders who are European French, European-Eastern, European-Northern, European-Southern, European-Western, Multiracial/Ethnic, Oceania, British Isles, Caribbean, Sub-Sahara African, offenders unable to identify to one race, other and unknown.
The data reflect all active offenders, who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised, and offenders who are unlawfully at large for less than 90 days.
The data reflect the number of offenders active at the end of each fiscal year. A fiscal year runs from April 1 to March 31 of the following year.
Due to rounding, percentages may not add up to 100 percent.

56% OF OFFENDERS ARE CAUCASIAN

Table C9

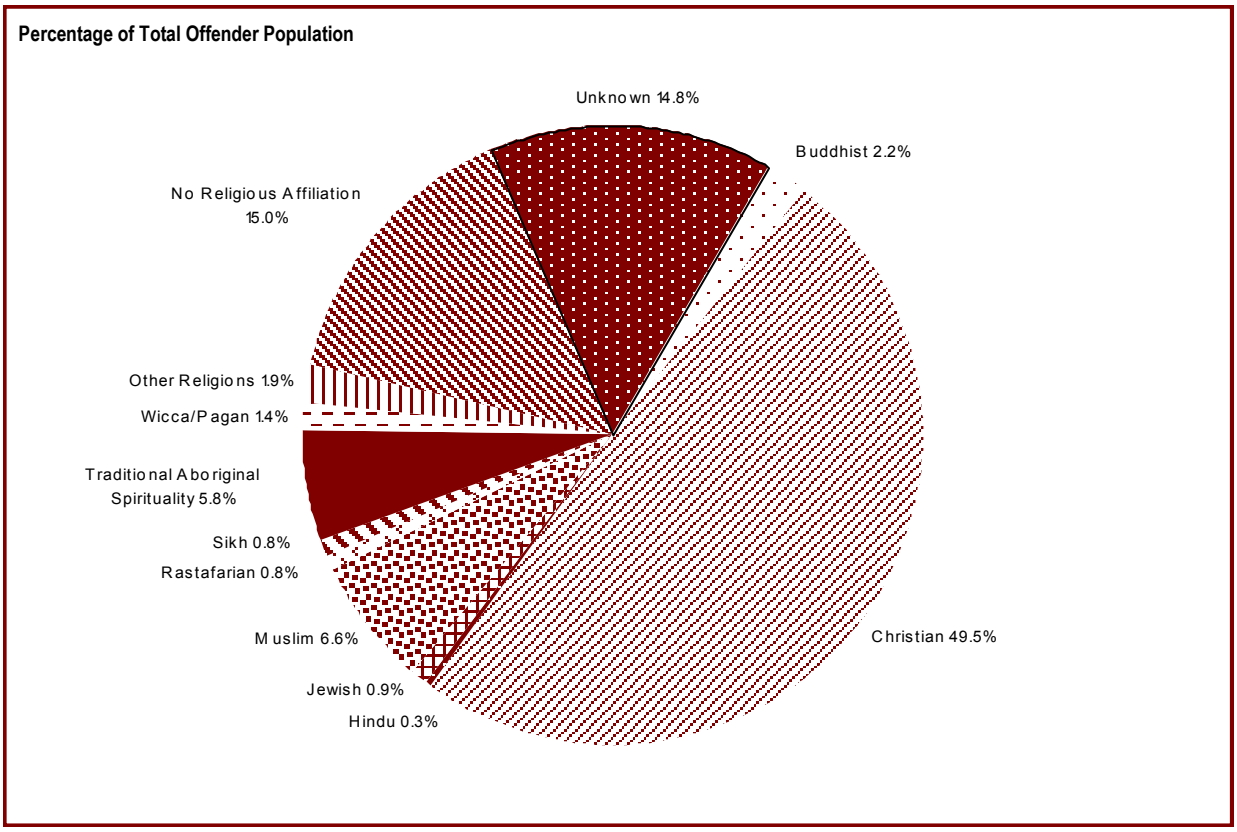
	Total Offender Population			
	2013-14		2017-18	
	#	%	#	%
Indigenous	**4,856**	**21.0**	**5,572**	**24.0**
Inuit	218	0.9	203	0.9
Métis	1,317	5.7	1,619	7.0
North American Indian	3,321	14.3	3,750	16.1
Asian	**1,349**	**5.8**	**1,268**	**5.5**
Arab/West Asian	352	1.5	360	1.6
Asiatic*	197	0.9	377	1.6
Chinese	143	0.6	97	0.4
East Indian	15	0.1	13	0.1
Filipino	66	0.3	75	0.3
Japanese	6	0.0	8	0.0
Korean	19	0.1	16	0.1
South East Asian	326	1.4	196	0.8
South Asian	225	1.0	126	0.5
Black	**1,904**	**8.2**	**1,700**	**7.3**
Caucasian	**14,084**	**60.8**	**13,072**	**56.3**
Hispanic	**249**	**1.1**	**245**	**1.1**
Hispanic	7	0.0	7	0.0
Latin American	242	1.0	238	1.0
Other/Unknown	**713**	**3.1**	**1,366**	**5.9**
Total	**23,155**	**100.0**	**23,223**	**100.0**

Source: Correctional Service Canada.

Note:
*Total for Asiatic includes Asian-East and Southeast, Asian South, Asian West, and Asiatic.
The offenders themselves identify to which race they belong. The list of categories may not fully account for all races and the race groupings information has changed starting in 2012 -13; therefore, the comparisons before and after 2012-13 should be done with caution.
"Indigenous" includes offenders who are Inuit, Innu, Métis and North American Indian. "Asian" includes offenders who are Arab, Arab/West Asian, Asian-East and Southeast, Asian-South, Asian West, Asiatic, Chinese, East Indian, Filipino, Japanese, Korean, South Asian, South East Asian. "Asiatic" includes offenders who are Asian-East and Southeast, Asian-South, Asian West, and Asiatic. "Hispanic" includes offenders who are Hispanic and Latin American. "Black" includes offenders who are Black. "Other/Unknown" includes offenders who are European French, European-Eastern, European-Northern, European-Southern, European-Western, Multiracial/Ethnic, Oceania, British Isles, Caribbean, Sub-Sahara African, offenders unable to identify to one race, other and unknown.
The data reflect all active offenders, who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised, and offenders who are unlawfully at large for less than 90 days.
The data reflect the number of offenders active at the end of each fiscal year. A fiscal year runs from April 1 to March 31 of the following year.
Due to rounding, percentages may not add up to 100 percent.

THE RELIGIOUS IDENTIFICATION OF THE OFFENDER POPULATION IS DIVERSE

Figure C10



Source: Correctional Service Canada.

- The religious identification of the Offender population is diverse. While the proportion of offenders who identified as Christian still represented the majority, their proportions decreased from 56.1% in 2013-2014 to 49.5% in 2017-2018.
- Religious identification was unknown for 14.8% of offenders, and 15.0% stated they had no religion.
- Religion groupings have changed from previous publication to reflect the same groupings as Statistics Canada.

Note:
Religious identification is self-declared by offenders while they are incarcerated, and the categories are not comprehensive; therefore, the reader should interpret these data with caution. Buddhist includes offenders who are Buddhist, Mahayana Buddhist, Theravadan Buddhist and Vajrayana Buddhist. Christian includes offenders who are Amish, Anglican (Episcopal Church of England), Antiochian Orthodox, Apostolic Christian Church, Armenian Orthodox/Apostolic, Associated Gospel, Assyrian Chaldean Catholic, Baptist, Brethren In Christ, Bulgarian Orthodox, Canadian Reformed Church, Catholic- Greek, Catholic-Roman, Catholic-Ukranian, Catholic Non-Specific, Churches of Christ/Christian Churches, Charismatic, Christadelphian, Christian & Missionary Alliance, Christian Congregational, Christian Non Specific, Christian Or Plymouth Brethren, Christian Orthodox, Christian Reformed, Christian Reformed Church, Christian Science, Church of Christ Scientist, Church of God, Church of Jesus Christ of Latter-Day Saint, Community of Christ, Coptic Orthodox, Doukhobor, Dutch Reformed Church, Ethiopian Orthodox, Evangelical, Evangelical Free Church , Evangelical Missionary Church, Free Methodist, Free Reformed Church, Grace Communion International, Greek Orthodox, Hutterite, Iglesia Ni Cristo, Jehovah's Witnesses, Lutheran, Macedonian Orthodox, Maronite, Melkite, Mennonite, Methodist Christian, Metropolitan Community Church, Mission de l'Esprit Saint, Moravian, Mormon (Latter Day Saints), Nazarene Christian, Netherlands Reformed, New Apostolic, Pentecostal (4-Square), Pentecostal Assembly of God, Pentecôtiste, Philadelphia Church of God, Presbyterian, Protestant Non-Specific, Quaker (Society of Friends), Reformed Christian, Romanian Orthodox, Russian Orthodox, Salvation Army, Serbian Orthodox, Seventh Day Adventist, Shaker, Swedenborgian (New Church), Syrian/Syriac Orthodox, Ukrainian Catholic, Ukrainian Orthodox, United Church, United Reformed Church, Vineyard Christian Fellowship, Wesleyan Christian and Worldwide Church of God. Hindu includes offenders who are Hindu and Siddha Yoga. Jewish includes offenders who are Jewish Orthodox, Jewish Reformed and Judaism. Muslim includes offenders who are Muslim and Sufism. Rastafarian includes offenders who are Rastafarian. Sikh includes offenders who are Sikh. Traditional Aboriginal Spirituality includes offenders who are Aboriginal Spirituality Catholic, Aboriginal Spirituality Protestant, Native Spirituality, Catholic - Native Spirituality, Native Spirituality Protestant and Aboriginal Spirituality. Wiccan/Pagan includes offenders who are Asatru Paganism, Druidry Paganism, Pagan and Wicca. Other Religion includes offenders who are Baha'i, Eckankar, Gnostic, Independent Spirituality, Jain, Krishna, New Age, New Thought-Unity-Religious Science, Other, Pantheist, Rosicrucian, Satanist, Scientology, Shintoïste, Spiritualist, Taoism, Transcendental Meditation, Unification Church, Unitarian, Visnabha and Zoroastrian. No religion Affiliation includes offenders who are Agnostic, Atheist, Humanist and offenders who have no religion affiliation. The data reflect all active offenders, who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised, and offenders who are unlawfully at large for less than 90 days. The data reflect the number of offenders active at the end of each fiscal year. A fiscal year runs from April 1 to March 31 of the following year.
Due to rounding, percentages may not add to 100 percent.

THE RELIGIOUS IDENTIFICATION OF THE OFFENDER POPULATION IS DIVERSE

Table C10

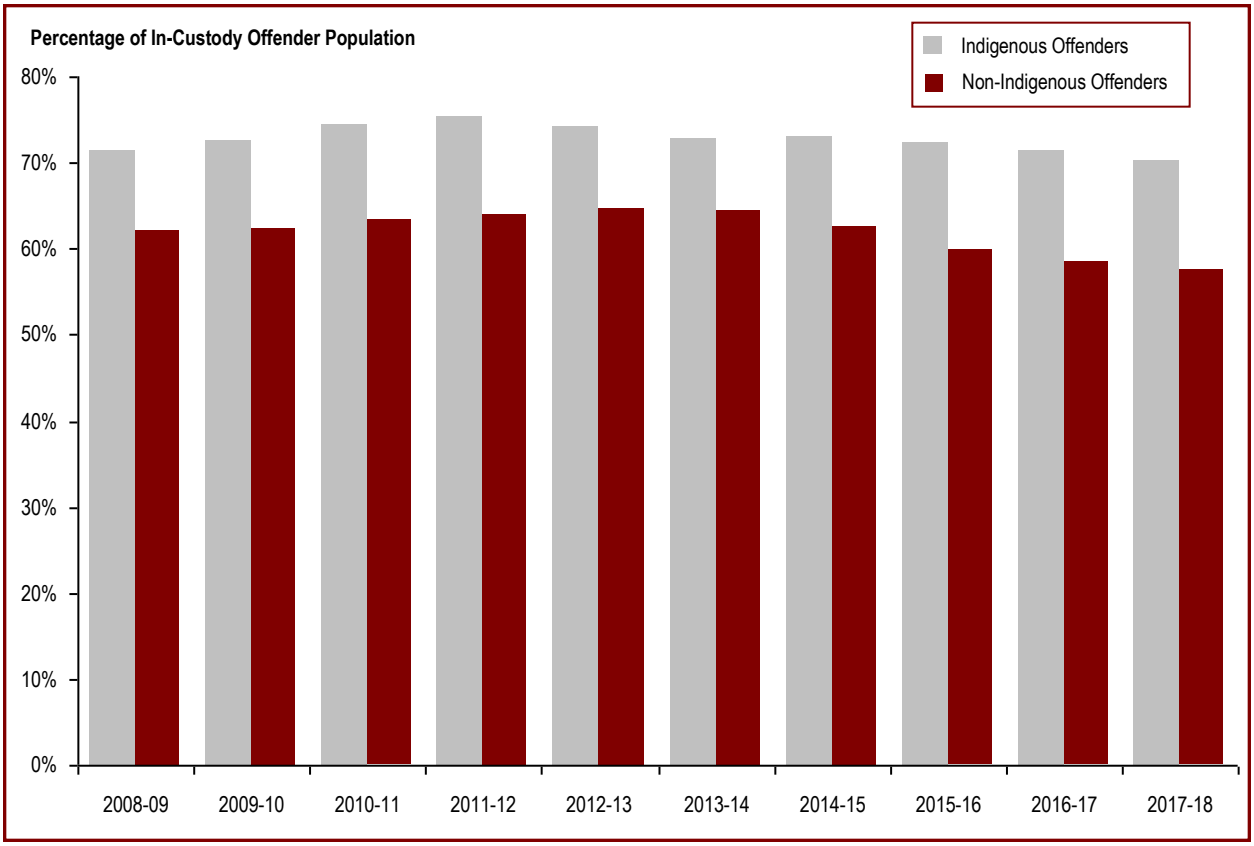
	Total Offender Population			
	2013-14		2017-18	
	#	%	#	%
Buddhist	477	2.1	508	2.2
Christian	12,986	56.1	11,503	49.5
Hindu	47	0.2	63	0.3
Jewish	177	0.8	220	0.9
Muslim	1,264	5.5	1,539	6.6
Rastafarian	171	0.7	178	0.8
Sikh	180	0.8	188	0.8
Traditional Aboriginal Spirituality	1,305	5.6	1,338	5.8
Wicca/Pagan	138	0.6	318	1.4
Other Religions	521	2.3	442	1.9
No Religion Affiliation	3,816	16.5	3,480	15.0
Unknown	2,073	9.0	3,446	14.8
Total	**23,155**	**100.0**	**23,223**	**100.0**

Source: Correctional Service Canada.

Note:
Religious identification is self-declared by offenders while they are incarcerated, and the categories are not comprehensive; therefore, the reader should interpret these data with caution. Buddhist includes offenders who are Buddhist, Mahayana Buddhist, Theravadan Buddhist and Vajrayana Buddhist. Christian includes offenders who are Amish, Anglican (Episcopal Church of England), Antiochian Orthodox, Apostolic Christian Church, Armenian Orthodox/Apostolic, Associated Gospel, Assyrian Chaldean Catholic, Baptist, Brethren In Christ, Bulgarian Orthodox, Canadian Reformed Church, Catholic- Greek, Catholic-Roman, Catholic-Ukranian, Catholic Non-Specific, Churches of Christ/Christian Churches, Charismatic, Christadelphian, Christian & Missionary Alliance, Christian Congregational, Christian Non Specific, Christian Or Plymouth Brethren, Christian Orthodox, Christian Reformed, Christian Reformed Church, Christian Science, Church of Christ Scientist, Church of God, Church of Jesus Christ of Latter-Day Saint, Community of Christ, Coptic Orthodox, Doukhobor, Dutch Reformed Church, Ethiopian Orthodox, Evangelical, Evangelical Free Church , Evangelical Missionary Church, Free Methodist, Free Reformed Church, Grace Communion International, Greek Orthodox, Hutterite, Iglesia Ni Cristo, Jehovah's Witnesses, Lutheran, Macedonian Orthodox, Maronite, Melkite, Mennonite, Methodist Christian, Metropolitan Community Church, Mission de l'Esprit Saint, Moravian, Mormon (Latter Day Saints), Nazarene Christian, Netherlands Reformed, New Apostolic, Pentecostal (4-Square), Pentecostal Assembly of God, Pentecôtiste, Philadelphia Church of God, Presbyterian, Protestant Non-Specific, Quaker (Society of Friends), Reformed Christian, Romanian Orthodox, Russian Orthodox, Salvation Army, Serbian Orthodox, Seventh Day Adventist, Shaker, Swedenborgian (New Church), Syrian/Syriac Orthodox, Ukrainian Catholic, Ukrainian Orthodox, United Church, United Reformed Church, Vineyard Christian Fellowship, Wesleyan Christian and Worldwide Church of God. Hindu includes offenders who are Hindu and Siddha Yoga. Jewish includes offenders who are Jewish Orthodox, Jewish Reformed and Judaism. Muslim includes offenders who are Muslim and Sufism. Rastafarian includes offenders who are Rastafarian. Sikh includes offenders who are Sikh. Traditional Aboriginal Spirituality includes offenders who are Aboriginal Spirituality Catholic, Aboriginal Spirituality Protestant, Native Spirituality, Catholic - Native Spirituality, Native Spirituality Protestant and Aboriginal Spirituality. Wiccan/Pagan includes offenders who are Asatru Paganism, Druidry Paganism, Pagan and Wicca. Other Religion includes offenders who are Baha'i, Eckankar, Gnostic, Independent Spirituality, Jain, Krishna, New Age, New Thought-Unity-Religious Science, Other, Pantheist, Rosicrucian, Satanist, Scientology, Shintoïste, Spiritualist, Taoism, Transcendental Meditation, Unification Church, Unitarian, Visnabha and Zoroastrian. No religion Affiliation includes offenders who are Agnostic, Atheist, Humanist and offenders who have no religion affiliation. The data reflect all active offenders, who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised, and offenders who are unlawfully at large for less than 90 days. The data reflect the number of offenders active at the end of each fiscal year. A fiscal year runs from April 1 to March 31 of the following year.
Due to rounding, percentages may not add to 100 percent.

THE PROPORTION OF INDIGENOUS OFFENDERS IN CUSTODY IS HIGHER THAN FOR NON-INDIGENOUS OFFENDERS

Figure C11



Source: Correctional Service Canada.

- At the end of fiscal year 2017-18, the proportion of offenders in custody was about 12.7% greater for Indigenous offenders (70.3%) than for non-Indigenous offenders (57.6%).
- Indigenous women in custody represent 39.9% of all in-custody women while Indigenous men who were in custody represented 27.2% of all men in custody.
- In 2017-18, Indigenous offenders represented 24.0% of the total offender population.
- Indigenous offenders accounted for 27.8% of the in-custody population and 18.1% of the community population in 2017-18.

Note:
Total Offender Population includes all active offenders, who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised, and offenders who are unlawfully at large for less than 90 days.
In Custody includes all active offenders incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained in a CSC facility and offenders on remand in a CSC facility.
In Community Under Supervision includes all active offenders on day parole, full parole, statutory release, or in the community supervised on a long-term supervision order, offenders who are temporarily detained in a non-CSC facility, offenders who are unlawfully at large for less than 90 days, offenders on remand in a non-CSC facility, and offenders supervised and subject to an immigration hold by the Canada Border Services Agency.
The data reflect the number of offenders active at the end of each fiscal year. A fiscal year runs from April 1 to March 31 of the following year.

THE PROPORTION OF INDIGENOUS OFFENDERS IN CUSTODY IS HIGHER THAN FOR NON-INDIGENOUS OFFENDERS

Table C11

		In-Custody Population		In Community Under Supervision		**Total**
		#	%	#	%	
Men						
2014-15	Indigenous	3,417	73.4	1,238	26.6	**4,655**
	Non-Indigenous	10,788	63.0	6,327	37.0	**17,115**
	Total	14,205	65.3	7,565	34.7	**21,770**
2015-16	Indigenous	3,532	73.2	1,293	26.8	**4,825**
	Non-Indigenous	10,485	61.8	6,468	38.2	**16,953**
	Total	14,017	64.4	7,761	35.6	**21,778**
2016-17	Indigenous	3,545	72.2	1,362	27.8	**4,907**
	Non-Indigenous	9,922	59.0	6,885	41.0	**16,807**
	Total	13,467	62.0	8,247	38.0	**21,714**
2017-18	Indigenous	3,647	71.4	1,464	28.6	**5,111**
	Non-Indigenous	9,769	58.4	6,946	41.6	**16,715**
	Total	13,416	61.5	8,410	38.5	**21,826**
Women						
2014-15	Indigenous	240	67.8	114	32.2	**354**
	Non-Indigenous	441	52.7	396	47.3	**837**
	Total	681	57.2	510	42.8	**1,191**
2015-16	Indigenous	251	62.4	151	37.6	**402**
	Non-Indigenous	444	50.6	433	49.4	**877**
	Total	695	54.3	584	45.7	**1,279**
2016-17	Indigenous	253	61.0	162	39.0	**415**
	Non-Indigenous	439	47.9	477	52.1	**916**
	Total	692	52.0	639	48.0	**1,331**
2017-18	Indigenous	270	58.6	191	41.4	**461**
	Non-Indigenous	406	43.4	530	56.6	**936**
	Total	676	48.4	721	51.6	**1,397**

Source: Correctional Service Canada.

Note:

Total Offender Population includes all active offenders, who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised, and offenders who are unlawfully at large for less than 90 days.

In Custody includes all active offenders incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained in a CSC facility and offenders on remand in a CSC facility.

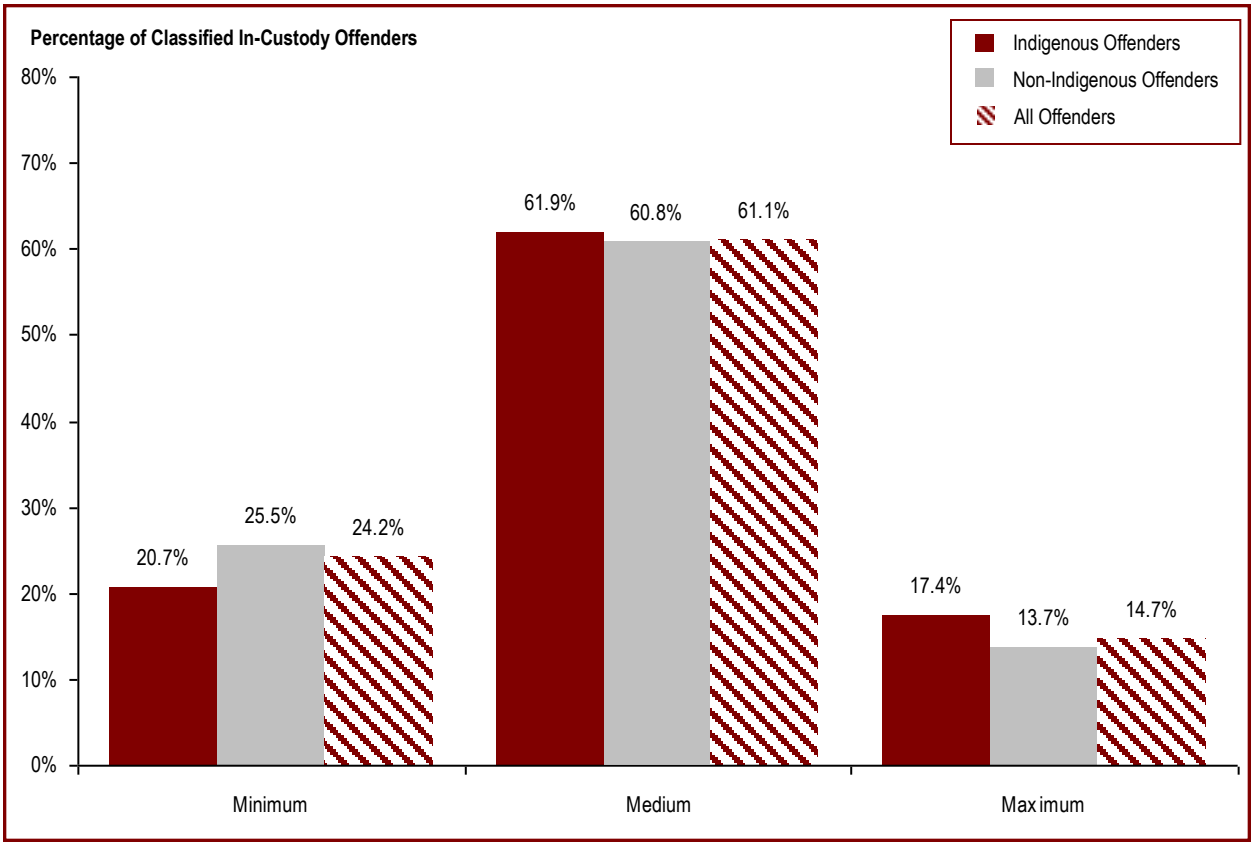
In Community Under Supervision includes all active offenders on day parole, full parole, statutory release, or in the community supervised on a long-term supervision order, offenders who are temporarily detained in a non-CSC facility, offenders who are unlawfully at large for less than 90 days, offenders on remand in a non-CSC facility, and offenders supervised and subject to an immigration hold by the Canada Border Services Agency.

The data reflect the number of offenders active at the end of each fiscal year. A fiscal year runs from April 1 to March 31 of the following year.

Public Safety Canada
2018

THE MAJORITY OF IN-CUSTODY OFFENDERS ARE CLASSIFIED AS MEDIUM SECURITY RISK

Figure C12



Source: Correctional Service Canada.

- Approximately two-thirds (61.1%) of offenders were classified as medium security risk.
- Indigenous offenders were more likely to be classified to a medium or maximum security risk compared to non-Indigenous.
- Compared to non-Indigenous offenders, a lower percentage of Indigenous offenders were classified as minimum security risk (20.7% vs. 25.5%) and a higher percentage were classified as medium (61.9% vs. 60.8%) and maximum (17.4% vs. 13.7%) security risk.

Note:
The data represent the offender security level decision as of end of fiscal year 2017-2018.
In Custody includes all active offenders incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained in a CSC facility and offenders on remand in a CSC facility.

THE MAJORITY OF IN-CUSTODY OFFENDERS ARE CLASSIFIED AS MEDIUM SECURITY RISK

Table C12

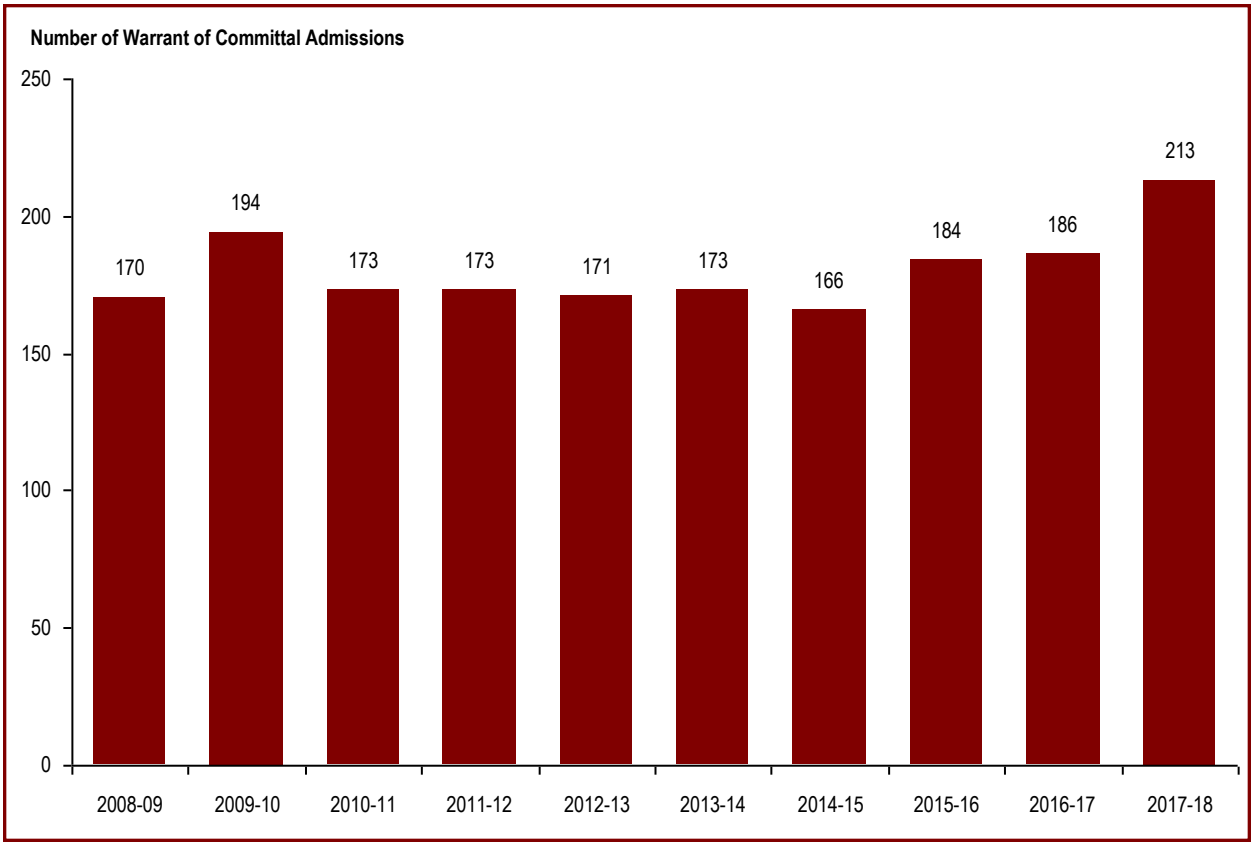
Security Risk Level	Indigenous		Non-Indigenous		Total	
	#	%	#	%	#	%
Minimum	742	20.7	2,328	25.5	3,070	24.2
Medium	2,224	61.9	5,546	60.8	7,770	61.1
Maximum	625	17.4	1,245	13.7	1,870	14.7
Total	**3,591**	**100.0**	**9,119**	**100.0**	**12,710**	**100.0**
Not Yet Determined*	326		1,056		1,382	
Total	**3,917**		**10,175**		**14,092**	

Source: Correctional Service Canada.

Note:
The data represent the offender security level decision as of end of fiscal year 2017-2018.
The "Not yet determined" category includes offenders who have not yet been classified.

ADMISSIONS WITH A LIFE OR INDETERMINATE SENTENCE ARE INCREASING

Figure C13



Source: Correctional Service Canada.

- From 2008-09 to 2017-18, there was an increase of 25.3% in the number of warrant of committal admissions to federal jurisdiction with a life/indeterminate* sentence from 170 to 213.
- At the end of fiscal year 2017-18, there were a total of 3,672 offenders in custody with a life/indeterminate sentence. Of these, 3,539 (96.4%) were men and 133 (3.6%) were women; 972 (26.5%) were Indigenous and 2,700 (73.5%) were non-Indigenous.
- At the end of fiscal year 2017-18, 24.2% of the total population was serving a life/indeterminate sentence. Of these offenders, 65.3% were in custody and 34.7% were in the community under supervision.

Note:
*Although *life sentences* and *indeterminate sentences* both may result in imprisonment for life, they are different. A *life sentence* is a sentence of life imprisonment, imposed by a judge at the time of sentence, for example for murder. An *indeterminate sentence* is a result of a designation, where an application is made to the court to declare an offender a Dangerous Offender, and the consequence of this designation is imprisonment for an indeterminate period.
A warrant of committal is a new admission to federal jurisdiction from the courts.
Total Offender Population includes all active offenders, who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised, and offenders who are unlawfully at large for less than 90 days.
This table combines offenders serving life sentences and offenders serving indeterminate sentences.

ADMISSIONS WITH A LIFE OR INDETERMINATE SENTENCE ARE INCREASING

Table C13

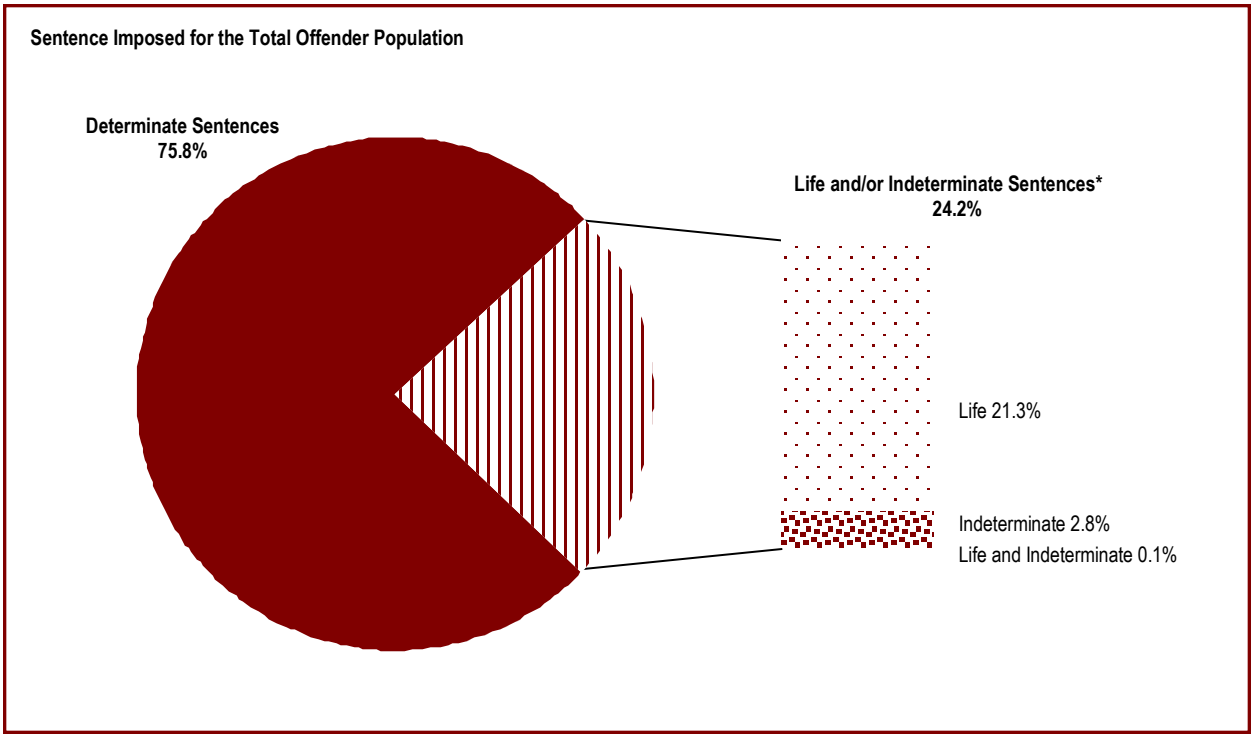
Year	Indigenous Offenders			Non-Indigenous Offenders			Total		
	Women	Men	Total	Women	Men	Total	Women	Men	Total
2008-09	3	36	39	2	129	131	5	165	170
2009-10	5	48	53	8	133	141	13	181	194
2010-11	3	35	38	6	129	135	9	164	173
2011-12	6	46	52	11	110	121	17	156	173
2012-13	6	46	52	2	117	119	8	163	171
2013-14	7	40	47	7	119	126	14	159	173
2014-15	1	37	38	8	120	128	9	157	166
2015-16	5	50	55	6	123	129	11	173	184
2016-17	1	40	41	11	134	145	12	174	186
2017-18	5	66	71	10	132	142	15	198	213

Source: Correctional Service Canada.

Note:
This table combines offenders serving life sentences and offenders serving indeterminate sentences.
*Although *life sentences* and *indeterminate sentences* both may result in imprisonment for life, they are different. A *life sentence* is a sentence of life imprisonment, imposed by a judge at the time of sentence, for example for murder. An *indeterminate sentence* is a result of a designation, where an application is made to the court to declare an offender a Dangerous Offender, and the consequence of this designation is imprisonment for an indeterminate period.
A warrant of committal is a new admission to federal jurisdiction from the courts.
Total Offender Population includes all active offenders, who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised, and offenders who are unlawfully at large for less than 90 days.

OFFENDERS WITH LIFE OR INDETERMINATE SENTENCES REPRESENT 24% OF THE TOTAL OFFENDER POPULATION

Figure C14



Source: Correctional Service Canada.

- At the end of fiscal year 2017-18, there were 5,619 offenders serving a life sentence and/or an indeterminate sentence. This represents 24.2% of the total offender population. The majority (65.3%) of these offenders were in custody. Of the 1,947 offenders who were in the community under supervision, the majority (80.9%) were serving a life sentence for 2nd Degree Murder.
- There were 21 offenders who were serving both a life sentence and an indeterminate sentence*.
- There were 641 offenders who were serving an indeterminate sentence as a result of a special designation. The remaining 4,957 offenders did not receive a special designation, but were serving a life sentence.
- 95.5% of the 623 Dangerous Offenders with indeterminate sentences were in custody and 4.5% were in the community under supervision.
- In contrast, 50.0% of the 16 Dangerous Sexual Offenders were in custody and all (2) of the offenders with an Habitual Offender designation were in the community under supervision (in this table there is one offender with an Habitual Offender designation included in the Designation and Life grouping, this offender was in the community under supervision as well).

Note:
*Although *life sentences* and *indeterminate sentences* may both result in imprisonment for life, they are different. A *life sentence* is a sentence of life imprisonment, imposed by a judge at the time of sentence, for example, for murder. An *indeterminate sentence* is a result of a designation, where an application is made to the court to declare an offender a Dangerous Offender, and the consequence of this designation is imprisonment for an indeterminate period. The Dangerous Sexual Offender and Habitual Offender designations were replaced with Dangerous Offender Legislation in 1977.
Total Offender Population includes all active offenders, who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised, and offenders who are unlawfully at large for less than 90 days. In Custody includes all active offenders incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained in a CSC facility and offenders on remand in a CSC facility. In Community Under Supervision includes all active offenders on day parole, full parole, statutory release, in the community supervised on a long-term supervision order, offenders who are temporarily detained in a non-CSC facility, offenders who are unlawfully at large for less than 90 days, offenders on remand in a non-CSC facility, and offenders supervised and subject to an immigration hold by the Canada Border Services Agency.

OFFENDERS WITH LIFE OR INDETERMINATE SENTENCES REPRESENT 24% OF THE TOTAL OFFENDER POPULATION

Table C14

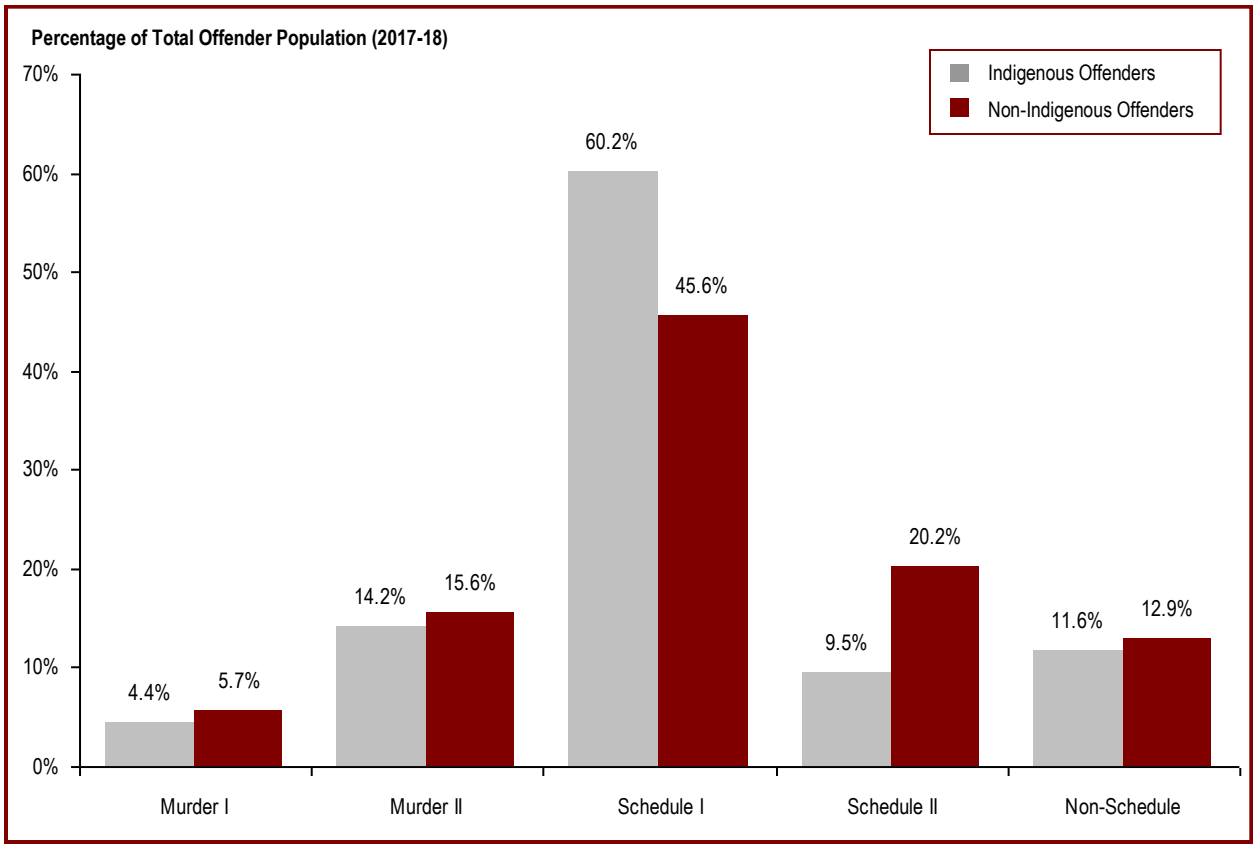
	Total Offender Population		Current Status			
			In Custody in a CSC Facility	In Community Under Supervision		
			Incarcerated	Day Parole	Full Parole	Other***
	#	%				
Offenders with a life sentence for:						
1st Degree Murder	1,234	5.3	989	52	193	0
2nd Degree Murder	3,525	15.2	1,950	222	1,353	0
Other Offences*	198	0.9	111	12	75	0
Total	**4,957**	**21.3**	**3,050**	**286**	**1,621**	**0**
Offenders with indeterminate sentences resulting from the special designation of:						
Dangerous Offender	623	2.7	595	14	14	0
Dangerous Sexual Offender	16	0.1	8	2	6	0
Habitual Offender	2	0.0	0	0	2	0
Total	**641**	**2.8**	**603**	**16**	**22**	**0**
Offenders serving an indeterminate sentence (due to a special designation) and a life sentence (due to an offence)	21	0.1	19	0	2	0
Total offenders with Life and/or Indeterminate sentence	**5,619**	**24.2**	**3,672**	**302**	**1,645**	**0**
Offenders Serving Determinate sentences**	17,604	75.8	10,420	1,357	2,588	3,239
Total	**23,223**	**100.0**	**14,092**	**1,659**	**4,233**	**3,239**

Source: Correctional Service Canada.

Note:
*"Other offences" include Schedule I Schedule II and Non-Schedule types of offences.
**This includes 148 offenders designated as Dangerous Offenders who were serving determinate sentences.
***"Other" in the Community Under Supervision includes offenders on statutory release or on a long-term supervision order.
Among the 21 offenders serving an indeterminate sentence (due to a special designation) and a life sentence (due to an offence), there was one offender with an Habitual Offender designation.
Although life sentences and indeterminate sentences both may result in imprisonment for life, they are different. A life sentence is a sentence of life imprisonment, imposed by a judge at the time of sentence, for example for murder. An indeterminate sentence is a result of a designation, where an application is made to the court to declare an offender a Dangerous Offender, and the consequence of this designation is imprisonment for an indeterminate period. The Dangerous Sexual Offender and Habitual Offender designations were replaced with Dangerous Offender legislation in 1977.
Total Offender Population includes all active offenders, who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised, and offenders who are unlawfully at large for less than 90 days. *In Custody* includes all active offenders incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained in a CSC facility and offenders on remand in a CSC facility. *In Community Under Supervision* includes all active offenders on day parole, full parole, statutory release, in the community supervised on a long-term supervision order, offenders who are temporarily detained in a non-CSC facility, offenders who are unlawfully at large for less than 90 days, offenders on remand in a non-CSC facility, and offenders supervised and subject to an immigration hold by the Canada Border Services Agency.

69.7% OF OFFENDERS ARE SERVING A SENTENCE FOR A VIOLENT OFFENCE*

Figure C15



Source: Correctional Service Canada.

- At the end fiscal year 2017-18, Indigenous offenders were more likely to be serving a sentence for a violent offence (78.8% for Indigenous versus 66.9% for non-Indigenous offenders).
- 68.5% of Indigenous women offenders were serving a sentence for a violent offence compared to 44.3% of non-Indigenous women offenders.
- Of those offenders serving a sentence for Murder, 4.9% were women and 21.7% were Indigenous.
- A greater proportion of Indigenous offenders than non-Indigenous offenders were serving a sentence for a Schedule I offence (60.2% versus 45.6%, respectively).
- 9.5% of Indigenous offenders were serving a sentence for a Schedule II offence compared to 20.2% of non-Indigenous offenders.
- 29.7% of women were serving a sentence for a Schedule II offence compared to 16.9% of men.

Note:
*Violent offences include Murder I, Murder II and Schedule I offences.
Schedule I is comprised of sexual offences and other violent crimes excluding 1st and 2nd degree murder (see the *Corrections and Conditional Release Act*).
Schedule II is comprised of serious drug offences or conspiracy to commit serious drug offences (see the *Corrections and Conditional Release Act*).
In cases where the offender is serving a sentence for more than one offence, the data reflect the most serious offence.
The data reflect all active offenders who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised, and offenders who are unlawfully at large for less than 90 days.

69.7% OF OFFENDERS ARE SERVING A SENTENCE FOR A VIOLENT OFFENCE*

Table C15

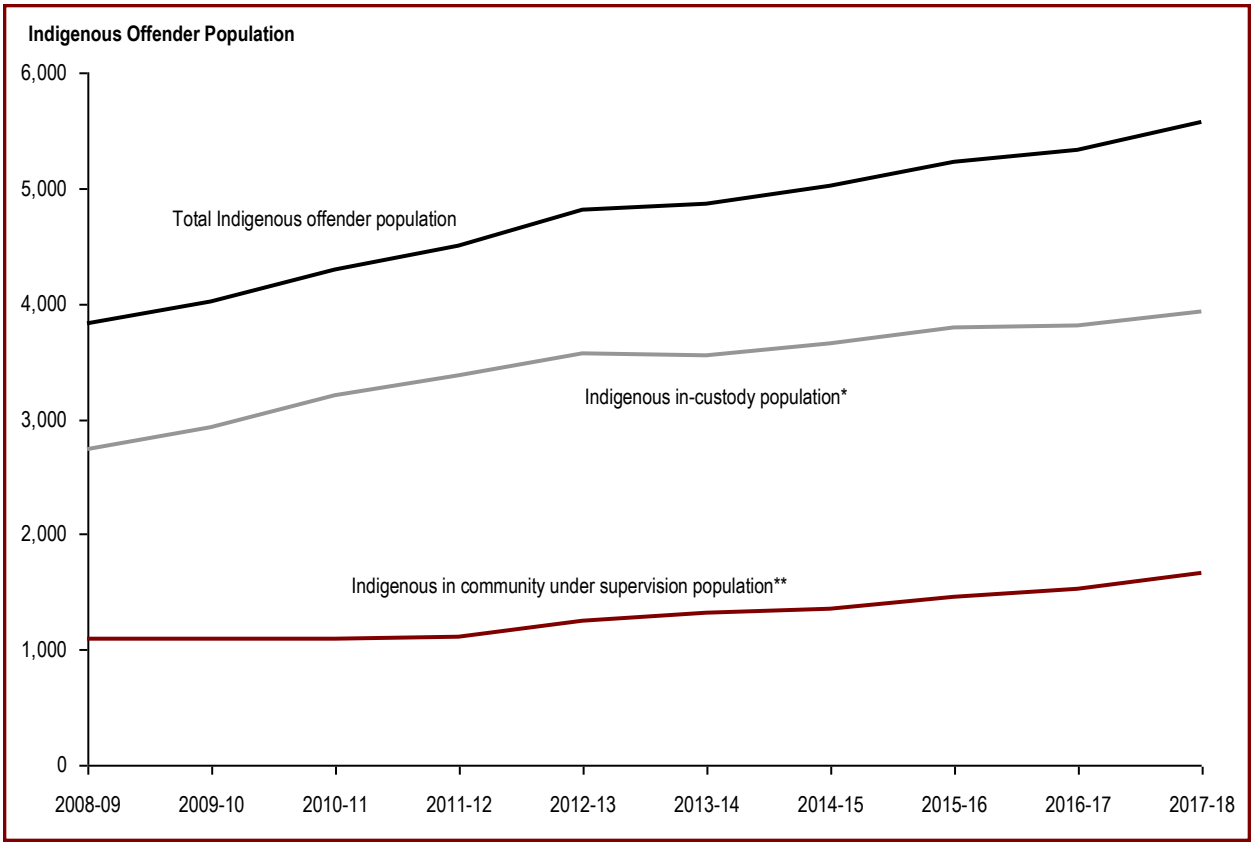
Offence Category	Indigenous			Non-Indigenous			Total		
	Women	Men	Total	Women	Men	Total	Women	Men	Total
Murder I	8	237	245	47	959	1,006	55	1,196	1,251
%	1.7	4.6	4.4	5.0	5.7	5.7	3.9	5.5	5.4
Murder II	60	734	794	119	2,635	2,754	179	3,369	3,548
%	13.0	14.4	14.2	12.7	15.8	15.6	12.8	15.4	15.3
Schedule I	248	3,105	3,353	249	7,792	8,041	497	10,897	11,394
%	53.8	60.8	60.2	26.6	46.6	45.6	35.6	49.9	49.1
Schedule II	82	449	531	333	3,233	3,566	415	3,682	4,097
%	17.8	8.8	9.5	35.6	19.3	20.2	29.7	16.9	17.6
Non-Schedule	63	586	649	188	2,096	2,284	251	2,682	2,933
%	13.7	11.5	11.6	20.1	12.5	12.9	18.0	12.3	12.6
	461	**5,111**		**936**	**16,715**		**1,397**	**21,826**	
Total	**5,572**			**17,651**			**23,223**		

Source: Correctional Service Canada.

Note:
*Violent offences include Murder I, Murder II and Schedule I offences.
Schedule I is comprised of sexual offences and other violent crimes excluding first and second degree murder (see the Corrections and Conditional Release Act).
Schedule II is comprised of serious drug offences or conspiracy to commit serious drug offences (see the Corrections and Conditional Release Act).
In cases where the offender is serving a sentence for more than one offence, the data reflect the most serious offence.
The data reflect all active offenders, who are incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained, offenders who are actively supervised, and offenders who are unlawfully at large for less than 90 days.

THE NUMBER OF INDIGENOUS OFFENDERS HAS INCREASED

Figure C16



Source: Correctional Service Canada.

- From 2008-09 to 2017-18, the in-custody Indigenous offender population increased by 43.3%, while the total Indigenous offender population increased by 45.7% over the same time period.
- The number of in-custody Indigenous women offenders increased steadily from 168 in 2008-09 to 270 in 2017-18, for an increase of 60.7% in the last ten years. The increase for in-custody Indigenous men offenders was 42.2% for the same period, increasing from 2,565 to 3,647.
- From 2008-09 to 2017-18, the number of Indigenous offenders on community supervision increased by 51.6%, from 1,092 to 1,655. The Indigenous community population accounted for 18.1% of the total community population in 2017-18.

Note:
**In-Custody Population* includes all active offenders incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained in a CSC facility, and offenders on remand in a CSC facility.
***In Community Under Supervision Population* includes all active offenders on day parole, full parole, statutory release, or in the community supervised on a long-term supervision order, offenders who are temporarily detained in a non-CSC facility, offenders who are unlawfully at large for less than 90 days, offenders on remand in a non-CSC facility, and offenders supervised and subject to an immigration hold by the Canada Border Services Agency.
Regional statistics for Correctional Service Canada account for data relating to the northern territories in the following manner: data for Nunavut are reported in the Ontario Region, data for the Northwest Territories are reported in the Prairies Region, and data for Yukon are reported in the Pacific Region.

THE NUMBER OF INDIGENOUS OFFENDERS HAS INCREASED

Table C16

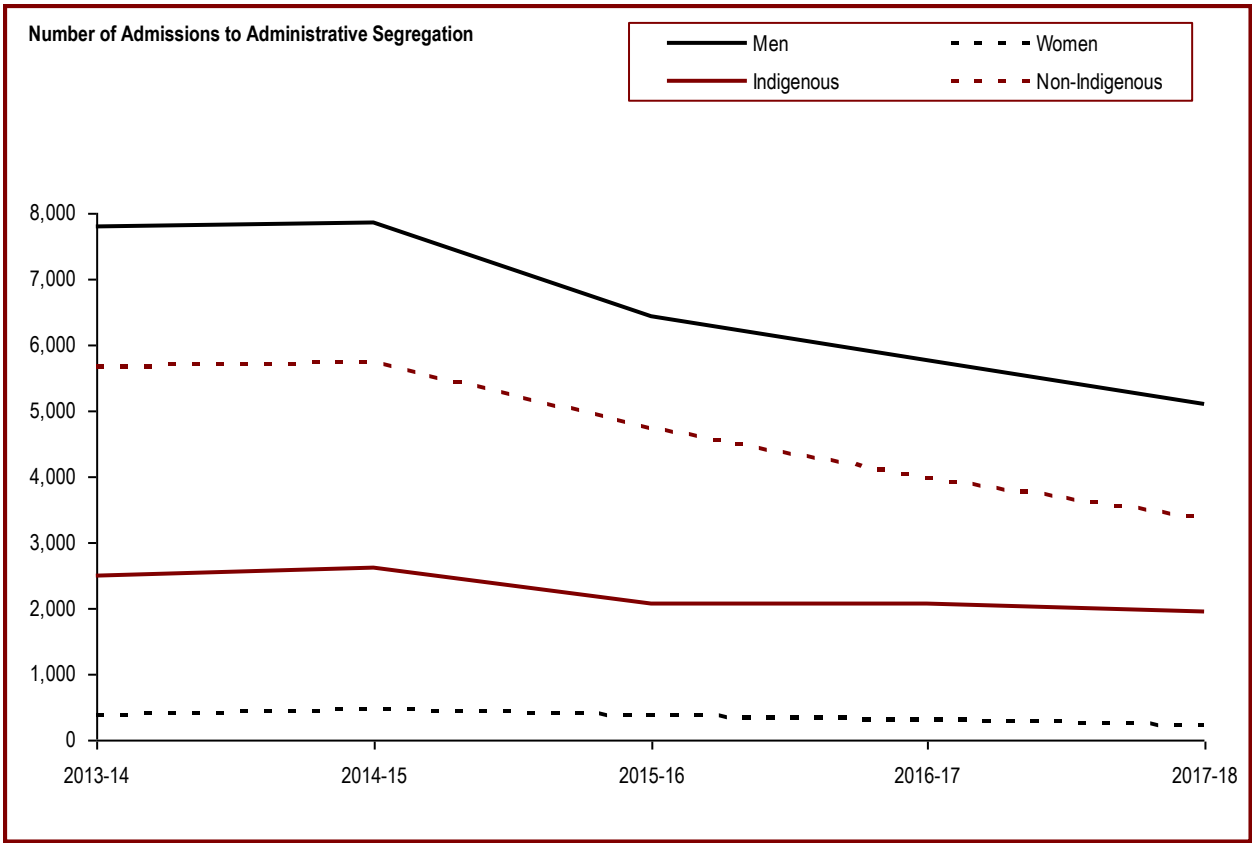
Indigenous Offenders		Fiscal Year				
		2013-14	2014-15	2015-16	2016-17	2017-18
In-Custody						
Atlantic Region	Men	181	174	157	175	184
	Women	14	11	12	8	14
Quebec Region	Men	422	443	425	384	392
	Women	15	19	24	14	11
Ontario Region	Men	440	441	453	487	534
	Women	36	34	39	37	43
Prairie Region	Men	1,686	1,757	1,868	1,861	1,879
	Women	110	139	133	155	163
Pacific Region	Men	600	602	629	638	658
	Women	38	37	43	39	39
National Total	Men	3,329	3,417	3,532	3,545	3,647
	Women	213	240	251	253	270
	Total	**3,542**	**3,657**	**3,783**	**3,798**	**3,917**
In Community Under Supervision						
Atlantic Region	Men	50	60	68	71	88
	Women	11	12	10	11	9
Quebec Region	Men	134	158	185	185	181
	Women	7	12	18	10	6
Ontario Region	Men	180	178	204	201	231
	Women	20	21	24	31	29
Prairie Region	Men	582	574	560	604	645
	Women	63	52	77	78	111
Pacific Region	Men	250	268	276	301	319
	Women	17	17	22	32	36
National Total	Men	1,196	1,238	1,293	1,362	1,464
	Women	118	114	151	162	191
	Total	**1,314**	**1,352**	**1,444**	**1,524**	**1,655**
Total In-Custody & In Community Under Supervision		**4,856**	**5,009**	**5,227**	**5,322**	**5,572**

Source: Correctional Service Canada.

Note:
In-Custody Population includes all active offenders incarcerated in a CSC facility, offenders on temporary absence from a CSC facility, offenders who are temporarily detained in a CSC facility, and offenders on remand in a CSC facility.
In Community Under Supervision Population includes all active offenders on day parole, full parole, statutory release, or in the community supervised on a long -term supervision order, offenders who are temporarily detained in a non-CSC facility, offenders who are unlawfully at large for less than 90 days, offenders on remand in a non-CSC facility, and offenders supervised and subject to an immigration hold by the Canada Border Services Agency.
Regional statistics for Correctional Service Canada account for data relating to the northern territories in the following manner: data for Nunavut are reported in the Ontario Region, data for the Northwest Territories are reported in the Prairies Region, and data for Yukon are reported in the Pacific Region.

THE TOTAL NUMBER OF ADMISSIONS TO ADMINISTRATIVE SEGREGATION HAS DECREASED

Figure C17



Source: Correctional Service Canada.

- In 2017-18, the total admissions to administrative segregation decreased by 12.3% from 6,037 in 2016-17 to 5,295 in 2017-18.
- In 2017-18, 96.2% of the total admissions were men, and admissions of Indigenous offenders accounted for 36.5%.
- At the end of fiscal year 2017-18, there were 310 offenders in administrative segregation. Of these, 305 were men and five were women. A total of 136 Indigenous offenders were in administrative segregation.

Note:
These reports count admissions, not offenders. Offenders admitted multiple times to segregation are counted once for each admission. Offenders segregated under paragraph (f), subsection 44(1) of the *Corrections and Conditional Release Act* (Disciplinary Segregation) are not included.
Administrative segregation is the separation, when specific legal requirements are met, of an inmate from the general population, other than pursuant to a disciplinary decision. As per subsection 31(3) of the *Corrections and Conditional Release Act*: The institutional head may order that an inmate be confined in administrative segregation if the institutional head is satisfied that there is no reasonable alternative to administrative segregation and he or she believes on reasonable grounds that (a) the inmate has acted, has attempted to act or intends to act in a manner that jeopardizes the security of the penitentiary or the safety of any person and allowing the inmate to associate with other inmates would jeopardize the security of the penitentiary or the safety of any person; (b) allowing the inmate to associate with other inmates would interfere with an investigation that could lead to a criminal charge or a charge under subsection 41(2) of a serious disciplinary offence; or (c) allowing the inmate to associate with other inmates would jeopardize the inmate's safety.

THE TOTAL NUMBER OF ADMISSIONS TO ADMINISTRATIVE SEGREGATION HAS DECREASED

Table C17

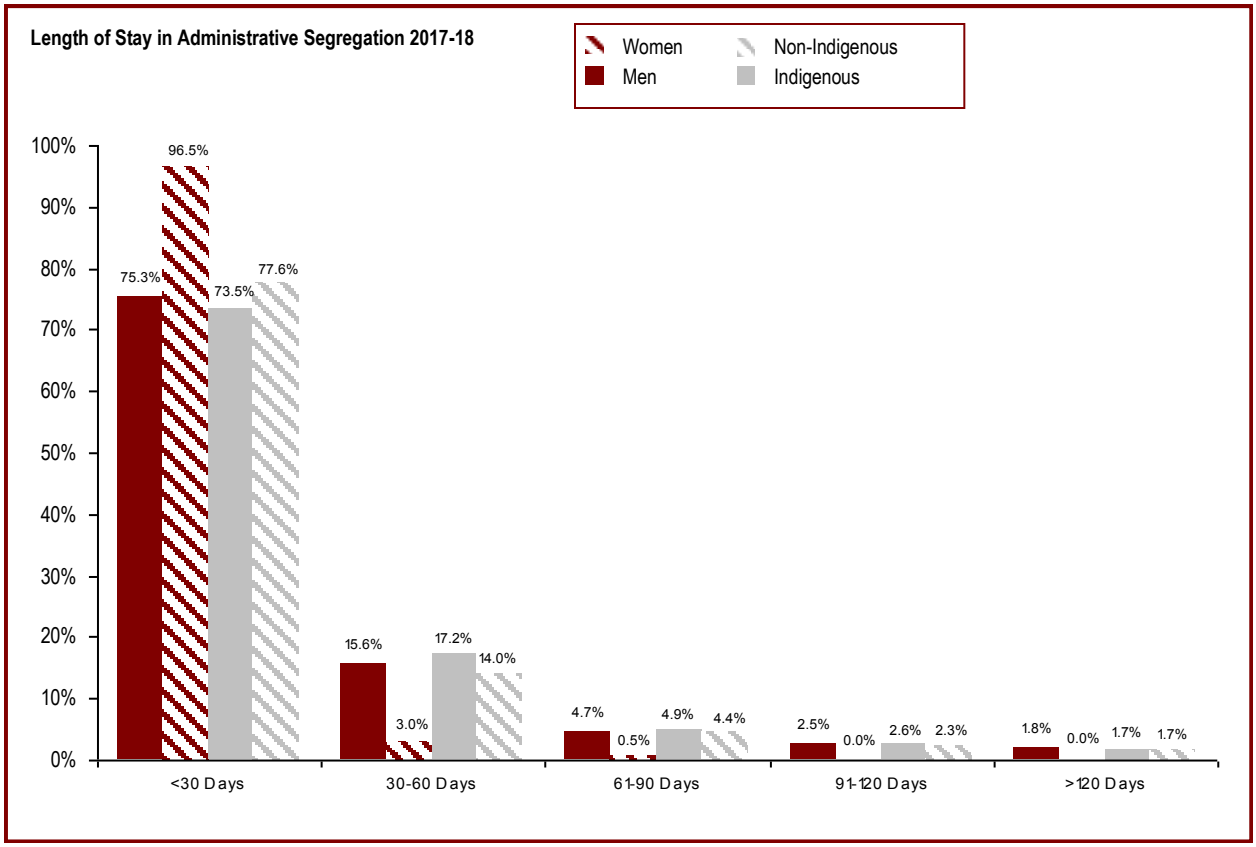
Year and Type of Administrative Segregation	By Gender			By Race		
	Women	Men	Total	Indigenous	Non-Indigenous	Total
2013-14						
CCRA 31(3-A)*	315	5,196	5,511	1,602	3,909	5,511
CCRA 31(3-B)*	5	320	325	95	230	325
CCRA 31(3-C)*	28	2,272	2,300	806	1,494	2,300
Total	**348**	**7,788**	**8,136**	**2,482**	**5,654**	**8,136**
2014-15						
CCRA 31(3-A)	426	5,289	5,715	1,723	3,992	5,715
CCRA 31(3-B)	7	329	336	109	227	335
CCRA 31(3-C)	27	2,242	2,269	793	1,476	2,269
Total	**460**	**7,860**	**8,320**	**2,595**	**5,724**	**8,320**
2015-16						
CCRA 31(3-A)	342	4,200	4,542	1,345	3,197	4,542
CCRA 31(3-B)	2	235	237	91	146	237
CCRA 31(3-C)	33	1,976	2,009	645	1,364	2,009
Total	**377**	**6,411**	**6,788**	**2,056**	**4,732**	**6,788**
2016-17						
CCRA 31(3-A)	270	3,826	4,096	1,370	2,726	4,096
CCRA 31(3-B)	3	273	276	74	202	276
CCRA 31(3-C)	16	1,649	1,665	635	1,030	1,665
Total	**289**	**5,748**	**6,037**	**2,058**	**3,979**	**6,037**
2017-18						
CCRA 31(3-A)	180	3,167	3,347	1,171	2,176	3,347
CCRA 31(3-B)	9	229	238	75	163	238
CCRA 31(3-C)	13	1,697	1,710	687	1,023	1,710
Total	**202**	**5,093**	**5,295**	**1,933**	**3,362**	**5,295**

Source: Correctional Service Canada.

Note:
These reports count admissions, not offenders. Offenders admitted multiple times to segregation are counted once for each admission. Offenders segregated under paragraph (f), subsection 44(1) of the *Corrections and Conditional Release Act* (Disciplinary Segregation) are not included.
*Administrative segregation is the separation, when specific legal requirements are met, of an inmate from the general population, other than pursuant to a disciplinary decision. As per subsection 31(3) of the *Corrections and Conditional Release Act*: The institutional head may order that an inmate be confined in administrative segregation if the institutional head is satisfied that there is no reasonable alternative to administrative segregation and he or she believes on reasonable grounds that (a) the inmate has acted, has attempted to act or intends to act in a manner that jeopardizes the security of the penitentiary or the safety of any person and allowing the inmate to associate with other inmates would jeopardize the security of the penitentiary or the safety of any person; (b) allowing the inmate to associate with other inmates would interfere with an investigation that could lead to a criminal charge or a charge under subsection 41(2) of a serious disciplinary offence; or (c) allowing the inmate to associate with other inmates would jeopardize the inmate's safety.

76% OF ADMISSIONS TO ADMINISTRATIVE SEGREGATION STAY FOR LESS THAN 30 DAYS

Figure C18



Source: Correctional Service Canada.

- Most (76.1%) placements in administrative segregation ended in less than 30 days, and 15.2% lasted between 30 and 60 days. 1.7% of placements in administrative segregation ended after more than 120 days.
- 96.5% of placements of women in administrative segregation ended in less than 30 days.
- The number of admissions to administrative segregation that resulted in placements lasting more than 120 days was the same for Indigenous offenders and non-Indigenous offenders (1.7%).

Note:
These reports count admissions, not offenders. Offenders admitted multiple times to segregation are counted once for each admission. Offenders segregated under paragraph (f), subsection 44(1) of the *Corrections and Conditional Release Act* (Disciplinary Segregation) are not included.
Administrative segregation is the involuntary or voluntary separation, when specific legal requirements are met, of an inmate from the general population, other than pursuant to a disciplinary decision. As per subsection 31(3) of the *Corrections and Conditional Release Act*: The institutional head may order that an inmate be confined in administrative segregation if the institutional head is satisfied that there is no reasonable alternative to administrative segregation and he or she believes on reasonable grounds that (a) the inmate has acted, has attempted to act or intends to act in a manner that jeopardizes the security of the penitentiary or the safety of any person and allowing the inmate to associate with other inmates would jeopardize the security of the penitentiary or the safety of any person; (b) allowing the inmate to associate with other inmates would interfere with an investigation that could lead to a criminal charge or a charge under subsection 41(2) of a serious disciplinary offence; or (c) allowing the inmate to associate with other inmates would jeopardize the inmate's safety.

76% OF ADMISSIONS TO ADMINISTRATIVE SEGREGATION STAY FOR LESS THAN 30 DAYS

Table C18

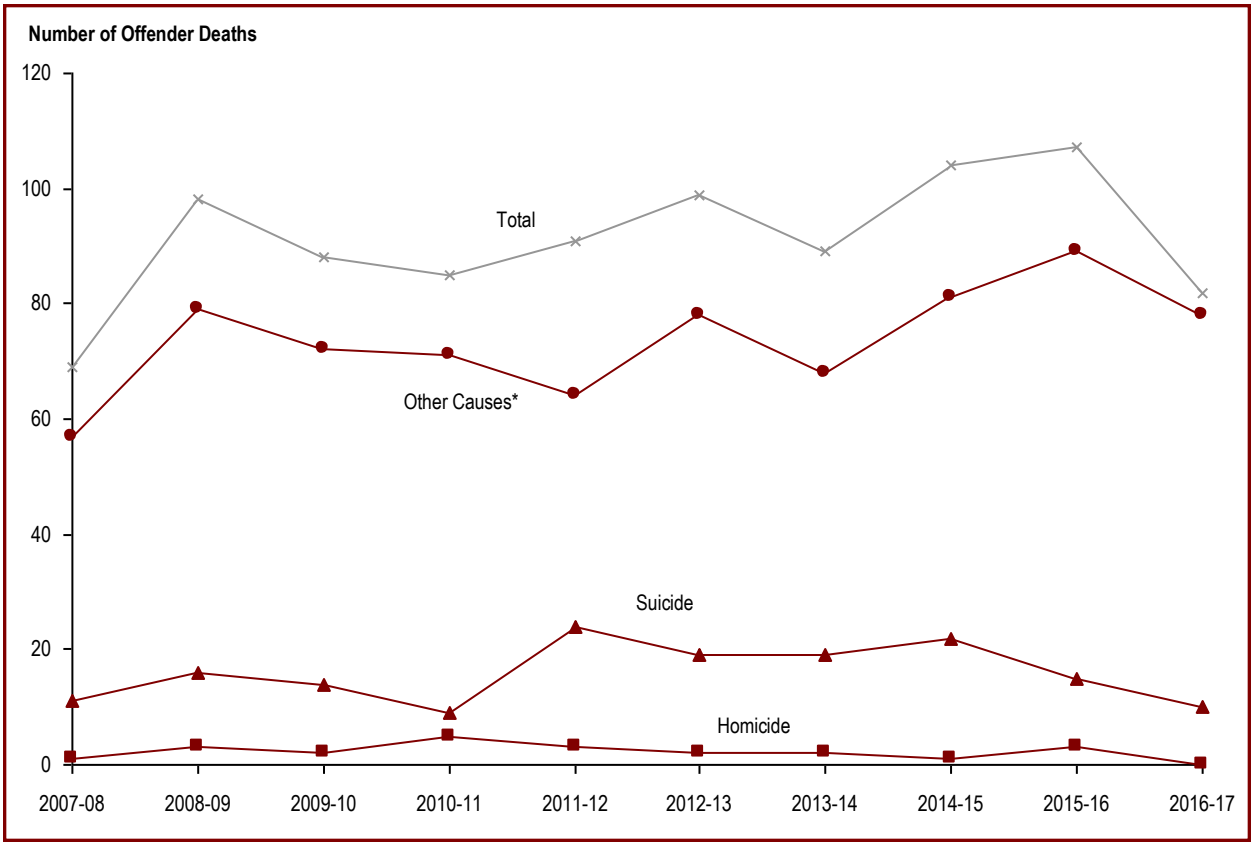
Length of Stay in Administrative Segregation	By Gender				By Race					
	Women		Men		Indigenous		Non-Indigenous		Total	
	#	%	#	%	#	%	#	%	#	%
2017-18										
< 30 days	193	96.5	3,910	75.3	1,432	73.5	2,671	76.1	4,103	76.1
30-60 days	6	3.0	812	15.6	336	17.2	482	15.2	818	15.2
61-90 days	1	0.5	246	4.7	96	4.9	151	4.6	247	4.6
91-120 days	0	0.0	130	2.5	51	2.6	79	2.4	130	2.4
> 120 days	0	0.0	92	1.8	34	1.7	58	1.7	92	1.7
Total	**200**	**100.0**	**5,190**	**100.0**	**1,949**	**100.0**	**3,441**	**100.0**	**5,390**	**100.0**

Source: Correctional Service Canada.

Note:
These reports count admissions, not offenders. Offenders admitted multiple times to segregation are counted once for each admission. Offenders segregated under paragraph (f), subsection 44(1) of the *Corrections and Conditional Release Act* (Disciplinary Segregation) are not included.
Administrative segregation is the involuntary or voluntary separation, when specific legal requirements are met, of an inmate from the general population, other than pursuant to a disciplinary decision. As per subsection 31(3) of the *Corrections and Conditional Release Act*:
The institutional head may order that an inmate be confined in administrative segregation if the institutional head is satisfied that there is no reasonable alternative to administrative segregation and he or she believes on reasonable grounds that
(a) the inmate has acted, has attempted to act or intends to act in a manner that jeopardizes the security of the penitentiary or the safety of any person and allowing the inmate to associate with other inmates would jeopardize the security of the penitentiary or the safety of any person;
(b) allowing the inmate to associate with other inmates would interfere with an investigation that could lead to a criminal charge or a charge under subsection 41(2) of a serious disciplinary offence; or
(c) allowing the inmate to associate with other inmates would jeopardize the inmate's safety.

THE NUMBER OF OFFENDER DEATHS WHILE IN CUSTODY

Figure C19



Source: Adult Correctional Services Survey, Canadian Centre for Justice Statistics, Statistics Canada

- In the ten-year period from 2006-07 to 2016-17, a total of 539 federal offenders and 379 provincial offenders died while in custody.
- During this time period, suicides accounted for 14.8% of federal offender deaths and 20.8% of provincial offender deaths. The suicide rate was approximately 56 per 100,000 for incarcerated federal offenders, and approximately 33 per 100,000 for incarcerated provincial offenders.** These rates are significantly higher than the 2009 rate of 11.5 suicides per 100,000 people in Canada.
- Between 2007-08 and 2016-17, 3.3% of federal offender deaths and 1.1% of provincial offender deaths were due to homicide. The homicide rate for incarcerated federal offenders was approximately 12.7 per 100,000 and 1.7 per 100,000 for incarcerated provincial offenders**. The federal rate is significantly higher than the national homicide rate of 1.8 per 100,000 people in 2017.

Note:
*Other causes of death include: natural causes, accidental deaths, death as a result of a legal intervention, other causes of death and where cause of death was unknown. Data for Alberta for 2013-14 and onward are now available.
**For the calculation of rates, the total actual in-count numbers between 2006-07 and 2016-17 was used as the denominator.
The data on cause of death are subject to change following an official review or investigation, and should be used/interpreted with caution. The data presented were provided by the Canadian Centre for Justice Statistics at Statistics Canada, and may not reflect the outcome of recent reviews or investigations on cause of death.

THE NUMBER OF OFFENDER DEATHS WHILE IN CUSTODY

Table C19

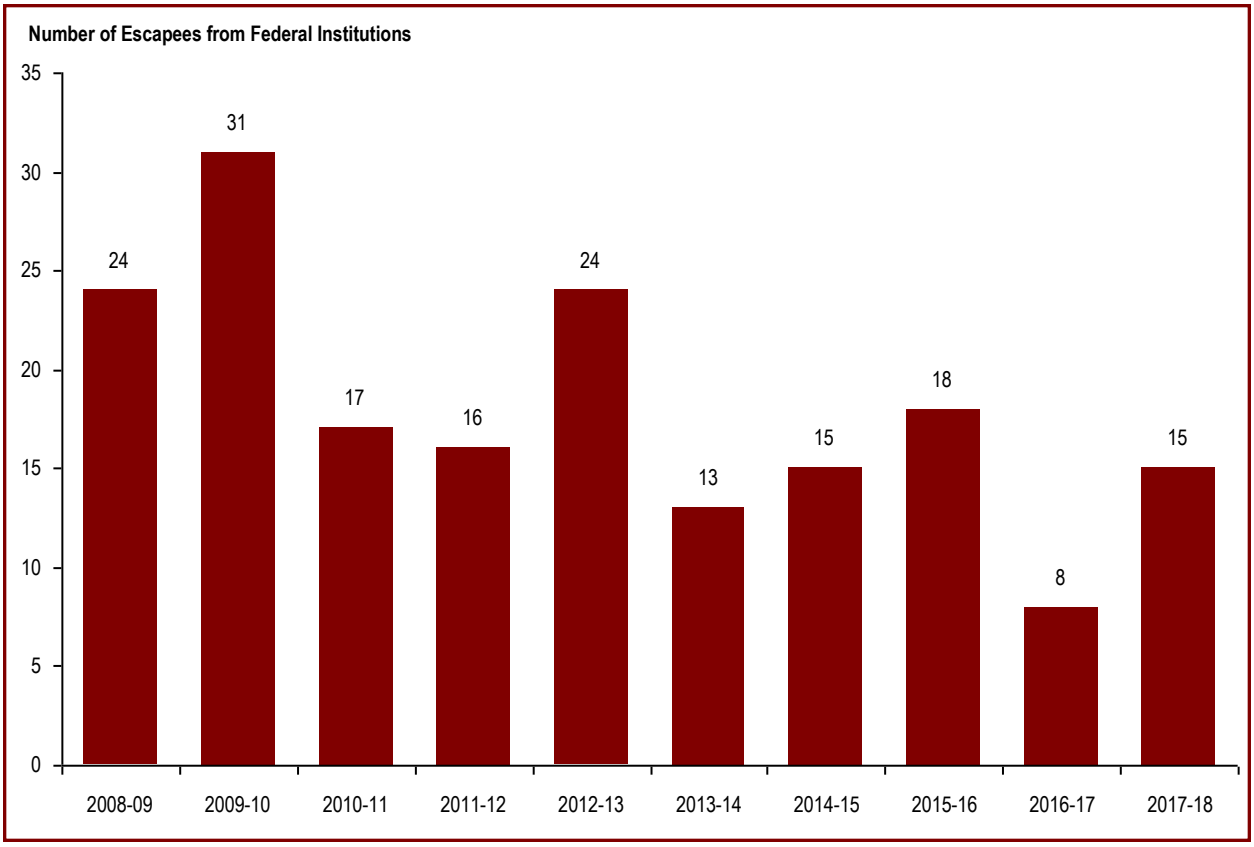
Year	Type of Death						
	Homicide		Suicide		Other*		Total
	#	%	#	%	#	%	#
Federal							
2007-08	1	2.5	5	12.5	34	85.0	40
2008-09	2	3.1	9	13.8	54	83.1	65
2009-10	1	2.0	9	18.4	39	79.6	49
2010-11	5	10.0	4	8.0	41	82.0	50
2011-12	3	5.7	8	15.1	42	79.2	53
2012-13	1	1.8	11	20.0	43	78.2	55
2013-14	1	2.1	9	18.8	38	79.2	48
2014-15	1	1.5	13	19.4	53	79.1	67
2015-16	3	4.6	9	13.8	53	81.5	65
2016-17	0	0.0	3	6.4	44	9.4	47
Total	**18**	3.3	**80**	14.8	**441**	81.8	**539**
Provincial							
2007-08	0	0.0	6	20.7	23	79.3	29
2008-09	1	3.0	7	21.2	25	75.8	33
2009-10	1	2.6	5	12.8	33	84.6	39
2010-11	0	0.0	5	14.3	30	85.7	35
2011-12	0	0.0	16	42.1	22	57.9	38
2012-13	1	2.3	8	18.2	35	79.5	44
2013-14	1	2.4	10	24.4	30	73.2	41
2014-15	0	0.0	9	24.3	28	73.2	37
2015-16	0	0.0	6	14.3	36	85.7	42
2016-17	0	0.0	7	17.1	34	83.0	41
Total	**4**	1.1	**79**	20.8	**296**	78.1	**379**
Total Federal and Provincial Offender Deaths	**22**	**2.4**	**159**	**17.3**	**737**	**80.3**	**918**

Source: Adult Correctional Services Survey, Canadian Centre for Justice Statistics, Statistics Canada

Note:
*Other causes of death include: natural causes, accidental deaths, death as a result of a legal intervention, other causes of death and where cause of death was unknown.
Data for Alberta for 2013-14 and onward are now available.
The data on cause of death are subject to change following an official review or investigation, and should be used/interpreted with caution. The data presented were provided by the Canadian Centre for Justice Statistics at Statistics Canada, and may not reflect the outcome of recent reviews or investigations on cause of death.

THE NUMBER OF ESCAPEES HAS REMAINED STABLE SINCE 2013-2014

Figure C20



Source: Security, Correctional Service Canada.

- In 2017-18, there were 11 escape incidents involving a total of 15 offenders. All of the 15 offenders were recaptured.
- Offenders who escaped from federal institutions in 2017-18 represented 0.1% of the in-custody population.

Note:
The data represents the number of escape incidents from federal facilities during each fiscal year. An escape can involve more than one offender.
A fiscal year runs from April 1 to March 31 of the following year.

THE NUMBER OF ESCAPEES HAS REMAINED STABLE SINCE 2013-2014

Table C20

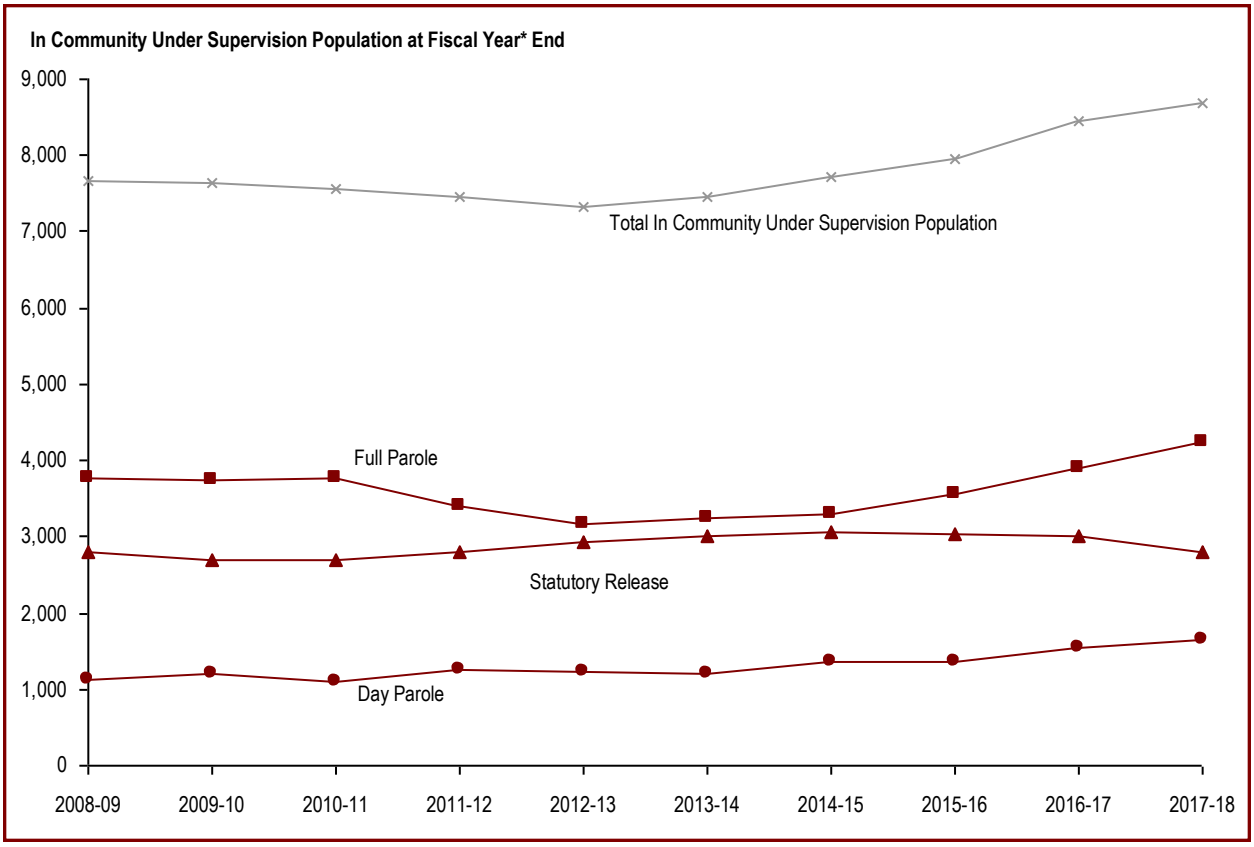
Escapes	2013-14	2014-15	2015-16	2016-17	2017-18
Total Number of Escape Incidents	11	14	15	8	11
Total Number of Escapees	13	15	18	8	15

Source: Security, Correctional Service Canada.

Note:
The data represents the number of escape incidents from federal facilities during each fiscal year. An escape can involve more than one offender.
A fiscal year runs from April 1 to March 31 of the following year.

THE POPULATION OF OFFENDERS IN THE COMMUNITY UNDER SUPERVISION HAS INCREASED IN THE PAST FIVE YEARS

Figure C21



Source: Correctional Service Canada.

- Over the past five years, the total offender population supervised in the community increased by 16.3%. For the same period, the total number of offenders on full parole increased by 30.6% while the proportion of offenders on statutory release decreased by 7.4%.
- At the end of fiscal year 2017-18, there were 7,970 men and 711 women on active community supervision.

Note:
*These cases reflect the number of offenders on active supervision at fiscal year end. A fiscal year runs from April 1 to March 31 of the following year.
The data reflect the offender population in the community under supervision which includes all active offenders on day parole, full parole, statutory release, offenders who are temporarily detained in a non-CSC facility, offenders on remand in a non-CSC facility, offenders who are unlawfully at large for less than 90 days, and offenders supervised and subject to an immigration hold by the Canada Border Services Agency.
The data presented above do not include offenders who were on long-term supervision orders (see Figure/Table E4).
Day parole is a type of conditional release granted by the Parole Board of Canada whereby offenders are permitted to participate in community-based activities in preparation for full parole or statutory release. The conditions require offenders to return nightly to an institution or half-way house unless otherwise authorized by the Parole Board of Canada. Full parole is a type of conditional release granted by the Parole Board of Canada whereby the remainder of the sentence is served under supervision in the community. Statutory release refers to a conditional release that is subject to supervision after the offender has served two-thirds of the sentence.

THE POPULATION OF OFFENDERS IN THE COMMUNITY UNDER SUPERVISION HAS INCREASED IN THE PAST FIVE YEARS

Table C21

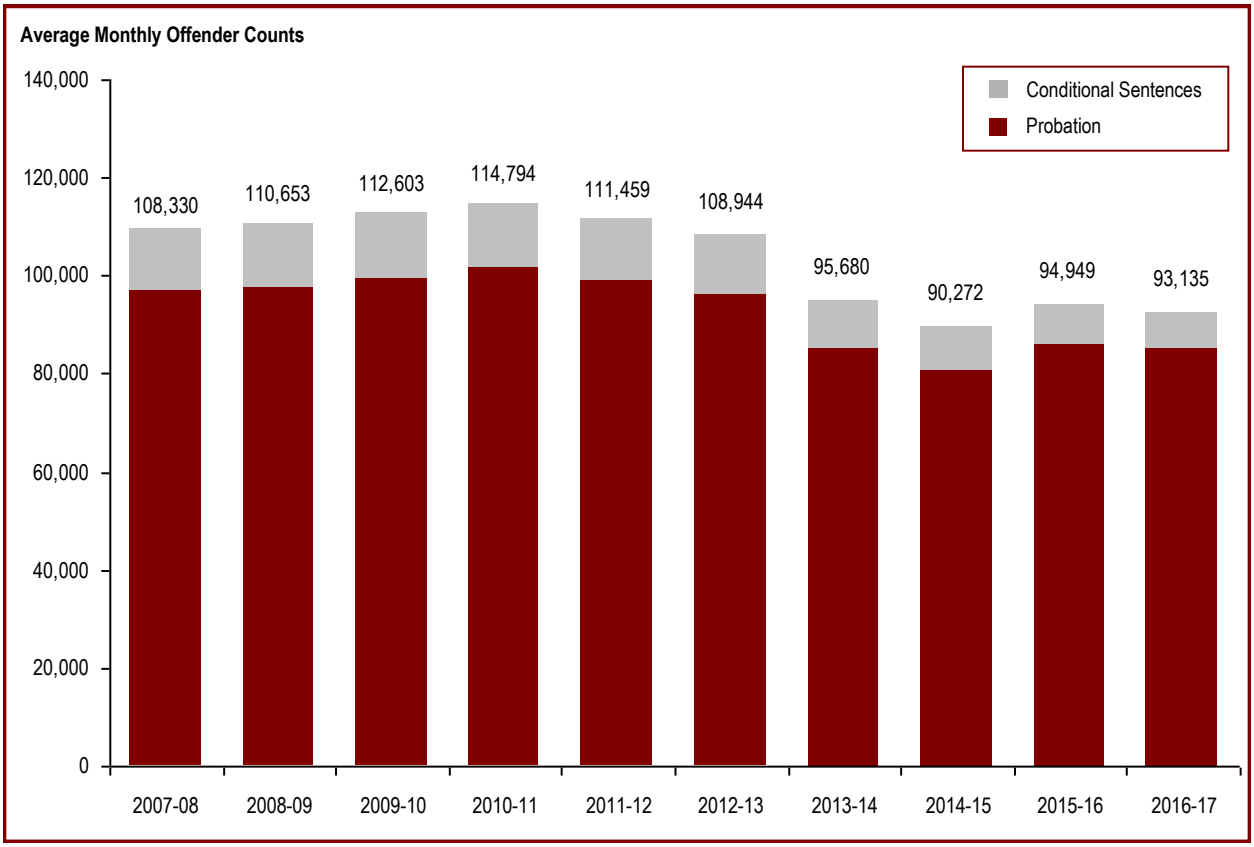
Year	Supervision Type of Offenders									
	Day Parole		Full Parole		Statutory Release		Totals			% change*
	Women	Men	Women	Men	Women	Men	Women	Men	Both	Both
2008-09	106	1,017	344	3,419	113	2,675	563	7,111	7,674	
2009-10	108	1,083	328	3,418	93	2,602	529	7,103	7,632	-0.5
2010-11	79	1,017	314	3,441	109	2,598	502	7,056	7,558	-1.0
2011-12	123	1,123	257	3,154	127	2,661	507	6,938	7,445	-1.5
2012-13	116	1,106	225	2,932	136	2,801	477	6,839	7,316	-1.7
2013-14	106	1,104	225	3,017	153	2,858	484	6,979	7,463	2.0
2014-15	115	1,236	239	3,065	150	2,909	504	7,210	7,714	3.4
2015-16	124	1,248	273	3,276	177	2,849	574	7,373	7,947	3.0
2016-17	158	1,392	316	3,587	154	2,856	628	7,835	8,463	6.5
2017-18	197	1,462	369	3,864	145	2,644	711	7,970	8,681	2.6

Source: Correctional Service Canada.

Note:
These cases reflect the number of offenders on active supervision at fiscal year end. A fiscal year runs from April 1 to March 31 of the following year.
The data reflect the offender population in the community under supervision which includes all active offenders on day parole, full parole, statutory release, offenders who are temporarily detained in a non-CSC facility, offenders on remand in a non-CSC facility, offenders who are unlawfully at large for less than 90 days, and offenders supervised and subject to an immigration hold by the Canada Border Services Agency.
The data presented above do not include offenders who were on long-term supervision orders (see Figure/Table E4).
Day parole is a type of conditional release granted by the Parole Board of Canada whereby offenders are permitted to participate in community-based activities in preparation for full parole or statutory release. The conditions require offenders to return nightly to an institution or half-way house unless otherwise authorized by the Parole Board of Canada. Full parole is a type of conditional release granted by the Parole Board of Canada whereby the remainder of the sentence is served under supervision in the community. Statutory release refers to a conditional release that is subject to supervision after the offender has served two-thirds of the sentence.
*Percent change is measured from the previous year.

PROVINCIAL/TERRITORIAL COMMUNITY CORRECTIONS POPULATION DECREASED

Figure C22



Source: Table 35-10-0154-01, Corrections Key Indicator Report for Adults and Youth, Canadian Centre for Justice Statistics, Statistics Canada.

- The provincial/territorial community corrections population decreased 1.9% in 2016-17, from 94,949 in 2015-16 to 93,135 in 2016-17.
- There has been a gradual decline in the number of offenders on conditional sentence orders over the past decade. It has decreased 42.2% from 12,535 in 2007-08 to 7,249 in 2016-17.

Note:
A conditional sentence is a disposition of the court where the offender serves a term of imprisonment in the community under specified conditions. This type of sentence can only be imposed in cases where the term of imprisonment would be less than two years. Conditional sentences have been a provincial and territorial sentencing option since September 1996.

PROVINCIAL/TERRITORIAL COMMUNITY CORRECTIONS POPULATION DECREASED

Table C22

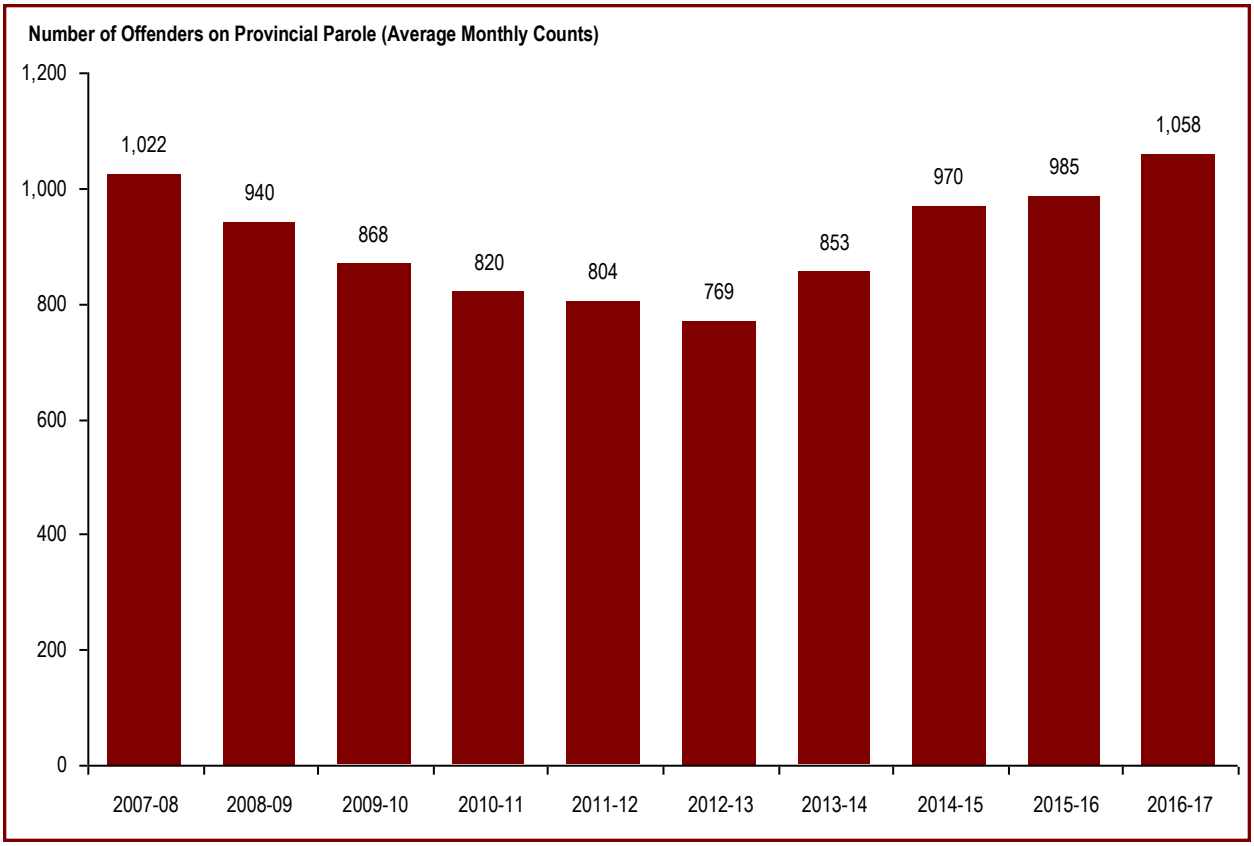
Year	Average Monthly Offender Counts on Probation	Average Monthly Offender Counts on Conditional Sentence	Total
2007-08	96,795	12,535	108,330
2008-09	97,529	13,124	110,653
2009-10	99,498	13,105	112,603
2010-11	101,825	12,969	114,794
2011-12	98,843	12,616	111,459
2012-13	96,116	12,202	108,944
2013-14	84,905	10,077	95,680
2014-15	80,705	8,746	90,272
2015-16	85,845	8,259	94,949
2016-17	84,978	7,249	93,135

Source: Table 35-10-0154-01, Corrections Key Indicator Report for Adults and Youth, Canadian Centre for Justice Statistics, Statistics Canada.

Note:
A conditional sentence is a disposition of the court where the offender serves a term of imprisonment in the community under specified conditions. This type of sentence can only be imposed in cases where the term of imprisonment would be less than two years. Conditional sentences have been a provincial and territorial sentencing option since September 1996.

THE NUMBER OF OFFENDERS ON PROVINCIAL PAROLE INCREASED

Figure C23



Source: Table 35-10-0154-01, Corrections Key Indicator Report for Adults and Youth, Canadian Centre for Justice Statistics, Statistics Canada

- The number of offenders on provincial parole increased by 7.4% from 985 offenders in 2015-16 to 1,058 in 2016-17.
- Since 2013-14, there has been a 24.0% increase in the number of offenders on provincial parole, up from 853 in 2013-14 to 1,058 in 2016-17.

Note:
Provincial parole boards operate in Quebec and Ontario. On April 1, 2007, the Parole Board of Canada assumed responsibility for parole decisions relating to offenders serving sentences in British Columbia's provincial correctional facilities. The Parole Board of Canada has jurisdiction over granting parole to provincial offenders in the Atlantic and Prairie provinces, British Columbia, and to territorial offenders in Yukon, Nunavut and the Northwest Territories.

THE NUMBER OF OFFENDERS ON PROVINCIAL PAROLE INCREASED

Table C23

Year	Average Monthly Counts on Provincial Parole						
	Provincial Boards				Parole Board of Canada**	**Total**	Percent Change
	Quebec	Ontario	British Columbia*	Total			
2007-08	581	205	n/a	785	237	**1,022**	
2008-09	533	217	n/a	750	190	**940**	-8.0
2009-10	506	194	n/a	700	168	**868**	-7.7
2010-11	482	171	n/a	653	167	**820**	-5.6
2011-12	481	179	n/a	660	144	**804**	-2.0
2012-13	462	164	n/a	626	143	**769**	-4.4
2013-14	527	172	n/a	699	154	**853**	11.0
2014-15	612	207	n/a	821	151	**970**	13.7
2015-16	639	207	n/a	846	139	**985**	1.5
2016-17	701	205	n/a	907	151	**1,058**	7.4

Source: Table 35-10-0154-01, Corrections Key Indicator Report for Adults and Youth, Canadian Centre for Justice Statistics, Statistics Canada.

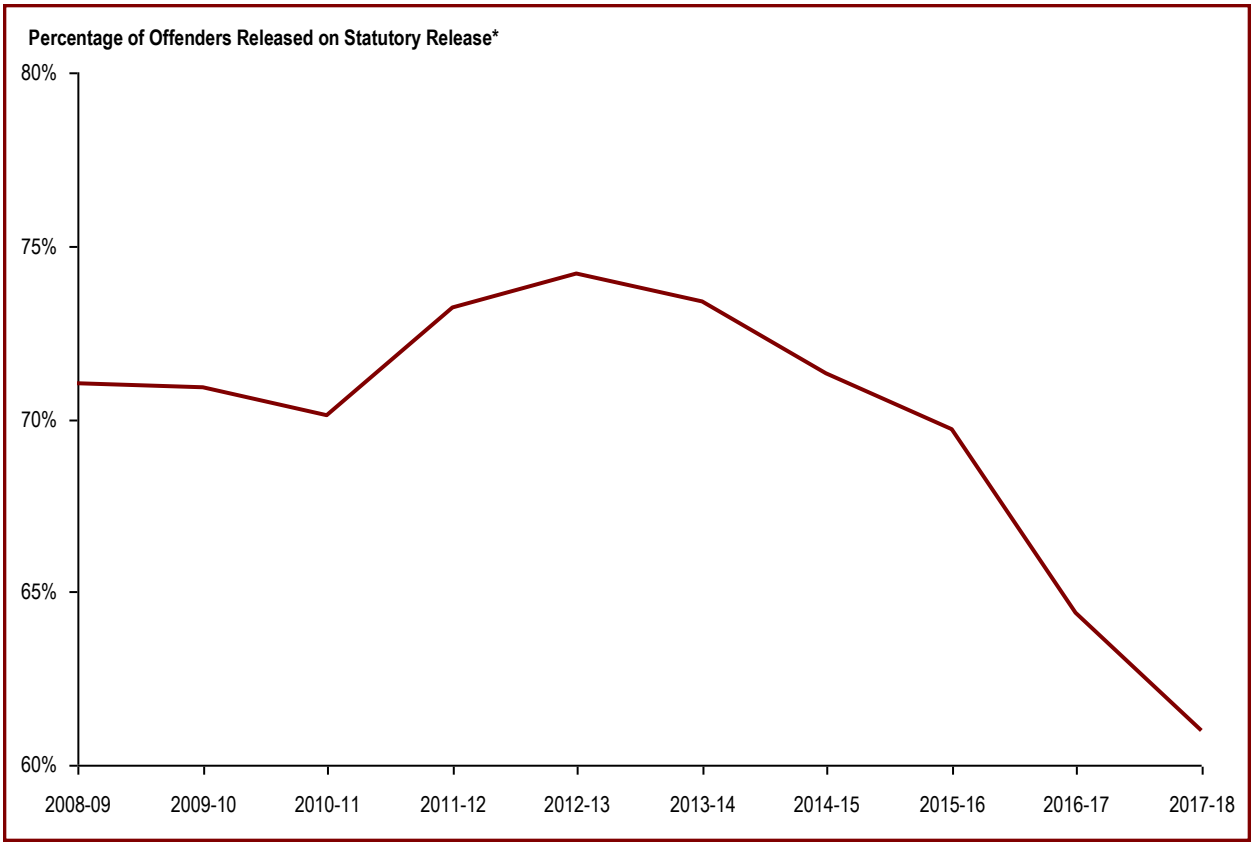
Note:
*On April 1, 2007, the Parole Board of Canada assumed responsibility for parole decisions relating to offenders serving sentences in British Columbia's provincial correctional facilities.
**The data represent the number of provincial offenders who are released from custody on the authority of the Parole Board of Canada and supervised by the Correctional Service of Canada.
Provincial parole boards operate in Quebec and Ontario. The Parole Board of Canada has jurisdiction over granting parole to provincial offenders in the Atlantic and Prairie provinces, British Columbia, and to territorial offenders in Yukon, Nunavut and the Northwest Territories.

SECTION D

CONDITIONAL RELEASE

THE PERCENTAGE OF OFFENDERS RELEASED FROM FEDERAL PENITENTIARIES AT STATUTORY RELEASE DECREASED IN THE PAST FIVE YEARS

Figure D1



Source: Correctional Service Canada.

- In fiscal year 2017-18, 61.0% of all releases from federal institutions were at statutory release.
- In fiscal year 2017-18, 74.4% of releases for Indigenous offenders were at statutory release compared to 55.8% of releases for non-Indigenous offenders.
- Over the past ten years, the percentage of releases at statutory release has decreased from 71.0% to 61.0%.

Note:
*Percentage is calculated based on the number of statutory releases compared to the total releases for each offender group.
The data includes all releases from a federal institution or Healing Lodge in a given fiscal year excluding offenders with quashed sentences, offenders who died in custody, LTSO (Long-Term Supervision Orders) releases, offenders released at warrant expiry and offenders transferred to foreign countries. An offender may be released more than once a year in cases where a previous release was subject to revocation, suspension, temporary detention, or interruption.
Statutory release refers to a conditional release that is subject to supervision after the offender has served two-thirds of the sentence.
A fiscal year runs from April 1 to March 31 of the following year.

THE PERCENTAGE OF OFFENDERS RELEASED FROM FEDERAL PENITENTIARIES AT STATUTORY RELEASE DECREASED IN THE PAST FIVE YEARS

Table D1

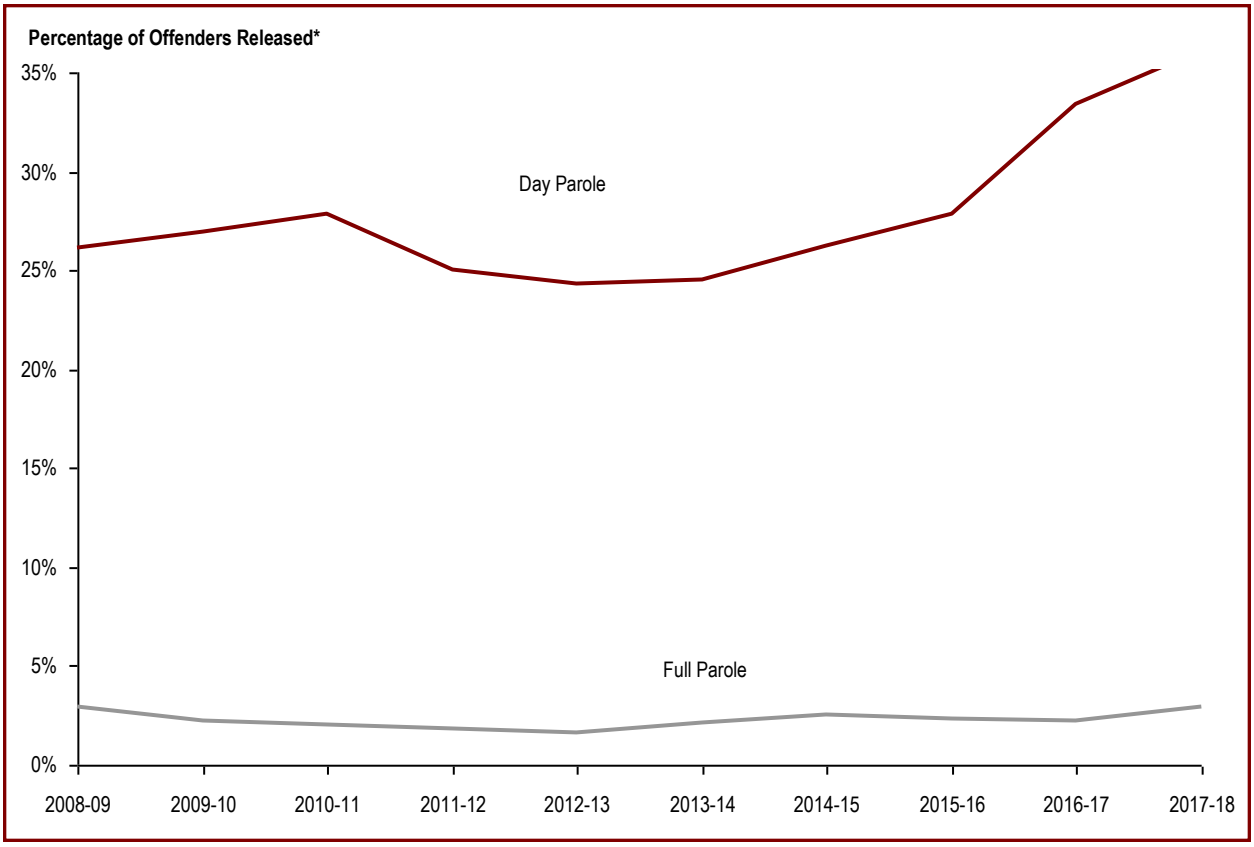
	Indigenous			Non-Indigenous			Total Offender Population		
Year	Statutory Release	Total Releases	%*	Statutory Release	Total Releases	%*	Statutory Release	Total Releases	%*
2008-09	1,437	1,719	83.6	4,278	6,331	67.6	5,715	8,050	71.0
2009-10	1,417	1,725	82.1	4,121	6,081	67.8	5,538	7,806	70.9
2010-11	1,327	1,589	83.5	3,753	5,657	66.3	5,080	7,246	70.1
2011-12	1,457	1,754	83.1	3,844	5,486	70.1	5,301	7,240	73.2
2012-13	1,603	1,923	83.4	3,985	5,610	71.0	5,588	7,533	74.2
2013-14	1,698	1,996	85.1	3,938	5,685	69.3	5,636	7,681	73.4
2014-15	1,712	2,029	84.4	3,661	5,504	66.5	5,373	7,533	71.3
2015-16	1,659	2,010	82.5	3,650	5,607	65.1	5,309	7,617	69.7
2016-17	1,569	2,017	77.8	3,315	5,560	59.6	4,884	7,577	64.5
2017-18	1,518	2,040	74.4	2,909	5,216	55.8	4,427	7,256	61.0

Source: Correctional Service Canada.

Note:
*Percentage is calculated based on the number of statutory releases compared to the total releases for each offender group.
The data includes all releases from a federal institution or Healing Lodge in a given fiscal year excluding offenders with quashed sentences, offenders who died in custody, LTSO releases, offenders released at warrant expiry and offenders transferred to foreign countries. An offender may be released more than once a year in cases where a previous release was subject to revocation, suspension, temporary detention, or interruption.
Statutory release refers to a conditional release that is subject to supervision after the offender has served two-thirds of the sentence.
A fiscal year runs from April 1 to March 31 of the following year.

THE PERCENTAGE OF OFFENDERS RELEASED FROM FEDERAL PENITENTIARIES ON DAY PAROLE INCREASED IN THE PAST SIX YEARS

Figure D2



Source: Correctional Service Canada.

- In fiscal year 2017-18, 36.1% of all releases from federal institutions were on day parole and 2.9% were on full parole.
- In fiscal year 2017-18, 24.4% of releases for Indigenous offenders were on day parole and 1.2% were on full parole compared to 40.7% and 3.5%, respectively for non-Indigenous offenders.
- Over the past ten years, the percentage of releases on day parole has increased from 26.1% to 36.1% and the percentage of releases on full parole was the same at 2.9%.

Note:
*Percentage is calculated based on the number of day and full paroles compared to the total releases for each offender group.
The data includes all releases from federal penitentiaries in a given fiscal year excluding offenders with quashed sentences, offenders who died in custody, LTSO releases, offenders released at warrant expiry and offenders transferred to foreign countries. An offender may be released more than once a year in cases where a previous release was subject to revocation, suspension, temporary detention, or interruption.
Day parole is a type of conditional release granted by the Parole Board of Canada whereby offenders are permitted to participate in community-based activities in preparation for full parole or statutory release. The conditions require offenders to return nightly to an institution or half-way house unless otherwise authorized by the Parole Board of Canada.
Full parole is a type of conditional release granted by the Parole Board of Canada whereby the remainder of the sentence is served under supervision in the community.
A fiscal year runs from April 1 to March 31 of the following year.

THE PERCENTAGE OF OFFENDERS RELEASED FROM FEDERAL PENITENTIARIES ON DAY PAROLE INCREASED IN THE PAST SIX YEARS

Table D2

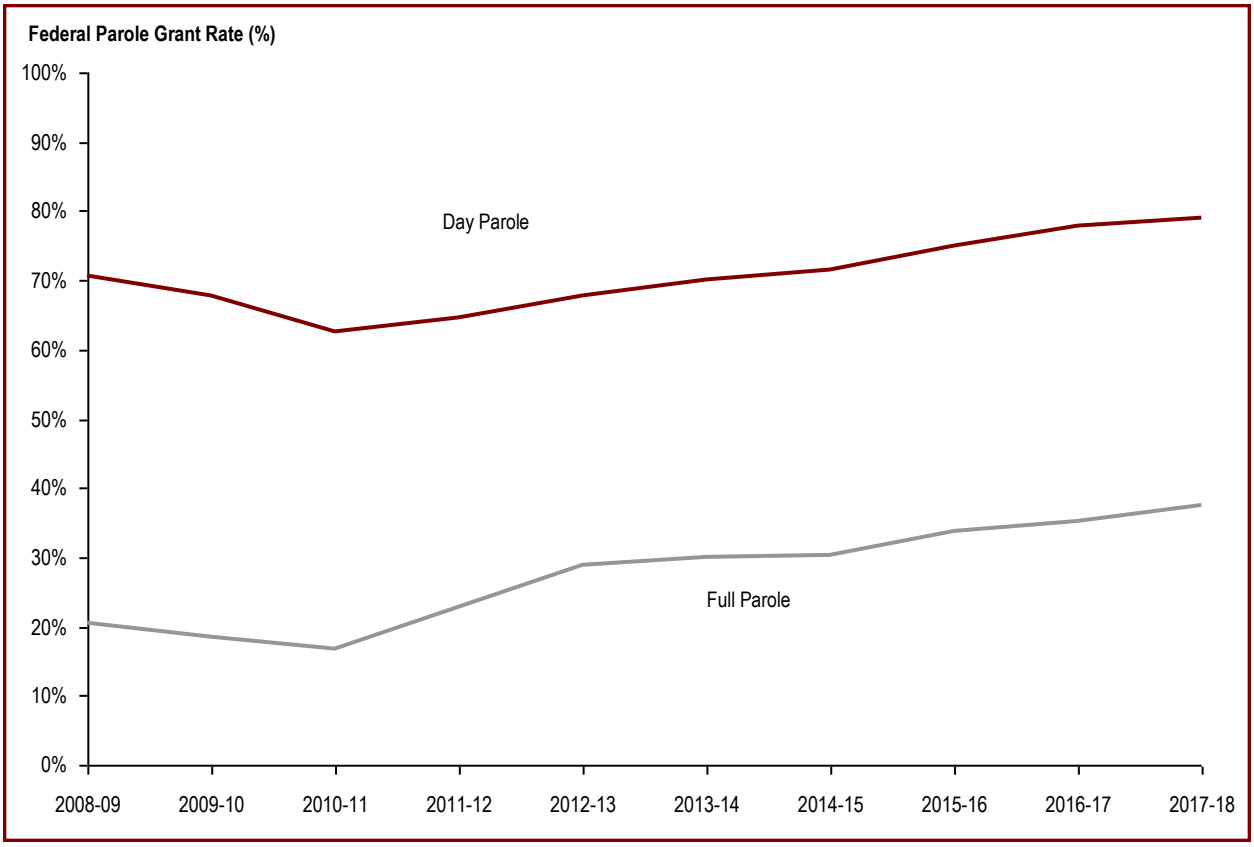
		Indigenous			Non-Indigenous			Total Offender Population		
Year		Day Parole	Full Parole	Total Releases	Day Parole	Full Parole	Total Releases	Day Parole	Full Parole	Total Releases
2008-09	#	266	16	1,719	1,839	214	6,331	2,105	230	8,050
	%	15.5	0.9		29.0	3.4		26.1	2.9	
2009-10	#	296	12	1,725	1,800	160	6,081	2,096	172	7,806
	%	17.2	0.7		29.6	2.6		26.9	2.2	
2010-11	#	251	11	1,589	1,767	137	5,657	2,018	148	7,246
	%	15.8	0.7		31.2	2.4		27.8	2.0	
2011-12	#	285	12	1,754	1,526	116	5,486	1,811	128	7,240
	%	16.2	0.7		27.8	2.1		25.0	1.8	
2012-13	#	313	7	1,923	1,515	110	5,610	1,828	117	7,533
	%	16.3	0.4		27.0	2.0		24.3	1.6	
2013-14	#	280	18	1,996	1,602	145	5,685	1,882	163	7,681
	%	14.0	0.9		28.2	2.6		24.5	2.1	
2014-15	#	307	10	2,029	1,668	175	5,504	1,975	185	7,533
	%	15.1	0.5		30.3	3.2		26.2	2.5	
2015-16	#	337	14	2,010	1,793	164	5,607	2,130	178	7,617
	%	16.8	0.7		32.0	2.9		28.0	2.3	
2016-17	#	435	13	2,017	2,092	153	5,560	2,527	166	7,577
	%	21.6	0.6		37.6	2.8		33.4	2.2	
2017-18	#	497	25	2,040	2,124	183	5,216	2,621	208	7,256
	%	24.4	1.2		40.7	3.5		36.1	2.9	

Source: Correctional Service Canada.

Note:
The data includes all releases from a federal institution or Healing Lodge in a given fiscal year excluding offenders with quashed sentences, offenders who died in custody, LTSO releases, offenders released at warrant expiry and offenders transferred to foreign countries. An offender may be released more than once a year in cases where a previous release was subject to revocation, suspension, temporary detention, or interruption.
Day parole is a type of conditional release granted by the Parole Board of Canada whereby offenders are permitted to participate in community-based activities in preparation for full parole or statutory release. The conditions require offenders to return nightly to an institution or half-way house unless otherwise authorized by the Parole Board of Canada.
Full parole is a type of conditional release granted by the Parole Board of Canada whereby the remainder of the sentence is served under supervision in the community.
A fiscal year runs from April 1 to March 31 of the following year.
Percentage is calculated based on the number of day and full paroles compared to the total releases for each offender group.
Due to rounding, percentages may not add up to 100 percent.

FEDERAL DAY AND FULL PAROLE GRANT RATES INCREASED

Figure D3



Source: Parole Board of Canada.

- In 2017-18, the federal day parole grant rate increased 1.2 percentage points to 79.1% compared to the previous year.
- In 2017-18, the federal full parole grant rate increased 2.3 percentage points to 37.5% compared to the previous year.
- Over the last 10 years, female offenders had a much higher grant rate for federal day parole (84.7%) and federal full parole (41.2%) than male offenders (70.1% and 27.5% respectfully).

Note:
The grant rate represents the percentage of pre-release reviews resulting in a grant by the Parole Board of Canada.
Day parole is a type of conditional release granted by the Parole Board of Canada in which offenders are permitted to participate in community-based activities in preparation for full parole or statutory release. The conditions require offenders to return nightly to an institution or half-way house unless otherwise authorized by the Parole Board of Canada. Not all offenders apply for day parole, and some apply more than once before being granted day parole.
Full parole is a type of conditional release granted by the Parole Board of Canada in which the remainder of the sentence is served under supervision in the community. The Parole Board of Canada must review the cases of all offenders for full parole at the time prescribed by legislation, unless the offender advises the Parole Board of Canada in writing that he/she does not wish to be considered for full parole.
On March 28, 2011, Bill C-59 (Abolition of Early Parole Act) eliminated the accelerated parole review (APR) process, affecting first-time non-violent offenders serving sentences for Schedule II and non-Schedule offences, who in 2011-12 were no longer eligible for an APR review. These offenders are now assessed on general reoffending as compared to the APR risk assessment, which considered the risk of committing a violent offence only. To better illustrate historical trends, APR decisions were excluded.
Even though comparisons were made between federal regular day parole and full parole grant rates only, they nevertheless contain an APR residual effect between 2011-12 and 2015-16 as a sufficiently large proportion of the APR-affected population was granted regular federal day parole and full parole, perhaps inflating the grant rates.

FEDERAL DAY AND FULL PAROLE GRANT RATES INCREASED

Table D3

Type of Release	Year	Granted		Denied		Grant Rate (%)			APR*	
		Women	Men	Women	Men	Women	Men	Total	*Directed*	*Total*
Day Parole	2008-09	136	1,907	25	824	84.5	69.8	70.6	1,000	1,525
	2009-10	153	1,957	40	967	79.3	66.9	67.7	947	1,491
	2010-11	136	1,854	42	1,149	76.4	61.7	62.6	970	1,591
	2011-12	249	2,491	65	1,442	79.3	63.3	64.5	0	0
	2012-13	289	2,821	72	1,416	80.1	66.6	67.6	14	21
	2013-14	248	2,824	52	1,273	82.7	68.9	69.9	39	47
	2014-15	298	3,023	51	1,282	85.4	70.2	71.4	38	45
	2015-16	291	3,093	52	1,077	84.8	74.2	75.0	86	90
	2016-17	399	3,445	47	1,042	89.5	76.8	77.9	80	83
	2017-18	436	3,612	30	1,039	93.6	77.7	79.1	100	106
Full Parole	2008-09	44	495	62	2,016	41.5	19.7	20.6	1,097	1,100
	2009-10	32	461	89	2,080	26.4	18.1	18.5	1,004	1,010
	2010-11	20	436	87	2,205	18.7	16.5	16.6	1,046	1,059
	2011-12	77	644	126	2,317	37.9	21.7	22.8	0	0
	2012-13	90	914	142	2,328	38.8	28.2	28.9	26	26
	2013-14	84	904	103	2,201	44.9	29.1	30.0	126	142
	2014-15	87	969	106	2,307	45.1	29.6	30.4	119	137
	2015-16	96	1,063	127	2,153	43.0	33.1	33.7	166	185
	2016-17	138	1,237	157	2,384	46.8	34.2	35.1	122	126
	2017-18	153	1,363	175	2,357	46.6	36.6	37.5	161	165

Source: Parole Board of Canada.

Note:

The grant rate represents the percentage of pre-release reviews resulting in a grant by the Parole Board of Canada.

Day parole is a type of conditional release granted by the Parole Board of Canada in which offenders are permitted to participate in community-based activities in preparation for full parole or statutory release. The conditions require offenders to return nightly to an institution or half-way house unless otherwise authorized by the Parole Board of Canada. Not all offenders apply for day parole, and some apply more than once before being granted day parole.

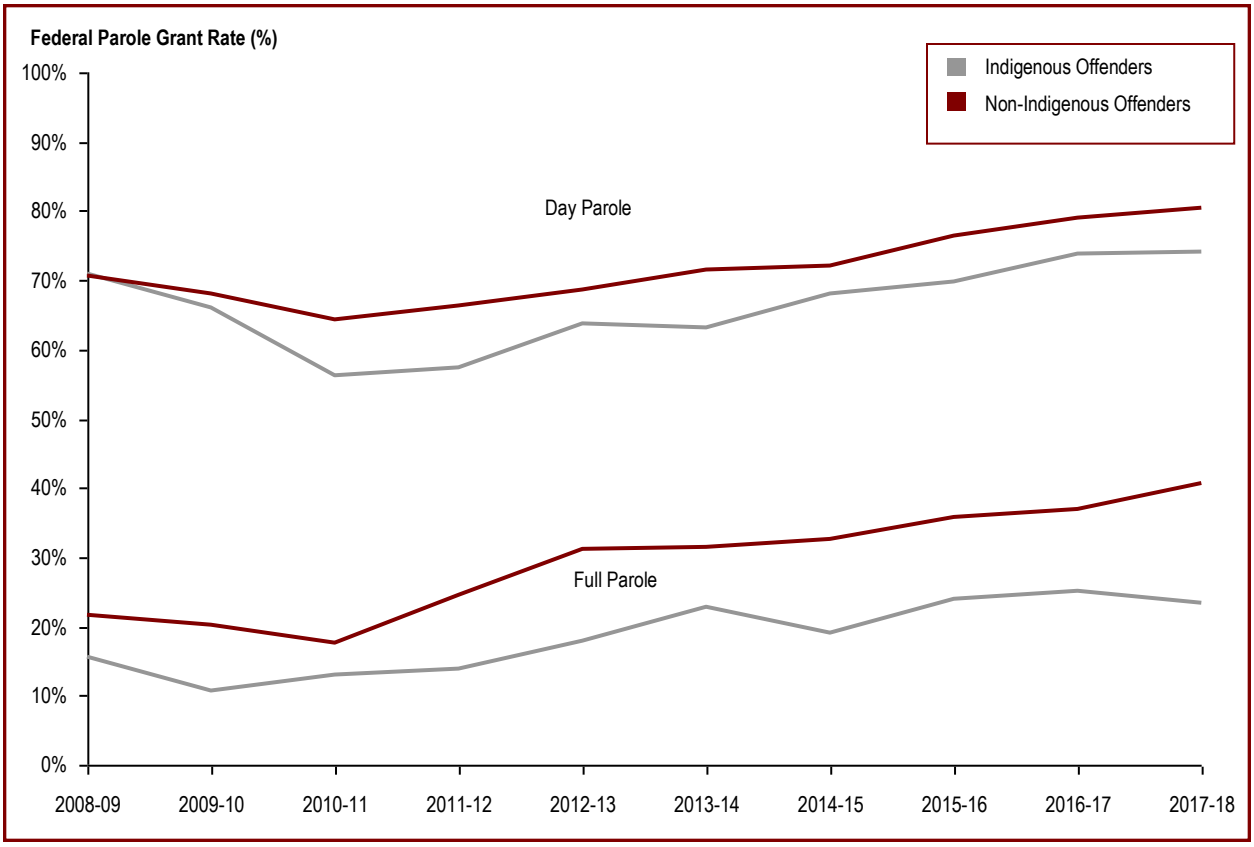
Full parole is a type of conditional release granted by the Parole Board of Canada in which the remainder of the sentence is served under supervision in the community. The Parole Board of Canada must review the cases of all offenders for full parole at the time prescribed by legislation, unless the offender advises the Parole Board of Canada in writing that he/she does not wish to be considered for full parole. Grant rates should be read with caution.

*On March 28, 2011, Bill C-59 (*Abolition of Early Parole Act*) eliminated the accelerated parole review (APR) process, affecting first-time non-violent offenders serving sentences for Schedule II and non-Schedule offences, who in 2011-12 were no longer eligible for an APR review. These offenders are now assessed on general reoffending as compared to the APR risk assessment, which considered the risk of committing a violent offence only. To better illustrate historical trends, APR decisions were excluded. However, the information on APR (the number of paroles directed and the total number of APR decisions) is presented in a separate section of the table. Grant rates should be read with caution. Even though comparisons were made between federal regular day parole and full parole grant rates only, they nevertheless contain an APR residual effect between 2011-12 and 2015-16 as a sufficiently large proportion of the APR-affected population were granted regular federal day parole and full parole, perhaps inflating the grant rates.

*As a result of court challenges, the Pacific Region (in 2012) and the Quebec Region (in 2013) have been processing active APR cases for offenders sentenced or convicted prior to the abolition of APR. Following the *Canada (Attorney General) v. Whaling* decision on March 20, 2014, the accelerated parole review process was reinstated across all regions for offenders sentenced prior to the abolition of APR.

FEDERAL DAY AND FULL PAROLE GRANT RATES FOR INDIGENOUS OFFENDERS INCREASED

Figure D4



Source: Parole Board of Canada.

- In 2017-18, the federal day parole grant rate increased slightly for Indigenous offenders (to 74.0%; +0.2%) and increased by 1.6% for non-Indigenous offenders to 80.5% compared to 2016-17.
- In 2017-18, the federal full parole grant decreased for Indigenous offenders (to 23.2%; -2.0%) and increased for non-Indigenous offenders (to 40.7%; +3.7%) compared to 2016-17.
- Over the last 10 years, lower federal day and full parole grant rates were reported for Indigenous offenders (66.7%; 18.9%) than for non-Indigenous offenders (72.3%; 30.3%).

Note:

The grant rate represents the percentage of pre-release reviews resulting in a grant by the Parole Board of Canada.

Day parole is a type of conditional release granted by the Parole Board of Canada in which offenders are permitted to participate in community-based activities in preparation for full parole or statutory release. The conditions require offenders to return nightly to an institution or half-way house unless otherwise authorized by the Parole Board of Canada. Not all offenders apply for day parole, and some apply more than once before being granted day parole.

Full parole is a type of conditional release granted by the Parole Board of Canada in which the remainder of the sentence is served under supervision in the community. The Parole Board of Canada must review the cases of all offenders for full parole at the time prescribed by legislation, unless the offender advises the Parole Board of Canada in writing that he/she does not wish to be considered for full parole.

On March 28, 2011, Bill C-59 (*Abolition of Early Parole Act*) eliminated the accelerated parole review (APR) process, affecting first-time non-violent offenders serving sentences for schedule II and non-scheduled offences, who in 2011-12 were no longer eligible for an APR review. These offenders are now assessed on general reoffending as compared to the APR risk assessment, which considered the risk of committing a violent offence only. To better illustrate historical trends, APR were excluded. Grant rates should be read with caution. Even though comparisons were made between federal regular day parole and full parole grant rates only, they nevertheless contain an APR residual effect between 2011-12 and 2015-16 as a sufficiently large proportion of the APR-affected population were granted regular federal day parole and full parole, perhaps inflating the grant rates.

FEDERAL DAY AND FULL PAROLE GRANT RATES FOR INDIGENOUS OFFENDERS INCREASED

Table D4

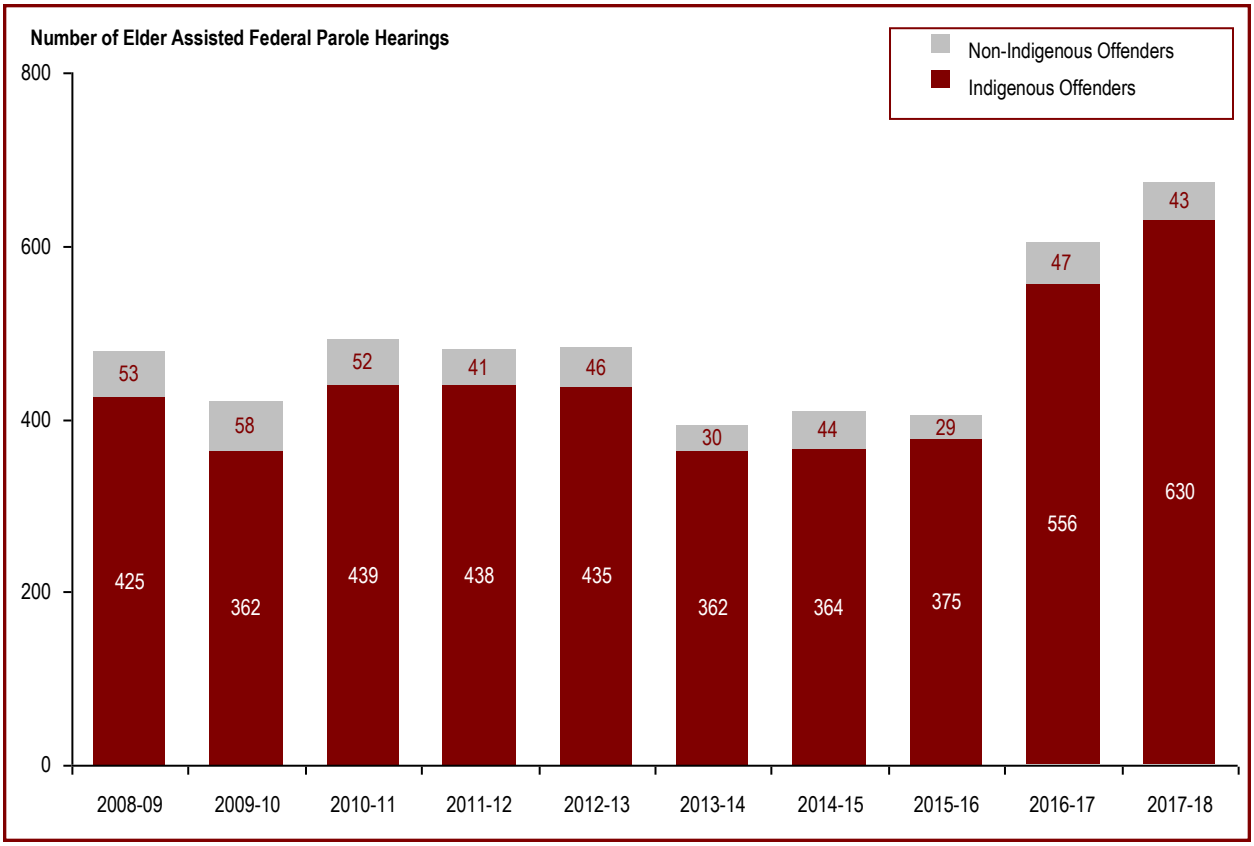
Type of Release	Year	Granted		Denied		Grant Rate (%)		
		Indigenous	Non-Ind.	Indigenous	Non-Ind.	Indigenous	Non-Ind.	Total
Day Parole	2008-09	390	1,653	159	690	71.0	70.6	2,892
	2009-10	407	1,703	211	796	65.9	68.1	3,117
	2010-11	373	1,617	289	902	56.3	64.2	3,181
	2011-12	466	2,274	347	1,160	57.3	66.2	4,247
	2012-13	556	2,554	318	1,170	63.6	68.6	4,598
	2013-14	520	2,552	303	1,022	63.2	71.4	4,397
	2014-15	563	2,758	266	1,067	67.9	72.1	4,654
	2015-16	605	2,779	264	865	69.6	76.3	4,513
	2016-17	714	3,130	253	836	73.8	78.9	4,933
	2017-18	819	3,229	288	781	74.0	80.5	5,117
Full Parole	2008-09	73	466	395	1,683	15.6	21.7	2,617
	2009-10	50	443	413	1,756	10.8	20.1	2,662
	2010-11	71	385	480	1,812	12.9	17.5	2,748
	2011-12	75	646	467	1,976	13.8	24.6	3,164
	2012-13	102	904	472	1,998	17.8	31.1	3,474
	2013-14	124	864	421	1,883	22.8	31.5	3,292
	2014-15	106	950	450	1,963	19.1	32.6	3,469
	2015-16	136	1,023	436	1,844	23.8	35.7	3,439
	2016-17	156	1,219	463	2,078	25.2	37.0	3,916
	2017-18	173	1,343	573	1,959	23.2	40.7	4,048

Source: Parole Board of Canada.

Note:
The grant rate represents the percentage of pre-release reviews resulting in a grant by the Parole Board of Canada.
Day parole is a type of conditional release granted by the Parole Board of Canada in which offenders are permitted to participate in community-based activities in preparation for full parole or statutory release. The conditions require offenders to return nightly to an institution or half-way house unless otherwise authorized by the Parole Board of Canada. Not all offenders apply for day parole, and some apply more than once before being granted day parole.
Full parole is a type of conditional release granted by the Parole Board of Canada in which the remainder of the sentence is served under supervision in the community. The Parole Board of Canada must review the cases of all offenders for full parole at the time prescribed by legislation, unless the offender advises the Parole Board of Canada in writing that he/she does not wish to be considered for full parole.
On March 28, 2011, Bill C-59 (*Abolition of Early Parole Act*) eliminated the accelerated parole review (APR) process, affecting first-time non-violent offenders serving sentences for Schedule II and non-Schedule offences, who in 2011-12 were no longer eligible for an APR review. These offenders are now assessed on general reoffending as compared to the APR risk assessment, which considered the risk of committing a violent offence only. To better illustrate historical trends, APR were excluded. Grant rates should be read with caution. Even though comparisons were made between federal regular day parole and full parole grant rates only, they nevertheless contain an APR residual effect between 2011-12 and 2015-16 as a sufficiently large proportion of the APR-affected population were granted regular federal day parole and full parole, perhaps inflating the grant rates.

THE NUMBER OF FEDERAL PAROLE HEARINGS INVOLVING AN INDIGENOUS CULTURAL ADVISOR INCREASED

Figure D5



Source: Parole Board of Canada.

- The number of Elder Assisted federal parole hearings increased by 11.6% in 2017-18, following a 49.3% increase in 2016-17 (from 404 in 2015-16 to 603 in 2016-17, to 673 in 2017-18). The increase is associated with the in-reach conducted by the Board with Indigenous offenders.
- In 2017-18, 41.1% (630) of all federal hearings with Indigenous offenders, and 0.9% (43) of all federal parole hearings for offenders who did not self-identify as Indigenous were Elder Assisted Hearings.

Note:
The presence of an Indigenous Cultural Advisor is an alternative approach to the traditional parole hearing, and was introduced by the Parole Board of Canada to ensure that conditional release hearings are sensitive to Indigenous cultural values and traditions. This type of hearing is available to both Indigenous and non-Indigenous offenders.

THE NUMBER OF FEDERAL PAROLE HEARINGS INVOLVING AN INDIGENOUS CULTURAL ADVISOR INCREASED

Table D5

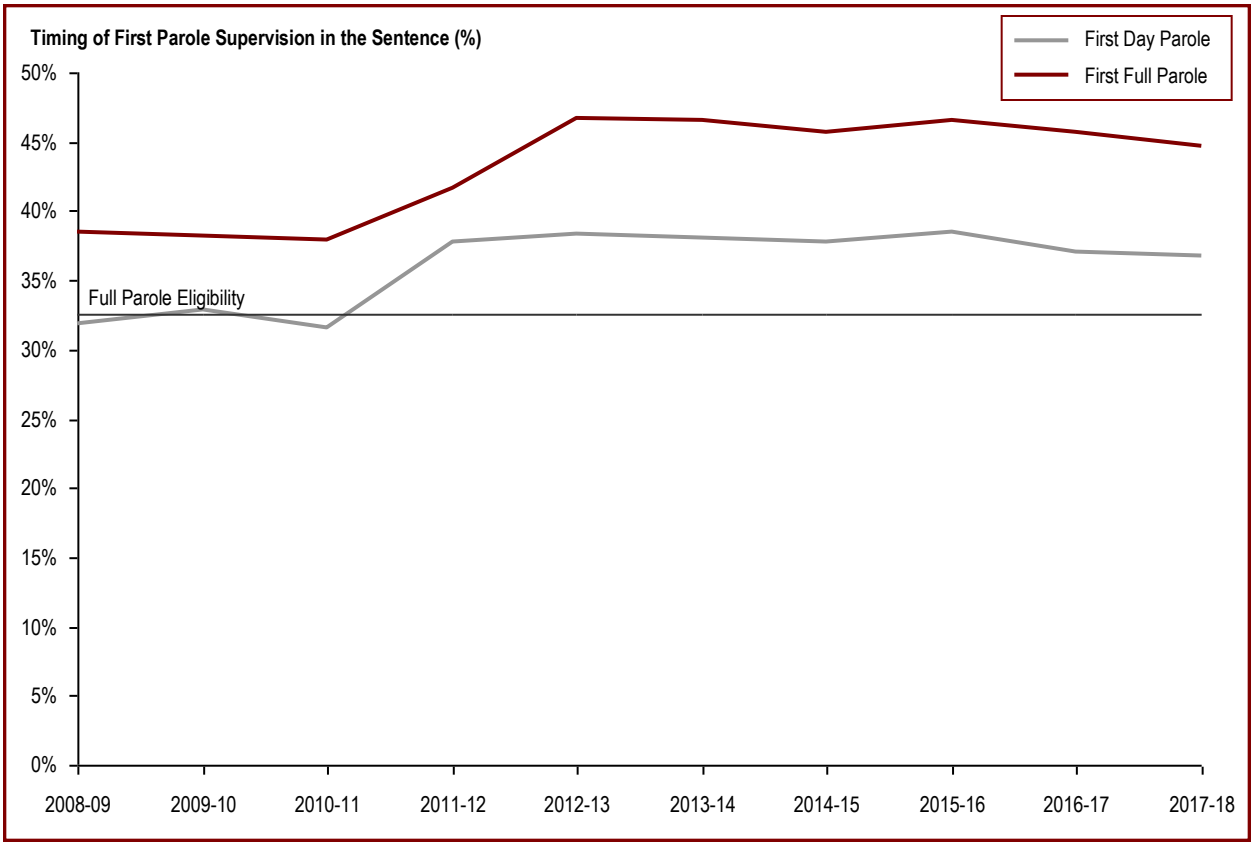
Year	Elder Assisted Hearings								
	Indigenous Offenders			Non-Indigenous Offenders			All Offenders		
	Total Hearings	With Cultural Advisor		Total Hearings	With Cultural Advisor		Total Hearings	With Cultural Advisor	
	#	#	%	#	#	%	#	#	%
2008-09	1,250	425	34.0	4,370	53	1.2	5,620	478	8.5
2009-10	1,209	362	29.9	4,471	58	1.3	5,680	420	7.4
2010-11	1,237	439	35.5	4,343	52	1.2	5,580	491	8.8
2011-12	1,266	438	34.6	4,645	41	0.9	5,911	479	8.1
2012-13	1,305	435	33.3	4,660	46	1.0	5,965	481	8.1
2013-14	922	362	39.3	3,678	30	0.8	4,600	392	8.5
2014-15	881	364	41.3	3,835	44	1.1	4,716	408	8.7
2015-16	957	375	39.2	3,972	29	0.7	4,929	404	8.2
2016-17	1,295	556	42.9	4,498	47	1.0	5,793	603	10.4
2017-18	1,534	630	41.1	4,855	43	0.9	6,389	673	10.5

Source: Parole Board of Canada.

Note:
The presence of an Indigenous Cultural Advisor is an alternative approach to the traditional parole hearing, and was introduced by the Parole Board of Canada to ensure that conditional release hearings are sensitive to Indigenous cultural values and traditions. This type of hearing is available to both Indigenous and non-Indigenous offenders.

PROPORTION OF SENTENCE SERVED PRIOR TO BEING RELEASED ON PAROLE DECREASED

Figure D6



Source: Parole Board of Canada.

- In 2017-18, the average proportion of sentence served before the first federal day parole release for offenders serving determinate sentences decreased negligibly 0.3 of a percentage point (to 36.7%) from the previous year.
- The average proportion of sentence served before the first federal full parole release for offenders serving determinate sentences decreased 1 percentage point in 2017-18 (to 44.6%) when compared to the previous year.
- In 2017-18, male offenders served higher proportions of their sentences before being released on their first federal day parole and full parole (37.2%; 44.9%) then female offenders (33.4%; 42.4%).
- In 2017-18, female offenders and male offenders served an average of 5.2 and 4.8 percentage points more of their sentences before the first federal day parole release, and 5.9 and 6.2 percentage points more of their sentences before the first federal full parole release compared to 2008-09.

Note:
Timing of parole in the sentence refers to the percentage of the sentence served at the time the first day parole or full parole starts during the sentence. In most cases a full parole is preceded by a day parole. These calculations are based on sentences under federal jurisdiction, excluding life sentences and indeterminate sentences. Offenders (other than those serving life or indeterminate sentences or subject to judicial determination) normally become eligible for full parole after serving 1/3 of their sentence or seven years, whichever is less. Eligibility for day parole is normally at six months before full parole eligibility.
The increases in the average proportion of time served after 2010-11 are in part due to the effect of Bill C-59 and were driven primarily by offenders serving sentences for Schedule II and non-Schedule offences (some of whom were former APR-eligible offenders).

PROPORTION OF SENTENCE SERVED PRIOR TO BEING RELEASED ON PAROLE DECREASED

Table D6

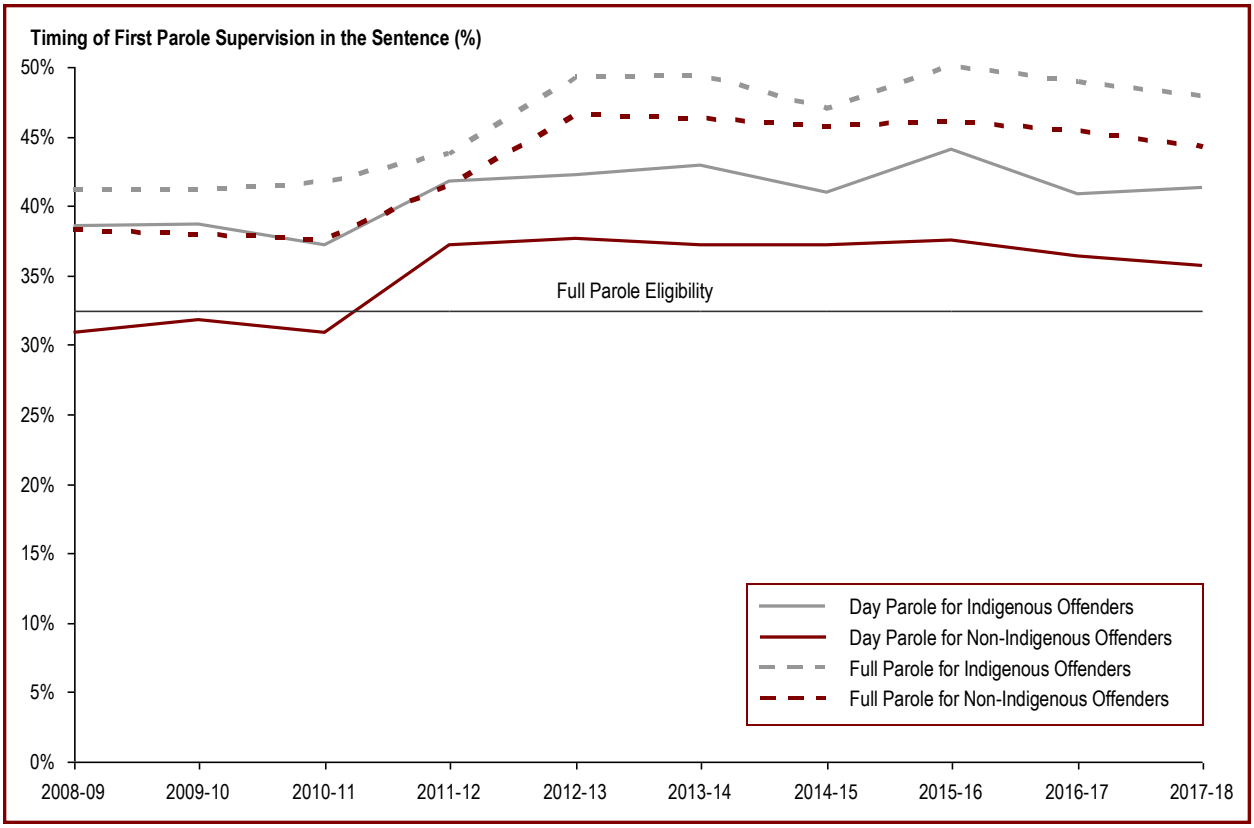
Year	Type of Supervision					
	First Federal Day Parole			First Federal Full Parole		
	Women	Men	**Total**	Women	Men	**Total**
	Percentage of Sentence Incarcerated					
2008-09	28.2	32.4	**31.9**	36.6	38.7	**38.5**
2009-10	29.5	33.2	**32.8**	36.1	38.5	**38.2**
2010-11	29.2	31.8	**31.6**	36.6	38.1	**37.9**
2011-12	35.0	38.1	**37.8**	40.3	41.7	**41.6**
2012-13	38.9	38.3	**38.4**	45.6	46.9	**46.7**
2013-14	34.9	38.3	**38.0**	44.2	46.8	**46.6**
2014-15	35.3	37.9	**37.7**	44.9	45.8	**45.7**
2015-16	36.9	38.7	**38.5**	45.2	46.6	**46.5**
2016-17	33.6	37.5	**37.0**	43.5	46.0	**45.7**
2017-18	33.4	37.2	**36.7**	42.4	44.9	**44.6**

Source: Parole Board of Canada.

Note:
Timing of parole in the sentence refers to the percentage of the sentence served at the time the first day parole or full parole starts during the sentence. In most cases a full parole is preceded by a day parole.
These calculations are based on sentences under federal jurisdiction, excluding life sentences and indeterminate sentences.
Offenders (other than those serving life or indeterminate sentences or subject to judicial determination) normally become eligible for full parole after serving 1/3 of their sentence or seven years, whichever is less. Eligibility for day parole is normally at six months before full parole eligibility.
The increases in the average proportion of time served after 2010-11 are in part due to the effect of Bill C-59 and were driven primarily by offenders serving sentences for Schedule II and non-Schedule offences (some of whom were former APR-eligible offenders).

INDIGENOUS OFFENDERS SERVE A HIGHER PROPORTION OF THEIR SENTENCES BEFORE BEING RELEASED ON PAROLE

Figure D7



Source: Parole Board of Canada.

- In 2017-18, Indigenous offenders served higher proportions of their sentences before being released on their first federal day parole (41.3%) and full parole (47.8%, a decrease of one percentage point compared 2016-17), than non-Indigenous offenders (35.7%; 44.2%).
- Over the last ten years, Indigenous offenders served higher proportions of their sentences before their first federal day parole and full parole release (41.0%; 46.2%), than non-Indigenous offenders (35.1%; 42.6%).

Note:
Timing of parole in the sentence refers to the percentage of the sentence served at the time the first day parole or full parole starts during the sentence. In most cases a full parole is preceded by a day parole.
These calculations are based on sentences under federal jurisdiction, excluding life sentences and indeterminate sentences.
Offenders (other than those serving life or indeterminate sentences or subject to judicial determination) normally become eligible for full parole after serving 1/3 of their sentence or seven years, whichever is less. Eligibility for day parole is normally at six months before full parole eligibility.
The increases in the average proportion of time served after 2010-11 are in part due to the effect of Bill C-59 and were driven primarily by offenders serving sentences for Schedule II and non-Schedule offences (some of whom were former APR-eligible offenders).

INDIGENOUS OFFENDERS SERVE A HIGHER PROPORTION OF THEIR SENTENCES BEFORE BEING RELEASED ON PAROLE

Table D7

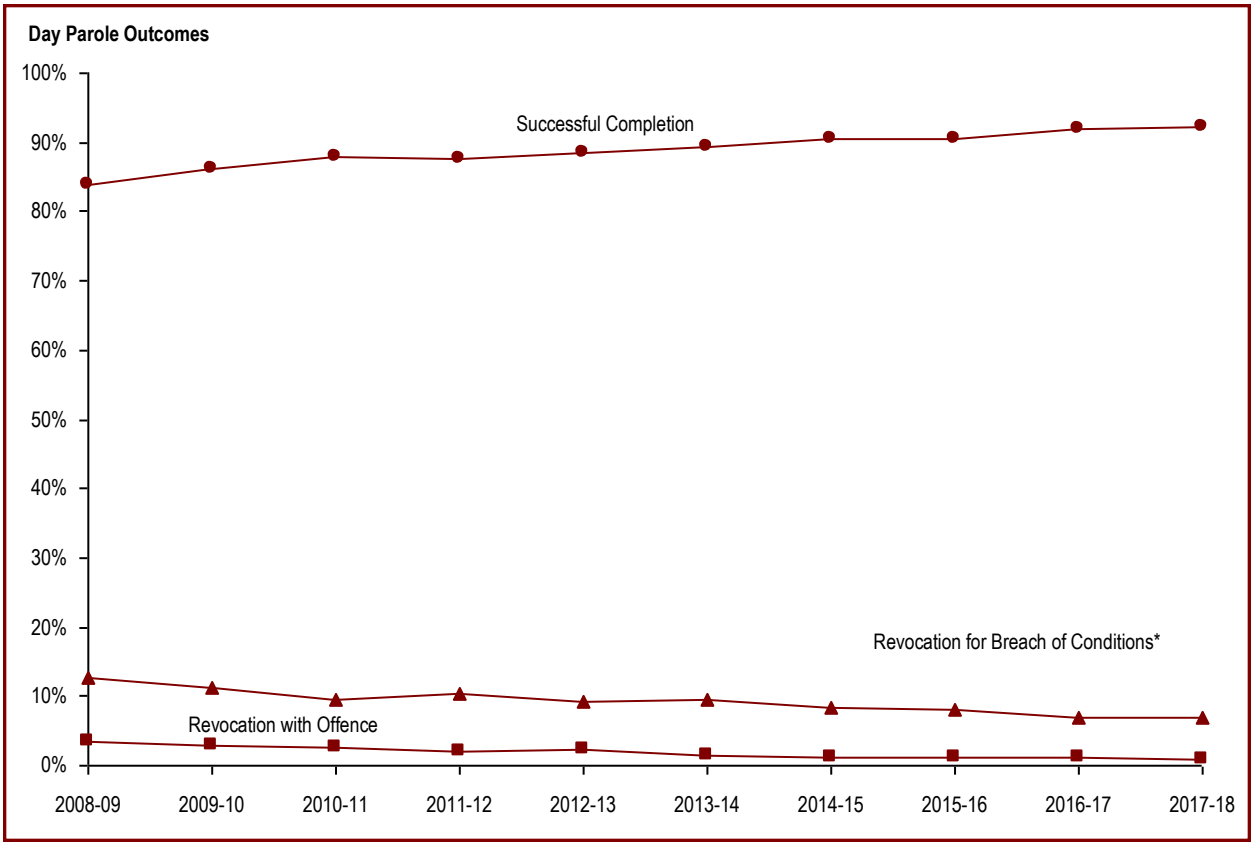
Year	Type of Supervision					
	First Federal Day Parole			First Federal Full Parole		
	Indigenous	Non-Indigenous	**Total**	Indigenous	Non-Indigenous	**Total**
	Percentage of Sentence Incarcerated					
2008-09	38.5	30.9	**31.9**	41.0	38.2	**38.5**
2009-10	38.7	31.8	**32.8**	41.0	37.9	**38.2**
2010-11	37.2	30.8	**31.6**	41.6	37.5	**37.9**
2011-12	41.7	37.1	**37.8**	43.7	41.4	**41.6**
2012-13	42.2	37.6	**38.4**	49.2	46.5	**46.7**
2013-14	42.9	37.1	**38.0**	49.3	46.2	**46.6**
2014-15	40.9	37.1	**37.7**	46.9	45.6	**45.7**
2015-16	44.0	37.5	**38.5**	50.8	46.0	**46.5**
2016-17	40.8	36.3	**37.0**	48.9	45.3	**45.7**
2017-18	41.3	35.7	**36.7**	47.8	44.2	**44.6**

Source: Parole Board of Canada.

Note:
Timing of parole in the sentence refers to the percentage of the sentence served at the time the first day parole or full parole starts during the sentence. In most cases a full parole is preceded by a day parole.
These calculations are based on sentences under federal jurisdiction, excluding life sentences and indeterminate sentences.
Offenders (other than those serving life or indeterminate sentences or subject to judicial determination) normally become eligible for full parole after serving 1/3 of their sentence or seven years, whichever is less. Eligibility for day parole is normally at six months before full parole eligibility.
The increases in the average proportion of time served after 2010-11 are in part due to the effect of Bill C-59 and were driven primarily by offenders serving sentences for Schedule II and non-Schedule offences (some of whom were former APR-eligible offenders).

THE SUCCESSFUL COMPLETION OF FEDERAL DAY PAROLE INCREASED

Figure D8



Source: Parole Board of Canada.

- In nine of the last ten years, the successful completion rate of federal day parole was over 85%.
- In 2017-18, the successful completion rate of federal day parole increased 0.4 of a percentage point to 92.2% compared to 2016-17.
- During the five-year period (between 2013-14 and 2017-18), the successful completion rate on federal day parole was on average 6.3 percentage points lower than the rate for federal APR day parole (90.8% and 97.1%, respectively).
- The rate of violent reoffending on federal day parole has been very low in the last five years, averaging 0.1%.

Note:
*Revocation for Breach of Conditions includes revocation with outstanding charges.
A day parole is considered successful if it was completed without a return to prison for a breach of conditions or for a new offence.

THE SUCCESSFUL COMPLETION OF FEDERAL DAY PAROLE INCREASED

Table D8

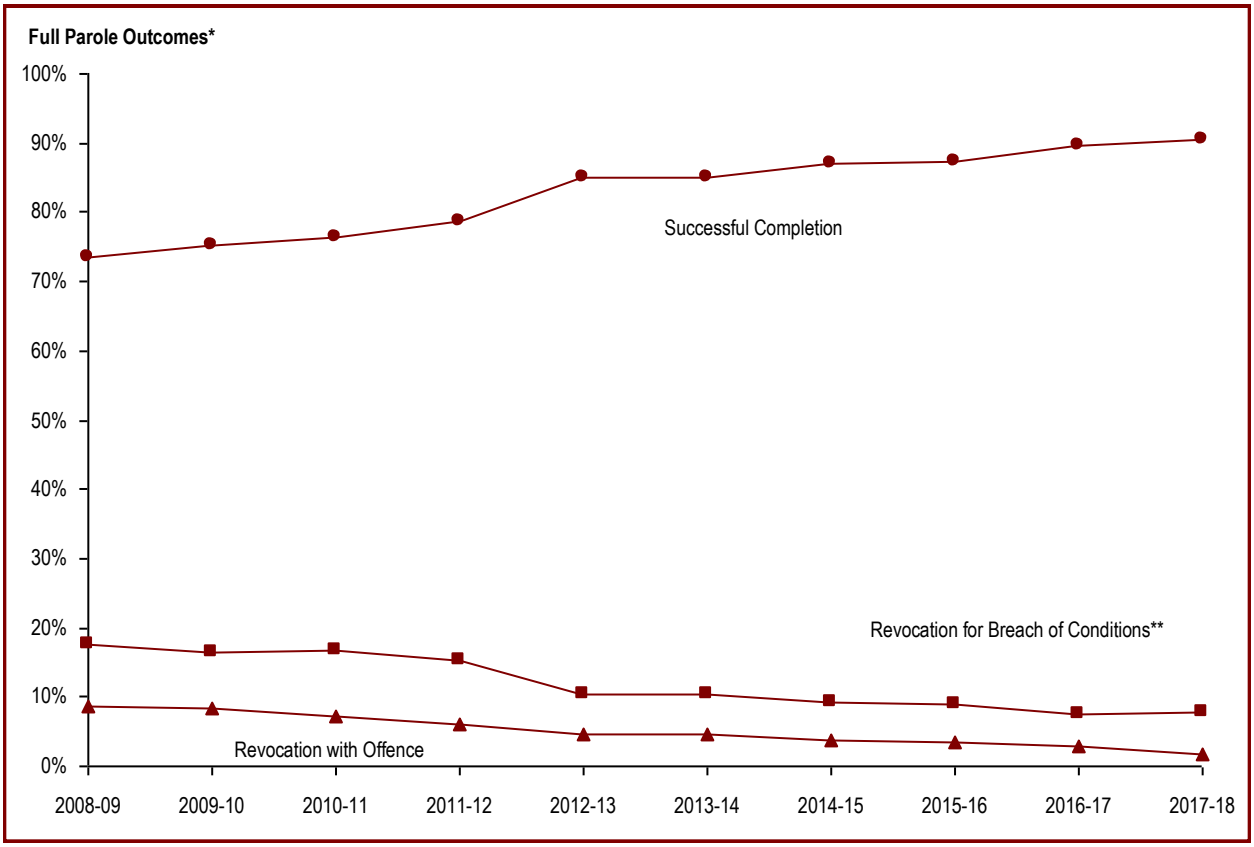
Federal Day Parole Outcomes	2013-14		2014-15		2015-16		2016-17		2017-18	
	#	%	#	%	#	%	#	%	#	%
Successful Completion										
Regular	2,766	89.2	2,784	90.4	2,981	90.5	3,171	91.6	3,452	92.2
Accelerated	27	100.0	36	100.0	38	100.0	86	97.7	84	93.3
Total	2,793	89.3	2,820	90.5	3,019	90.6	3,257	91.8	3,536	92.2
Revocation for Breach of Conditions*										
Regular	293	9.4	260	8.4	273	8.3	248	7.2	261	7.0
Accelerated	0	0.0	0	0.0	0	0.0	2	2.3	6	6.7
Total	293	9.4	260	8.3	273	8.2	250	7.0	267	7.0
Revocation with Non-Violent Offence										
Regular	36	1.2	35	1.1	32	1.0	35	1.0	31	0.8
Accelerated	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Total	36	1.2	35	1.1	32	1.0	35	1.0	31	0.8
Revocation with Violent Offence**										
Regular	6	0.2	1	<0.01	8	0.2	7	0.2	2	0.1
Accelerated	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Total	6	0.2	1	<0.01	8	0.2	7	0.2	2	0.1
Total										
Regular	3,102	99.1	3,080	98.8	3,294	98.9	3,461	97.5	3,746	97.7
Accelerated	27	0.9	36	1.2	38	1.1	88	2.5	90	2.3
Total	**3,129**	**100.0**	**3,116**	**100.0**	**3,332**	**100.0**	**3,549**	**100.0**	**3,836**	**100.0**

Source: Parole Board of Canada.

Note:
*Revocation for Breach of Conditions includes revocation with outstanding charges.
**Violent offences include murder and Schedule I offences (listed in the *Corrections and Conditional Release Act*) such as assaults, sexual offences, arson, abduction, robbery and some weapon offences.
A day parole is considered successful if it was completed without a return to prison for a breach of conditions or for a new offence.

THE SUCCESSFUL COMPLETION OF FEDERAL FULL PAROLE INCREASED

Figure D9



Source: Parole Board of Canada.

- In 2017-18, the successful completion rate on federal full parole for offenders serving determinate sentences increased 0.9 of a percentage point (to 90.5%) compared to 2016-17.
- While the average successful completion rate over the last five years (between 2013-14 and 2017-18) on federal full parole was 2.1 percentage points higher for offenders released on APR full parole than for offenders released on regular full parole (89.7%; 87.8%), the successful completion rate over the last three years has been higher for offenders released on regular full parole.
- The rate of violent reoffending on federal full parole has been decreasing in the last five years, averaging 0.5%.

Note:
*Excludes offenders serving indeterminate sentences because they do not have a warrant expiry date and can only successfully complete full parole upon [their] death.
**Revocation for Breach of Conditions includes revocation with outstanding charges.
A full parole is considered successful if it was completed without a return to prison for a breach of conditions or for a new offence.

THE SUCCESSFUL COMPLETION OF FEDERAL FULL PAROLE INCREASED

Table D9

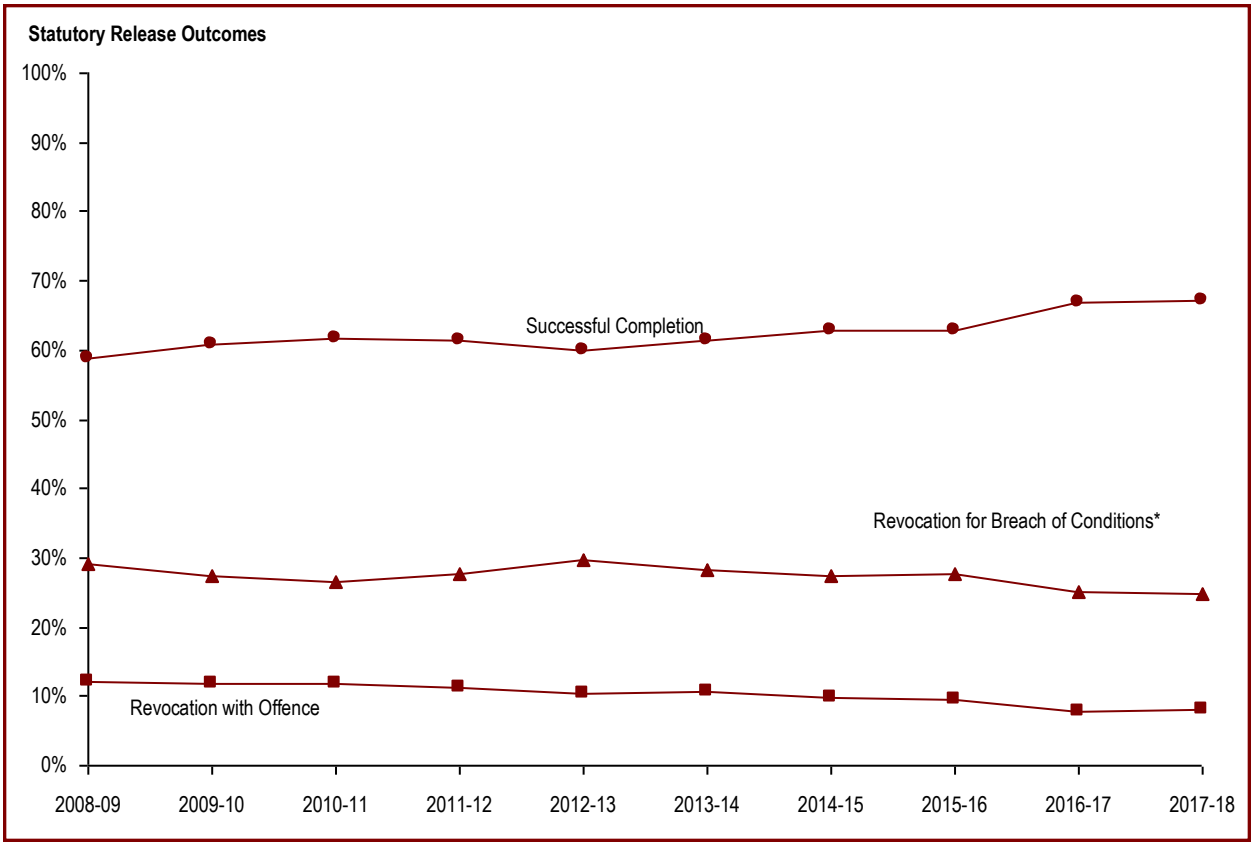
Federal Full Parole Outcomes*	2013-14		2014-15		2015-16		2016-17		2017-18	
	#	%	#	%	#	%	#	%	#	%
Successful Completion										
Regular	579	81.9	734	86.9	757	87.5	847	89.8	961	90.7
Accelerated	246	93.2	97	87.4	95	86.4	89	88.1	101	88.6
Total	825	85.0	831	86.9	852	87.4	936	89.7	1,062	90.5
Revocation for Breach of Conditions**										
Regular	90	12.7	78	9.2	76	8.8	67	7.1	81	7.6
Accelerated	12	4.5	12	9.9	12	10.9	10	9.9	10	8.8
Total	102	10.5	89	9.3	88	9.0	77	7.4	91	7.8
Revocation with Non-Violent Offence										
Regular	30	4.2	32	3.8	25	2.9	25	2.7	14	1.3
Accelerated	5	1.9	3	2.7	3	2.7	1	1.0	3	2.6
Total	35	3.6	35	3.7	28	2.9	26	2.5	17	1.4
Revocation with Violent Offence***										
Regular	8	1.1	1	0.1	7	0.8	4	0.4	3	0.3
Accelerated	1	0.4	0	0.0	0	0.0	1	1.0	0	0.0
Total	9	0.9	1	0.1	7	0.7	5	0.5	3	0.3
Total										
Regular	707	72.8	845	88.4	865	88.7	943	90.3	1,059	90.3
Accelerated	264	27.2	111	11.6	110	11.3	101	9.7	114	9.7
Total	**971**	**100.0**	**956**	**100.0**	**975**	**100.0**	**1,044**	**100.0**	**1,173**	**100.0**

Source: Parole Board of Canada.

Note:
*Excludes offenders serving indeterminate sentences because they do not have a warrant expiry date and can only successfully complete full parole upon [their] death.
**Revocation for Breach of Conditions includes revocation with outstanding charges.
***Violent offences include murder and Schedule I offences (listed in the *Corrections and Conditional Release Act*) such as assaults, sexual offences, arson, abduction, robbery and some weapon offences.
A full parole is considered successful if it was completed without a return to prison for a breach of conditions or for a new offence.

THE SUCCESSFUL COMPLETION OF STATUTORY RELEASE INCREASED

Figure D10



Source: Parole Board of Canada.

- In 2017-18, the successful completion rate of statutory release increased negligibly (+0.1%) to 67.1% compared to 2016-17.
- Over the last five years, the revocation with violent offence rates were, on average, ten times higher for offenders on statutory release than for offenders on federal day parole and three times higher than for offenders on federal full parole.
- The rate of revocation with a violent offence for statutory release has been declining in the last five years, averaging 1.5%.

Note:
*Revocation for Breach of Conditions includes revocation with outstanding charges.
A statutory release is considered successful if it was completed without a return to prison for a breach of conditions or for a new offence.
An offender serving a determinate sentence, if he/she is not detained, will be subject to statutory release after serving 2/3 of his/her sentence if he/she is not on full parole at that time. On statutory release, an offender is subject to supervision until the end of his/her sentence.

THE SUCCESSFUL COMPLETION OF STATUTORY RELEASE INCREASED

Table D10

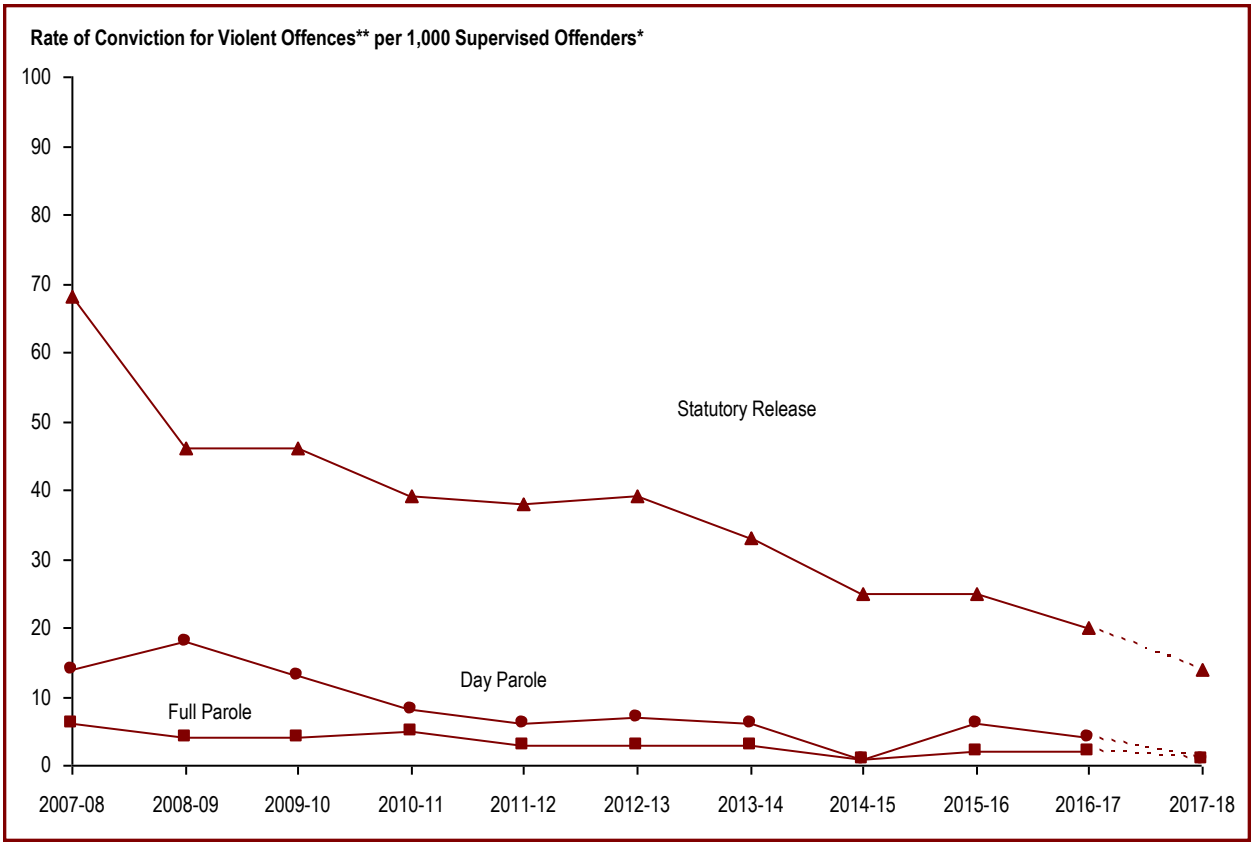
Statutory Release Outcomes	2013-14		2014-15		2015-16		2016-17		2017-78	
	#	%	#	%	#	%	#	%	#	%
Successful Completion	3,805	61.4	3,759	62.8	3,780	62.8	3,789	67.0	3,545	67.1
Revocation for Breach of Conditions*	1,740	28.1	1,648	27.5	1,668	27.7	1,417	25.1	1,307	24.7
Revocation with Non-Violent Offence	536	8.6	489	8.2	481	8.0	374	6.6	384	7.3
Revocation with Violent Offence**	118	1.9	89	1.5	91	1.5	75	1.3	50	0.9
Total	**6,199**	**100.0**	**5,985**	**100.0**	**6,020**	**100.0**	**5,655**	**100.0**	**5,286**	**100.0**

Source: Parole Board of Canada.

Note:
*Revocation for Breach of Conditions includes revocation with outstanding charges.
**Violent offences include murder and Schedule I offences (listed in the *Corrections and Conditional Release Act*) such as assaults, sexual offences, arson, abduction, robbery and some weapon offences.
A statutory release is considered successful if it was completed without a return to prison for a breach of conditions or for a new offence.
An offender serving a determinate sentence, if he/she is not detained, will be subject to statutory release after serving 2/3 of his/her sentence if he/she is not on full parole at that time. On statutory release, an offender is subject to supervision until the end of his/her sentence.

OVER THE PAST DECADE, THE RATE OF VIOLENT CONVICTIONS FOR OFFENDERS WHILE UNDER SUPERVISION HAS DECLINED

Figure D11



Source: Parole Board of Canada.

- Over the last ten years (between 2007-08 and 2016-17), the number of convictions for a violent offence decreased 65% for offenders on federal conditional release (from 255 in 2007-08 to 90 in 2016-17). Day parolees averaged 11 convictions for violent offences annually and full parolees, 13 convictions, compared to 129 by offenders on statutory release.
- Over the last ten years (between 2007-08 and 2016-17), convictions for violent offences on statutory release accounted for 85% of all convictions by offenders on federal conditional release.
- When comparing the rates of conviction for violent offences per 1,000 supervised offenders (between 2007-08 and 2016-17), offenders on statutory release were 11 and a half times more likely to commit a violent offence during their supervision periods than offenders on full parole, and 4 and a half times more likely to commit a violent offence than offenders on day parole.

Note:
*Supervised offenders include offenders who are on parole, statutory release, those temporarily detained in federal institutions, and those who are unlawfully at large.
**Violent offences include murder and Schedule I offences (listed in the *Corrections and Conditional Release Act*) such as assaults, sexual offences, arson, abduction, robbery and some weapon offences.
Day and full parole include those offenders serving determinate and indeterminate sentences.
The dotted line between 2016-17 and 2017-18 is intended to signify that due to delays in the court process, these numbers under-represent the actual number of convictions, as verdicts may have not been reached by year-end.

OVER THE PAST DECADE, THE RATE OF VIOLENT CONVICTIONS FOR OFFENDERS WHILE UNDER SUPERVISION HAS DECLINED

Table D11

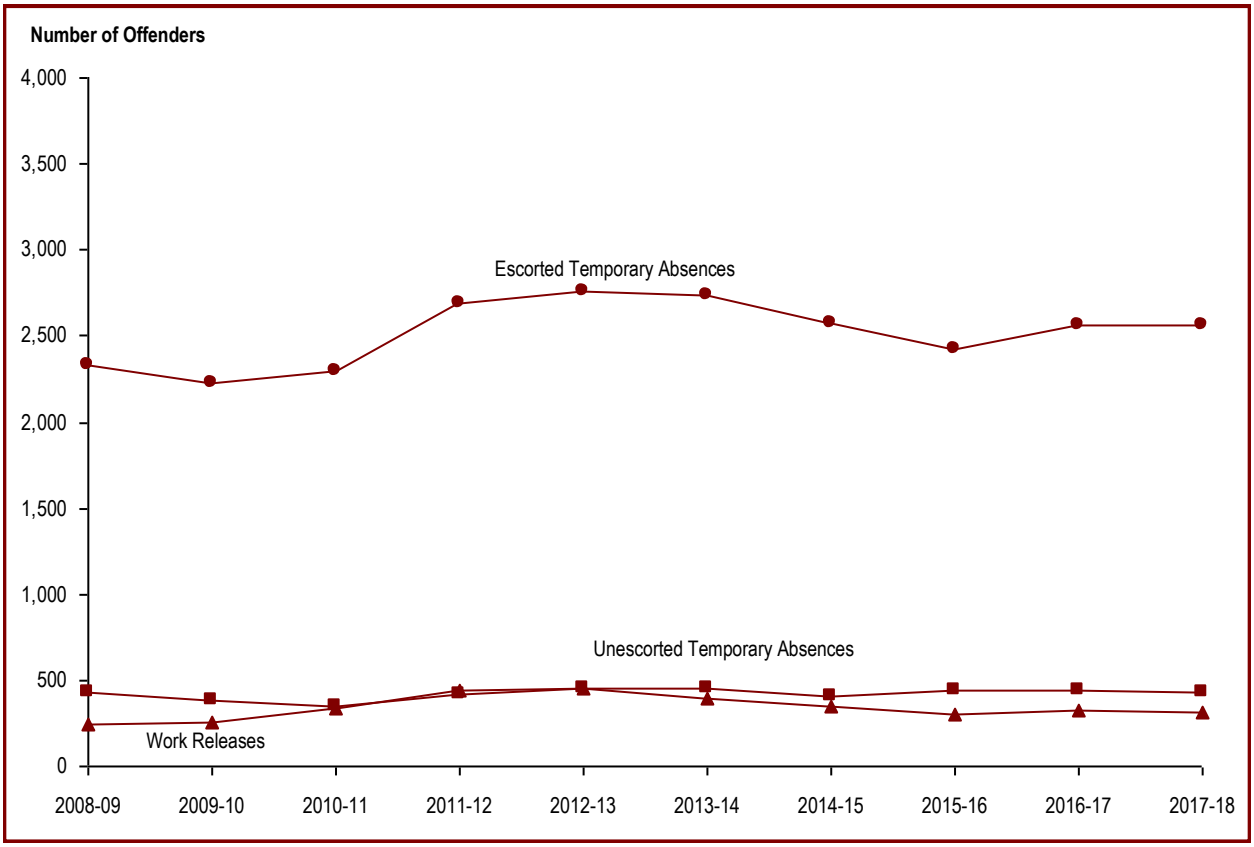
Year	# of Offenders Convicted for Violent Offences***				Rate per 1,000 Supervised Offenders*		
	Day Parole	Full Parole	Statutory Release	Total	Day Parole	Full Parole	Statutory Release
2007-08	18	23	214	255	14	6	68
2008-09	22	17	153	192	18	4	46
2009-10	17	16	149	182	13	4	46
2010-11	10	19	128	157	8	5	39
2011-12	8	10	135	153	6	3	38
2012-13	9	11	136	156	7	3	39
2013-14	7	10	118	135	6	3	33
2014-15	1	4	89	94	1	1	25
2015-16	8	9	91	108	6	2	25
2016-17	7	8	75	90	4	2	20
2017-18**	2	3	50	55	1	1	14

Source: Parole Board of Canada.

Note:
*Supervised offenders include offenders who are on parole, statutory release, those temporarily detained in federal institutions, and those who are unlawfully at large.
**Due to delays in the court processes, the numbers under-represent the actual number of convictions, as verdicts may not have been reached by year-end. Day and full parole include those offenders serving determinate and indeterminate sentences.
***Violent offences include murder and Schedule I offences (listed in the *Corrections and Conditional Release Act*) such as assaults, sexual offences, arson, abduction, robbery and some weapon offences.

THE NUMBER OF OFFENDERS GRANTED TEMPORARY ABSENCES

Figure D12



Source: Correctional Service Canada.

- There was a small increase in the number of offenders receiving escorted temporary absences, from 2,546 in 2016-17 to 2,567 in 2017-18. There was a small decrease in the number of offenders receiving unescorted temporary absences, from 443 in 2016-17 to 428 in 2017-18.
- The number of offenders receiving work releases has decreased by 3.7%, from 324 in 2016-17 to 312 in 2017-18.
- For the past 10 years, the average successful completion rates for escorted temporary absences was 99.5%, 98.8% for unescorted temporary absences and 94.6% for work releases.

Note:
A *temporary absence* is permission given to an eligible offender to be away from the normal place of confinement for medical, administrative, community service, family contact, personal development for rehabilitative purposes, or compassionate reasons, including parental responsibilities.
A *work release* is a structure program of release of specified duration for work or community service outside the penitentiary, under the supervision of a staff member or other authorized person or organization.
These numbers depict the number of offenders who received at least one temporary absence permit (excluding those for medical purposes) or at least one work release. An offender may be granted more than one temporary absence permit or work release over a period of time.

THE NUMBER OF OFFENDERS GRANTED TEMPORARY ABSENCES

Table D12

Year	Temporary Absences				Work Releases	
	Escorted		Unescorted			
	# of Offenders	# of Permits	# of Offenders	# of Permits	# of Offenders	# of Permits
2008-09	2,336	36,137	432	3,659	243	663
2009-10	2,222	35,816	388	3,295	254	1,063
2010-11	2,301	40,074	353	3,117	339	1,343
2011-12	2,685	44,399	418	3,891	435	875
2012-13	2,753	47,815	448	3,709	455	815
2013-14	2,740	49,502	447	4,004	400	643
2014-15	2,574	49,633	411	3,563	346	490
2015-16	2,428	47,084	445	4,078	304	418
2016-17	2,546	48,590	443	3,798	324	482
2017-18	2,567	50,711	428	3,190	312	445

Source: Correctional Service Canada.

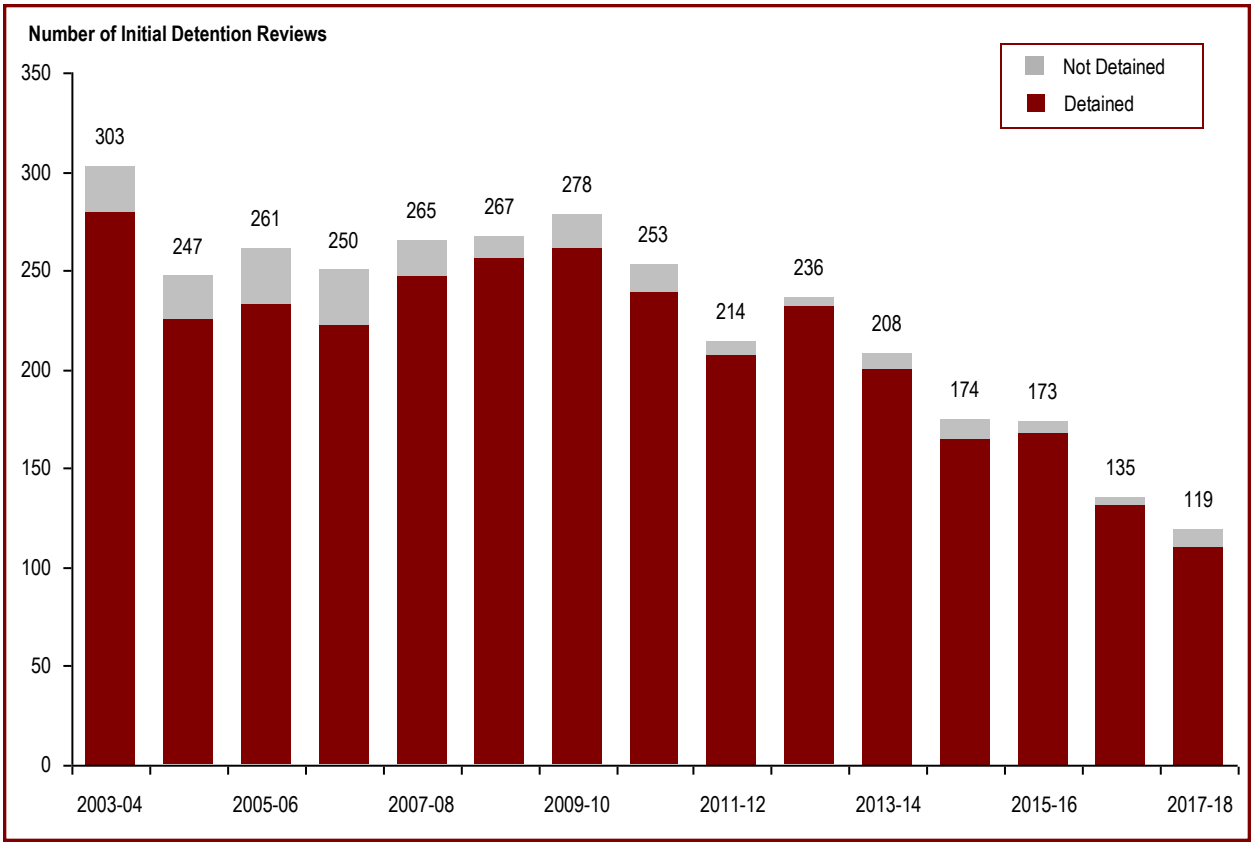
Note:
A *temporary absence* is permission given to an eligible offender to be away from the normal place of confinement for medical, administrative, community service, family contact, personal development for rehabilitative purposes, or compassionate reasons, including parental responsibilities.
A *work release* is a structured program of release of specified duration for work or community service outside the penitentiary, under the supervision of a staff member or other authorized person or organization.
These numbers depict the number of offenders who received at least one temporary absence permit (excluding those for medical purposes) or at least one work release. An offender may be granted more than one temporary absence permit or work release over a period of time.

SECTION E

STATISTICS ON SPECIAL APPLICATIONS OF CRIMINAL JUSTICE

THE NUMBER OF INITIAL DETENTION REVIEWS DECREASED

Figure E1



Source: Parole Board of Canada.

- In 2017-18, the number of referrals for detention decreased by 12% to 119 (from 135) when compared to 2016-17.
- The numbers of offenders detained as a result of a detention review decreased to 110 (-16%) compared to the previous year, while the proportion decreased to 92.4%. Nine offenders were released on statutory release following a detention review in 2017-18.
- Averaged over the last five years, the detention rate for Indigenous offenders was 94.6% compared to 96.1% for non-Indigenous offenders. Nineteen Indigenous offenders and eighteen non-Indigenous offenders were released on statutory release in the last five years.
- In 2017-18, Indigenous offenders accounted for 27.7% of federal incarcerated offenders serving determinate sentences while they accounted for 47.9% of offenders referred for detention and 42.9% of offenders detained.

Note:
According to the *Corrections and Conditional Release Act*, an offender entitled to statutory release after serving two-thirds of the sentence may be held in custody until warrant expiry if it is established that the offender is likely to commit, before the expiry of his/her sentence, an offence causing death or serious harm, a serious drug offence or a sex offence involving a child.

THE NUMBER OF INITIAL DETENTION REVIEWS DECREASED

Table E1

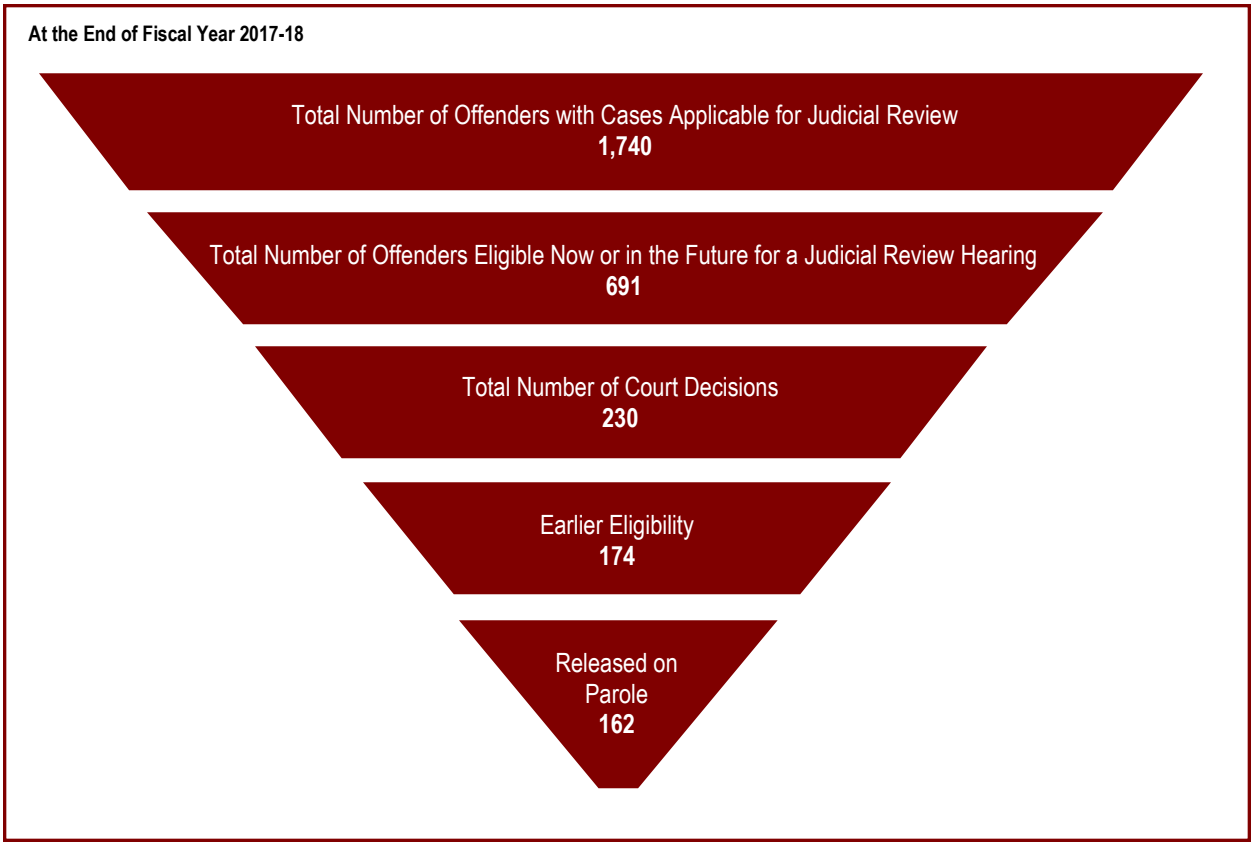
Year	Outcome of Initial Detention Reviews										Total
	Detained				Statutory Release				Total		
	Ind.	Non - Ind.	Total	%	Ind.	Non - Ind.	Total	%	Ind.	Non - Ind.	
2003-04	76	203	279	92.1	8	16	24	7.9	84	219	**303**
2004-05	71	154	225	91.1	6	16	22	8.9	77	170	**247**
2005-06	75	158	233	89.3	11	17	28	10.7	86	175	**261**
2006-07	65	157	222	88.8	4	24	28	11.2	69	181	**250**
2007-08	91	156	247	93.2	7	11	18	6.8	98	167	**265**
2008-09	107	149	256	95.9	5	6	11	4.1	112	155	**267**
2009-10	99	162	261	93.9	2	15	17	6.1	101	177	**278**
2010-11	113	126	239	94.5	5	9	14	5.5	118	135	**253**
2011-12	88	119	207	96.7	3	4	7	3.3	91	123	**214**
2012-13	92	140	232	98.3	4	0	4	1.7	96	140	**236**
2013-14	85	115	200	96.2	4	4	8	3.8	89	119	**208**
2014-15	67	97	164	94.3	5	5	10	5.7	72	102	**174**
2015-16	73	94	167	96.5	2	4	6	3.5	75	98	**173**
2016-17	56	75	131	97.0	2	2	4	3.0	58	77	**135**
2017-18	51	59	110	92.4	6	3	9	7.6	57	62	**119**
Total	**1,209**	**1,964**	**3,173**	**93.8**	**74**	**136**	**210**	**6.2**	**1,283**	**2,100**	**3,383**

Source: Parole Board of Canada.

Note:
According to the *Corrections and Conditional Release Act*, an offender entitled to statutory release after serving two-thirds of the sentence may be held in custody until warrant expiry if it is established that the offender is likely to commit, before the expiry of his/her sentence, an offence causing death or serious harm, a serious drug offence or a sex offence involving a child.

76% OF JUDICIAL REVIEW HEARINGS RESULT IN EARLIER PAROLE ELIGIBILITY

Figure E2



Source: Correctional Service Canada.

- Since the first judicial review hearing in 1987, there have been a total of 230 court decisions.
- Of these cases, 75.7% of the court decisions resulted in a reduction of the period that must be served before parole eligibility.
- Of the 691 offenders eligible to apply for a judicial review, 275 had already served 15 years of their sentence, whereas 416 had not.
- Of the 174 offenders who had their parole eligibility date moved closer, 171 had reached their revised Day Parole eligibility date. Of these offenders, 162 were released on parole, and 113 were being actively supervised in the community*.
- A higher percentage of second degree (83.3%) than first degree (74.8%) murder cases have resulted in a reduction of the period required to be served before parole eligibility.

Note:
*Of the 49 offenders no longer under active supervision, 7 were in custody, 34 were deceased, 6 were deported, and 2 were temporarily detained.
Judicial review is an application to the court for a reduction in the time required to be served before being eligible for parole. Judicial review procedures apply to offenders who committed the offences prior to December 2, 2011 and have been sentenced to imprisonment for life without eligibility for parole for 15 years or more. Judicial reviews exclude offenders convicted of more than one murder. Eligible offenders can apply for a reduction in parole ineligibility when they have served at least 15 years of their sentence.
Judicial reviews are conducted in the province where the conviction took place.

76% OF JUDICIAL REVIEW HEARINGS RESULT IN EARLIER PAROLE ELIGIBILITY

Table E2

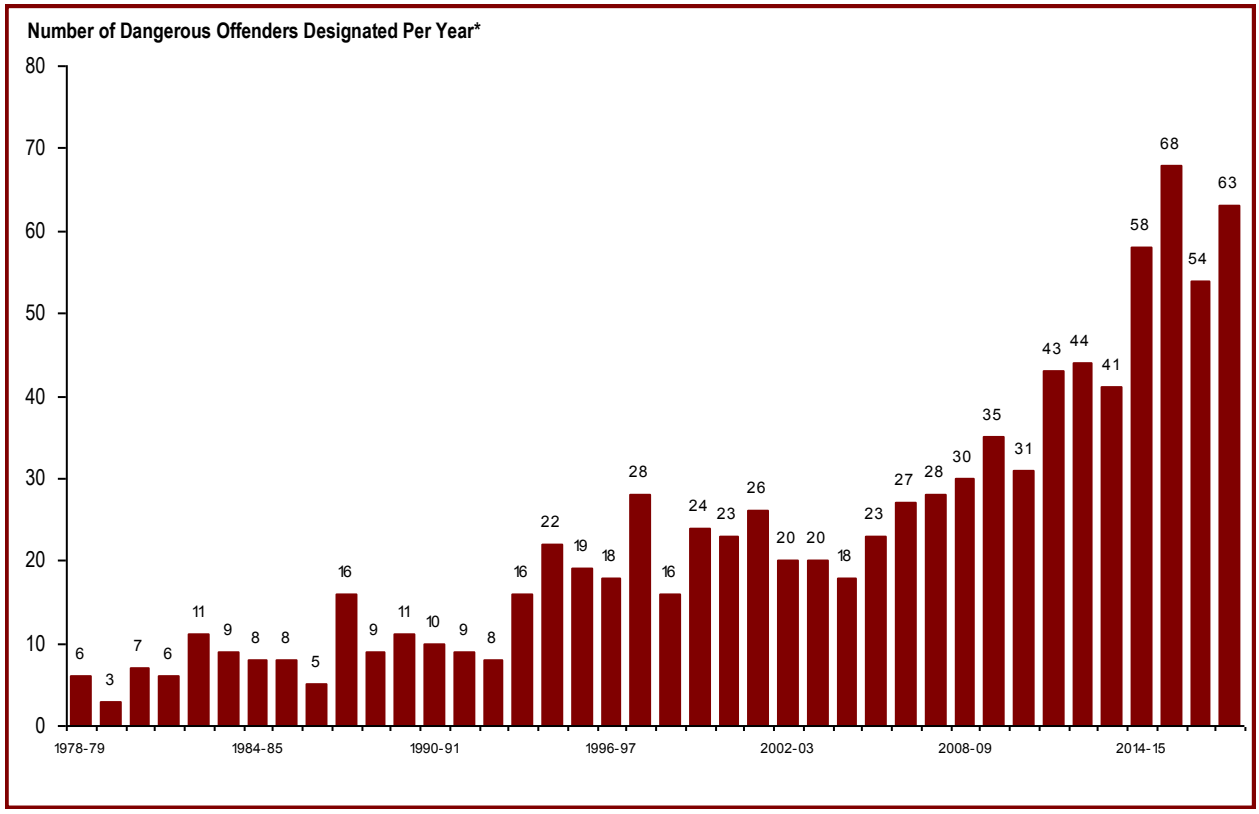
Province/Territory of Judicial Review	Parole Ineligibility Reduced by Court		Reduction Denied by Court		Total	
	1st Degree Murder	2nd Degree Murder	1st Degree Murder	2nd Degree Murder	1st Degree Murder	2nd Degree murder
Northwest Territories	0	0	0	0	0	0
Nunavut	0	0	0	0	0	0
Yukon Territories	0	0	0	0	0	0
Newfoundland & Labrador	0	0	0	0	0	0
Prince Edward Island	0	0	0	0	0	0
Nova Scotia	1	1	1	0	2	1
New Brunswick	1	0	0	0	1	0
Quebec	73	15	6	2	79	17
Ontario	23	0	28	1	51	1
Manitoba	8	3	1	0	9	3
Saskatchewan	7	0	3	0	10	0
Alberta	19	0	7	1	26	1
British Columbia	22	1	6	0	28	1
Sub-total	**154**	**20**	**52**	**4**	**206**	**24**
Total	**174**		**56**		**230**	

Source: Correctional Service Canada.

Note:
These numbers represent total decisions at the end of fiscal year 2017-18.
Judicial reviews are conducted in the province where the conviction took place.

THE NUMBER OF DANGEROUS OFFENDER DESIGNATIONS

Figure E3



Source: Correctional Service Canada.

- At the end of fiscal year 2017-18, there have been 921 offenders designated as Dangerous Offenders (DOs) since 1978. Of these, 67.9% had at least one current conviction for a sexual offence.
- At the end of fiscal year 2017-18, there were 792 DOs under the responsibility of Correctional Service Canada, and of those, 81.3% had indeterminate sentences.
- Of these 792 DOs, 712 were in custody (representing 5.1% of the In-Custody Population) and 80 were in the community under supervision.
- There were eight women with a Dangerous Offender designation.
- Indigenous offenders accounted for 35.5% of DOs and 24.0% of the total offender population.

Note:
The number of Dangerous Offenders designated per year does not include overturned decisions.
Offenders who have died since receiving designations are no longer classified as "active"; however, they are still represented in the above graph, which depicts the total number of offenders '"designated". Dangerous Offender legislation came into effect in Canada on October 15, 1977, replacing the Habitual Offender and Dangerous Sexual Offender provisions that were abolished. A Dangerous Offender (DO) is an individual given an indeterminate or *determinate sentence on the basis of a particularly violent crime or pattern of serious violent offences where it is judged that the offender's behaviour is unlikely to be inhibited by normal standards of behavioural restraint (see section 753 of the *Criminal Code of Canada*).
In addition to the DOs, there were 15 Dangerous Sexual Offenders and 3 Habitual Offenders under the responsibility of CSC at the end of fiscal year 2017-18.
*Determinate sentences for Dangerous Offenders must be a minimum punishment of imprisonment for a term of two years and have an order that the offender be subject to a long-term supervision period that does not exceed 10 years.

THE NUMBER OF DANGEROUS OFFENDER DESIGNATIONS

Table E3

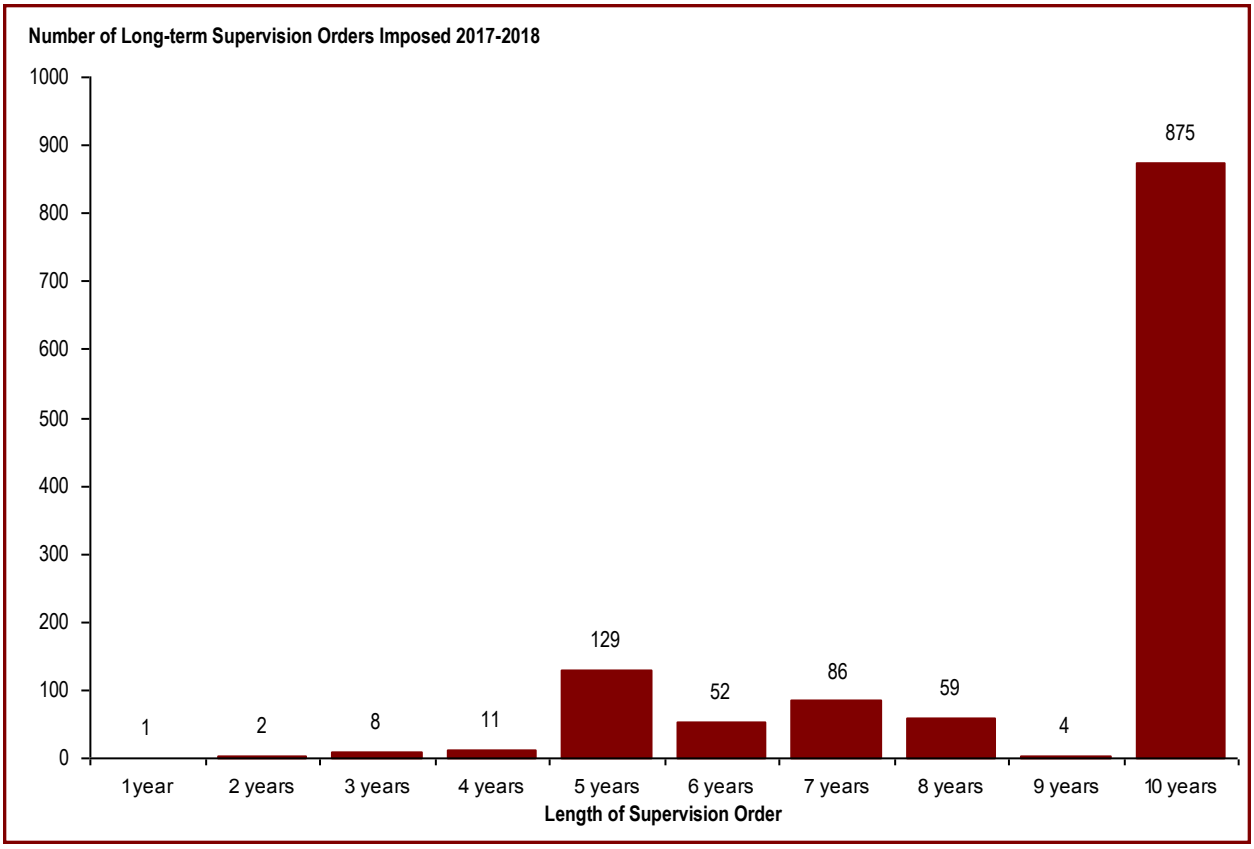
Province/Territory of Designation	All Designations (# Designated Since 1978)	Active Dangerous Offenders		
		# of Indeterminate Offenders	# of Determinate Offenders	Total
Newfoundland & Labrador	13	8	1	9
Nova Scotia	25	19	2	21
Prince Edward Island	0	0	0	0
New Brunswick	8	4	0	4
Quebec	116	91	16	107
Ontario	391	263	72	335
Manitoba	29	26	2	28
Saskatchewan	98	56	33	89
Alberta	65	52	3	55
British Columbia	156	111	13	124
Yukon Territories	7	2	5	7
Northwest Territories	11	11	0	11
Nunavut	2	1	1	2
Total	**921**	**644**	**148**	**792**

Source: Correctional Service Canada.

Note:
Numbers presented are as of end of fiscal year 2017-18.
The number of Dangerous Offenders declared per year does not include overturned decisions.
Offenders who have died since receiving designations are no longer classified as “active”; however, they are still represented in the total number of offenders “designated”.

MOST LONG-TERM SUPERVISION ORDERS ARE FOR A 10-YEAR PERIOD

Figure E4



Source: Correctional Service Canada.

- At the end of fiscal year 2017-18, the courts had imposed 1,227 long-term supervision orders. Of these, 71.3% were for a period of 10 years.
- At the end of fiscal year 2017-18, there were 880 offenders with long-term supervision orders under the responsibility of Correctional Services Canada, and of these, 565 (64.2%) had at least one current conviction for a sexual offence.
- There were 17 women with long-term supervision orders.
- There were 450 offenders being supervised in the community on their long-term supervision orders at the end of fiscal year 2017-18. Of these, 396 offenders were supervised in the community, seven offenders were temporarily detained, 42 offenders were on remand, four offenders were unlawfully at large for less than 90 days and one offender was supervised and subject to an immigration hold by Canada Border Services Agency.

Note:
Long-term Supervision Order (LTSO) legislation, which came into effect in Canada on August 1, 1997, allows the court to impose a sentence of two years or more for the predicate offence and order that the offender be supervised in the community for a further period not exceeding 10 years.
Seventy five offenders under these provisions have died, and 210 offenders have completed their long-term supervision period.
Remand is the temporary detention of a person while awaiting trial, sentencing or the commencement of a custodial disposition.

MOST LONG-TERM SUPERVISION ORDERS ARE FOR A 10-YEAR PERIOD

Table E4

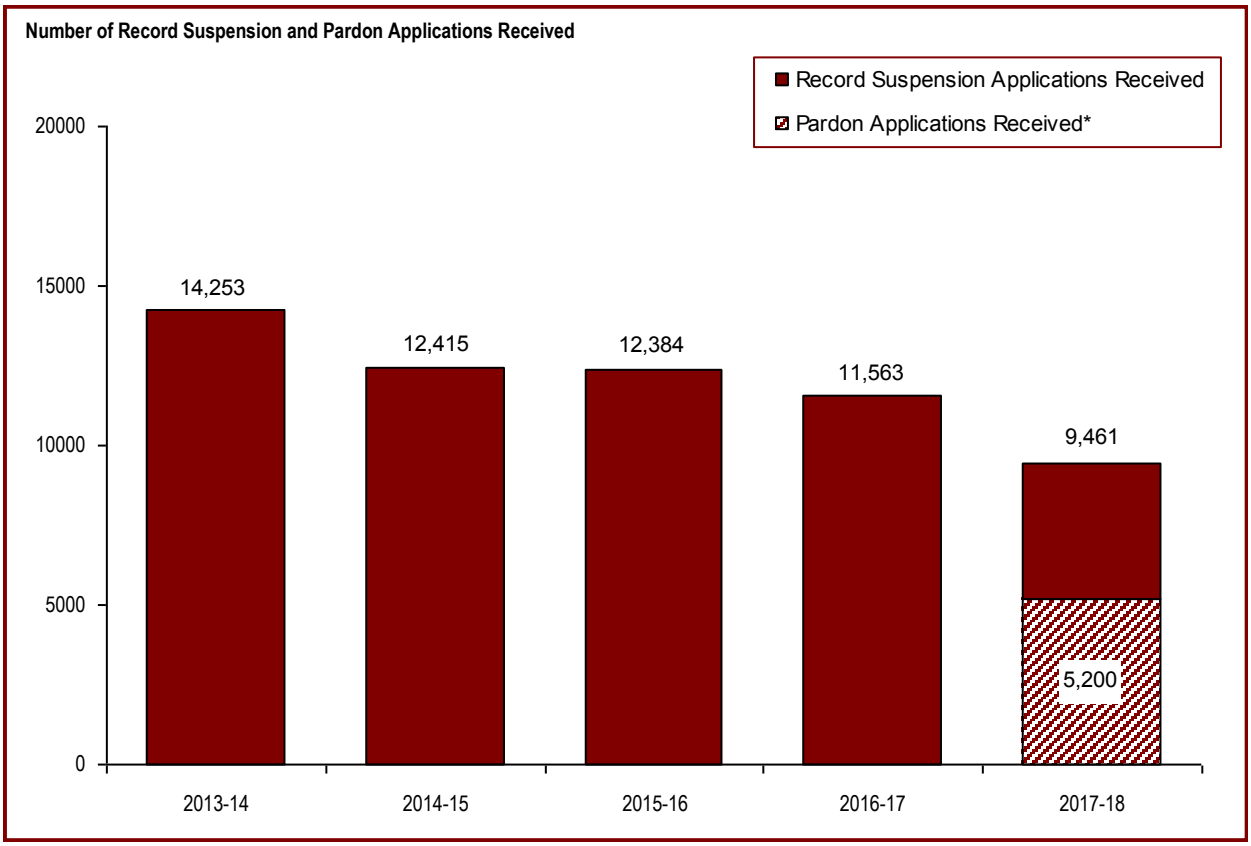
Province or Territory of Order	Length of Supervision Order (Years)											Current Status 2017-2018				
	1	2	3	4	5	6	7	8	9	10	Total	Incarcerated	DP, FP or SR*	LTSO period	LTSO** interrupted	**Total**
Newfoundland & Labrador	0	0	0	0	0	0	0	1	0	10	11	3	0	6	0	**9**
Nova Scotia	0	0	0	0	5	0	1	2	0	13	21	3	1	10	0	**14**
Prince Edward Island	0	0	0	0	1	0	0	0	0	1	2	0	0	0	0	**0**
New Brunswick	0	0	1	0	2	0	0	1	0	8	12	2	1	2	2	**7**
Quebec	1	1	7	2	63	18	40	12	2	258	404	108	19	143	22	**292**
Ontario	0	0	0	6	20	15	21	23	0	275	360	73	14	152	27	**266**
Manitoba	0	0	0	0	1	2	3	1	0	37	44	6	0	12	7	**25**
Saskatchewan	0	1	0	1	11	9	13	11	2	70	118	48	3	30	14	**95**
Alberta	0	0	0	0	8	1	0	1	0	67	77	13	3	27	6	**49**
British Columbia	0	0	0	2	14	5	5	6	0	116	148	35	4	56	6	**101**
Yukon Territories	0	0	0	0	1	0	3	0	0	15	19	8	0	7	0	**15**
Northwest Territories	0	0	0	0	1	1	0	0	0	2	4	1	0	1	0	**2**
Nunavut	0	0	0	0	2	1	0	1	0	3	7	0	0	4	1	**5**
Total	**1**	**2**	**8**	**11**	**129**	**52**	**86**	**59**	**4**	**875**	**1,227**	**300**	**45**	**450**	**85**	**880**

Source: Correctional Service Canada.

Note:
* This category includes offenders whose current status is either supervised on day parole (DP), full parole (FP) or statutory release (SR).
** This category includes offenders convicted of a new offence while on the supervision portion of an LTSO. When this occurs, the LTSO supervision period is interrupted until the offender has served the new sentence to its warrant expiry date. At that time, the LTSO supervision period resumes where it left off. From the 85, 69 offenders were in custody, 15 were supervised in the community on statutory release and 1 offender was on remand.
Long-term Supervision Order (LTSO) legislation, which came into effect in Canada on August 1, 1997, allows the court to impose a sentence of two years or more for the predicate offence and order that the offender be supervised in the community for a further period not exceeding 10 years.
75 offenders under these provisions have died, and 210 offenders have completed their long-term supervision period.
Remand is the temporary detention of a person while awaiting trial, sentencing or the commencement of a custodial disposition.

THE NUMBER OF RECORD SUSPENSION APPLICATIONS RECEIVED HAS DECREASED

Figure E5



Source: Parole Board of Canada.

- In 2017-18, the Parole Board received 9,461 record suspension applications and accepted 6,529 applications for processing as record suspensions and 638, as pardons (Ontario and British Columbia cases). The Board also received 5,200 pardon applications and accepted 4,429 pardon applications for processing. The acceptance rate was 79.1%.
- In 2017-18, the Board rendered 2,089 pardon decisions, granting a pardon in 93.6% of cases and denying a pardon in 6.4% of cases.
- In 2017-18, the Board made 7,180 record suspension decisions; 98% of record suspensions were ordered and 2% were refused.
- Since 1970, when the pardon/record suspension process began, 525,187 pardons/record suspensions have been granted/issued and ordered.

Note:
*Refers to pardon applications processed for residents of Ontario and British Columbia following the reversal of the amendments to the CRA (Canada Revenue Agency) by Supreme Court decisions in those provinces.
On March 13, 2012, Bill C-10 amended the *CRA* by replacing the term "pardon" with the term "record suspension". The Record Suspension and Clemency program involves the review of record suspension applications, the ordering of record suspensions and the making of clemency recommendations. The amendments to the *CRA* increased the waiting periods for a record suspension to five years for all summary convictions and to ten years for all indictable offences. Individuals convicted of sexual offences against minors (with certain exceptions) and those who have been convicted of more than three indictable offences, each with a sentence of two or more years, became ineligible for a record suspension.

THE NUMBER OF RECORD SUSPENSION APPLICATIONS RECEIVED HAS DECREASED

Table E5

Record Suspension Applications Processed	2013-14	2014-15	2015-16	2016-17	2017-18
Applications Received	14,253	12,415	12,384	11,563	9,461
Applications Accepted	9,624	9,071	8,917	8,191	7,167[1]
% Accepted	67.5	73.1	72.0	70.8	75.8
Record Suspensions					
Ordered	8,511	8,422	8,428	8,340	7,038
Refused	772	726	525	439	142
Total Ordered/Refused	9,283	9,148	8,953	8,779	7,180
% Ordered	91.7	92.1	94.1	95.0	98.0
Pardon Applications Processed					
Applications Received	- -	- -	- -	- -	5,200[2]
Applications Accepted	- -	- -	- -	- -	4,429[2]
% Accepted	- -	- -	- -	- -	85.2
Pardons					
Granted	8,265	5,625	1,628	3,740	222
Issued	- -	- -	- -	- -	1,734
Denied	581	681	349	125	133
Total Granted/Issued/Denied	8,846[3]	6,306[3]	1,977[3]	3,865[3]	2,089[2]
% Granted	93.4	89.2	82.3	96.8	93.6
Pardon/Record Suspension Revocations/Cessations					
Revocations[4]	669	438	670	501	85
Cessations	589	578	636	776	692
Total Revocations/Cessations	1,258	1,016	1,306	1,277	777
Cumulative Granted/Issued and Ordered[5]	480,010	494,057	504,113	516,193	525,187
Cumulative Revocations/Cessations[5]	22,321	23,337	24,643	25,920	26,697

Source: Parole Board of Canada.

Note:

[1] Includes 638 record suspension applications that were discontinued and reclassified as pardon applications for residents of Ontario and British Columbia following the reversal of amendments to the CRA by Supreme Court decisions in those provinces.

[2] Refers to pardon applications processed for residents of Ontario and British Columbia following the reversal of the amendments to the CRA by Supreme Court decisions in those provinces.

[3] Refers to pardon applications received on or before March 12, 2012 (C-10).

[4] Revocations fluctuate due to resource re-allocation to deal with backlogs.

[5] Cumulative data reflects activity since 1970, when the pardon process was established under the *Criminal Records Act.*

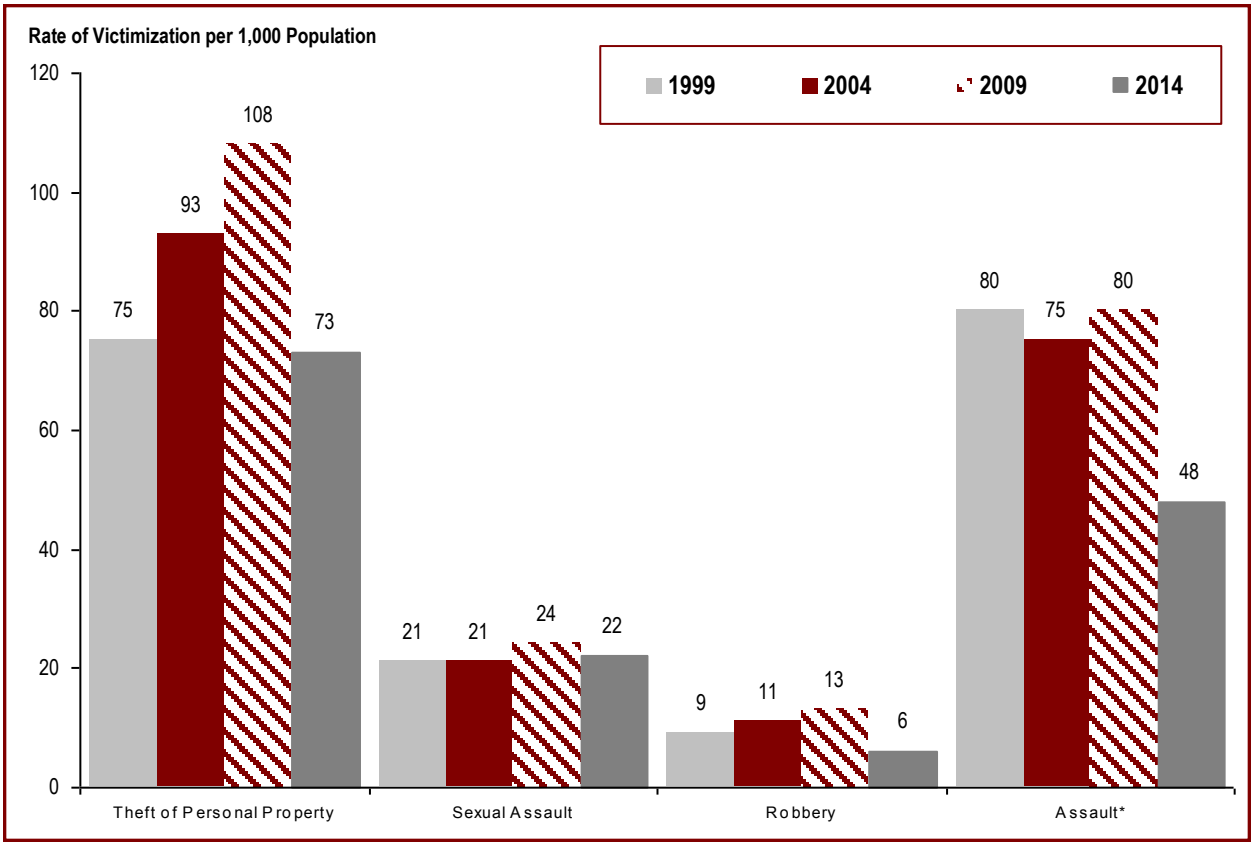
On June 29, 2010, Bill C-23A amended the *CRA* by extending the ineligibility periods for certain applications for pardon. Additionally, the bill resulted in significant changes to program operations. The process was modified to include additional inquiries and new, more exhaustive investigations by staff for some applications and required additional review time by Board members. New concepts of merit and disrepute to the administration of justice form part of the statute. As a result of these new changes, application processing time increased. On March 13, 2012, Bill C-10 amended the *CRA* by replacing the term "pardon" with the term "record suspension". The Record Suspension and Clemency program involves the review of record suspension applications, the ordering of record suspensions and the making of clemency recommendations. The amendments to the *CRA* increased the waiting periods for a record suspension to five years for all summary convictions and to ten years for all indictable offences. Individuals convicted of sexual offences against minors (with certain exceptions) and those who have been convicted of more than three indictable offences, each with a sentence of two or more years, became ineligible for a record suspension.

SECTION F

VICTIMS OF CRIME

VICTIMIZATION RATES FOR THEFT OF PERSONAL PROPERTY AND ASSAULT DECREASED IN 2014

Figure F1



Source: General Social Survey, Statistics Canada, 1999, 2004, 2009 and 2014.

- Victimization rates for theft of personal property were lower in 2014 than in previous years.
- Victimization rates for assault were lower in 2014 than in previous years.
- Since 1999, the rates of victimization for sexual assault have remained stable.

Note:
The General Social Survey is administered every five years by Statistics Canada. Updated data were not available during the preparation of this report. It is anticipated that updated data will be available in 2020.
*Assault data includes incidents of spousal violence. In previous editions of this document, the victimization data excluded incidents of spousal violence. Rates are based on 1,000 population, 15 years of age and older, across the 10 provinces.

VICTIMIZATION RATES FOR THEFT OF PERSONAL PROPERTY AND ASSAULT DECREASED IN 2014

Table F1

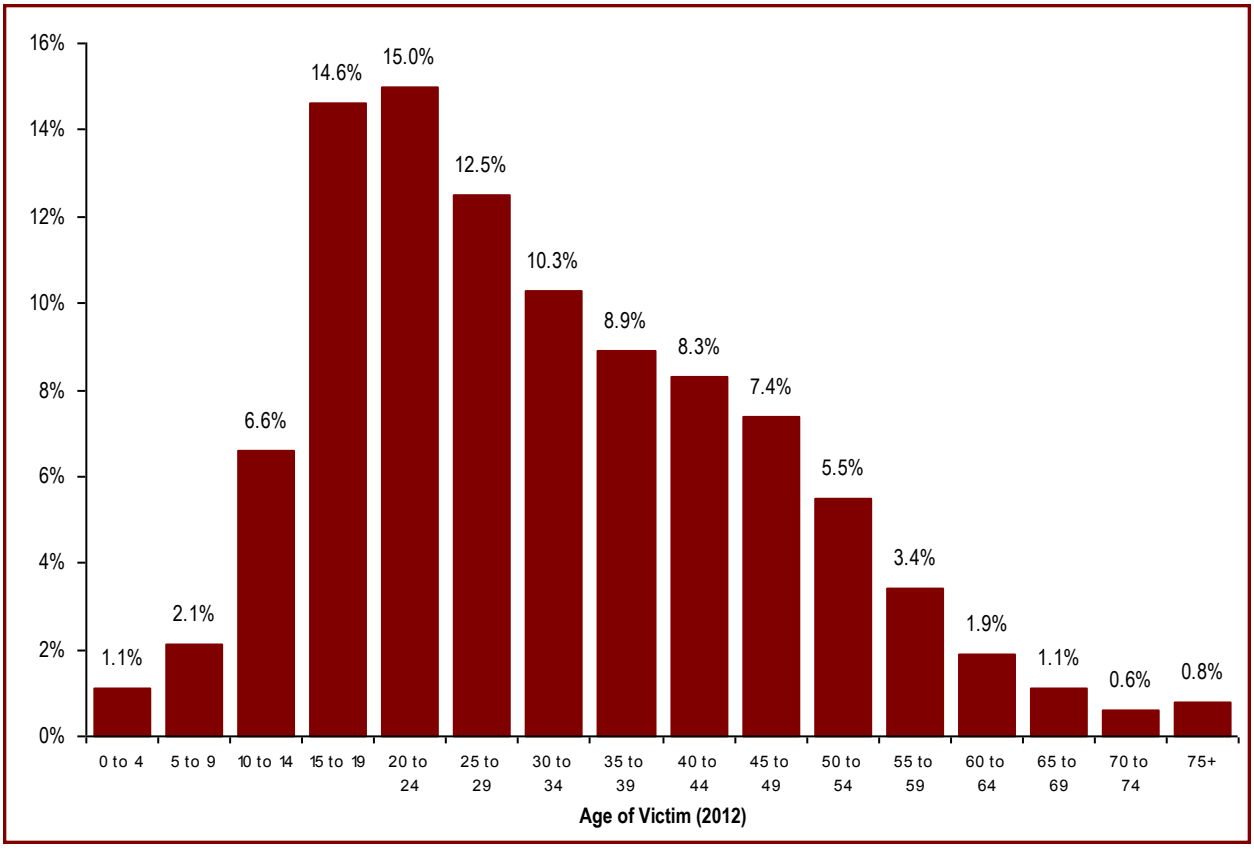
Type of Incident	Year			
	1999	2004	2009	2014
Theft of Personal Property	75	93	108	73
Sexual Assault	21	21	24	22
Robbery	9	11	13	6
Assault*	80	75	80	48

Source: General Social Survey, Statistics Canada, 1999, 2004, 2009 and 2014.

Note:
The General Social Survey is administered every five years by Statistics Canada. Updated data were not available during the preparation of this report. It is anticipated that updated data will be available in 2020.
*Assault data includes incidents of spousal violence. In previous editions of this document, the victimization data excluded incidents of spousal violence. Rates are based on 1,000 population, 15 years of age and older, across the 10 provinces.

THE MAJORITY OF VICTIMS OF VIOLENT CRIME ARE UNDER AGE 30

Figure F2



Source: Incident-based Uniform Crime Reporting Survey, Canadian Centre for Justice Statistics, Statistics Canada.

- More than half (51.9%) of all victims of violent crime reported in 2012 were under the age of 30, whereas 36.9% of the Canadian population is under the age of 30*.
- Women aged 15 to 39 were more likely than men of that age to be victims of crime.
- Canadians aged 65 and older, who account for 14.1% of the general population*, represent 2.4% of victims of crime.

Note:
Updated data were not available during the preparation of this report.
*Population estimates are as of July 1, 2010.
The data excludes traffic violations, victims whose age is above 89, victims whose age is unknown and victims whose gender is unknown.
Due to rounding, totals may not add up to 100 percent.

THE MAJORITY OF VICTIMS OF VIOLENT CRIME ARE UNDER AGE 30

Table F2 (2012)

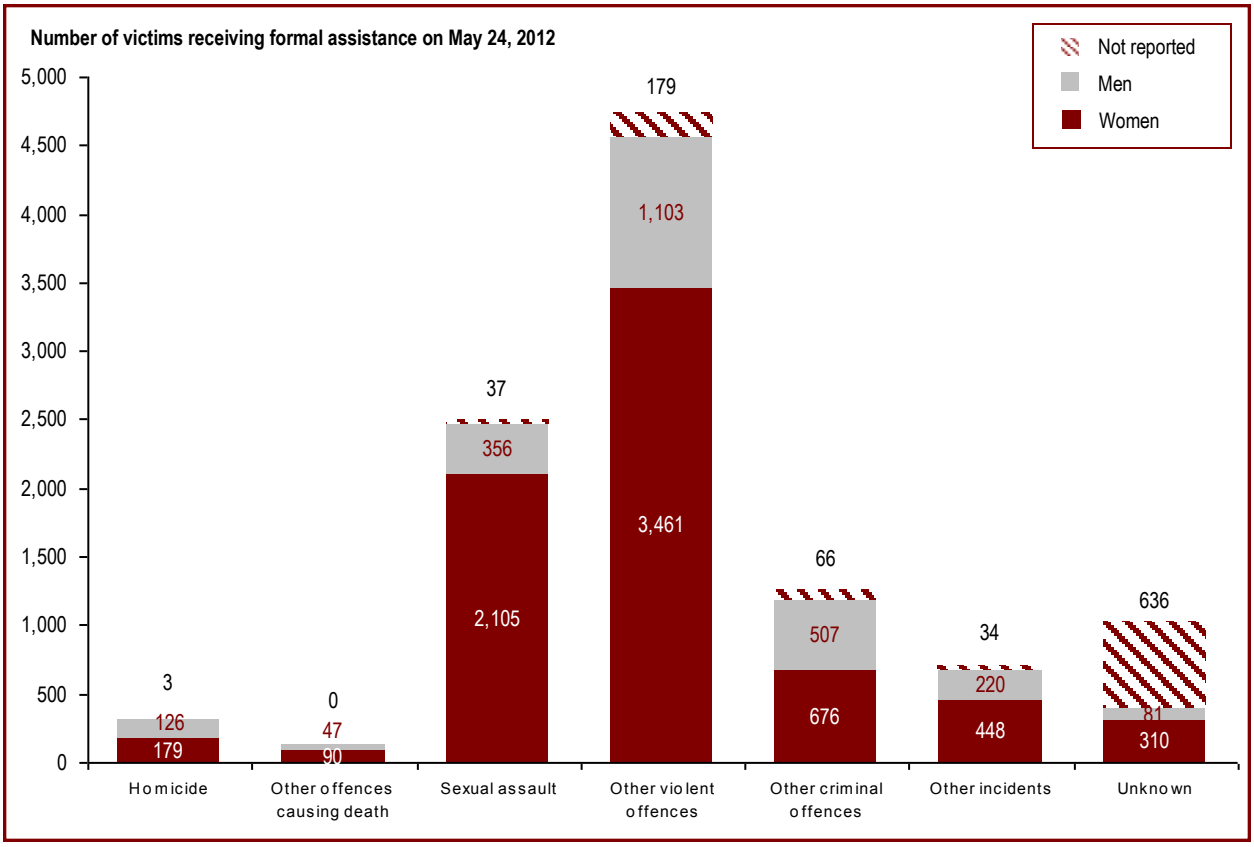
Age of Victim	Men		Women		Total	
	#	%	#	%	#	%
0 to 4 years	1,761	1.0	2,053	1.1	3,814	1.1
5 to 9 years	3,803	2.2	3,724	2.0	7,527	2.1
10 to 14 years	11,716	6.7	12,109	6.5	23,825	6.6
15 to 19 years	25,294	14.4	27,674	14.9	52,968	14.6
20 to 24 years	24,712	14.1	29,380	15.8	54,092	15.0
25 to 29 years	21,477	12.2	23,897	12.9	45,374	12.5
30 to 34 years	17,282	9.8	20,001	10.8	37,283	10.3
35 to 39 years	14,829	8.4	17,403	9.4	32,232	8.9
40 to 44 years	14,607	8.3	15,456	8.3	30,063	8.3
45 to 49 years	13,568	7.7	13,038	7.0	26,606	7.4
50 to 54 years	10,965	6.2	9,051	4.9	20,016	5.5
55 to 59 years	6,983	4.0	5,149	2.8	12,132	3.4
60 to 64 years	4,081	2.3	2,792	1.5	6,873	1.9
65 to 69 years	2,321	1.3	1,605	0.9	3,926	1.1
70 to 74 years	1,128	0.6	977	0.5	2,105	0.6
75 and over	1,228	0.7	1,507	0.8	2,735	0.8
Total	**175,755**	**100.0**	**185,816**	**100.0**	**361,571**	**100.0**

Source: Incident-based Uniform Crime Reporting Survey, Canadian Centre for Justice Statistics, Statistics Canada.

Note:
Updated data were not available during the preparation of this report.
The data excludes traffic violations, victims whose age is above 89, victims whose age is unknown and victims whose gender is unknown.
Due to rounding, totals may not add up to 100 percent.

THE MAJORITY OF VICTIMS RECEIVING SERVICES ARE VICTIMS OF VIOLENT CRIME

Figure F3



Source: Victim Services in Canada, 2011/2012; Canadian Centre for Justice Statistics, Statistics Canada.

- On May 24, 2012, the *Victim Services Survey* snapshot day, 10,664 victims received formal assistance from a victim service office. This represents an increase of 12.7% from 9,462 on May 27, 2010. Of the 9,637 where the crime was known, the majority, 79.8% were victims of a violent crime.
- Of the 9,709 cases in which gender of the victim was noted, women accounted for 74.9% of the victims who received formal assistance from a victim service office, and men represented 25.1%.
- Of the 6,959 women who received formal assistance where the type of crime was known, 83.8% were victims of violent crime. A total of 2,105 women (30.2%) were victims of sexual assault.
- Of the 2,359 men who received formal assistance where the type of crime was known, 69.2% were victims of violent crime. A total of 356 men (15.1%) were victims of sexual assault.

Note:
Updated data were not available during the preparation of this report.
Victim services are defined as agencies that provide direct services to primary or secondary victims of crime, and that are funded in whole or in part by a ministry responsible for justice matters. Survey respondents included 684 victim service providers.

THE MAJORITY OF VICTIMS RECEIVING SERVICES ARE VICTIMS OF VIOLENT CRIME

Table F3

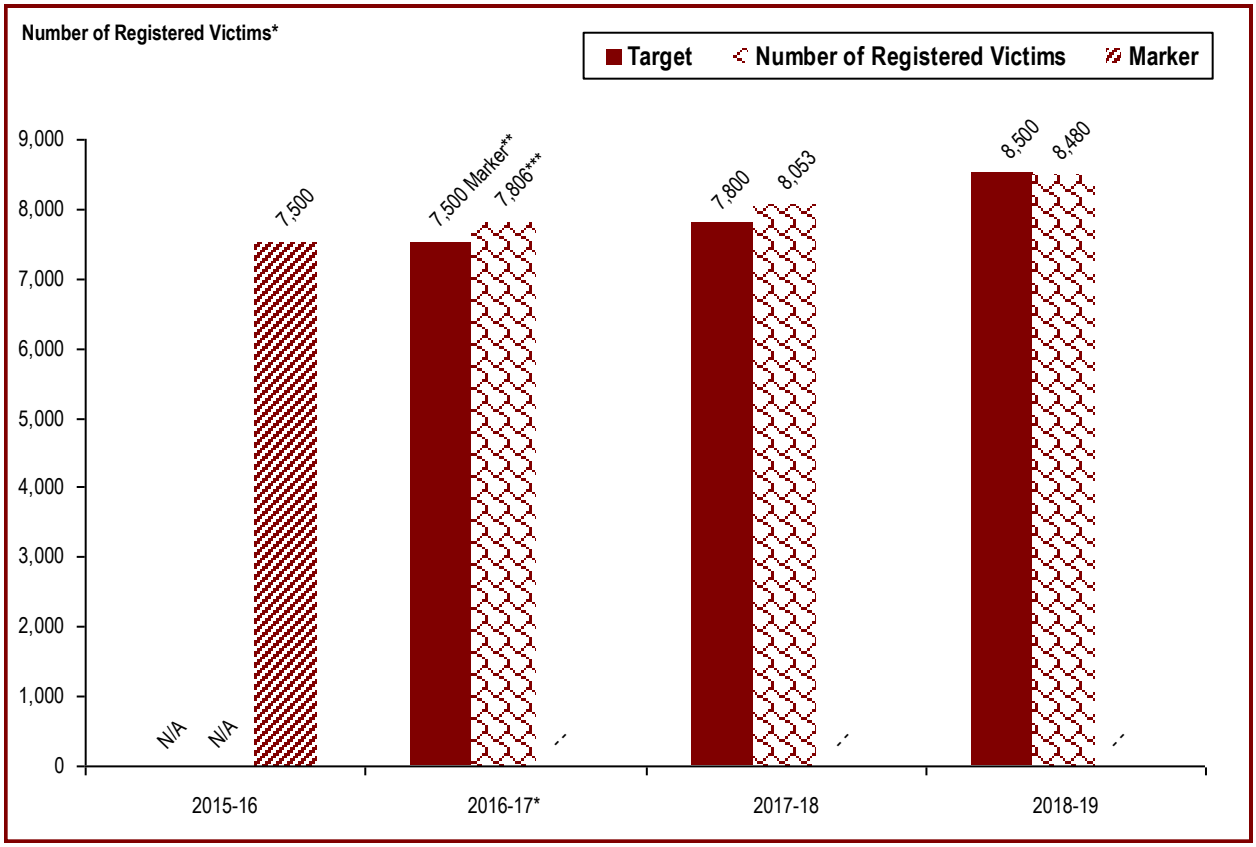
Type of Crime	Gender of Victim							
	Women		Men		Not Reported		Total	
Snapshot on May 27, 2010	#	%	#	%	#	%	#	%
Homicide	154	2.4	70	3.3	3	0.5	227	2.5
Other offences causing death	95	1.5	77	3.7	8	1.4	180	2.0
Sexual assault	1,922	30.0	379	18.1	160	28.3	2,461	27.1
Other violent offences	3,323	51.8	917	43.8	262	46.4	4,502	49.6
Other criminal offences*	496	7.7	357	17.0	73	12.9	926	10.2
Other incidents**	421	6.6	295	14.1	59	10.4	775	8.5
Total without unknown	**6,411**	**100.0**	**2,095**	**100.0**	**565**	**100.0**	**9,071**	**100.0**
Unknown type of crime	197	—	81	—	113	—	391	—
Total	**6,608**		**2,176**		**678**		**9,462**	
Snapshot on May 24, 2012								
Homicide	179	2.6	126	5.3	3	0.9	308	3.2
Other offences causing death	90	1.3	47	2.0	0	0.0	137	1.4
Sexual assault	2,105	30.2	356	15.1	37	11.6	2,498	25.9
Other violent offences	3,461	49.7	1,103	46.8	179	56.1	4,743	49.2
Other criminal offences*	676	9.7	507	21.5	66	20.7	1,249	13.0
Other incidents**	448	6.4	220	9.3	34	10.7	702	7.3
Total without unknown	**6,959**	**100.0**	**2,359**	**100.0**	**319**	**100.0**	**9,637**	**100.0**
Unknown type of crime	310	—	81	—	636	—	1,027	—
Total	**7,269**		**2,440**		**955**		**10,664**	

Source: Victim Services in Canada, 2009/2010; Victim Services in Canada 2011/2012; Canadian Centre for Justice Statistics, Statistics Canada.

Note:
Updated data were not available during the preparation of this report.
*Other criminal offences include arson, property crimes, traffic offences, and other *Criminal Code* offences.
**Other incidents include those of a non-criminal nature as well as those that are still under investigation to determine if they are criminal offences.
Victim services are defined as agencies that provide direct services to primary or secondary victims of crime, and that are funded in whole or in part by a ministry responsible for justice matters. Survey respondents included 684 victim service providers.

THE NUMBER OF VICTIMS REGISTERED WITH THE FEDERAL CORRECTIONAL SYSTEM HAS INCREASED

Figure F4



Source: Correctional Service Canada.

Note:

*Indicator new as of the 2016-17 reporting cycle; therefore, data not available from 2013-14 to 2015-16.

**A 'marker' was set for the new 2016-17 indicator, estimating the number of registered victims. This was done because CSC was changing from management of victim files within OMS, offender file based, to the newly built Victims Application Module (VAM), victim file based and no data was available until year end due to data migration.

***When Victim Services used OMS as their database, the prior indicator counted the number of offenders with registered victims. Over the last three years, CSC has used a new indicator reflective of the VAM; counting number of registered victims. This provides the true number of registered victims. For example, in the old system (OMS) = one offender could have six victims, but only one offender with registered victims was counted. In the new system (VAM) = six registered victims as each victim has their own electronic file and is counted separately.

THE NUMBER OF VICTIMS REGISTERED WITH THE FEDERAL CORRECTIONAL SYSTEM HAS INCREASED

Table F4

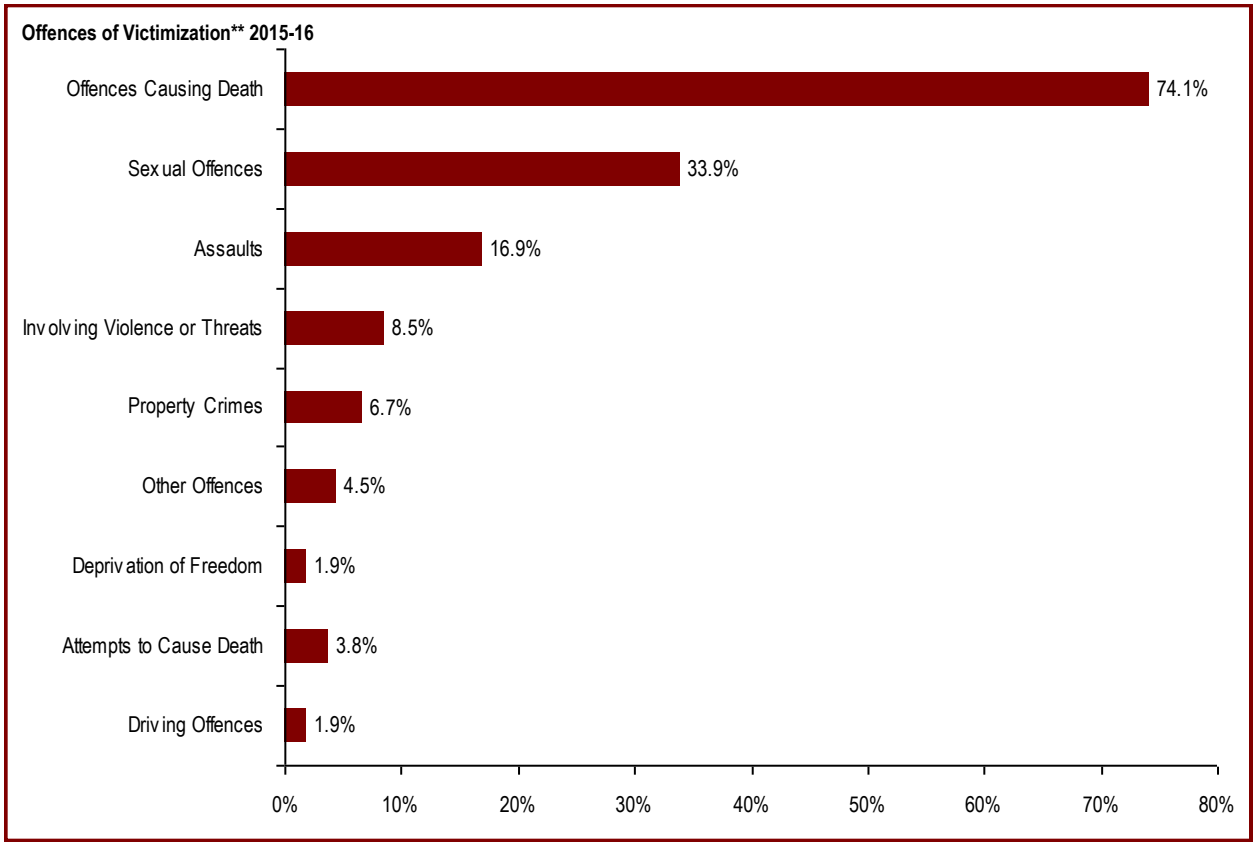
Year	Target	Number of Registered Victims	Marker
2015-16	N/A	N/A	7,500
2016-17*	7,500 Marker**	7,806***	- -
2017-18	7,800	8,053	- -
2018-19	8,500	8,480	- -

Source: Correctional Service Canada.

Note:
*Indicator new as of the 2016-17 reporting cycle; therefore, data not available from 2013-14 to 2015-16.
**A 'marker' was set for the new 2016-17 indicator, estimating the number of registered victims. This was done because CSC Services was changing from management of victim files within OMS, offender file based, to the newly built Victims Application Module (VAM), victim file based and no data was available until year end due to data migration.
***When Victim Services used OMS as their database, the prior indicator counted the number of offenders with registered victims. Over the last three years, CSC has used a new indicator reflective of the VAM; counting number of registered victims. This provides the true number of registered victims. For example, in the old system (OMS) = one offender could have six victims, but only one offender with registered victims was counted. In the new system (VAM) = six registered victims as each victim has their own electronic file and is counted separately.

OFFENCES CAUSING DEATH ARE THE MOST COMMON TYPE OF OFFENCE** THAT HARMED THE VICTIMS REGISTERED* WITH THE FEDERAL CORRECTIONAL SYSTEM

Figure F5



Source: Correctional Service Canada.

- Of the 8,303 registered victims, 74.1% (6,151) were victims of an offence that caused death.
- Victims of sexual offences (2,817) accounted for 33.9% of the registered victims.
- Victims of assault (1,401) and victims of offences involving violence or threats (706) accounted for 16.9% and 8.5% of the registered victims.

Note:
In 2016, CSC implemented the new Victims Application Module (VAM). Following some implementation and development challenges, CSC has worked towards greater stabilization of the VAM system. This caused a delay in the creation of a new reporting mechanism. For this reason, CSC is unable to report beyond the number of registered victims and is working to develop a new reporting mechanism for VAM.
*In order to register to receive information under sections 26 and 142 of the *Corrections and Conditional Release Act*, a person must meet the definition of a victim that appears in section 2, or subsections 26(3) or 142(3) of the Act. Victims can register with the Correctional Service of Canada or the Parole Board of Canada by completing a *Victims Request for Information* form, though a signed letter of request can be considered as meeting this requirement.
**Some victims were harmed by more than one offence; therefore the number of Offences of Victimization are higher than the actual number of Registered Victims. The percentages represent the number of registered victims who were harmed by that offence.

OFFENCES CAUSING DEATH ARE THE MOST COMMON TYPE OF OFFENCE THAT HARMED THE VICTIMS REGISTERED* WITH THE FEDERAL CORRECTIONAL SYSTEM

Table F5

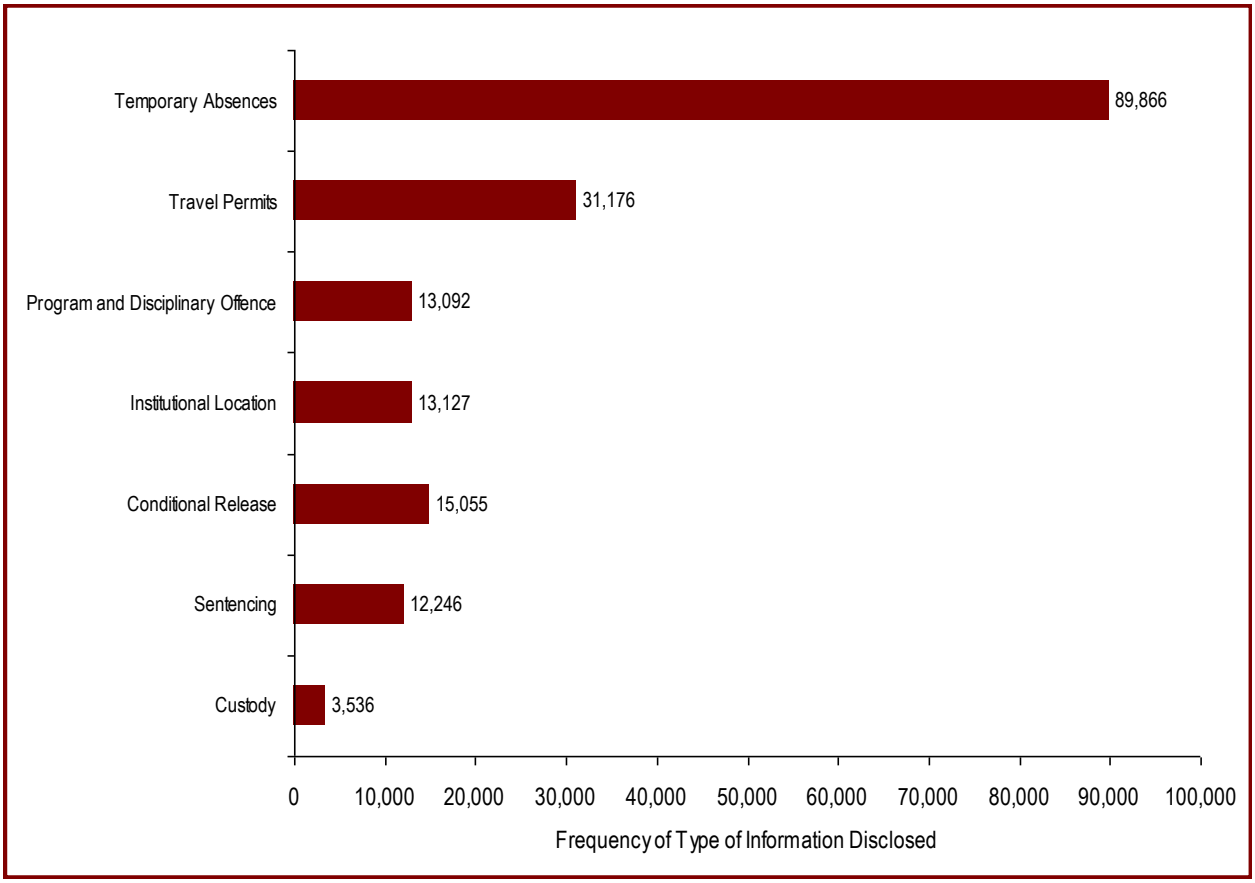
Type of Offence** That Harmed Victim*	2011-12		2012-13		2013-14		2014-15		2015-16	
	#	%	#	%	#	%	#	%	#	%
Offences Causing Death	4,056	55.4	4,292	56.6	4,533	57.8	5,432	68.5	6,151	74.1
Sexual Offences	2,114	28.9	2,169	28.6	2,237	28.5	2,493	31.4	2,817	33.9
Assaults	998	13.6	965	12.7	941	12.0	1,178	14.9	1,401	16.9
Involving Violence or Threats	707	9.7	710	9.4	720	9.2	849	10.7	706	8.5
Property Crimes	534	7.3	551	7.3	541	6.9	617	7.8	558	6.7
Other Offences	452	6.2	441	5.8	475	6.1	583	7.4	377	4.5
Deprivation of Freedom	272	3.7	281	3.7	249	3.2	330	4.2	157	1.9
Attempts to Cause Death	241	3.3	246	3.2	283	3.6	299	3.8	318	3.8
Driving Offences	125	1.7	152	2.0	153	2.0	163	2.1	157	1.9
Offence Not Recorded	6	0.1	4	0.1	9	0.1	85	1.1	0	0
Total Number of Victims**	**7,322**		**7,585**		**7,838**		**7,929**		**8,303**	

Source: Correctional Service Canada.

Note:
In 2016, CSC implemented the new Victims Application Module (VAM). Following some implementation and development challenges, CSC has worked towards greater stabilization of the VAM system. This caused a delay in the creation of a new reporting mechanism. For this reason, CSC is unable to report beyond the number of registered victims and is working to develop a new reporting mechanism for VAM.
*In order to register to receive information under sections 26 and 142 of the *Corrections and Conditional Release Act*, a person must meet the definition of a victim that appears in section 2, or subsections 26(3) or 142(3) of the Act. Victims can register with the Correctional Service of Canada or the Parole Board of Canada by completing a *Victims Request for Information* form, though a signed letter of request can be considered as meeting this requirement.
**Some victims were harmed by more than one offence, therefore the number of Offences of Victimization are higher than the number of Registered Victims. The percentages in the table represent the number of registered victims who were harmed by that offence and do not add up to 100%.

TEMPORARY ABSENCE INFORMATION IS THE MOST COMMON TYPE OF INFORMATION PROVIDED DURING A NOTIFICATION TO REGISTERED VICTIMS* WITH CORRECTIONAL SERVICE CANADA

Figure F6



Source: Correctional Service Canada.

- In 2015-16, information on Temporary Absences (41.2%) and Travel Permits (17.5%) were the most frequent pieces of information about offenders that were provided during a notification to registered victims*.
- There has been a 44.6% increase in the number of pieces of information provided to registered victims* during notifications from 123,136 in 2011-12 to 178,098 in 2015-16.

Note:
In 2016, CSC implemented the new Victims Application Module (VAM). Following some implementation and development challenges, CSC has worked towards greater stabilization of the VAM system. This caused a delay in the creation of a new reporting mechanism. For this reason, CSC is unable to report beyond the number of registered victims and is working to develop a new reporting mechanism for VAM.
Temporary Absence information includes information on unescorted and escorted temporary absences and work release. Conditional Release information includes information regarding day and full parole, statutory release, suspensions, detention, and long-term supervision orders. Sentencing information includes information on the offender's sentence, offender information, warrant expiry date, judicial review, and public domain.
Disclosure means a type of information identified in section 26 of the *CCRA* that has been disclosed to a registered victim during a notification.
As of December 2, 2011 as per Bill S6, Correctional Service Canada now provides information to some victims who are not registered which requires providing information to family members of murdered victims where the offender is still eligible to apply for Judicial Review including when the offender does not apply for a Judicial Review within the allotted time period, as well as the next date the offender can apply. Notification to unregistered victims are excluded for the data.
*In order to register to receive information under section 26 and 142 of the *Corrections and Conditional Release Act*, a person must meet the definition of a victim that appears in section 2 or subsection 26(3) or 142(3) of the Act. Victims can register with the Correctional Service of Canada or the Parole Board of Canada by completing a Victims Request for Information form, though a signed letter of request can be considered as meeting this requirement.

TEMPORARY ABSENCE INFORMATION IS THE MOST COMMON TYPE OF INFORMATION PROVIDED DURING A NOTIFICATION TO REGISTERED VICTIMS* WITH CORRECTIONAL SERVICE CANADA

Table F6

Information	2011-12	2012-13	2013-14	2014-15	2015-16
Temporary Absences	75,848	93,609	100,934	96,131	89,866
Travel Permits	10,877	28,763	34,294	34,501	31,176
Institutional Location	6,859	14,434	17,495	16,242	13,127
Program & Disciplinary Offence Information		11,208	14,826	16,790	13,092
Conditional Release	10,870	11,803	12,318	13,253	15,055
Sentencing Information	16,268	12,813	10,333	10,792	12,246
Custody	2,414	2,569	2,476	2,423	3,536
TOTAL	**123,136**	**175,199**	**192,676**	**190,132**	**178,098**

Source: Correctional Service Canada.

Note:
In 2016, CSC implemented the new Victims Application Module (VAM). Following some implementation and development challenges, CSC has worked towards greater stabilization of the VAM system. This caused a delay in the creation of a new reporting mechanism. For this reason, CSC is unable to report beyond the number of registered victims and is working to develop a new reporting mechanism for VAM.
Temporary Absence information includes information on unescorted and escorted temporary absences and work release. Conditional Release information includes information regarding day and full parole, statutory release, suspensions, detention, and long-term supervision orders. Sentencing information includes information on the offender's sentence, offender information, warrant expiry date, judicial review, and public domain.
Disclosure means a type of information identified in section 26 of the *CCRA* that has been disclosed to a registered victim during a notification.
As of December 2, 2011 as per *Bill S6,* Correctional Services Canada now provides information to some victims who are not registered which requires providing information to family members of murdered victims where the offender is still eligible to apply for Judicial Review including when the offender does not apply for a Judicial Review within the allotted time period, as well as the next date the offender can apply. Notification to unregistered victims are excluded for the data.
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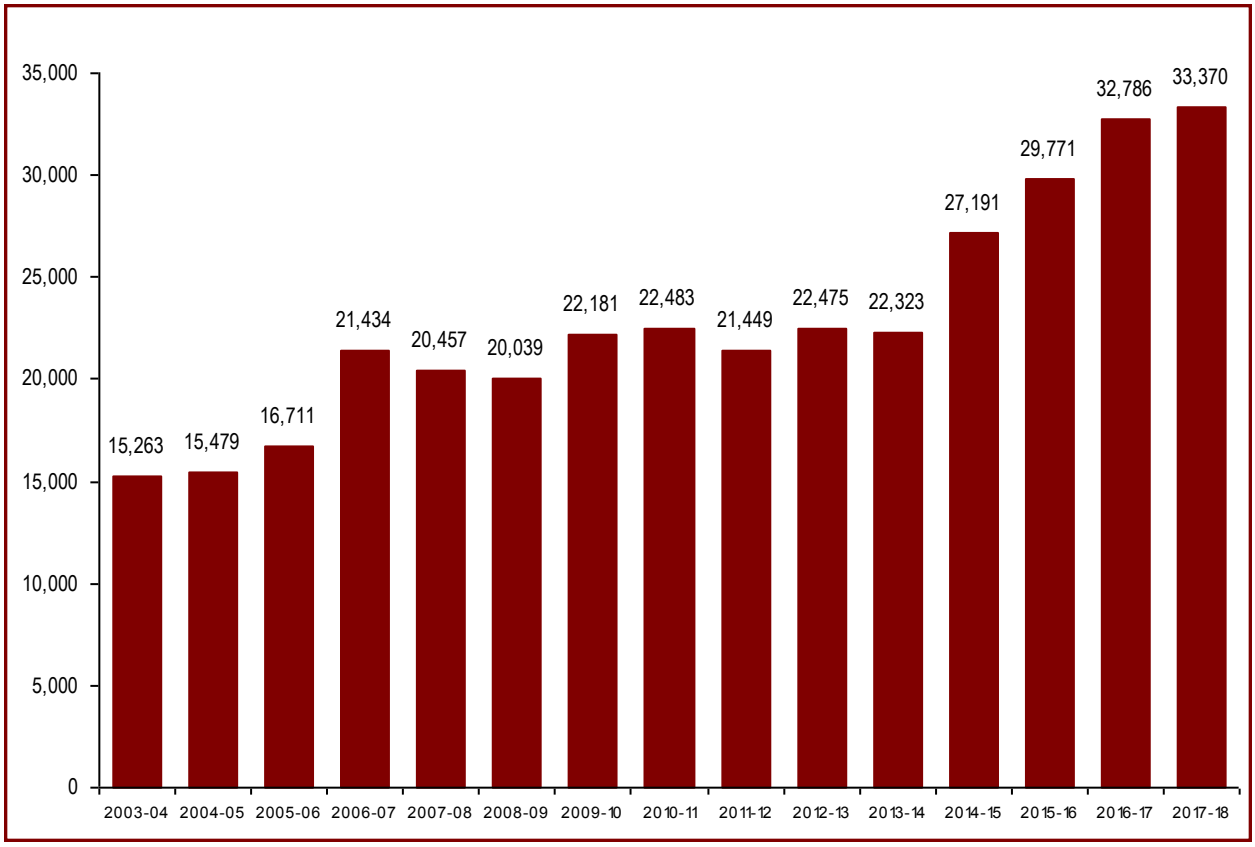
PAROLE BOARD OF CANADA CONTACT WITH VICTIMS HAS INCREASED

Figure F7



Source: Parole Board of Canada.

- In 2017-18, PBC reported 33,370 contacts* with victims, an increase of 2% from the previous year.
- Compared to 2003-04, the number of PBC contacts with victims has increased by 119% (18,107 more contacts).

Note:
*A victim contact refers to each time the Parole Board of Canada has contact with a victim by mail, fax, or by telephone.

PAROLE BOARD OF CANADA CONTACT WITH VICTIMS HAS INCREASED

Table F7

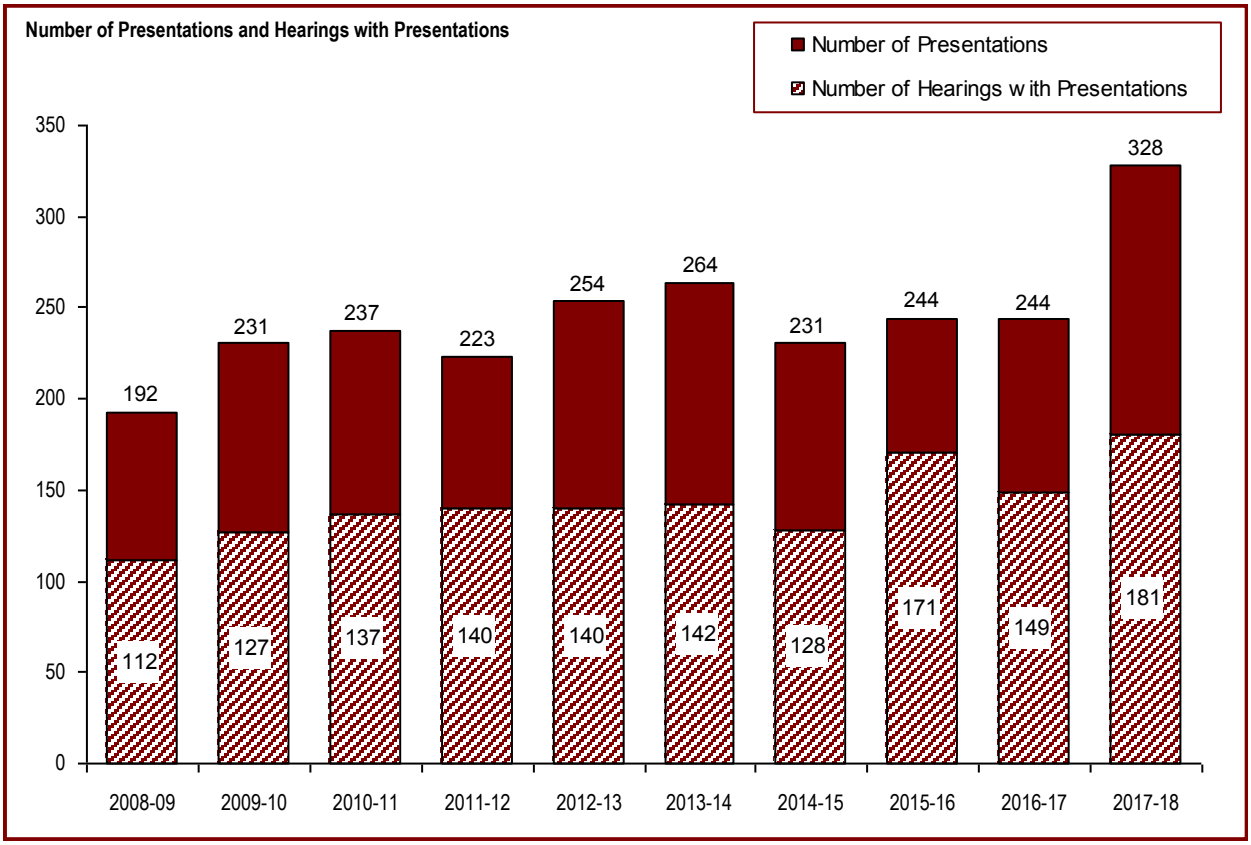
Year	Total Number of Contacts*
2003-04	**15,263**
2004-05	**15,479**
2005-06	**16,711**
2006-07	**21,434**
2007-08	**20,457**
2008-09	**20,039**
2009-10	**22,181**
2010-11	**22,483**
2011-12	**21,449**
2012-13	**22,475**
2013-14	**22,323**
2014-15	**27,191**
2015-16	**29,771**
2016-17	**32,786**
2017-18	**33,370**

Source: Parole Board of Canada.

Note:
*A victim contact refers to each time the Parole Board of Canada has contact with a victim by mail, fax, or by telephone.

VICTIMS PRESENTING A STATEMENT AT PAROLE BOARD OF CANADA HEARINGS

Figure F8



Source: Parole Board of Canada.

- In 2017-18, victims made 328 presentations at 181 hearings. By comparison, victims made 244 presentations at 149 hearings the previous year.
- When compared to 2008-09, the number of victims who present a statement at hearings increased by 71% in 2017-18.
- Between 2008-09 and 2017-18, the majority of presentations were done in person (89%) followed by presentations via video conferencing or tele conferencing (7%) and pre-recorded presentations (audiotape or videotape/DVD) (4%).
- The major offence of victimization for victims making presentations in 2017-18 was most likely to have been murder (31%), sexual assault (18%), and manslaughter (17%).

VICTIMS PRESENTING A STATEMENT AT PAROLE BOARD OF CANADA HEARINGS

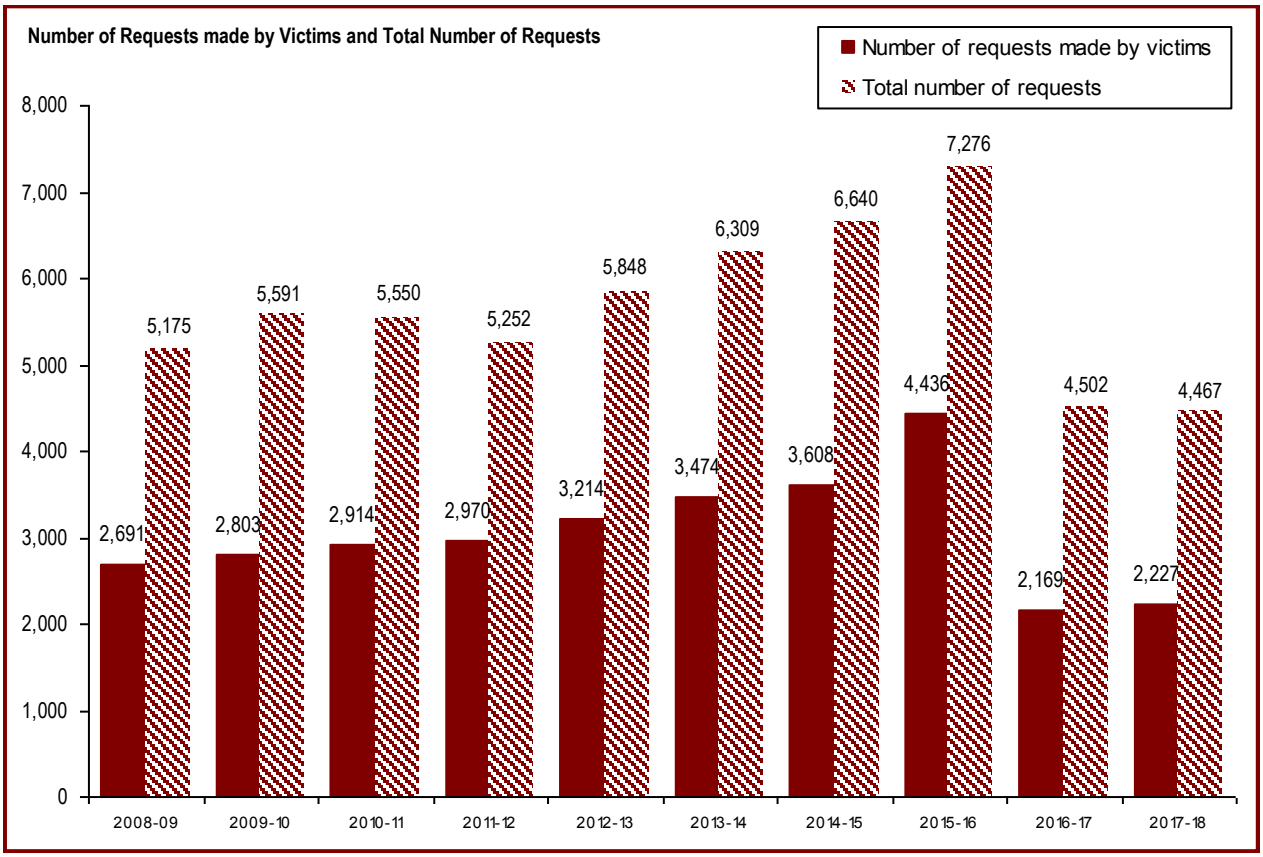
Table F8

Year	Number of Hearings with Presentations	Number of Presentations
2008-09	112	192
2009-10	127	231
2010-11	137	237
2011-12	140	223
2012-13	140	254
2013-14	142	264
2014-15	128	231
2015-16	171	244
2016-17	149	244
2017-18	181	328

Source: Parole Board of Canada.

VICTIMS REQUESTING ACCESS TO THE DECISION REGISTRY

Figure F9



Source: Parole Board of Canada.

- In 2017-18, the number of request for access to the decision registry* made by victims increased to 2,227 (+2.7%) compared to 2016-17, and decreased by 49.8% compared to 2015-16 after reaching a peak (4,436) in the last decade.
- When averaged over the last ten years (between 2008-09 and 2017-18), 53.9% of request for access to the decision registry were made by victims.

Note:
Victims also include victims' agents and victims' organizations.
*Since November 1, 1992, the Corrections and Conditional Release Act (CCRA) requires the Parole Board of Canada (PBC) to maintain a registry of its decisions along with the reasons for those decisions. Anyone may request, in writing, a copy of these decisions.

VICTIMS REQUESTING ACCESS TO THE DECISION REGISTRY

Table F9

Year	Request made by victims*		Total number of requests
	#	%	
2008-09	2,691	52.0	5,175
2009-10	2,803	50.1	5,591
2010-11	2,914	52.5	5,550
2011-12	2,970	56.5	5,252
2012-13	3,214	55.0	5,848
2013-14	3,474	55.1	6,309
2014-15	3,608	54.3	6,640
2015-16	4,436	61.0	7,276
2016-17	2,169	48.2	4,502
2017-18	2,227	49.9	4,467

Source: Parole Board of Canada.

Note:
*Also include victims' agents and victims' organizations.

QUESTIONNAIRE

In order to improve the *Corrections and Conditional Release Statistical Overview*, we are asking our readers to complete the following voluntary questionnaire.

1. Where did you obtain this copy of the *Corrections and Conditional Release Statistical Overview*?

2. How did you become aware of it?

3. Did you experience any difficulties in obtaining or accessing the document? ❒ Yes ❒ No
   Please elaborate.

4. Have you found the *Corrections and Conditional Release Statistical Overview* to be a useful document? ❒ Yes ❒ No Please elaborate.

5. Are there any tables, figures, bullets or notes that are not clear?

6. Are there any topics you would like to see addressed in future publications of the *Corrections and Conditional Release Statistical Overview* that are not currently included?

7. Any additional comments?

(See over for return address)

Please return completed questionnaires to:

Portfolio Corrections Statistics Committee
Public Safety Canada
340 Laurier Avenue West, 12th Floor
Ottawa, Ontario
K1A 0P8

Telephone: 613-946-9994
Fax: 613-990-8295
E-mail: ps.csccbresearch-recherchsscrc.sp@canada.ca

For further information, please visit:

Correctional Service Canada: www.csc-scc.gc.ca

Canadian Centre for Justice Statistics, Statistics Canada: www.statcan.gc.ca

Parole Board of Canada: www.pbc-clcc.gc.ca

Office of the Correctional Investigator: www.oci-bec.gc.ca

Public Safety Canada: www.publicsafety.gc.ca

This is **Exhibit "C"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

_____

A Commissioner, etc

Office of the Correctional Investigator

Presentation to the First Nations Policing and Indigenous Justice National Symposium

Indigenous Peoples in the Federal Correctional System

November 5th, 2019

Dr. Ivan Zinger
Correctional Investigator of Canada

Canadian Corrections in Context

Federal offenders are those serving a sentence of **two years or more.**
Individuals with sentences of **two years or less** fall under the jurisdiction of **provincial correctional systems**.

Federal sentences are administered by the **Correctional Service of Canada (CSC).**
CSC operates 43 federal correctional institutions across Canada,
and employs ~19,000 full-time employees.

Rate of Incarceration : 131 per 100,000 adult population

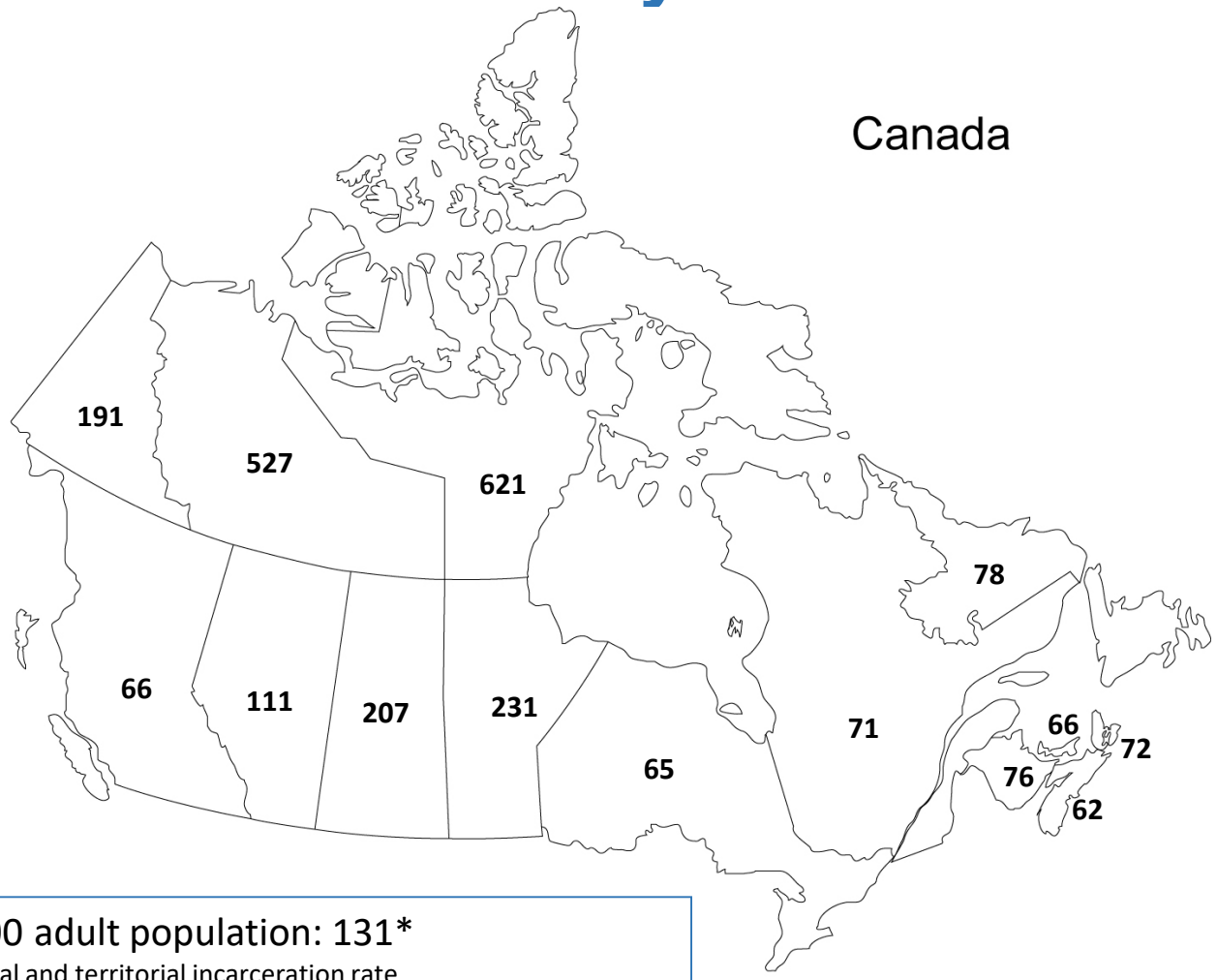
2017/18 Costs

$120,571 (Federal custody)
$84,915 (Provincial custody)

2018/19 Avg. Daily Counts

Provincial Custody = 9,543
Remand Custody = 14,812
Federal Custody = 14,129

Incarceration Rate by Province 2017/18



2017/18 rate per 100,000 adult population: 131*

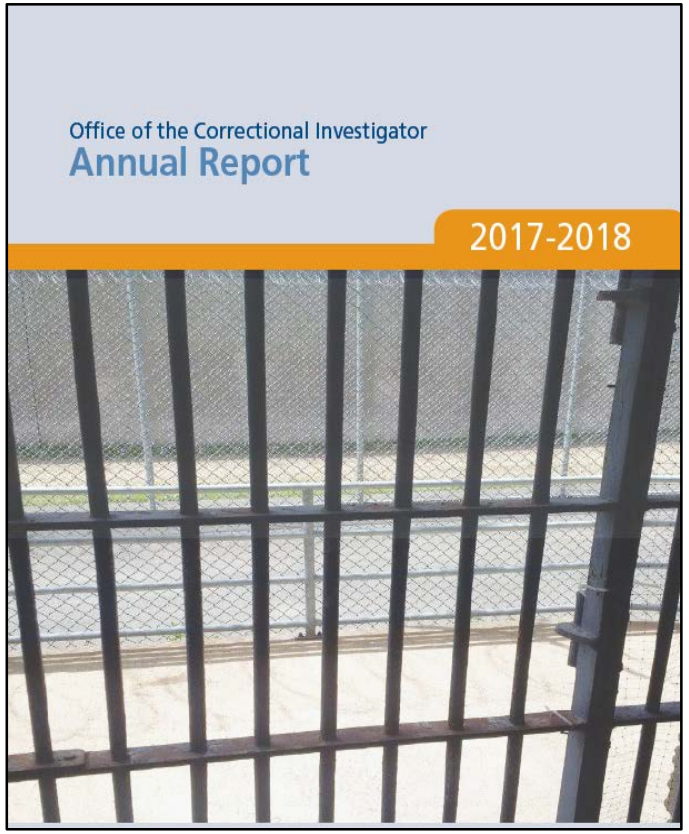
*Numbers include federal, provincial and territorial incarceration rate
(Source: Statistics Canada)

Office of the Correctional Investigator
Role and Mandate

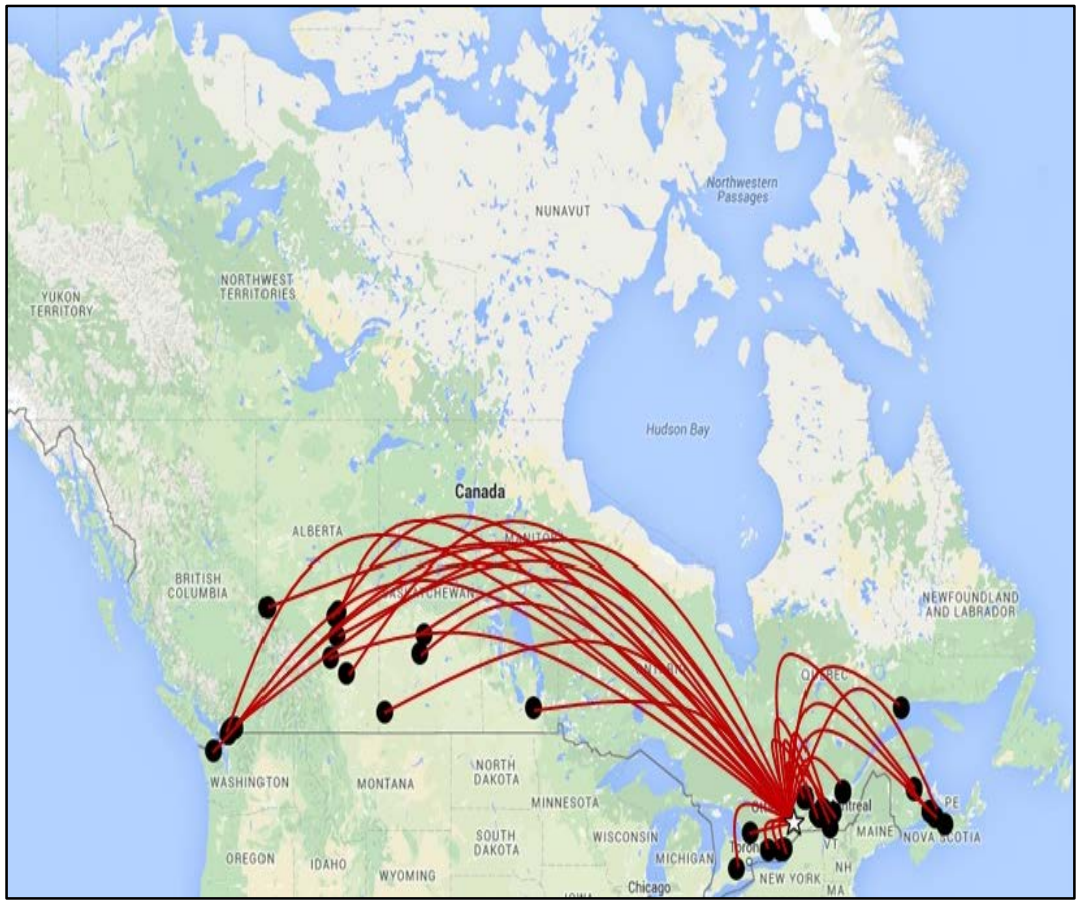
- Ombudsman for federally sentenced offenders
- Independent oversight of federal corrections
- Conducts investigations into the problems of offenders related to “decisions, recommendations, acts or omissions” of the Correctional Service of Canada
- Focus is on compliance, fairness and legality

Mission Statement

"*As the ombudsman for federally sentenced offenders, the Office of the Correctional Investigator serves Canadians and contributes to safe, lawful and humane corrections through independent oversight of the Correctional Service of Canada by providing accessible, impartial and timely investigation of individual and systemic concerns.*"

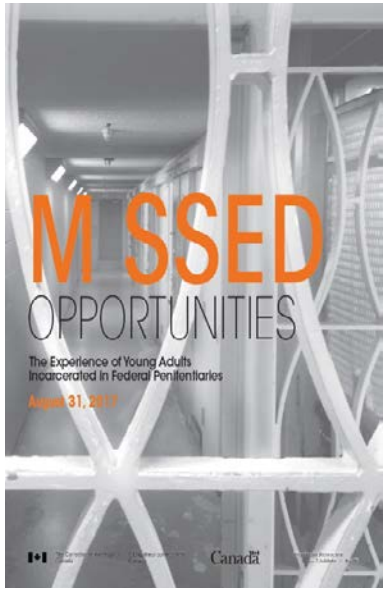


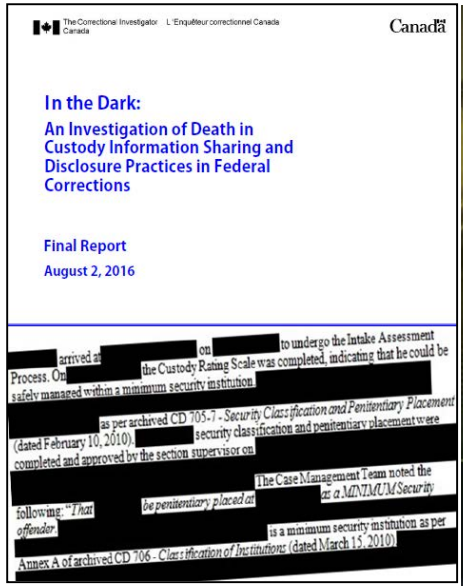
Annual Statistics (2018-19)

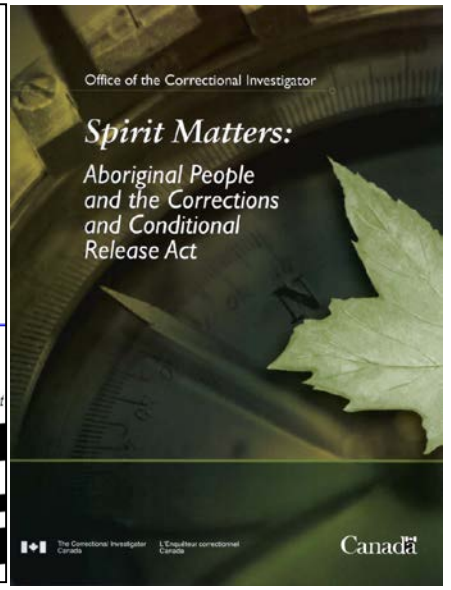


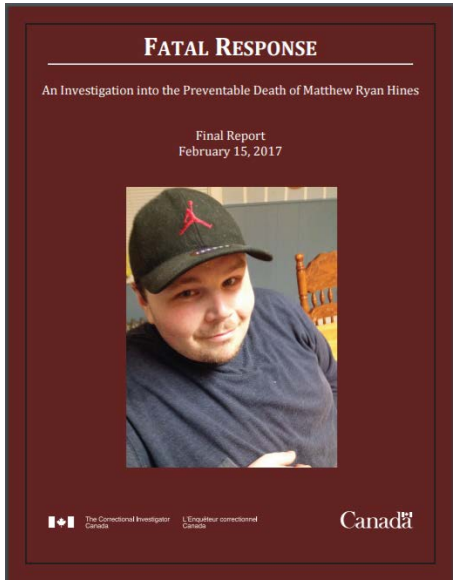
- $5.4M budget
- 40 FTEs
- 476 days spent in penitentiaries
- 5,251 offender complaints
- 1,345 interviews with offenders
- 1,616 use of force reviews
- 116 deaths in custody and serious bodily injury reviews

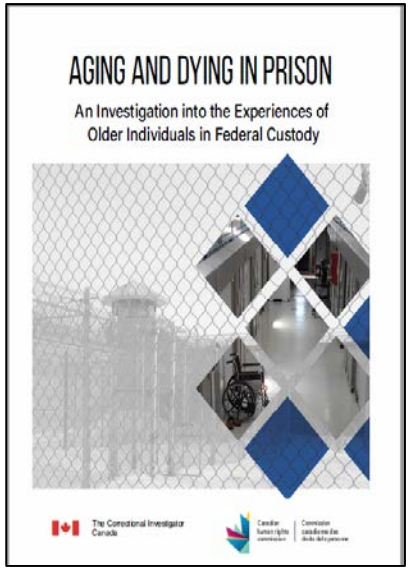
Systemic Investigations

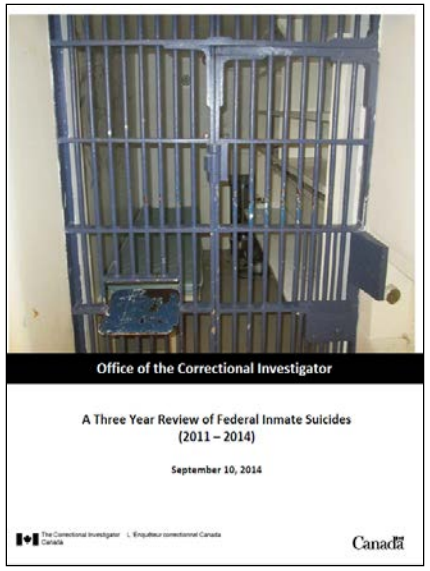


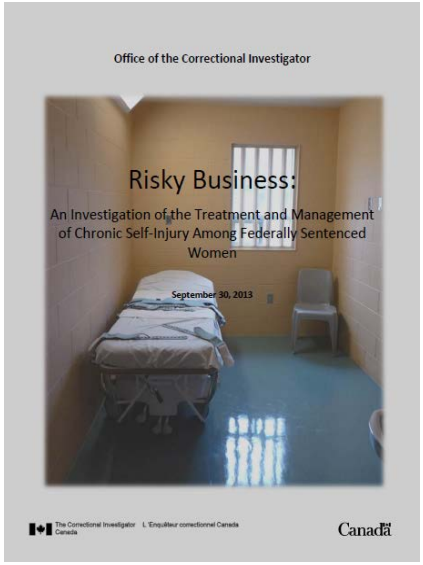


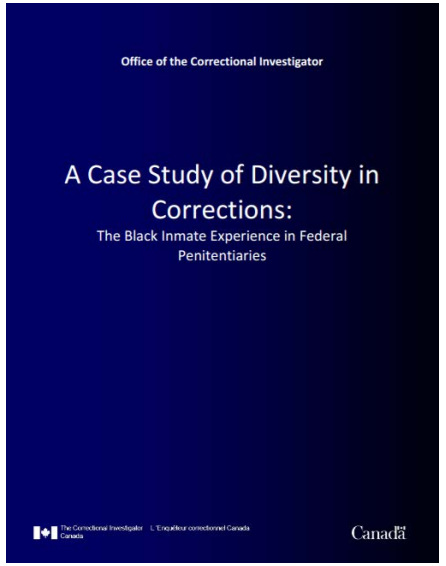


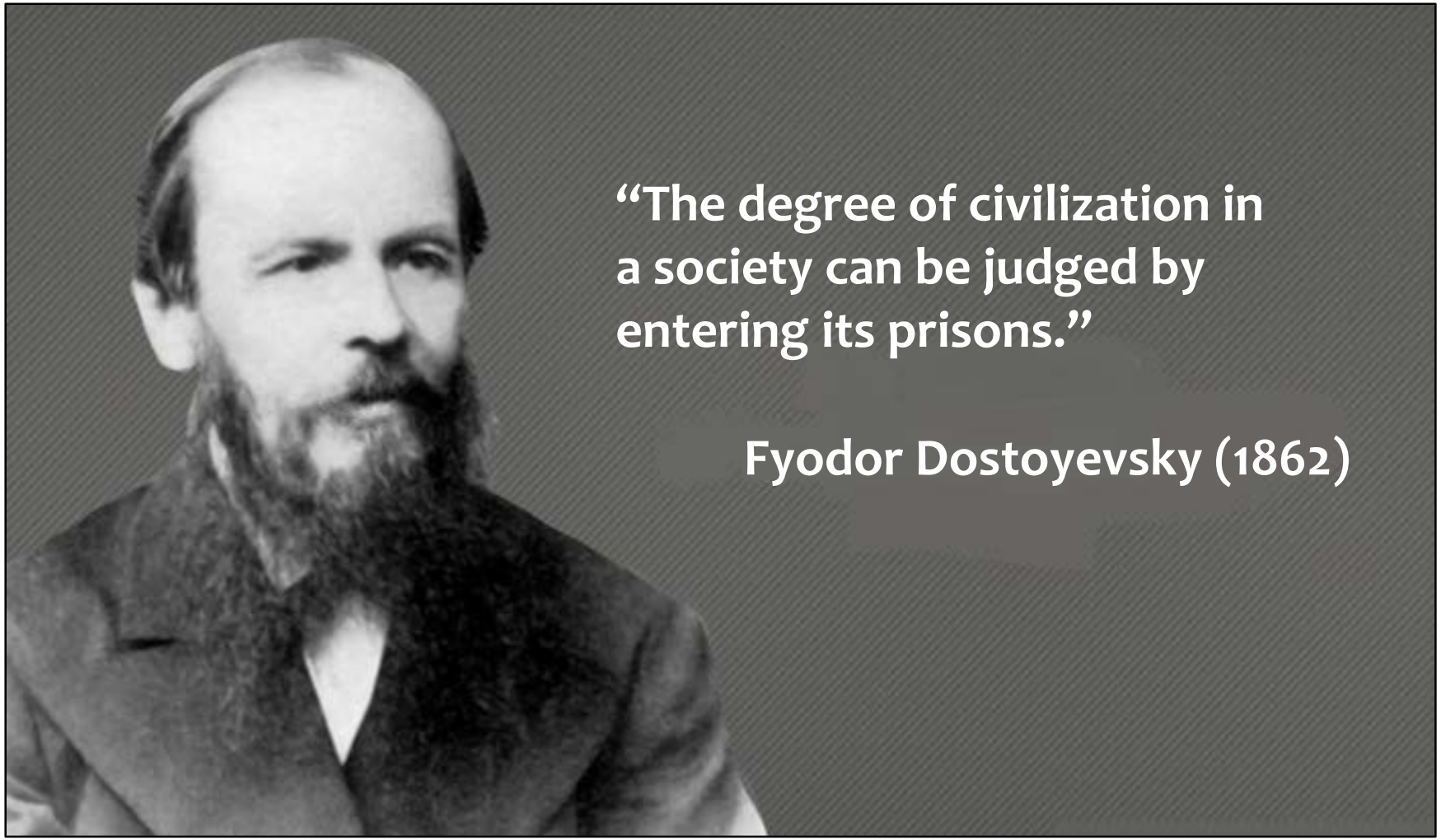











“The degree of civilization in a society can be judged by entering its prisons.”
Fyodor Dostoyevsky (1862)

Profile of the Inmate Population

Changing Inmate Profile

- **Access to Community Health Care**
  - 73% of federally sentenced men and 80% of women meet criteria for any current mental disorder.
  - 29% identified by CSC as requiring follow-up mental health services at admission.
  - Psychotropic drugs are prescribed to federal inmates at a rate of almost 4x the Canadian Average (30.4% versus 8.0%).
  - 33% of women meet the diagnosis for PTSD.
  - Incidents of self-injury doubled in last decade (now 975 by 301 prisoners).
  - Attempted suicides quadrupled in last decade (now 126 attempts).

- **Support for Cognitive Deficit**
  - 25% of incoming male admissions had some level of “cognitive deficit” (2014).
  - Twice as many female offenders are within “intellectually impaired” (IQ) range compared to the general Canadian population.
  - Individuals with learning disabilities and acquired brain injuries are vastly over-represented.
  - 10% to 23% of federally incarcerated individuals meet the criteria for Fetal Alcohol Spectrum Disorders (FASD).

- **Aboriginal Self-Governance** – 29.7% of prisoners are of Aboriginal ancestry, but comprise about 5% of the Canadian adult population. 41.4% federally sentenced women are Indigenous.

- **Diversity in Canadian Society** – Black Canadians represent less than 3% of the Canadian general population, but make up to 8% of the federal inmate population. The proportion of Caucasian inmates declined by about 10% in the last decade.

- **National Drug Strategy** – 75% of prisoners have a history of substance abuse/addiction at admission. Substance abuse was directly linked with index offences in over 60% of cases.

Changing Inmate Profile (continued)

- **Education** – 75% of federal offenders reported no high school diploma (or equivalent) at admission. 65% enter the system with lower than Grade 8.

- **Employment** – 62% of federally sentenced men were unemployed at the time of arrest.

- **Harm Reduction** – In 2017, the prevalence of HIV in federal institutions was 1.2%, and 9% of federally sentenced men reported being Hepatitis C positive.

- **Women in Canadian Society** – The number of women prisoners has increased 30% in the last 10 years (compared to -1.5% for males). The Aboriginal women offender population increased by 43%. 68% of women offenders reported sexual abuse and 86% physical abuse.

- **Aging in Canadian Society** – Over 25% of federally incarcerated offenders is aged 50 or over. This segment of the offender population increased by 50% over the past decade. 15% of federally sentenced women are over the age of 50.

- **Life Expectancy** – The average age of death in custody is 60 years of age (natural, suicide, overdose, homicide) .

Indigenous Corrections

Identified Needs

Social History

- Other family members likely to have spent time in prison.
- Over half attended or had a family member attend a residential school.
- Significant involvement with child welfare system and youth criminal justice system

Mental Health

- 83% meet criteria for any current mental disorder.

Substance Use/ Addictions

- 84% were identified as having high or moderate substance abuse needs.
- For 84%, alcohol and/or drug use was part of the offence cycle.

Infectious Diseases

- Data from between 2005 and 2012 found HCV and HIV prevalence higher among Indigenous inmates (32% and 2.62%) compared to non-Indigenous (24% and 1.51%).

Education & Employment

- Upon admission, 61% have lower than Grade 10 (or equivalent), and 81% reported no high school.
- 72% were unemployed at the time of arrest.

Poor Correctional Outcomes

Compared to non-Indigenous Offenders

Segregation

- On April 7, 2019, 43% of the segregation population was Indigenous.

Use of Force Incidents

- In 2018/19, 45% of incidents reviewed by the Office involved at least one Indigenous inmate.

Self-Injurious Incidents

- Indigenous persons were involved in more than half of all incidents of prison self-injury in 2018/19.

Maximum Security

- A higher proportion (18% vs. 14%) are classified as maximum security.

Conditional Release and Community Supervision

- Most (70%) Indigenous offenders are released at their Statutory Release date.
- Day parole rates remain far below those for the overall population (18% vs. 35%)
- More often returned to custody on a revocation (39% vs. 31%)

Recidivism

- Indigenous men have the highest rates of recidivism (65%), followed by Indigenous women (47%), non-Indigenous men (39%), and non-Indigenous women (21%).

Profile of Federally Sentenced Women

Compared to men, incarcerated women are:

- Twice as likely to have a serious mental health diagnosis.
- Twice as likely to be serving a sentence for drug-related offences.
- More likely to be serving a shorter sentence (2 to 4 years).
- More likely to be supporting dependents on the outside.
  - ¾ of incarcerated women are mothers
- Higher motivation for correctional intervention and higher potential for reintegration.

Indigenous Corrections

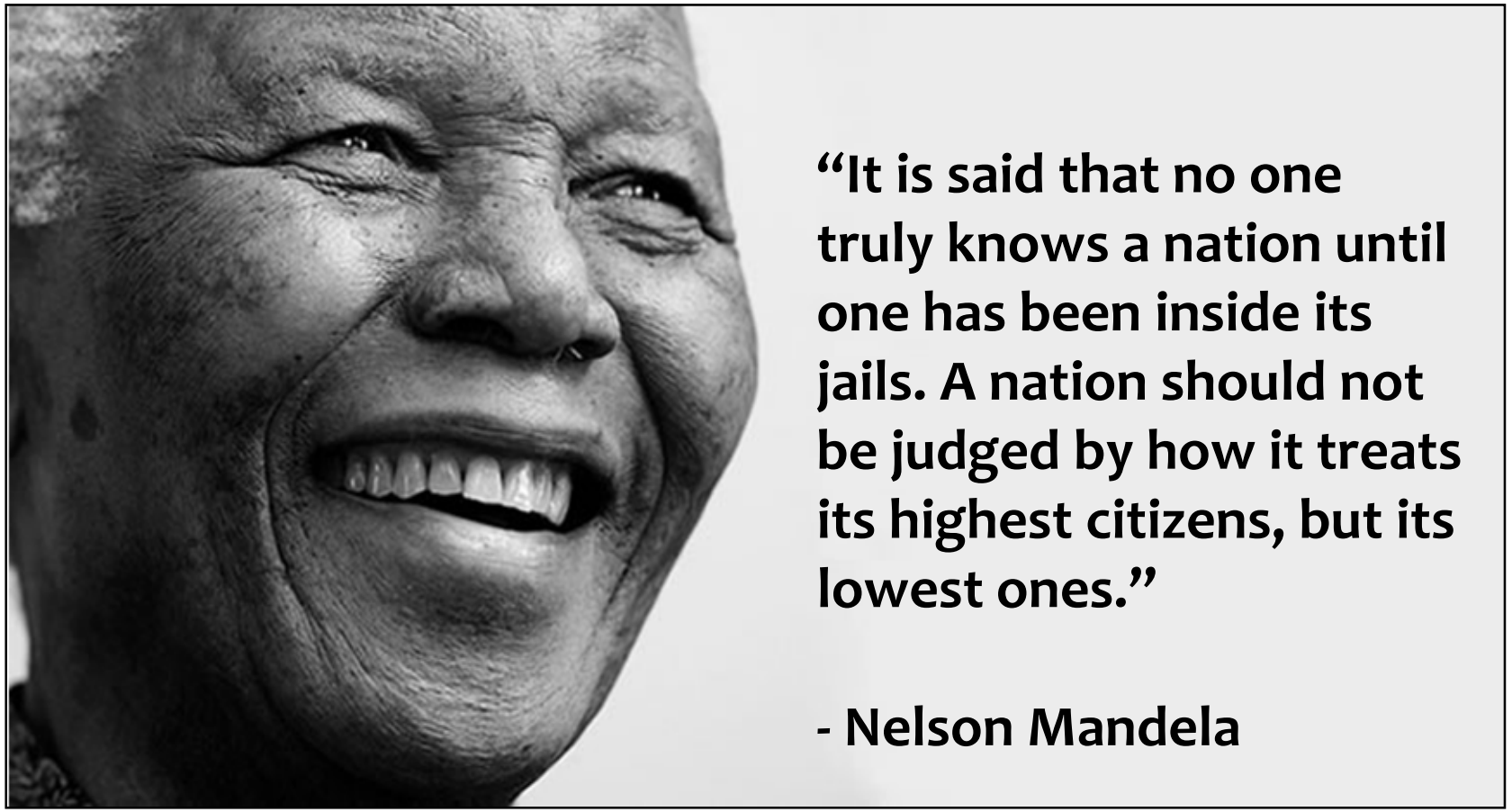
OCI Recommendations

1. Appoint a Deputy Commissioner for Indigenous Affairs
2. Reallocation of significant CSC budget to Indigenous communities to fund Section 81 and 84 agreements
3. Implement a national gang and disaffiliation strategy
4. Create risk assessment and classification tools responsive to the reality of Indigenous people
5. Enhance the role of Elders
6. Administer the sentence of an Indigenous person informed by *Gladue* principles

Recent Reports

Other Similar Recommendations

- Truth and Reconciliation Commission of Canada (TRC) December 2015 – *Honouring the Truth, Reconciling for the Future* (17 relevant *Calls to Action*)
- Auditor General of Canada (OAG) *Preparing Indigenous Offenders for Release* November 2016 (8 recommendations)
- Standing Committee on Public Safety and National Security (SECU) June 2018 – *Indigenous People in the Federal Correctional System* (19 recommendations)
- Standing Committee on the Status of Women (FEWO) June 2018 – *A Call to Action: Reconciliation with Indigenous Women in the Federal Justice and Correctional Systems* (96 recommendations)
- National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG) June 2019 (14 relevant calls to Justice to CSC)



WWW.OCI-BEC.GC.CA

This is **Exhibit "D"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

_____

A Commissioner, etc

PRISON POLICY INITIATIVE

Responses to the COVID-19 pandemic

Last update: June 17, 2020

Newest page updates:

- California announced a new community supervision plan for people in prison within 180 days of completing their sentences, with specific offense criteria. (See prison releases section.)
- Oregon Governor Brown is preparing to potentially release medically vulnerable people from prisons. She provided the Department of Corrections with a list of specific criteria to evaluate eligibility. (See prison releases section.)
- Only two states have not suspended medical co-pays for people in state prisons: Nevada and Hawaii. (See medical co-pays section.)

Can't find what you're looking for on this page?

See our main coronavirus page for other resources.

Prisons and jails are amplifiers of infectious diseases such as the coronavirus, because social distancing is impossible inside and movement in and out of facilities is common. But criminal justice officials have the power to prevent coronavirus deaths.

On this page, we're tracking which state and local governments are taking meaningful steps to protect people behind bars (and the general public). We've also published a detailed guide to what the criminal justice system should be doing, as well as several other resources about the coronavirus in prisons and jails.

Jails releasing people

Jails and prisons house large numbers of people with chronic diseases and complex medical needs who are more vulnerable to COVID-19.

One of the best ways to protect these people is to reduce overcrowding in correctional facilities. **Many jails are already making these changes:**

- Officials in the Detroit, Michigan area have taken numerous steps to reduce the county jail populations over the past three months. Sentencing judges ordered the release of 384 people from the Wayne County Jail and 150 people from the Oakland County jail, law enforcement reduced the number of arrests, and the chief judge of the county

circuit court signed at least 200 orders for administrative releases since early March. (June 2)

- On April 6th, California set an statewide emergency bail schedule that reduced bail to $0 for most misdemeanor and some low-level felony offenses. Since then, California jail populations have dropped. In Los Angeles County and Sacramento County, jail populations have decreased by over 30%. Orange County's jail population has dropped by almost 45%, while other counties — including San Diego, San Mateo, and Stanislaus — have released hundreds of people held pretrial. (May 27)
- In North Dakota, the Cass County Jail population has declined by over 30% since mid-March, and the Stutsman County Jail population has dropped by about 50%. (May 26)
- Following an April 5th order from the Massachusetts Supreme Judicial Court, which authorized the release of people held in jails pretrial for "nonviolent" offenses and those held on technical probation and parole violations, both the Plymouth County and Norfolk County jails have reduced their populations by around 20%. The Bristol County jail population, meanwhile, has decreased 11% since April 5th. (An April 14th story previously reported that 300 people held in jails across the state had been released as a result of the court order.) (May 20)
- In Colorado Springs, Colorado, the El Paso County Jail population has dropped by about 30% from February to May. News reports are unclear about how the county achieved these population cuts. (May 20)
- In Miami-Dade County jails, in Florida, the jail population has reportedly dropped from about 4,000 people before the pandemic to about 3,200 people -- about a 20% decrease in the average daily population. This reduction is the result of efforts by "lawyers and judges." (May 19)
- In March, Ohio courts in Cuyahoga County (Cleveland) and Hamilton County began to issue court orders and conduct special hearings to increase the number of people released from local jails. Since March 10th, the Cuyahoga County jail has released about 900 people, reducing its population by more than 30%. (May 13)
- The Northwestern Regional Adult Detention Center in Virginia has reduced the jail population by about 20% from the daily average of the past 5 years. Most people who were released were placed on probation. (April 29)
- In Charles County, Maryland, people have been released from jail following recent bail hearings and people serving short weekend sentences, and the jail is now reportedly "at less than 30% capacity." A county public defender reports that of the 60 motions for release that he has filed, 30 people had been released as of April 28th. (April 29)
- The Duval County, Florida jail population has dropped by approximately 16% over about a month, after the jail released people who were nearing the end of their misdemeanor sentences. (April 28)
- In Washington County, Oregon, early releases of people held for "low-level" offenses have reportedly helped drop the jail population by "half." (April 28)
- Maricopa County, Arizona, reduced the jail population since the beginning of the COVID-19 pandemic from an average of 7,500 to 5,306 people on April 24th (almost a 30% reduction). (April 27)

- The Sheriff's Office reports that in Anderson County, Tennessee, the jail population has dropped from an average daily population of 415 to 280 people on April 27th (a more than 30% reduction). (April 27)
- Approximately 300 people have been released from Orange County Jail in Florida in response to the pandemic. Those released were held pretrial. (April 25)
- In Philadelphia, Pennsylvania, the local jail population has dropped by 17% since the beginning of April, following special court hearings to release hundreds of people held for low-level charges, cash-bail, and "nonviolent" charges. (April 22)
- Over the course of a month, the jail population in Hennepin County, Minnesota, dropped by 44% following collaborative efforts to increase jail releases. (April 22)
- In Clark County, Nevada (Las Vegas), 115 people have been released from county jail in the past week and the sheriff reports that over 100 more people may be eligible for release under the same court petition. (April 21)
- From March 1st to April 15th, the average daily number of people in jail in Denver, Colorado, dropped by about 41% following the release of people over 60 years old, those who are pregnant or have health conditions, people with low bond amounts, and those with less than 60 days remaining on their sentences. (April 21)
- Morgan County Jail, in Alabama, has released about 16% of their jail population — 107 people — since March 16th. The Sheriff's Office provided lists of detained people to be considered for release including those held for "nonviolent" offenses and those with medical issues. (April 19)
- As of April 14th, the Franklin County Jail population in Ohio has decreased by more than 30% over the course of 30 days. To do this, the county reduced average daily bookings from over 70 to about 25 per day and released people held pretrial for "non-violent misdemeanors," people over the age of 60, and people held for technical violations of probation and parole. Franklin County has a page detailing the steps they have taken to reduce their jail population available here. (April 17)
- In the past months, 45 people have been released from the Centre County Jail in Pennsylvania, reducing the jail population to only 195 people. (April 16)
- Over the past month, some jails in Pennsylvania — including Bucks County and Northumberland County — have reduced the jail population by 30% via increased releases. (April 16)
- Approximately 1,000 people were released from the jails in Dallas County, Texas to help reduce the risk of transmission. (April 16)
- From March 18th to April 15th, the Washington, D.C. jail population has decreased by about 21.8%. (April 15)
- In Cumberland County, Maine, the sheriff reports that the jail population has decreased by 25% since January, due in large part to release of people who were held for "low level, nonviolent crimes" with less than 90 days left on their sentences. (April 15)
- Multnomah County Jail in Oregon has reduced their jail population by about 30% in the past month by reducing arrests and increasing early and pretrial releases. (April 14)
- A judge in the Bronx approved the release of 51 people jailed for alleged parole violations on Rikers Island in New York City. (April 13)

- 65 people have been released early from the Westchester County Jail in Valhalla, New York, following discussions between the District Attorney and the Legal Aid Society of Westchester. (April 13)
- A judge in Georgia ordered the release of over 100 people being held at the Dekalb County Jail, decreasing the jail's population by a reported 7%. (April 13)
- In Alabama, Mobile Metro Jail's population decreased from 1,580 to 1,100 in four weeks. The people who were released were charged with nonviolent offenses, over 55 years old, or had preexisting medical conditions that made them particularly vulnerable to COVID-19. (April 10)
- More than 100 people have been released from Boulder County Jail in Colorado following efforts from the district attorney's office to reduce the jail population based on preexisting medical conditions and utilizing personal recognizance bonds. (April 4)
- Over the course of the month of March, West Virginia jails have reduced their overall population by over 600 people. (April 1)
- A Pennsylvania District Court judge ordered ICE to release more than 10 people being detained at the York County Prison, Clinton County Correctional Facility, and Pike County Correctional Facility because they are at elevated risk for serious complications from COVID-19. (March 31)
- The Legal Aid Society in NYC secured the immediate release of over 100 individuals held at Rikers Island on non-criminal, technical parole violations. (March 27)
- In Allegheny County, PA, 545 people held in the county jail were approved for release by the courts and physically discharged from custody. (March 27)
- In New Orleans, Louisiana, the District Court judges have issued orders calling for the immediate release of people held in the New Orleans jail awaiting trial for misdemeanors, arrested for failure to appear at probation status hearing, detained in contempt of court, or detained for failing a drug test while on bond. (March 26)
- New York City has released 200 people from Rikers Island in the past week, and expects to release another 175 people before the weekend. (March 26)
- The Los Angeles County Sheriff's Department has reduced their jail population by 10% in the past month to mitigate the risk of virus transmission in crowded jails. To reduce the jail population by 1,700 people, the Sheriff reports releasing people with less than 30 days left on their sentences and the Department is considering releasing pregnant women and older adults at high risk. (March 24)
- New Jersey Chief Justice Stuart Rabner signed an order calling for the temporary release of 1,000 people from jails(almost a tenth of the entire state's county jail population) across the state of New Jersey who are serving county jail sentences for probation violations, municipal court convictions, "low-level indictable crimes," and "disorderly persons offenses. (March 23)
- In Salt Lake County, Utah, the District Attorney reported that the county jail plans to release at least 90 people this week and to conduct another set of releases of up to 100 more people in the next week. (March 21)
- In Arizona, the Coconino County court system and jail have released around 50 people who were held in the county jail on non-violent charges. (March 20)
- More than 85 people (almost 7% of the jail's population) have been released from the Greenville County Detention Center in Greenville, South Carolina, following a state order from the Supreme Court Chief Justice Donald Beatty urging South Carolina

judicial circuits to avoid issuing bench warrants and start releasing people charged with non-violent offenses. (March 20)
- In Hillsborough County, Florida, over 160 people were released following authorization via administrative order for people accused of ordinance violations, misdemeanors, traffic offenses, and third degree felonies. (March 19)
- Court orders in Spokane, Washington and in three counties in Alabama have authorized the release of people being held pretrial and some people serving sentences for "low-level" misdemeanor offenses. (March 17 and March 18)
- In Travis County, Texas, judges have begun to release more people from local jails on personal bonds (about 50% more often than usual), focusing on preventing people with health issues who are charged with non-violent offenses from going into the jail system. (March 16)
- District attorneys in San Francisco, California and Boulder, Colorado have taken steps to release people held pretrial, with limited time left on their sentence, and charged with non-violent offenses. (March 11 and March 16)

Prisons releasing people

Prisons are releasing almost no one, especially when compared to local jails, as we explained in a May 1st briefing. But state prisons are filled with people with preexisting medical conditions that put them a heightened risk for complications from this virus. So far, we are aware of these **state corrections departments taking steps to reduce the prison population** in the face of the pandemic:

- The California Department of Corrections and Rehabilitation (CDCR) announced on June 16th that people in state prisons for “non-violent” offenses with less than 180 days left on their sentence are eligible for supervised release beginning July 1st. At the end of March, 3,500 people with parole dates scheduled for April were paroled a few days or weeks early. (June 16)
- In Oregon, Governor Kate Brown provided an outline of criteria for the Department of Corrections to present her office with a list of people who may be eligible for early releases, including medical vulnerability, not serving a sentence for a crime against another person, and having served at least 50% of their sentence with a release plan for returning to community. The Department of Corrections reports that about 100 people in state prisons may fit the narrow criteria provided by the governor. (June 12)
- In Michigan, the number of people being paroled from state prisons has reportedly increased by about 1,000 people per month to reduce prison density in the face of the pandemic. The Department of Corrections reported that almost 13% of the state prison population was eligible for parole, and that the agency is looking to first release parole-eligible, “nonviolent offenders who are older than 60 with health issues, though no offenses are off-limits” in April. As of June 5th, the Department of Corrections reports that the overall prison population has decreased by 1,958 — or about 5% — since March 20th. (June 9)
- In New York at the end of March, Governor Cuomo announced that up to 1,100 people who are being held in jails and prisons across the state *may* be released with

community supervision. As of June 8th, the Department of Corrections and Community Supervision reports that 898 people have been released after reviewing individuals for early release in light of COVID-19. (June 8)

- In Connecticut (which has a combined prison and jail system), the Department of Correction Commissioner granted discretionary release to 560 people in May. Since March 1st, the prison population has dropped by about 2,000 people (or 16%). In June, following a federal lawsuit, the DOC is now required to identify people 65 and older who meet specific criteria to "fast track" them for release consideration. (June 8) (June 8)
- The Colorado Department of Corrections has released 290 people following the March 25th executive order from the governor, which gave the DOC authority to release people within 180 days of their parole eligibility date. In April, reports suggested that "hundreds" of people could be eligible for early release. (May 29)
- In New Mexico, the Corrections Department has released 46 people since April 6th following an executive order from the governor to commute sentences of people within 30 days of their release date who meet specific offense criteria. (May 27)
- New Jersey Governor Phil Murphy signed an executive order on April 10th, supposedly beginning the process of "temporarily" releasing some people in state prisons who had been convicted of nonviolent offenses. Since then, there has not been much clarity about the number of people released. On May 15th, the Governor's office reported that 268 people had been paroled or furloughed from state prisons, but on May 21st, the DOC spokesperson stated that only 146 people had been temporarily furloughed and the State Parole Board did not report how many people had been paroled in response to the governor's order. (May 26)
- On May 19th, a federal judge ordered the federal Bureau of Prisons to "expedite the release" of 837 people in the Elkton Federal Correctional Institution in Ohio. (May 20)
- The Oklahoma Department of Corrections identified 126 incarcerated people with medical issues that elevate their risk for COVID-19 and recommended 14 of those to the Pardon and Parole Board to review in an emergency medical parole docket on May 13th. The Board recommended medical parole for 12 of those people (of the other 2 people, one was already paroled and the other waived his right for parole because his release date is imminent). (May 14)
- In Arkansas, the governor issued a directive on April 20th to consider the early release of some people in state prison. Since then, the state Board of Corrections has made over 1,200 people "immediately" eligible for parole. On May 12th, state officials reported that 300 people had been released from Arkansas state prisons. (May 14)
- The North Dakota Parole Board granted 120 applicants parole in March, all related to the COVID-19 pandemic. In April, more than 100 other people were granted parole, although there is no official statement that these were also exclusively the result of mitigation efforts around COVID-19. (May 8)
- On April 23, lawmakers approved the governor's proposal to grant the Virginia Department of Corrections the authority to release people in prison for "nonviolent" offenses with one year or less remaining in their sentences. Since then, as of May 7th, 130 people have been released, and another 100 have been approved for early release. (May 8)

- According to the Wisconsin Department of Corrections, almost 1,600 people have been released from state prisons from March 2nd to May 4th in response to the COVID-19 pandemic. The majority of them - 1,447 people - were detained for technical violations of probation or parole. (May 8)
- On April 10th, Pennsylvania Governor Tom Wolf agreed to temporary reprieve for people in state prisons who met specific eligibility criteria. This was expected to potentially affect up to 1,800 incarcerated people, but almost one month later, only 150 people have been released under this program. (May 8)
- Following Governor Cuomo's announcement on April 30th, 6 pregnant women were released from New York state prisons on May 5th. Two more incarcerated pregnant women are expected to be released as well. These women met the criteria set out by the governor for the release of "pregnant, nonviolent offenders with under six months remaining on their sentences." (May 6)
- According to a report from the Massachusetts Supreme Judicial Court, almost 1,000 people have been released from state prisons between April 3rd and May 3rd, but it is not clear how many of these people were let out in response to the pandemic or how many were already scheduled to be released. (May 5)
- On April 30, the governor of Kansas announced the upcoming release of some people nearing the end of their prison sentences. As of May 4th, only 6 people had been released from prison to home confinement as a result of the pandemic. (May 4)
- The North Carolina Department of Public Safety announced that they have released 485 people early from state prisons since March 1st. In addition, 182 people were released to serve their sentences outside of prison, in home confinement. (The ACLU of North Carolina pointed out that this is not a significant improvement upon normal release schedules, as approximately 68 people were released daily prior to the pandemic. The same could be said of other states that are releasing people slowly.) (May 3)
- In Hawaii (which has a combined jail and prison system), the state supreme court appointed a special master to coordinate potential releases with public defenders beginning in early April. Since March 2nd, courts have reportedly granted early release to 655 people, following motions filed primarily by the Office of the Public Defender. (May 1)
- In early April, the Louisiana Department of Corrections created a review panel to consider people for temporary medical release. As of April 30th, only 53 people have been approved for release out of the 249 people to be considered. (April 30)
- **Misleading news reports** (such as this one from WMBD) are suggesting that 4,000 people in Illinois have been released early since March 1. Readers should be aware that over 3,000 of those 4,000 had completed their sentences already, and most of those remaining were very close to their release dates.
- In New Jersey, 54 people have been released from prison to emergency medical-home confinement, following an executive order from the governor signed on April 10th. This represents less than 3% of the people considered eligible for release under that order. (April 28)
- On April 16th, the Washington Department of Corrections published the names of over 1,500 people to be released early from state prisons. As of April 23rd, the

governor has commuted the sentences of 293 people and about 41 people received work release furloughs. (April 23)

- On March 23rd, the Iowa Department of Corrections announced the planned, expedited release of about 700 incarcerated people who have been determined eligible for release by the Iowa Board of Parole. Since March 1st, 811 people have been released from prison. On April 20th, the Iowa DOC announced that the department is in the process of releasing 482 more people early. (April 20)
- In Maryland, Governor Lawrence J. Hogan Jr. signed an executive order allowing for the accelerated release of people within 4 months of completing their sentence, prioritizing release for older people, and encouraging consideration of release to home detention. (April 19)
- On April 16th, Ohio Governor Mike DeWine authorized the early release of 105 people from state prison who are nearing the end of their sentence. On April 17th, he commuted the sentences of 7 people in Ohio state prisons. (April 17)
- In April, Oklahoma Governor Kevin Stitt commuted the sentences of over 450 people. An initial press release stated that approximately 400 of those people would be released on April 16th, but the Governor's office has since claimed this was a communication error, and it is now being reported that only about 100 individuals will be released on the 16th. (April 16)
- Following a ruling from the Massachusetts Supreme Judicial Court on April 3rd, 13 people have been released and 58 people have been paroled from state prisons. In addition, 23 requests for medical parole were approved. (April 14)
- Maryland Chief Judge Mary Ellen Barbera ordered the state's trial courts to identify and release people in prisons who are at risk for COVID-19 and "pose no threat to public safety." (April 14)
- The Massachusetts Supreme Judicial Court ruled that people held pretrial for non-violent offenses and those held for technical probation/parole violations are eligible for hearings to determine if they can be released. (April 3)
- Kentucky Governor Andy Beshear signed an executive order to commute the sentences of 186 people convicted of felonies. The state also plans to release 743 people who are within 6 months of completing their sentences. (April 2)
- In Wisconsin, the Department of Corrections released 1,000 people held on probation or parole detainers (i.e. for a probation or parole violation). (April 2)
- In the month of March, the West Virginia Division of Corrections and Rehabilitation reduced their prison population by over 100 people. The releases included 70 people who were serving short prison terms for "parole-related sanctions," and some people who were eligible for weekend furloughs have had their furloughs extended to two weeks. (April 1)
- The Georgia Board of Pardons and Paroles has begun to review approximately 200 people for early release. They are considering people serving time for nonviolent offenses who are within 180 days of completing their prison sentences (or of their tentative parole date). (March 31)
- The Utah Department of Corrections has recommended over 80 people for release from state prisons to the Board of Pardons and Parole. The DOC reports that the people referred for release are within 90 days of completing their sentences. (March 26)

- The Director of the Rhode Island Department of Corrections is submitting weekly lists of people being held on low bail amounts to the public defender's and attorney general's offices for assessment in efforts to have them released. (Rhode Island is one of a handful of states that do not have jails, meaning that pretrial detainees are held in prisons.) The state DOC is also evaluating people with less than 4 years on their sentences to see if they can apply "good time" and release them early. (March 25)
- In Illinois, the governor signed an executive order that eases the restrictions on early prison releases for "good behavior" by waiving the required 14-day notification to the State Attorney's office. The executive order explicitly states that this is an effort to reduce the prison population, which is particularly vulnerable to the COVID-19 outbreak. (March 23)

Reducing jail and prison admissions

Lowering jail admissions reduces "jail churn" — the rapid movement of people in and out of jails — and will allow the facility's total population to drop very quickly.

- Across the state of Delaware (which has a combined jail and prison system), arrests for felony and misdemeanor crimes have dropped by about 45% following the governor's March 12th emergency stay-at-home order. Some Delaware law enforcement officials attribute this to a combined effect of people adhering to the stay-at-home order and also to "changes in policing...for the safety of officers and to prevent the spread of COVID-19." (May 5)
- Hawaii's statewide jail population has decreased by about 37%. Information about specific jails is limited, but we know that the Maui Community Correctional Center in Hawaii has seen a population drop of 38%. The Department of Public Safety attributes these decreases to diversion efforts by law enforcement, the Public Safety's Intake Services Division, and the court systems; as well as release efforts driven by the Office of the Public Defender and the state Supreme Court. (May 4)
- District attorneys in Brooklyn, New York and Philadelphia, Pennsylvania, took steps in mid-March to reduce jail admissions by releasing people charged with non-violent offenses and not actively prosecuting low-level, non-violent offenses. The Philadelphia Police Department announced on May 1st that they will resume arrests for certain property crimes. (May 1)
- In Maricopa County, Arizona, county prosecutors have reduced the number of charges they are filing, which has helped effect a jail population drop of almost 30%. In the first week of March 2020, prosecutors filed 734 cases, and last week, they filed only 107. (April 28)
- The population of the Halifax County Adult Detention Center, in Virginia, has decreased from 184 people in December 2019 to 150 people currently (about an 19% reduction). The jail administrator cites reduced court commitments, as well as individual court orders to release people. (April 26)
- In San Marcos, Texas, the city council passed a city ordinance that compels police to use citations -- instead of arrests and subsequent jail admissions -- for certain crimes,

including marijuana possession under 4 ounces, petty theft, graffiti, criminal mischief, and other “Class C” misdemeanors. (April 23)

- Since the California statewide emergency order issued on April 6th, the Santa Barbara County Sheriff’s Office has released half of the people who have been arrested with citations, rather than admitting them to the county jail. (April 20)
- In Kentucky, arrests have decreased from about 700 per day to 175 per day to reduce the pretrial jail population, according to the director of the Kentucky Administrative Office of the Courts. (April 17)
- The Lincoln County Sheriff’s Office in Oregon reduced their county jail population to 83 people by reducing arrests (the average population is 165 people). Since March 14th, they have only admitted people who were arrested for “serious crimes’ or people who “pose an extreme risk to the community.” Instead, they have relied on citation and release processes. (April 16)
- In Ramsey County, Minnesota (Minneapolis), daily jail bookings have dropped by about 74% between the first week of March and the first week of April. Last year, the jail averaged 60 new admissions to the jail and this March, the average was under 20 new admissions per day. (April 16)
- In York County, Maine, police officers are making fewer arrests, issuing summons for less serious offenses, and judges are allowing sentences to be delayed. Over the course of the month of March, this approach reduced the jail population by about one third. Since March 11th, only 61 arrests have taken place in York County. (April 15)
- The Chippewa County Sheriff’s Office in Wisconsin has reduced the county jail population from an average of 120 people to 50-60 people, primarily through citation and release rather than arrest and pretrial detention. (April 10)
- In King County, Washington (Seattle), jails are no longer accepting people booked for misdemeanor charges that do not present a public safety concern or people who are arrested for violating terms of community supervision. The Department of Adult and Juvenile Detention is also delaying all misdemeanor "commitment sentences" (court orders requiring someone to report to a jail at a later date to serve their sentence). (March 24)
- In response to the Oklahoma Department of Corrections' decision not to admit any new people to state prisons, Tulsa and Oklahoma counties are trying to keep their jail population down by not arresting people for misdemeanor offenses and warrants, and by releasing 130 people this past week through accelerated bond reviews and plea agreements. (March 22)
- The state of Maine vacated all outstanding bench warrants (for over 12,000 people) for unpaid court fines and fees and for failure to appear for hearings in an effort to reduce jail admissions. (March 17)
- Police departments in Los Angeles County, California, Denver, Colorado, and Philadelphia, Pennsylvania are reducing arrests by using cite and release practices, delaying arrests, and issuing summons. In Los Angeles County, the number of arrests has decreased from an average of 300 per day to about 60 per day. (March 16 and March 17)
- Baltimore, Maryland State's Attorney Marilyn Mosby will dismiss pending criminal charges against anyone arrested for drug offenses, trespassing, and minor traffic offenses, among other nonviolent offenses. (March 18)

- In Bexar County, Texas, Sheriff Javier Salazar released a COVID-19 mitigation plan that includes encouraging the use of cite and release and "filing non-violent offenses at large," rather than locking more people up during this pandemic. (March 14)

Reducing prison admissions reduces the risk of viral transmission into the prison population and helps maintain a prison population size to which the facility can provide appropriate medical care.

- The governor of Colorado issued an executive order that gives the Department of Corrections director the authority to refuse to admit people to state prisons. (March 26)
- In Illinois, an executive order from the governor has halted new admissions to state prison facilities. (March 26)
- California's Governor Newsom signed an executive order halting new intakes at California's five state prisons and the four juvenile facilities, stating that the effort is to prevent transmission of the virus from jails into state prisons. (March 24)
- The Colorado Department of Corrections states that, in concert with law enforcement, arrests for “low level technical parole violations” are temporarily suspended to help reduce the number of people being returned to state prisons. (March 23)
- The Oklahoma Department of Corrections announced that they are suspending admissions of newly sentenced individuals to state prisons, in an effort to prevent the virus from spreading rapidly behind prison bars. (March 22)

Reducing incarceration and unnecessary face-to-face contact for people on parole and probation

Below, we list jurisdictions that are limiting unnecessary check-ins and visits to offices for people on parole, probation, or on registries — steps that will reduce the risk of viral transmission. Given the unprecedented rate of unemployment, the Fines & Fees Justice Center is also tracking jurisdictions suspending supervision fees for people on probation and parole. For recommended measures that probation and parole agencies should take during the pandemic to protect people under supervision, see EXiT’s response tracker and recommendations.

- The Mississippi Department of Corrections temporarily suspended check-ins for people on probation, parole, house arrest, and any other forms of community supervision. Check-ins can now take place by phone, email, or video during the week. (April 1)
- In Nevada, the Division of Parole and Probation has suspended in-person check-ins for people on probation and parole, although fees are still being collected - including monthly supervision fees, charges for drug tests, and court-ordered restitution payments - despite record high unemployment rates. (March 23)
- The Arkansas Department of Corrections Division of Community Corrections has suspended supervision fees for the month of April 2020 and suspended face-to-face office visits. (March 20)

- In New York state, all in-person parole visits have been suspended and replaced with telephone call, text message, and video call check-ins. (March 20)
- The Rhode Island Department of Corrections announced that probation and parole offices will not hold in-person check-ins and that individual parole or probation officers will provide instructions to people on parole and probation about maintaining appropriate remote communication. (March 18)
- The California Department of Adult Parole Operations has reduced the number of required check-ins to protect staff and the supervised population by suspending office visits for people 65 and older, and those with chronic medical conditions. (March 17)

Eliminating medical co-pays

In most states, incarcerated people are expected to pay $2-$5 co-pays for physician visits, medications, and testing. Because incarcerated people typically earn 14 to 63 cents per hour, these charges are the equivalent of charging a free-world worker $200 or $500 for a medical visit. The result is to discourage medical treatment and to put public health at risk. In 2019, some states recognized the harm and eliminated these co-pays. We're tracking how states are responding to the COVID-19 pandemic:

States that do not charge co-pays	States that have suspended all co-pays for incarcerated people in response to the COVID-19 pandemic	States that have suspended all co-pays for respiratory, flu-related, or COVID-19 symptoms	States that have not made any changes in co-pay policy regarding COVID-19 pandemic
California	Alabama	Alaska	Nevada
District of Columbia	Arkansas	Arizona	Hawaii
Illinois	Connecticut	Colorado	
Missouri	Maryland	Delaware*	
Montana	Massachusetts	Florida	
Nebraska	Minnesota	Georgia	
New Mexico	Idaho	Indiana	
New York	Louisiana	Iowa	
Oregon	Rhode Island	Kansas	
Vermont	Tennessee	Kentucky	
Virginia	West Virginia	Maine	
Wyoming		Michigan	
		Mississippi	
		New Hampshire	
		New Jersey	
		North Carolina	
		North Dakota	
		Ohio	
		Oklahoma	
		Pennsylvania	
		South Carolina	
		South Dakota	
		Texas	
		Utah	
		Washington	
		Wisconsin	

*Table created March 13, 2020 and last updated: June 1, 2020. We welcome updates from states that have revised their policies. States can contact us at virusresponse@prisonpolicy.org. *The Delaware Department of Corrections has not changed their co-pay policy. According to the DOC's co-pay policy dated December 2019, there are no copays for "diagnostic and treatment of contagious/communicable diseases." The Delaware DOC has confirmed that this includes diagnosis and treatment of COVID-19.*

Reducing the cost of phone and video calls

Most federal prisons, state prisons and many local jails have decided to drastically reduce or completely eliminate friends and family visitation so as to reduce the risk of COVID-19 exposure in facilities. In normal times, we would point to the significant evidence that sustained meaningful contact with family and friends benefits incarcerated people in the long run, including reducing recidivism. But it is even more important, in this time of crisis, for incarcerated people to know that their loved ones are safe and vice versa. While many facilities have suspended in-person visitation, only a few have made an effort to supplement this loss by waiving fees for phone calls and video communication. Here are two notable examples:

- The Federal Bureau of Prisons has made phone calls and video calls free. Access to these communication services is likely limited by facility-specific policies, lockdowns, and availability of video calling equipment. (April 14)
- Shelby County, Tennessee suspended jail visitations, but to maintain these vital connections between families, they are waiving fees for all phone calls and video communication. (March 12)
- The California Department of Corrections and Rehabilitation (CDCR) is providing free calls on three days each week (although there may be time limits imposed by individual facilities). (March 31)

Other jurisdictions have implemented cost reductions that - while better than nothing - still severely restrict contact between incarcerated people and their loved ones:

- The Utah Department of Corrections is giving people in prison 10 free phone calls per week, with each call limited to 15 minutes. (Calls that go beyond the 15-minute limit will incur charges.)
- Prisons in Connecticut, Delaware, Florida, Vermont, and Pennsylvania are offering residents even smaller numbers of free calls per week. The same is true for jails in Middlesex County, Massachusetts; Harris County, Texas; and Montgomery County, Ohio.

Help us update this page

If you know of notable reforms that should be listed here, please let us know at virusresponse@prisonpolicy.org. We won't list everything, but we appreciate what you can send us.

This is **Exhibit "E"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

_____

A Commissioner, etc

Access to Physical and Mental Health Care

On a consistent basis, delivery and access to health care services remains the number one area of offender complaint to the Office. Federal offenders are excluded from the *Canada Health Act* and are not covered by Health Canada or provincial health care systems. With an annual expenditure now exceeding $200M, the Correctional Service provides essential physical and mental health services directly to offenders inside federal penitentiaries. Under the *Corrections and Conditional Release Act*, the Service must ensure reasonable access to health care in conformity with professionally accepted standards of practice. The Service is further obligated to consider an offender's state of health and health care needs in decisions prior to penitentiary placement, transfer, segregation, discipline and community release and supervision.

Issues of Concern

The federal correctional system faces serious capacity, accessibility, quality of care and health service delivery challenges and constraints:

- Bed space at the five regional treatment centres (psychiatric hospitals)
- Aging and inappropriate infrastructure
- Lack of "intermediate" mental health care units
- Management of self-injurious offenders
- Recruitment and retention of mental health care professionals
- Sharing of information between health care and front-line staff.
- Meeting the needs of aging inmates
- Operational dilemmas - prison vs. hospital, inmate vs. patient, security vs. treatment
- Infectious diseases, drugs in prison and harm reduction
- Informed consent and involuntary treatment

Reports & Recommendations

- *Annual Report 2014-2015* (HTML) (PDF, 2mb)
  - Heath Care in Federal Institutions
- *Annual Report 2013-2014* (HTML) (PDF, 5mb)
  - Access to Health Care
- *Annual Report 2012-2013* (HTML) (PDF, 744kb)
  - Access to Health Care
- *Risky Business: An Investigation of the Treatment and Management of Chronic Self-Injury Among Federally Sentenced Women*
  Final Report (HTML) (PDF, 353kb)

  - News Release (HTML)
  - Backgrounder (HTML)

- *Annual Report 2011-2012* (HTML) (PDF, 1.4mb)
  - Access to Physical and Mental Health Care - OCI Recommendations & CSC Responses

- *Annual Report 2010-2011* (HTML) (PDF, 2.1mb)
  - Access to Mental Health Services - OCI Recommendations & CSC Responses
  - Physical Health Care - Special Focus on Elderly Offenders - OCI Recommendations & CSC Responses

- *Annual Report 2009-2010* (HTML) (PDF, 2mb)
  - Access to Physical and Mental Health Care - OCI Recommendations & CSC Responses

- *Annual Report 2008-2009* (HTML) (PDF, 2mb)
  - Mental Health - OCI Recommendations & CSC Responses
  - Addressing Incidents of Self-harm - OCI Recommendations & CSC Responses
  - Health Services Review - OCI Recommendations & CSC Responses

- *Under Warrant: A Review of the Implementation of the Correctional Service of Canada's Mental Health Strategy (September 23, 2010)* (HTML) (PDF, 529kb)

Speeches and Remarks

- Health Care and Federal Corrections: An Ombudsman’s Perspective 2013-10-03 (HTML)

- Speaking Notes for Correctional Investigator - *A Legacy of Missed Opportunities: The Case of Ashley Smith, Health Law Institute Open Seminar Series, University of Alberta (November 2011)* (HTML)

- Speaking Notes for Correctional Investigator - *Appearance before the Standing Committee on Public Safety and National Security (June 2009)* (HTML)

- Speaking Notes for Correctional Investigator - *Appearance before the Special Senate Committee on Aging (February 2008)* (HTML)

Presentations

- *Mental Health in Federal Corrections - CASHRA Annual Conference 2012 (June 2012)* (HTML) (PDF, 767kb)

- *Mental Health and Corrections: Saint Francis Xavier University Department of Psychology Colloquium Series (March 2011)* (HTML) (PDF, 682kb)

In the Media

- *Ashley Smith inquest: What should we do with other self-harming inmates?*, **The Star** (December 19, 2013)

- *Get severely mentally-ill out of prison, into secure hospitals: prison watchdog*, **Global News** (August 8, 2013)

- *Ashley Smith inquest: Did difficult inmate belong in a jail or a psychiatric facility?*, **The Star** (March 24, 2013)

- *Prison watchdog: Some lessons 'ignored' since Ashley Smith death*, **CTV News** (November 4, 2012)

- *Action needed on self-injury, segregation among inmates with mental illness in prisons*, **The Hill Times** (October 29, 2012)

- *Suicide attempts, self-harm rising in Canada's prisons*, **CBC News** (October 23, 2012)

- *Mental health problems treated as security issue in federal prisons, report says*, **The Star** (October 23, 2012)

- *Number of prisoners who self-harm almost tripled over past five years: report*, **The Canadian Press** (October 23, 2012)
- *UN urges Canada to ban solitary confinement for mentally ill prisoners*, **The Star** (June 2, 2012)
- *Where is the plan to replace disappearing treatment for mentally ill prisoners?*, **The Star** (April 27, 2012)
- *Les cas d'automutilation augmentent dans les prisons*, **La Press** (March 5, 2012)
- *Vieillir en prison : les établissements sont mal adaptés* (in French), **Radio Canada** (March 1, 2012)
- *Le C-10 ne fera rien pour traiter les graves pénuries de soins de santé mentale dans nos prisons* (in French), **Canadian Drug Policy Coalition** (February 23, 2012)
- *Rapport du Bureau de l'enquêteur correctionnel - Les pénitenciers sont mal adaptés aux détenus vieillissants* (in French), **Le Devoir** (November 2, 2011)
- *Aging prison population facing new challenges: federal ombudsman report*, **The Canadian Press** (November 1, 2011)
- *Where death is only escape*, **National Post** (July 16, 2011)
- *'Prison isn't a hospital,' investigator says*, **The Telegram**, (July 09, 2011)
- *Mental health and justice officials collaborate at national symposium*, (May 25, 2011)
- *Il y a trop de criminels avec des maladies mentales dans les prison, dit Toews* (in French), **La Presse Canadienne** (May 25, 2011)
- *Older prisoners pose new challenges for Canada's prisons*, **UBC Journalism News Services THETHUNDERBIRD.CA** (posted March 31, 2011)
- *Report finds Serious Gaps in the Planning and Delivery of Mental Health Services for Federally Sentenced Offenders*, **OCI** (September 23, 2010)
- *Prisons given funding, but no clear plan*, **The Star**, (September 22, 2010)
- *Pan-Canadian strategy being developed to tackle mental health in prisons*, **CMAJ** (December 14, 2010)
- *End long isolation of mentally ill inmates: watchdog*, **CTV News** (September 8, 2010)
- *No more Ashley Smiths*, **Globe and Mail** (September 8, 2010)
- *The wrong fix: We put the mentally ill in jail. Now they're ending up in solitary*, **Maclean's** (January 21, 2010)
- *Correctional Investigator of Canada Welcomes Call for National Strategy on Delivery of Mental Health Services to Youth and Adult Offenders*, **OCI** (June 9, 2008)

Additional Information and Resources

- *Mental Health and Drug and Alcohol Addiction in the Federal Correctional System*, (December 2010)
- *Planning Services for Elderly Inmates with Mental Illness (PDF, 373kb)*, **Corrections Today** (June 2010)
- *A Comparative Review of Suicide and Self-Injury Investigative Reports in a Canadian Federal Correctional Population*, Correctional Service of Canada (May 2010)
- *Criminal Justice Standards on Treatment of Prisoners*, (February 2010)
- *A Sourcebook on Solitary Confinement*, Mannheim Centre for Criminology, London (2008)

- *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, Report of the Standing Senate Committee on Social Affairs, Science and Technology (May 2006)

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Date modified 2016-03-14

This is **Exhibit "F"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

Notes for an Address
Mr. Howard Sapers, Correctional Investigator of Canada

Health Care and Federal Corrections: An Ombudsman's Perspective

Custody and Caring 13th Biennial International Conference On the Nurse's Role in the Criminal Justice System

Saskatoon, SK
October 3, 2013

Thank you for the invitation to be here with you today. I want to acknowledge the organizers – the College of Nursing, University of Saskatchewan – as well as the sponsors of this Conference, including the Correctional Service of Canada.

I have tremendous respect and admiration for health care professionals working in the criminal justice system. Your jobs are exceptionally difficult and demanding. Caring and compassion are not readily recognized or acknowledged in the criminal justice sector. I applaud the effort, innovation and initiative that bring you together at this highly regarded event.

I have four objectives in mind in speaking with you today in my capacity as Correctional Investigator of Canada. First, I want to explore the profile of the federal inmate population and how its health care needs are met by the Correctional Service of Canada.

A discussion of the challenges, conflicts and dilemmas that arise between health and security-centred perspectives on inmate management is my second order of business.

Thirdly, I will draw on a recently released investigation by my Office examining chronic self-injury among federally sentenced women to illustrate some of my concerns about managing mental health in a prison setting.

In keeping with the themes and objectives of this conference, I will conclude with some suggestions about what I consider to be among the most serious and urgent requirements facing correctional health care. To that end, some future directions for reform will be offered.

Allow me first to make a few introductory comments about my role as Correctional Investigator and the mandate of my Office. This "Cole's Notes" version of what I do may help situate some of my more critical comments about the accessibility and quality of health care service delivery in corrections.

First, a slight detour. The Office was established in 1973 following a Commission of Inquiry into the 1971 riot at Kingston Penitentiary. As most of you know, KP closed at the end of September. This is noteworthy for a number of reasons, including one you may not be aware of. Inger Hansen, Canada's first Correctional Investigator appointed in '73 passed away this week, just as the last inmates were being transferred from Kingston Pen. Inger's death is a solemn reminder of an end of an era in Canadian corrections. Inger will be missed by all who knew her.

The Office of the Correctional Investigator functions as an ombudsman for federally sentenced offenders in Canada, those serving sentences of two years or more.

As Correctional Investigator, I have statutory authority to conduct investigations into issues raised by offenders related to decisions, recommendations, acts and omissions of the Correctional Service of Canada. Decisions to commence, or terminate, as well as the methods used to conduct an investigation, are at my discretion.

I report to Parliament through the Minister of Public Safety on the individual and systemic concerns that offenders bring to my Office, and on the ability of the CSC to implement solutions. I am fully independent of the CSC and the Department of Public Safety.

My Office is an oversight, not an advocacy body; my staff does not take sides when investigating complaints. We look for compliance, fairness and legality. We view corrections through a human rights lens.

My staff have access to all facilities, records and personnel of the CSC. Our legislation provides for penalties for anyone who attempts to impede our work.

These are broad authorities and help us in the pursuit of fair, accountable and effective corrections. The Office is not an armchair critic of the CSC. It is an essential part of the legal framework that governs federal correctional practice.

On an annual basis my Office receives and addresses thousands of offender complaints, contacts and inquires. The Office has 35 permanent staff, most of whom are directly involved in the day-to-day resolution of offender complaints.

My team of investigators regularly visit federal institutions to meet with both offenders and staff. In 2012-13, investigators cumulatively spent 337 days in federal penitentiaries and interviewed more than 1,500 offenders. Last year, the Office reviewed 165 cases involving incidents of inmate serious bodily injury or death. Over 1,400 use of force files were reviewed, including an increasing proportion of use of force incidents involving mental health concerns.

Health care remains the single most frequent area of offender complaint to my Office. In fact, it consistently tops the list of concerns brought forward by inmates to my Office. When we break that number down a bit further, it is in the area of **access to health care** that inmates most frequently complain. Investigations and findings from prisons across the country confirm that timely access and quality of care remains problematic, especially in more remote penitentiaries.

I am not surprised that concerns about health care often elicit a strong reaction from the inmate population. In a prison setting, inmates have lots of time to think about their health and it’s one of the few areas in which they may exercise some degree of personal control — they still "own" their health.

For some, prison may be one of the few times in their life when there is some degree of continuity of care. On the other hand, a term of imprisonment, which may mean frequent transfers between institutions, can result in interruptions in treatment, changes in medication or disconnects between institutional care and community care upon release. On this last point, provincial and territorial health systems have much to contribute in order to ensure continuity of care.

While in custody, offenders have very little practical choice over who attends to their health needs, how or where that care is administered or what constitutes an “essential” health care item, service or need. Unlike most of us when we need physical or mental health care, inmates are offenders first and patients second. Deprived of their liberty, they cannot “shop” around for health care services or health care providers. They take what they can get, when they can get it.

Notwithstanding, a high standard of care is required, even if for no other reason than good prison health is good public health.

I want to be clear that these are not criticisms of those providing direct health care services to inmates, but rather of the factors that arise from how prison health care services are organized, structured and delivered in federal penitentiaries.

In Canada, unlike some other jurisdictions, there is no separate or distinct health care agency that directly provides for the health care needs of federally sentenced offenders. Persons under federal custody are excluded from the *Canada Health Act* and they are not covered by provincial health care systems.

Jurisdictional and constitutional realities mean that the Correctional Service of Canada is responsible for ensuring reasonable inmate access to health care in conformity with professionally accepted standards. The professionally accepted standard found in Canadian legislation is high – as it should be. The CSC is further obligated to consider an offender's state of health and health care needs in all decisions, including placements, transfer, segregation, discipline and community release and supervision.

These are important legislated obligations that cannot be ignored no matter how challenging they can be.

Domestically and internationally, governance, accountability and funding issues are driving a series of reforms in how correctional health care is administered, where those services are delivered and by whom.

As you heard yesterday, CSC is making progress in this area and is in the throes of governance reform. I am encouraged, but not entirely satisfied.

Alternative models for prison health care service delivery are in place in a number of countries – Norway, France, Australia and the United Kingdom (to name a few) – and can be found more close to home in provincial jurisdictions such as Ontario, British Columbia, Alberta and Nova Scotia.

In these systems, inmate health care may be delivered and regulated by national or provincial health care agencies, not correctional services. The delivery of health services by agencies outside the prison system means less chance of role conflict or confusion between health and correctional mandates. In some models, health care professionals report to health care administrators. Lines of authority, decision-making, oversight and reporting are clear, consistent and distinct from those of corrections.

The chance of security priorities over-riding clinical concerns is considerably reduced in such models.

I remain convinced that federal corrections has some catching up to do insofar as there are successfully implemented alternatives in the governance and administration of prison-based health services. CSC can benefit from the experience of others.

This is particularly true when thinking about the delivery of mental health care. Despite having achieved accreditation of physical health services and notwithstanding the ongoing realignment of health care functions and reporting relationships at CSC's five treatment centers, the system as it operates now still lacks integration and is subject to both individual and systemic limitations.

It is no secret that the inmate population is disproportionately comprised of persons from disadvantaged or vulnerable backgrounds. Offenders often arrive in prison with chronic or unaddressed health conditions. Their poor physical health is frequently exacerbated by histories of trauma, substance abuse or addiction issues, co-morbidities that are common among those living on the margins of society.

In correctional language, it is a high-risk, high-needs population that requires a wide variety of services and supports.

The federal inmate profile is especially revealing from a determinants of health perspective:

- One in five federal inmates are aged 50 or older. A significant number will require specialized and expensive care.
- 23% of the total inmate population is Aboriginal, despite comprising just 4% of the general Canadian population.
- 9% of inmates are Black Canadians; almost triple their representation rates in the community.
- In the last 5 years, the number of federally incarcerated women has increased by almost 40%.
- The number of Aboriginal women in federal custody has grown a staggering 93% in ten years. One in three federally sentenced women is now of Aboriginal ancestry.
- The average level of educational attainment upon admission to a federal penitentiary is Grade 8.
- Close to 70% of federally sentenced women report histories of sexual abuse and 86% have been physically abused at some point in their life.
- Before prison, most offenders are chronically under-employed.
- Addiction or substance abuse plagues 80% of offenders. Two-thirds of federal offenders were intoxicated when they committed their index offence.
- 31% of the inmate population is a carrier of Hepatitis C and 5% are HIV positive.
- At admission, nearly 40% of male offenders require further assessment to determine if they have mental health needs. 30% of women offenders have previously been hospitalized for psychiatric reasons.
- In FY 2011-12, the Correctional Service delivered at least one institutional mental health service to 48.3% of the total inmate population, with 47% of Aboriginal offenders and 75% of federally sentenced women receiving services in the last fiscal year.

These data point to the significant resource and capacity challenges facing Canada's correctional authority. In most cases, the numbers are probably lower than the reality, particularly measures of mental health needs, which tend to be under-reported in a prison setting.

Providing prison-based health care is an increasingly complex and expensive endeavour. The total annual health services expenditure for federal corrections now exceeds $216M. The cost to provide physical health care to inmates is about $150M annually. The annual cost to operate CSC's five treatment centres, with a combined capacity of 675 beds, is approximately $108 million.

On a per capita basis, data that is now five years old indicates that the average annual physical health care costs per inmate varies from a low of $6.1K in Ontario to a high of $9.2K in the Atlantic Region. Inmate health care costs are high and rising relative to the needs of a population that is growing older and sicker behind bars.

It is not an accident that the CSC has grown into the largest single employer of nurses and psychologists in the federal public service. Today, the Correctional Service employs a total of approximately 1,200 health care professionals, of which the vast majority are nurses followed by psychologists, pharmacists, medical doctors and social workers.

I have reported previously that CSC faces serious staffing, recruitment and retention challenges that reflect many of the concerns addressed at this conference – scope of practice, licensing and accreditation, issues related to rates of pay, professional development and terms and conditions of employment. As much as I can tell, these are common and prevailing concerns in many countries and their correctional systems.

For FY 2011-12, the national vacancy rate for all health care positions in CSC was just over 8.5%. This number is probably a low estimate of vacancies when compared to actual need, as many long term vacancies have resulted in positions simply being eliminated. The psychologist vacancy rate in 2011-12 was 16% or 51 positions.

In reality, this rate is much higher considering that 50 of 329 psychologist positions were filled by incumbents who are non-licensed staff (or "under-fills") and cannot deliver the same level or range of services as licensed psychologists. In other words, nearly one-third of CSC's total psychologist staff complement is either vacant or "under-filled."[1]

As health care professionals, you are challenged to provide care in a setting with a mission and mandate designed for other purposes – primarily security and control. Resource and infrastructure limitations impose unnatural barriers in terms of what can be reasonably and practicably accomplished.

I can't help but to think how incredibly difficult, even frustrating, it must be to build a therapeutic and trusting nurse-patient relationship in a setting where institutional security interests are paramount, and quite often, over-riding concerns.

Research confirms that conditions of work are strong predictors of job satisfaction. Heavy workloads, inadequate staffing and restricted access to equipment, technology and resources define the correctional nursing experience. A 2010 study exploring work-life issues among correctional nurses in Ontario confirms that workplace tension, overload and role conflict can lead to job stress and burnout.

Ironically perhaps, the same factors that can make correctional nursing so challenging – professional autonomy, respectful relationships with peers, overcoming patient care barriers and garnering organizational support – can also be a source of strength, pride and satisfaction.

It is not lost on me that many of the workplace concerns and challenges that correctional health care professionals face are organizational, systemic or structural in nature. Scopes of practice, attractive and competitive salaries, balanced workloads (including percentage of time spent on direct vs. indirect care), support for continuing education and skills training, participation in professional organizations, mobility of licensing and qualifications, all suggest that governance, along with organizational and administrative support, are critical elements of job satisfaction for correctional health care professionals.

The unique structure, culture and purpose of prison create inherent role conflict and confusion and invites ethical and professional dilemmas. These conflicts – security vs. care, penitentiary vs. hospital, assistance vs. control – arise from the fact that prisons are not intended to be hospitals, but some inmates are in fact patients.

Care and compassion can seem antithetic to the pursuit and aims of punishment and correction. The conditions of confinement that mark the modern prison – the degradations of over-crowding; the spread of infectious disease; the warehousing of society's most vulnerable; the observation, segregation and isolation cells used to manage or contain mental illness; the death that often comes without dignity behind prison bars – all reflect the lack of a health-centred focus in design and purpose.

Double-bunking, prison self-injury, use of force incidents, segregation, illicit drug use, attempted and completed acts of suicide add to the complexities of managing health care in an inherently punitive and unpredictable setting.

My Office continues to report on systemic issues of concern surrounding deaths in custody. These include: timely and appropriate response to medical emergencies; information-sharing between clinical and frontline staff; monitoring and management of suicidal and chronic self-injurious offenders; and, quality of CSC investigative reports and corrective measures.

In the period between FY 2002-2003 and FY 2012-2013, there were 583 deaths in CSC facilities. Over 70% of all deaths in federal custody over this time were attributable to "natural" causes.

An investigation into the Service's mortality review process (MRP) for natural cause deaths is currently underway by my Office.

I have previously expressed concern that the MRP falls considerably short of meeting legislative or investigative standards. For instance, having now reviewed hundreds of these files, I am struck by the fact mortality reviews hardly ever contain a specific finding or recommendation that speaks to quality or standard of health care. I will more fully report on my findings later this fall.

The incidence of prison self-injury in federal penitentiaries has more than tripled in the last five years. An investigative report titled *Risky Business* was released earlier this week by my Office. It assesses the response of Correctional Service to incidents of chronic self-injury among eight federally sentenced women. I would like to report some of the findings and recommendations of *Risky Business* to you today.

A total of 802 institutional security incidents were recorded for these eight women over the 30-month period of investigation. Just over half of these incidents were reported as self-injury or suicidal events. Nearly one-third of the documented self-injury incidents involved a use of force intervention (e.g. physical handling, pepper spray, use of restraints).

Reminiscent of Ashley Smith's case, six women were convicted of other criminal offences arising from their behaviour in custody and which resulted in time added to their sentence. Three were convicted for offences that occurred during staff interventions in acts of self-injury.

We found considerable tension between mental health care and security-focused interventions. Indeed, perceived security concerns, regardless of individual risk, tended to trump clinical or mental health care needs. Seven of the women served considerable periods of time under some form of seclusion.

Five women were routinely placed in administrative segregation following acts of self-injury. Resistive or assaultive behaviour most often occurred after staff intervened in an act of self-injury and was most frequently observed in context of mandatory strip searching required for an administrative segregation or clinical seclusion placement.

In general, security and control responses were found to be disproportionate to the risk presented, inappropriate from a mental health needs perspective and counterproductive to therapeutic treatment aims. For example, for some women, prolonged periods of seclusion and isolation exacerbated the frequency and severity of their self-injury and/or escalated their resort to other resistive behaviours.

Similarly, the frequent use of physical restraint equipment to gain control and to manage or prevent self-injury was often found to be problematic. Although CSC policy directs that physical restraints are neither a medical or clinical measure, some of the treatment plans provided for the "consensual" use of restraints to manage or prevent self-injury. In some extreme cases, reliance on the near perpetual use of physical restraints was justified as a "life-preserving" measure.

The report contains sixteen recommendations including:

- enhanced training for staff working with chronic self-injurious offenders;
- strengthened monitoring and reporting on the use of physical restraints in the management of prison self-injury;
- prohibition on placing self-injurious offenders in conditions of prolonged seclusion or segregation;
- appointment of an independent patient advocate or quality care coordinator at each of the five regional treatment centres, inclusive of the Churchill Unit, RPC, Prairies; and
- transfer of the most acute and high risk individuals to hospital settings.

While the Minister of Public Safety has agreed that individuals with chronic and complex mental health needs should not be in prisons, I await CSC's official response.

It is unfair to expect corrections to do the impossible. Afterall, corrections officials are in the business of running prisons, not hospitals. Notwithstanding, prisons do house some seriously ill people, and sometimes their health care needs exceed available services, capacities and resources.

This is particularly true when it comes to mental health. Given rising needs, there are far too few specially trained and dedicated psychiatric nurses employed by CSC. Training in mental health is too limited. Infrastructure is problematic. With one exception, there are no intermediate mental health care units available for male inmates. Self-injury continues to be managed as a behavioural or control issue rather than a sign or symptom of poor mental health.

That said, CSC recognizes its many challenges and has developed a good strategy for prison based mental health care. The strategic plan is good, but it must be fully embraced across the Service.

Before I conclude, I want to leave you with a few thoughts about what I believe to be among the most serious and urgent requirements for prison-based health care reform in Canada. This list is far from exhaustive or comprehensive, but it is a good starting point for initiating dialogue about priorities and reform.

First, let me come back to the need to urgently and seriously explore alternative mental health care service delivery models rather than relying on institutions that were never designed to care for individuals with serious mental health issues. These offenders should be transferred to community psychiatric or forensic hospitals as a matter of priority.

Second, the use of prolonged isolation or segregation to manage offenders at risk of suicide or self-injury as well as offenders with acute mental health issues should be prohibited. Such practices are not safe or humane.

Thirdly, it is time for CSC to fully implement its Mental Health Strategic Plan and develop intermediate mental health care capacity across the country.

Fourth, in my opinion, correctional administrators could benefit from the appointment of independent patient advocates or quality care coordinators, particularly with respect to forensic or psychiatric treatment settings. While I appreciate that health care professionals routinely act as advocates for their patients, additional oversight will help the Service meet the most rigorous standards of professional and community practice.

Finally, all medium, maximum and multi-level prisons should have primary health care providers, on site, on a 24-7 basis. There are simply too many medical emergencies and complex care needs to be handled part-time.

Concluding Remarks

As health care professionals, you are expected to provide and maintain high standards of care. On a daily basis, you are asked to perform activities, assessments or functions that may raise conflicts in the nurse-patient relationship. You are generalists in a specialized environment providing a range of interventions from health promotion and prevention through to chronic disease management and palliation.

Your work requires a high degree of creativity, flexibility, personal and professional autonomy that may, at times, blur conventional scopes of practice.

You may face situations of competing values, loyalties and obligations that can be the source of workplace angst and conflict.

You must preserve the integrity of the nursing code of ethics within the punitive structures of human confinement. You must advocate for the best interests of people that so many others condemn. Maintaining patient privacy and confidentiality and establishing a relationship of trust can conflict with ever-pervasive security requirements. With your peers and administrators, you seem to be endlessly engaged in struggles for professional respect, equivalence and recognition.

From my own experience serving as prison ombudsman, I also understand that the most rewarding work can happen in the most demanding of settings. I suspect that providing health care in prisons proves that point on a daily basis.

I want to thank you again for inviting me to here with you and for your attention. I wish you continued strength and success in your work, and I look forward to your questions and comments.

[1] CSC, *Health Services Sector 2011-2012 Performance Measurement Report*, November 2012.

Date modified 2014-01-23

This is **Exhibit "G"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

Health status of prisoners in Canada

Narrative review

Fiona Kouyoumdjian MD PhD CCFP FRCPC **Andrée Schuler** PhD **Flora I. Matheson** PhD **Stephen W. Hwang** MD MPH FRCPC

Abstract

Objective To review the literature for quantitative research on the health status of persons in custody in provincial, territorial, and federal correctional facilities in Canada, and summarize recent evidence.

Quality of evidence A search was performed in research databases and the websites of relevant Canadian governmental and non-governmental organizations for quantitative studies of health conducted between 1993 and 2014. Studies were included that provided quantitative data on health status for youth or adults who had been detained or incarcerated in a jail or prison in Canada.

Main message The health status of this population is poor compared with the general Canadian population, as indicated by data on social determinants of health, mortality in custody, mental health, substance use, communicable diseases, and sexual and reproductive health. Little is known about mortality after release, chronic diseases, injury, reproductive health, and health care access and quality.

Conclusion Health status data should be used to improve health care and to intervene to improve health for persons while in custody and after release, with potential benefits for all Canadians.

EDITOR'S KEY POINTS

- The health of persons who experience detention or incarceration in provincial, territorial, and federal facilities is poor compared with the general Canadian population.
- Health status data can be used to improve health care services and health for this population, with potential benefits for all Canadians, such as decreasing health care costs, improving health in the general population, improving public safety, and decreasing re-incarceration. The time in custody provides an opportunity to intervene.
- Information on health status is also important for defining areas of focus for improving health and health care. Health care in correctional facilities is largely delivered by government authorities in Canada, which makes the lack of data on some key indicators of health striking.

POINTS DE REPÈRE DU RÉDACTEUR

- L'état de santé des personnes en détention ou incarcérées dans les établissements provinciaux, territoriaux et fédéraux est médiocre par rapport à celui de la population canadienne en général.
- Il est possible d'utiliser les données sur l'état de santé pour améliorer les services médicaux et la santé dans cette population et, ce faisant, apporter potentiellement des avantages à tous les Canadiens en réduisant les coûts des soins de santé, en améliorant la santé et la sécurité publique dans l'ensemble de la population et en diminuant les incarcérations répétées. Le temps passé en détention donne l'occasion d'intervenir.
- Les renseignements sur l'état de santé revêtent aussi de l'importance pour définir les domaines où il est prioritaire d'améliorer la santé et les soins. Au Canada, les soins de santé dans les établissements correctionnels sont majoritairement fournis par les autorités gouvernementales et il est donc étonnant que les données sur certains indicateurs clés soient insuffisantes.

This article has been peer reviewed.
Cet article a fait l'objet d'une révision par des pairs.
Can Fam Physician 2016;62:215-22

L'état de santé des détenus au Canada

Révision narrative

Résumé

Objectif Passer en revue la documentation portant sur les recherches quantitatives concernant l'état de santé des personnes en détention dans les établissements correctionnels provinciaux, territoriaux et fédéraux au Canada et faire la synthèse des données probantes récentes.

Qualité des données Une recension a été effectuée dans les bases de données de recherche et les sites web des organisations gouvernementales et non gouvernementales canadiennes pour trouver des études quantitatives sur la santé réalisées entre 1993 et 2014. Les études qui comportaient des données quantitatives sur l'état de santé des jeunes ou des adultes détenus ou incarcérés dans une prison ou un établissement correctionnel au Canada ont été retenues.

Message principal L'état de santé de cette population est médiocre par rapport à celui de la population canadienne en général, comme le font valoir les données sur les déterminants sociaux de la santé, la mortalité en détention, la santé mentale, la toxicomanie, les maladies transmissibles et la santé sexuelle et de la reproduction. On en sait très peu à propos de la mortalité, des maladies chroniques, des blessures, de la santé de la reproduction, de même qu'en ce qui a trait à l'accessibilité et à la qualité des soins de santé après la libération.

Conclusion On devrait utiliser les données sur l'état de santé pour améliorer les soins de santé et intervenir pour que ces personnes soient en meilleure santé pendant et après leur détention, ce qui pourrait être bénéfique pour tous les Canadiens.

More than 11 million people are imprisoned worldwide at any given time,[1] and more than 30 million move through the prison system annually.[2] In Canada, there are more than 250 000 adult admissions each year to correctional facilities, about 8000 of which are to federal custody, and there are 14 000 youth admissions each year.[3,4] On an average day, there are about 40 000 people in correctional facilities.[5-7]

In Canada, the federal and provincial or territorial governments share jurisdiction over correctional institutions. Persons who are sentenced to less than 2 years or who are detained before sentencing (remanded) serve time in provincial and territorial facilities, whereas persons who are sentenced to 2 years or longer serve time in federal facilities. Health care in custody might be delivered by the governmental authority responsible for health, as in Nova Scotia and Alberta, by the governmental authority responsible for corrections, as in federal facilities and in Ontario, or contracted out to a private company, as in British Columbia.

Standards for health care in federal facilities are defined in the federal *Corrections and Conditional Release Act*.[8] In provincial facilities, federal legislation such as the *Canada Health Act* remains applicable to health care delivery,[9] and provincial or territorial legislation might also apply (eg, the *Ontario Health Protection and Promotion Act*[10]). The United Nations states that "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."[11] However, this obligation is not consistently met in Canada.[12-16]

Given the large number of persons in custody each year in Canada and that the median length of detention is less than 1 month,[3] most physicians in Canada likely encounter people either while in custody or after release. Knowledge about the health of this population is important to ensure appropriate care and to inform programs and policies to improve health. In this article, we describe the health status of people who experience detention or incarceration in correctional facilities in Canada, and we highlight opportunities to improve health.

Quality of evidence

We performed a search of quantitative studies of health conducted between 1993 and 2014. We searched MEDLINE, PsycINFO, EMBASE, the Cochrane Library, Social Sciences Abstracts, Social Services Abstracts, Sociological Abstracts, CINAHL, Criminal Justice Abstracts, ERIC, ProQuest Criminal Justice, ProQuest Dissertations and Theses, Web of Science, and Scopus in April 2014, and we also searched the websites of relevant Canadian governmental and non-governmental organizations. The search strategy is available from the corresponding author (F.K.) on request.

We included studies that provided quantitative data on health status[17,18] for youth and adults who had been detained or incarcerated in a jail or prison in Canada. We included studies that were conducted from 1993 to 2014 in order to capture data that reflect the current health status of this population.

Two reviewers (F.K. and A.S.) independently reviewed titles and abstracts for eligibility for inclusion, and 1 reviewer (F.K. or A.S.) reviewed each full article and extracted relevant data. Where the same data were reported across multiple publications, we included the publication that was most recent or that reported more comprehensive data. In some cases in which many studies had been conducted on a given risk factor or condition, we reported only data from key studies (eg, studies that were more recent or that had larger samples), as the main goal of our study was to describe the health status of this population.

Main message

Health status

Social determinants of health: More than 50% of those admitted to sentenced custody are younger than 35 years of age, compared with less than one-third of the Canadian population, and the median age of those admitted to remand ranges between 28 and 33 years across the provinces and territories.[3] About 1 in 10 adult admissions to federal, provincial, or territorial custody are for women,[3] and 1 in 5 youth admissions are for girls.[4] About 1 in 4 admissions are for aboriginal persons, while they make up only 4% of the general population.[3,4]

Most persons in custody have experienced substantial adverse events in childhood, such as witnessing family violence, having 1 or more parents absent, or being involved with the child welfare system.[19-32] At least half report a history of childhood physical, sexual, or emotional abuse.[19,21-23,25,28-50] About 15% to 20% of aboriginal persons in federal facilities have attended residential schools.[29,51]

The socioeconomic status of this population is low, as indicated by a lack of housing,[30,52-55] low employment rates,[22,26,30,52,54,56-58] low educational achievement,[30,58] and low income status.[58,59] One-fifth of men in provincial custody in Toronto, Ont, in 2009 and 2010 reported being homeless at the time of admission,[54] and more than half of youth in custody in British Columbia in 2012 and 2013 had been homeless at some time.[22] Most adults in custody have not completed high school[30,58] (eg, more than 55% of people admitted to federal custody in 2011 had less than a grade 10 education[30]), whereas only 19% of all Canadian adults have not obtained a high school diploma.[60]

Mortality: A large number of persons die in custody each year[61,62]: 536 persons died in federal custody between 2003 and 2013, and 327 died in provincial or territorial custody between 2001 and 2010.[63,64] Mortality rates are higher for persons in custody than for the general population[62]: in Ontario between 1990 and 1998, the crude mortality rate for men in federal facilities was 420.1 per 100 000 and in provincial facilities it was 211.5 per 100 000, compared with a rate of 187.5 per 100 000 in men with a similar age distribution in the general population. This is remarkable, as persons in custody are protected from many types of unintentional injuries, which are the leading cause of death in the general population for persons aged 25 to 44.[65] Rates of suicide and homicide are particularly high compared with the general population,[63,64] with suicide rates of 70 per 100 000 in federal custody and 43 per 100 000 in provincial custody compared with the overall Canadian rate of 10.2 per 100 000, and homicide rates of 22 per 100 000 in federal custody and 2.3 per 100 000 in provincial custody compared with the overall Canadian rate of 1.6 per 100 000.

International data consistently show high mortality rates subsequent to release from custody,[2] including from preventable causes such as overdose[66-71]; however, there are no Canadian data on rates or causes of death after release.

Mental health and substance use: Most persons in correctional facilities have mental disorders as defined by the *Diagnostic and Statistical Manual of Mental Disorders*.[22,23,28,32,35,39,52,58,72-84] Among men in provincial custody in Edmonton, Alta, lifetime prevalence rates and the corresponding rates in the general population of men were 91.7% versus 43.7% for any disorder, 87.2% versus 39.6% for substance use disorders, 56.7% versus 8.6% for antisocial personality, 22.8% versus 12.0% for affective disorders, 2.2% versus 0.5% for schizophrenia, and 1.1% versus 0.4% for cognitive impairment.[73] Similarly, men in federal detention in British Columbia in 1999 had lifetime rates 2 to 3 times greater than men in a community sample with respect to mood disorders, schizophrenia, anxiety disorders, substance use disorders, and eating disorders.[83] In 2 studies, more than 4 of 5 youth in detention in British Columbia and Ontario, respectively, met criteria for at least 1 disorder in the *Diagnostic and Statistical Manual of Mental Disorders*,[28,32] compared with 30.6% in the general community sample in the Ontario study.[32]

The recent tragic and preventable deaths of young persons in federal custody[85,86] have brought international attention to the high rates of suicide and self-injury in persons in custody in Canada.[19,22,23,38,45,52,55,73,74,87-98] Most studies have found that more than 1 in 5 persons in custody have attempted suicide.[38,52,73,74,88-90,92,94,95,99] Of men in provincial custody in Edmonton, 22.8% had attempted suicide, which was 7.1 times the expected rate.[73] In 2012 and 2013, 13% of youth in custody in British Columbia had seriously considered suicide and 10% had attempted suicide in the past year.[22]

Regarding substance use, many persons in custody report having initiated alcohol and drug use at a young age.[22,23,29,55,100,101] More than two-thirds of adults and youth in custody are current smokers[22,97,102] compared with 16% of all Canadians.[103] Alcohol use is very common in this population, as is risk behaviour such as binge drinking and drinking and driving.[21,22,24,48,55,92,104-107] Regarding drug use, most people report recent use at the time of admission to custody,[22,52,57,100,101,108,109] and injection drug use is common,[52,53,56,97,108-120] with about 1 in 10 adults reporting having injected in the months before admission and 1 in 20 youth reporting ever injecting.[20,21,52,53,108,109,114,115,121] People continue to use drugs in custody,[22,56,57,97,112,114,122-124] including by injection.[56,97,107,109,113,114,117-119,125]

Time in custody might serve as a unique opportunity to offer services and information to persons using substances who might otherwise be hard to reach. There is good evidence for interventions in custody and after release to reduce smoking,[126] drug use, and associated risk behaviour after release.[127]

Communicable diseases: Tuberculosis is relatively common in persons in federal custody, at 22.4 active cases per 100 000 compared with 4.6 per 100 000 in the general population.[128] Of persons in federal custody in 2007 and 2008, 15.9% were infected with latent tuberculosis, and the estimated annual rate of skin test conversion during incarceration was 1.2%.[129]

Several large serologic studies have identified that blood-borne infections are very common in adults in custody.[117,119,121,130-135] About 30% of those in federal facilities and 15% of men and 30% of women in provincial facilities are infected with hepatitis C,[118,119,129,130,132,134] and between 1% and 2% of men and 1% and 9% of women are infected with HIV.[117-119,129-131,133,136] There is evidence that people contract blood-borne infections while in custody, eg, the estimated incidence rate of hepatitis C for men in federal custody in 2007 was 16 infections per 1000 person-years.[109,137] Sharing needles and tattooing and piercing equipment, including in custody, likely contributes to these high rates.[21,53,97,114,115,118,119,121,137,138]

Sexually transmitted infections, such as chlamydia and gonorrhea, are also prevalent.[21,22,48,49,108,129,139] About 1 in 7 youth in British Columbia in 2012 and 2013 and 1 in 7 men in a provincial facility in Ontario in 2009 reported a history of sexually transmitted infections.[22,108,139] In 2007 and 2008, 0.9% of men and 2.8% of women in federal custody were diagnosed with chlamydia, 0.1% of men and 0.6% of women with gonorrhea, and 0.1% of men and 0.9% of women with syphilis.[129] In the 2009 Ontario study, 2.9% of men had positive test results for chlamydia and 0.6% for gonorrhea on admission.[139]

Vaccination rates might be suboptimal in this population,[140] and Canadian and international research indicates that recommended vaccinations could be effectively delivered while in custody.[127,140,141]

Chronic diseases: Little is known about chronic diseases in this population. There is some evidence that cardiovascular disease, diabetes, and asthma and other respiratory diseases occur at higher than expected rates,[53,63] but high-quality data are lacking. Three studies have identified an epilepsy prevalence between 1% and 4%.[21,48,74] While no data are available on cancer incidence or prevalence, 2 studies described the results of cervical cancer screening.[49,142] One found abnormal test results in 16% of girls,[49] and the other found that the proportion of findings of high-grade lesions was higher than in the general population.[142]

Sexual and reproductive health: Most people in custody report having been sexually active in the months preceding admission to custody,[22,48,53,109,113,119,143] and a minority of persons report having sex while in custody.[97,109,137] Sexual risk behaviour is common, such as early sexual debut,[22,121] a high number of lifetime sexual partners,[22,23,113,139] inconsistent condom use,[22,23,97,117,119,121,139,144] sex with high-risk partners such as persons who inject drugs,[119-121,137,145] and involvement in commercial sex.[56,113,116,117,119,120,146]

Little is known about the reproductive health status of people who experience detention or incarceration. More than half of adults have had children,[38,57,116,147] and about 1 in 3 youth in British Columbia in 2012 and 2013 had been pregnant (for girls) or caused a pregnancy (for boys).[22] A 2014 study in Ontario found that women in provincial custody had been pregnant an average of 4 times, at least 5% were currently pregnant, and more than half had had a therapeutic abortion.[148] Given that only 1 in 5 women who were sexually active and did not want to get pregnant were using contraception before admission to custody,[148] interventions to improve access to contraception might be appropriate in this population.[149]

Injury: Limited data suggest that rates of unintentional injury are high and are often associated with substantial consequences.[21,22,25,36,48,150] More than 1 in 2 youth in British Columbia in 2012 and 2013 had been injured seriously enough in the year before entering custody to require medical attention.[22] Three studies found that head injury was common in this population,[25,36,150] and in 2 studies more than half of men had evidence of traumatic brain injury.[25,150]

Health care

Health care use: Recent data are lacking on health care use. In the 1990s, most persons in federal custody saw a family physician while in custody[53,97] at a rate higher than expected for the general population.[53] Of those in federal custody, 5% had visited the emergency department during their incarceration, with a mean of 0.1 visits per year, and 3% had been admitted to a community hospital and 10% to a regional hospital.[53] The mean number of visits to a dentist was 1.7 per year.[53]

No Canadian data are available on access to primary care or general medical care in the community before admission or after release from custody. Such data could inform the role of health care services in custody, eg, whether preventive care services such as screening could reasonably be deferred until after release for those with a short length of stay or whether care in custody should be more comprehensive. Recent US data reveal low rates of primary care access and high rates of emergency department use and hospitalization after release.[151-153]

Rates of outpatient mental health care before admission vary across studies.[52,92,154] Overall, 6.3% of men admitted to a Quebec provincial facility in the 1990s reported previous psychological treatment,[92] 11.3% of 97 women in British Columbia in 1999 had had a mental health assessment and 28.9% had accessed mental health treatment,[52] and 8.7% of women and 5.9% of men admitted to federal custody in 2007 and 2008 had used psychiatric outpatient services.[154] A large number of persons report previous hospitalization for psychiatric illness. The rate of psychiatric hospitalization before admission was 9.2% of 97 women in custody in British Columbia in 1999,[52] and 30.1% of women and 14.5% of men admitted to federal custody in 2007 and 2008.[154] About half of those in federal custody receive some mental health service in custody,[30,63,97] and the psychiatric hospitalization rate in 2000 to 2001 was 69 per 1000 inmates, with an average length of stay ranging across regions from 147 to 232 days.[53]

Disease screening: In federal facilities, screening rates for tuberculosis and blood-borne infections are high, with recent data revealing that more than 70% of persons were screened for HIV, hepatitis C, and tuberculosis during their current incarceration.[109,129] Screening for blood-borne infections might occur less frequently in provincial facilities,[113] which could explain a relatively high proportion of persons not knowing about their HIV and hepatitis C infection status.[141]

Screening for mental health problems is typically done as part of routine intake procedures,[155] and there is some evidence that existing screening tools in some

jurisdictions might not adequately identify mental health problems, including risk of suicide.[94,156]

Only 15% of women in British Columbia in 1995 and less than 50% of girls in Ontario from 2003 to 2006 had Papanicolaou testing in custody.[49,142] Of women in custody in British Columbia in 2000 and 2001, 60% had been screened in the 30 months before admission, and of those who participated in a Pap testing intervention, only 50% were rescreened within 3 years.[116] No data are available on colorectal and breast cancer screening.

Treatment: A large proportion of persons in custody use prescribed medications,[38,157,158] in particular psychotropic medications.[52,82,92] At the time of intake to federal custody in 2007 to 2008, about 1 in 3 women and 1 in 5 men were using prescribed psychiatric medication,[154] and in 2013, 63% of women in federal custody were using prescribed psychotropic medication.[63]

The HIV treatment rate for persons with HIV in federal custody in 2007 to 2008 was 64.4%,[129] and almost half of those being treated for HIV in 2007 had missed their medications while in federal custody for at least 1 day because of temporary unavailability of medications at institutional pharmacies or transfers between institutions.[137] Studies of persons in federal custody have identified high rates of hepatitis C treatment adherence[159] and completion[160] in custody, high rates of treatment continuity after release with the support of a tailored program,[161] and similar treatment effectiveness rates to those in the community.[137,159-163]

Limitations

There are several limitations to the data presented and to this review. As noted elsewhere,[164] most of the studies conducted to date on the health status of this population have been cross-sectional, which might be associated with oversampling of persons who are in custody for longer periods. Most studies did not include a representative sample of persons in custody in Canada, and focused only on persons in federal custody or population subgroups. These issues might have affected the internal validity of the included studies and the generalizability of estimates to the whole population of persons in custody. While we used a broad and comprehensive search strategy, we might have missed some relevant studies, including those published outside of our search period and those in the gray literature. Similar to most narrative reviews, we did not appraise the quality of included studies, as our main goal was to provide a broad perspective on the health status of this population.[165]

Conclusion

Canadians in correctional facilities have poor health across a range of health status indicators, a finding that is consistent with international data on persons who experience imprisonment.[166] This information is relevant to physicians who assess and treat persons while in custody or after release, as it might inform history taking, counseling regarding pretest probability, investigations, and management strategies.

Information on health status is also important for defining areas of focus for improving health and health care. Health care in correctional facilities is largely delivered by government authorities in Canada, which makes the lack of data on some key indicators of health striking, including on mortality after release, chronic diseases, injury, and health care access and quality. Among other measures, the implementation of electronic medical records, which are still not available in correctional facilities in many jurisdictions, could facilitate the collection and management of data on many health status indicators.

The time in custody provides an opportunity to intervene to improve health, and an emerging literature on effective interventions in custody and after release suggests starting points for change,[127] such as linkage with primary care and navigation services at the time of release from custody.[152,167] Improving health in people who experience detention and incarceration is an important goal, and could lead to valuable secondary benefits for society, such as decreasing health care costs,[168] improving health in the general population,[168-173] improving public safety,[168] and decreasing re-incarceration.[168,174,175]

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Contributors

Dr Kouyoumdjian led the study and drafted the manuscript.
Drs Kouyoumdjian and **Schuler** conducted the review and extracted data.
All authors contributed to the study design and manuscript preparation.

Competing interests

None declared

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This is **Exhibit "H"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

Research at a glance

Self-Reported Physical Health Status of Incoming Federally-Sentenced Women Offenders

KEY WORDS: *physical health conditions, offender health status, women offenders*

What it means

Relative to men, health services for the Correctional Service of Canada's (CSC) incarcerated women may require a greater focus on promoting awareness of and treating some health conditions such as those that are related to blood borne viruses such as hepatitis C.

Overall, results can be used as a benchmark to examine health trends among CSC women offenders over time.

What we found

- The most common physical health conditions cited by newly-admitted women offenders were back pain (26%), head injury (23%), Hepatitis C virus (HCV) (19%), and asthma (16%).
- Rates were generally similar to those of men. Exceptions to this similarity were head injury, which was higher for men than women (34% vs. 23%), and HCV, which was higher for women than men (19% vs. 9%).
- Women offenders reported considerably higher rates of HCV than women in the general Canadian population (19% vs. 1%). Women also had slightly higher rates of asthma, back pain, and obesity. Other conditions compared were not higher among women offenders than Canadian women.
- A greater proportion of older women offenders reported a health condition affecting their cardiovascular system than younger women offenders (47% vs. 15%). They also had higher rates of being overweight or obese (60% vs. 52%) than younger women offenders.
- A greater proportion of Aboriginal women reported blood-borne viruses (HIV/AIDS and HCV) than non-Aboriginal women (27% vs. 17%). Notably, 27% of Aboriginal women reported having HCV, compared to 16% of non-Aboriginal women.

Why we did this study

The correctional health literature suggests that offenders report poorer health relative to the general population. As part of a larger research project to provide information on the prevalence of physical health conditions among newly-admitted offenders, the purpose of the present study was to assess the physical health status of incoming women offenders.

What we did

All incoming CSC offenders are approached to consent to a health assessment that collects information on self-reported health conditions. From April 2012 to May 2013, data from 280 newly-admitted women offenders were recorded. Rates of health conditions were examined and compared to those of incoming men collected in an earlier study[1] and to rates in the general female Canadian population (primarily based on data extracted from the Chronic Disease Infobase Data Cubes[2]). Results were also disaggregated by Aboriginal ancestry and age (younger and older than 50 years).

For more information

Nolan, A., & Stewart, L. (2014). *Self-reported physical health status of incoming federally-sentenced women offenders* (Research Report, R-332). Ottawa, ON: Correctional Service of Canada.

To obtain a PDF version of the full report, or for other inquiries, please e-mail the Research Branch or contact us by phone at (613) 995-3975.

You can also visit the website for a full list of research publications.

[1] Stewart, L.A., Sapers, J., Nolan, A., & Power, J. (2014). *Self-Reported Physical Health Status of Newly Admitted Federally-Sentenced Men Offenders* (Research report, R-314). Ottawa, ON: Correctional Service of Canada.
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This is **Exhibit "I"** referred to in the

Affidavit of Howard Sapers

affirmed before me this 19th day of June, 2020

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A Commissioner, etc

CMAJ OPEN

Research

Chronic health conditions reported by male inmates newly admitted to Canadian federal penitentiaries

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Abstract

Background: International health studies have shown that inmates have higher rates of infectious diseases, chronic diseases and psychiatric disorders relative to the general population. We conducted a systematic collection of data on chronic physical health conditions reported by newly admitted inmates in Canadian federal penitentiaries.

Methods: Over a 6-month period from April to September 2012, we collected and analyzed data from a standardized health interview routinely conducted with consenting incoming male inmates (n = 2273). Prevalence rates of health conditions were determined and disaggregated by age (< 50 yr and ≥ 50 yr) and by Aboriginal status.

Results: The most common health conditions reported by respondents were head injury (34.1%), back pain (19.3%), asthma (14.7%) and hepatitis C virus (HCV) infection (9.4%). Rates of many health conditions were higher among inmates 50 years of age or older than among younger inmates. Compared with their non-Aboriginal counterparts, Aboriginal inmates had higher rates of head injury and HCV infection.

Interpretation: Our study provides a benchmark that can be used to examine health trends within Canada's federal penitentiaries over time and points to subgroups of newly admitted inmates for whom health services may need to be concentrated.

International studies have shown that inmates have higher rates of infectious diseases, chronic diseases and psychiatric disorders relative to the general population.[1–6] Several factors could explain this difference. Inmates engage in more high-risk health behaviours (e.g., intravenous drug use, tattooing, smoking, physical aggression, sexual activity with multiple partners and alcohol abuse) than members of the general population.[1,5] Inmates' higher rates of brain injury also suggest an increased likelihood of being involved in activities that can result in physical injury.[7] Socioeconomic factors known to be associated with poorer health (e.g., poverty, low education, substandard housing and unemployment or underemployment) are also more common among inmate populations.[8,9] In some cases, incarceration itself, with the increased exposure to individuals with higher rates of infection and continued risky behaviours while in correctional facilities, may contribute to the generally poorer health status of inmates.[1,5,10]

Correctional Service Canada (CSC) is responsible for all adult offenders receiving sentences longer than 2 years. There is reason to be concerned that rates of chronic health conditions of federal inmates may be increasing because of demographic shifts in the incarcerated population. For example, the proportion of incoming offenders aged 50 years or older has grown over the last 10 years, from 7.5% in 2003/04 to 13.3% in 2012/13.[11] Among incarcerated offenders in 2012/13, 21.5% were 50 years or older.[11] Older inmates generally require more health care services than younger inmates because they are more likely to have chronic diseases and disabilities and consequently have more specialized needs for care and assistance with mobility and daily living.[12,13] Despite the increase in the proportion of older inmates, the overall inmate population is younger than the general Canadian population: based on the latest census, 15% of the general population is 65 years and older,[14] as compared with 3.5% of federal inmates.[11]

Another factor that could affect the overall prevalence of health conditions among federal inmates is the increased proportion of inmates who are of self-reported Aboriginal ancestry. From 2003/04 to 2012/13, the Aboriginal federal inmate population increased by 47.2%, and in 2012/13, 23% of federal inmates were of self-reported Aboriginal ancestry.[11] Overall, Aboriginal populations in Canada face a higher prevalence of health con-

Competing interests: The authors work for CSC. The data and their interpretation by the authors are fully represented in the paper, and no censorship has occurred.

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ditions and a lower life expectancy than the non-Aboriginal population.[15–17] Evidence suggests that many of the health conditions seen in the general population of Aboriginal Canadians (e.g., diabetes, obesity, and drug and alcohol abuse) are more prevalent in Aboriginal inmate populations.[18] Other areas that affect the relatively lower life expectancy of Aboriginal inmates are the higher rates of suicide and injury from violence.[15]

Canada is a signatory to the United Nations Basic Principles for the Treatment of Prisoners,[19] which declares that all prisoners shall have access to the same health services available in their country without discrimination on the grounds of their legal status. The Corrections and Conditional Release Act[20] legislates CSC to deliver essential health care to federal inmates. CSC policy requires that federal correctional institutions provide access to essential medical, public health, dental and mental health services, and specifies the requirement for informed consent.

A comprehensive profile of the health needs of federal inmates in Canada was compiled in 2004.[21] However, estimates of chronic diseases were tentative because of limitations owing to the lack of reliable data sources. The report's recommendation to examine inmates' health data more systematically was the basis for our current study. Although health problems present a challenge to officials mandated to provide health services for incarcerated populations, investment in this area can reap dividends for the management of infectious and chronic diseases. Identifying and treating inmates while they are in one location, have access to testing and treatment and can be monitored for adherence could improve the health outcomes of this high-risk group, many of whom may have erratic contact with health services when they are in the community.[4] It has been noted that assessing offenders in the correctional system is a public health opportunity to promote health in this vulnerable population and to decrease the risk of infectious diseases being transmitted by untreated offenders once released in the community.[22]

Methods

Study setting and population

We conducted a descriptive study of the prevalence of chronic physical health conditions reported by newly admitted federal male inmates over a 6-month period from Apr. 1 to Sept. 30, 2012. A chronic health condition was defined as a long-lasting condition that can be controlled or treated but not cured. We disaggregated the results by age (< 50 and ≥ 50 yr) and by self-reported Aboriginal ancestry. Participants included all consecutive male inmates admitted to federal penitentiaries across the 5 CSC regions (i.e., Atlantic, Quebec, Ontario, Prairies and Pacific) who consented to a health assessment interview during the 6-month period. The physical health status of newly admitted female inmates is also being examined; however, the relatively low number of women in the federal correctional system requires a longer period of data collection for a sufficient sample size. Hence, those results are not provided here. In addition, a separate study of mental health conditions among federal inmates is being conducted with the use of a standardized clinical diagnostic interview format.

Data sources

Within the first 24 hours after admission to CSC custody, all inmates are routinely seen by a nurse to attend to immediate medical needs, explain the health assessment process and seek informed consent for medical services. At this time, the nurse completes section I of the intake health status assessment form, which includes questions on current medical health requiring immediate attention. Within 2 weeks after admission, a comprehensive nursing assessment is offered to consenting inmates. This includes section II of the intake health status assessment, which records current vital signs and inmates' self-reported current and past health issues, and a separate form on infectious disease screening, which documents inmates' HIV and hepatitis C virus (HCV) infection screening results. All of the forms have been developed specifically for CSC health services (Appendix 1, available at www.cmajopen.ca/content/3/1/E97/suppl/DC1). Questions are generally formatted using Yes or No checkboxes to reflect whether there is a health condition. Further information on health assessments at intake is available in the Commissioner's Directive on Health Services.[23]

Statistical analysis

We determined prevalence rates of health conditions and lifestyle risk factors among the inmates and disaggregated them by self-identified Aboriginal ancestry and by age (< 50 v. ≥ 50 yr). We used only 2 age groups to allow an adequate number in each group for analysis. Based on research indicating that the physical effects of aging become evident earlier in groups where substance abuse and an unhealthy lifestyle are common, age 50 has been identified as the threshold to examine age effects among offenders.[11] Given that a specific subpopulation of male inmates was examined rather than a sampling, we interpreted results where practical differences existed and assessed the magnitude of these differences using effect sizes (i.e., Cramér's phi, denoted as φ_c); φ_c values range from 0 to 1, with values between 0.10 and 0.20 indicating a weak association, between 0.21 and 0.39 a moderate association, between 0.40 and 0.60 a strong association and above 0.60 a very strong association.[24]

Ethics approval

All inmates included in this study provided informed consent to participate in the intake health assessment. The resulting health data are routinely collected under the Treasury Board of Canada's Info Source Personal Identification Bank 060 (www.csc-scc.gc.ca/info-source/007007-0004-eng.shtml). Under the Privacy Act paragraph 8(2)(j), CSC is permitted to compile health data for statistical use without additional consent from offenders as long as the presentation of the information guarantees confidentiality and the information is used in a manner consistent with the purpose for which the data were collected. An ethics review board for research in the CSC is not required.

Results

We collected health data from 2273 male inmates, representing 96% of newly admitted inmates during the study period. The

mean age of the participants was 35.5 years (standard deviation 12.0, range 18.2–82.4). The mean age of the 496 men (21.9%) who self-identified as being of Aboriginal ancestry was 32.8 years, as compared with 36.3 years for the non-Aboriginal men. A higher proportion of Aboriginal inmates than of non-Aboriginal inmates were less than 50 years old (94.4% v. 84.6%; $\varphi_c = 0.12$).

The proportion of inmates with self-reported chronic health conditions is presented in Table 1. Over one-third of the inmates reported having had a head injury. Back pain, asthma, HCV infection, hypertension and arthritis were the other conditions most commonly reported.

Rates of many of the chronic health conditions, especially those affecting the cardiovascular system, were substantially higher among inmates 50 years of age or older than among younger inmates (Table 1). Notably, we found meaningful differences ($\varphi_c > 0.10$) indicating higher rates of hypertension, high cholesterol, angina, arthritis, diabetes, prostate problems and history of cancer among older inmates.

With the exception of head injury ($\varphi_c = 0.10$) and HCV

Table 1: Prevalence of self-reported chronic health conditions among 2273 male inmates newly admitted to federal penitentiaries, overall and by age group and Aboriginal status

		Age group, no. (%)*			Aboriginal ancestry, no. (%)*		
Health condition	Total, no. (%)* $n = 2273$	< 50 yr $n = 1970$	≥ 50 yr $n = 302$	φ_c value	Aboriginal $n = 496$	Non-Aboriginal $n = 1774$	φ_c value
Central nervous system							
Head injury	738 (34.1)	648 (34.6)	90 (30.7)	0.03	193 (43.0)	543 (31.7)	0.10†
Seizures	92 (4.3)	75 (4.0)	17 (5.8)	0.03	23 (5.1)	68 (4.0)	0.02
Spinal injury	56 (2.6)	47 (2.5)	9 (3.1)	0.01	13 (2.9)	43 (2.5)	0.01
Musculoskeletal system							
Back pain	411 (19.3)	332 (18.0)	79 (27.5)	0.08	73 (16.4)	338 (20.0)	0.04
Arthritis	177 (8.3)	122 (6.6)	55 (19.2)	0.16†	36 (8.1)	140 (8.3)	0.003
Osteoporosis	9 (0.4)	6 (0.3)	3 (1.1)	0.04	2 (0.5)	7 (0.4)	0.002
Respiratory system							
Asthma	318 (14.7)	284 (15.1)	34 (11.6)	0.03	57 (12.7)	261 (15.2)	0.03
Bronchitis	63 (2.9)	55 (2.9)	8 (2.7)	0.004	14 (3.1)	49 (2.9)	0.01
Other pulmonary disease	38 (1.8)	23 (1.2)	15 (5.1)	0.10†	3 (0.7)	35 (2.0)	0.04
Cardiovascular system							
Hypertension	184 (8.5)	114 (6.1)	70 (23.8)	0.22†	35 (7.8)	149 (8.7)	0.01
Elevated cholesterol	114 (5.3)	64 (3.4)	50 (17.1)	0.21†	11 (2.4)	103 (6.0)	0.06
Heart attack	44 (2.0)	24 (1.3)	20 (6.8)	0.13†	9 (2.0)	35 (2.0)	0.001
Arrhythmia	34 (1.6)	26 (1.4)	8 (2.7)	0.04	6 (1.3)	28 (1.6)	0.01
Angina	30 (1.4)	12 (0.6)	18 (6.1)	0.16†	5 (1.1)	25 (1.5)	0.01
Stroke	16 (0.7)	8 (0.4)	8 (2.7)	0.09	2 (0.4)	14 (0.8)	0.02
Blood-borne virus							
HIV/AIDS	27 (1.3)	23 (1.3)	4 (1.5)	0.005	10 (2.4)	17 (1.1)	0.05
HCV	191 (9.4)	156 (8.8)	35 (12.7)	0.05	66 (15.5)	124 (7.7)	0.11†
Endocrine system							
Diabetes	88 (4.2)	54 (2.9)	34 (11.9)	0.15†	16 (3.6)	72 (4.3)	0.01
Gastrointestinal system							
Ulcers	69 (3.2)	56 (3.0)	13 (4.4)	0.03	12 (2.7)	57 (3.3)	0.02
Reproductive system							
Prostate problems	60 (2.8)	26 (1.4)	34 (11.8)	0.21†	11 (2.5)	49 (2.9)	0.01
Any cancer history	39 (1.8)	19 (1.0)	20 (6.8)	0.15†	4 (0.9)	35 (2.0)	0.04

Note: HCV = hepatitis C virus.
*The denominator varies by condition owing to missing data.
†Value indicates a meaningful effect size (i.e., at least a weak association). Cramér's phi (denoted as φ_c) values between 0.10 and 0.20 indicate a weak association, between 0.20 and 0.40 a moderate association, between 0.40 and 0.60 a strong association and above 0.60 a very strong association.

infection (φ_c = 0.11) being higher among inmates of Aboriginal ancestry than among non-Aboriginal inmates, there were no meaningful differences in rates of chronic health conditions between these 2 groups (Table 1).

Table 2 shows the prevalence of lifestyle risk factors among the inmates that may have contributed to some of the chronic health conditions. Overall, 64.5% of the inmates were overweight or obese (as measured by their body mass index), 52.6% reported drinking alcohol, and 20.8% reported a history of injection drug use. As noted in Table 2, the rate of self-reported alcohol use was higher among Aboriginal inmates than among non-Aboriginal inmates (φ_c = 0.10).

Interpretation

We found that head injury, back pain, asthma and HCV infection were the most prevalent chronic health conditions reported by male inmates newly admitted to federal penitentiaries during the 6-month study period in 2012. Not surprisingly, older inmates (≥ 50 yr) reported generally higher rates of most physical health conditions than the younger inmates. There were no meaningful differences, however, between older and younger inmates in the most frequently reported conditions (i.e., head injury, back pain, asthma and HCV infection). Compared with non-Aboriginal inmates, those of Aboriginal ancestry had similar rates of most conditions except head injury and HCV infection. Aboriginal inmates had a lower mean age and a lower representation among older inmates, which is consistent with CSC admission data in 2011/12.[11] This may explain why we did not find meaningful differences in many of the health conditions between the Aboriginal and non-Aboriginal groups.

The rates of self-reported health conditions in our study cohort do not appear to be higher than rates reported among inmates in most other countries. In a review of the prevalence of some of the major physical and psychiatric diseases reported among prisoners, the rate of HIV infection in US jails and prisons was 1.5%, and the estimated prevalence of HCV infection based on antibody screening in US state prison systems ranged from 23% (Rhode Island) to 34% (California).[1] Reported rates of hypertension and asthma were higher in the US prisons than in our inmate population, and rates of diabetes appeared to be comparable. A survey of Australian inmates in New South Wales prisons[3] using a similar methodology to ours found much higher rates of self-reported health conditions than we did. The general health of underprivileged individuals in the US, with their restricted access to affordable or insured health care, may have contributed to the reported poorer health of American offenders relative to Canadian offenders, who benefit from universal health care. The high rates of reported health problems in Australia may have been due to the disproportionate sampling of indigenous people, who experience material and social deprivation related to poorer health outcomes.[25] The higher rates may also have been because the Australian inmates had already been incarcerated for a period of time, whereas the offenders in our study were newly admitted into custody.[3]

With the exception of asthma and blood-borne viruses, most chronic health conditions were not more prevalent in our study cohort than in the adult Canadian male population based on estimates provided through the 2011 Canadian Community Health Survey.[26] Indeed, rates for hypertension and arthritis were lower in our study. However, the comparison with the Canadian general population is not age-adjusted.

Most of the inmates newly admitted during the study period participated in the medical assessment at intake, so our estimates of self-reported chronic health conditions are likely representative of the incoming federal inmate population. Further research could clarify the extent to which chronic health conditions among inmates are associated with lifestyle risk factors, and therefore which conditions are expected to be more prevalent in certain subpopulations of inmates and what interventions could be appropriate to address them. For example, newly admitted inmates report engaging in high-risk lifestyle behaviours such as drinking and injection drug use at rates higher than those reported in the general Canadian population.[27] Correctional programs designed to reduce substance abuse have been proven to reduce criminal recidivism for a diverse range of offenders.[28] Furthermore, the presence of chronic health condi-

Table 2: Prevalence of lifestyle risk factors among the inmates, overall and by Aboriginal status

	Group; no. (%)*			
Lifestyle risk factor	Total *n* = 2273	Aboriginal *n* = 496	Non-Aboriginal *n* = 1774	φ_c value
Alcohol use	1049 (52.6)	257 (62.1)	786 (49.8)	0.10‡
History of injection drug use	415 (20.8)	114 (27.6)	299 (18.9)	0.09
Cigarette smoking	453 (21.1)	89 (19.7)	364 (21.5)	0.02
No physical exercise	407 (21.1)	61 (15.1)	346 (22.7)	0.08
Overweight or obese†	1164 (64.5)	243 (67.9)	919 (63.6)	0.04

*The denominator varies by condition owing to missing data.
†Overweight = body mass index (BMI) 25–29.9, obese = BMI ≥ 30.
‡Value indicates meaningful effect size (i.e., at least a weak association). Cramér's phi (denoted as φ_c) values between 0.10 and 0.20 indicate a weak association, between 0.20 and 0.40 a moderate association, between 0.40 and 0.60 a strong association and above 0.60 a very strong association.

tions may differ between specific groups of Aboriginal inmates; we did not disaggregate Aboriginal inmates by First Nations, Métis or Inuit ancestry. Based on recent Statistics Canada reports compiling the results of the Canadian Community Health Survey,[16,26] there is evidence that the higher rates of diabetes relative to the general Canadian population applies to First Nations people and less so to the Métis.[16,17]

Limitations

A limitation of our study is that height and weight were the only objectively measured health indicators; all other data were reported by the inmates. This methodology is the same as that used for the Canadian Community Health Survey to collect data on the Canadian population. However, incarcerated populations are known to underuse health services in the community,[4] and therefore some chronic health conditions may not be known to the individuals until they are diagnosed in prison. Incoming inmates are younger on average than those who are already incarcerated; therefore, relying on their responses to determine rates of chronic health conditions could underestimate the prevalence in the total incarcerated population.

A substantial proportion of the inmates reported having a blood-borne virus, but it is unknown whether the self-reported rates represent reliable estimates of the true prevalence of HIV and HCV infections on admission. Testing for HIV and HCV infection is offered by CSC to all consenting inmates at intake and upon request throughout incarceration. The latest infectious disease surveillance report from CSC for 2007/08 reported a 58% uptake of HIV testing at intake and found that 1.7% of these inmates had laboratory-confirmed infection.[29] It is not clear, however, whether those who agreed to the testing are representative of newly admitted inmates; therefore, we cannot determine whether self-reported data underestimate the true prevalence of blood-borne viruses. Both a previous CSC inmate survey[30] and routine infectious disease surveillance data concur that virtually all infected inmates were infected before their current incarceration.[31]

Although most of the incoming inmates participated in our study, some did not provide data on certain conditions; however, the large sample (n = 2273) provides confidence that the rates represent accurate estimates for the study period.

Because our study was designed to provide a simple descriptive analysis, we did not conduct advanced statistical modelling. Future research would benefit from a more in-depth analysis of how age, Aboriginal ancestry, lifestyle risk factors and social determinants are related to chronic health conditions.

Conclusion

This study provides a systematic estimate of the prevalence of chronic health conditions among male inmates newly admitted to federal penitentiaries in Canada. The results point to inmate subgroups who may require a higher concentration of health services (e.g., inmates of Aboriginal ancestry, older inmates and those with a history of intravenous drug use). Our research also provides a benchmark from which trends in the prevalence of chronic health conditions in Canada's penitentiaries can be monitored over time and can help to inform the design of primary and preventative health programs. CSC continues to address infectious diseases by education, tobacco-cessation counselling, harm reduction policies and offering testing and treatment to infected inmates. Future research should investigate whether these programs also have a beneficial effect in reducing related chronic health conditions among federal offenders. A systematic method for tracking the health status of offenders while incarcerated would provide evidence of the impact of these initiatives during the course of their incarceration. It would also contribute to our understanding of the extent to which incarceration itself can affect physical health.

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Contributors: All of the authors contributed to the study design and oversaw the data collection. Amanda Nolan and Jeremy Sapers were primarily responsible for the data analyses. Lynn Stewart drafted the manuscript, and all of the authors revised it critically for important intellectual content. All of the authors approved the final version and agreed to act as guarantors of the work.

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Supplemental information: For reviewer comments and the original submission of this manuscript, please see www.cmajopen.ca/content/3/1/E97/suppl/DC1

This is **Exhibit "J"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

COVID-19

Evergreen March 30 • 2020

preparedness and plans

General **Approach**

- Correctional Service of Canada (CSC) is focusing its efforts on minimizing the risk of introducing COVID-19 to institutions, Community Correctional Centres and workplaces. This includes CSC's active planning in early identification, containment and appropriate treatment should the virus be introduced to one of CSC's sites.
- CSC has strengthened infection prevention procedures to protect staff, offenders, volunteers and the public.
- CSC is actively engaging experts on public health and infection prevention to guide our response.

Supplies and **Facilities**

- CSC has taken full inventory of existing personal protective equipment supplies.
- As part of the FPT effort, CSC has worked with PHAC to purchase additional supplies.
- CSC is working with pharmaceutical industry to ensure sufficient supply of medications.
- CSC is distributing additional soap, cleaning supplies and hand sanitizer to inmates and staff.
- CSC is actively screening all persons entering CSC institutions, including staff and offenders.
- CSC has postponed all non-essential entry and activities within CSC sites. Access to institutions is available to those performing critical services, such as medical and mental health, food services and cleaning services.

Governance

- Public Safety Minister is on Special Cabinet Committee on COVID-19 response.
- CSC's National Medical Advisor is on the Federal, Provincial and Territorial (FPT) Special Advisory Committee reporting to the FPT conference of Deputy Ministers of Health.
- CSC is represented on the Logistics Advisory Committee organized by the Public Health Agency of Canada (PHAC).
- CSC is actively engaged with local public health departments who are responsible for COVID-19 testing and tracing.
- CSC is conducting regular meetings with PHAC.
- Local hospitals will provide care for offenders if the medical care required exceeds CSC's capacity.
- CSC is actively working with its National Medical Advisory Committee to provide clinical leadership.
- CSC is communicating frequently with inmates and inmate committees through wardens and management. CSC is also engaged with unions at every level.

Workforce

- Only critical staff who cannot work from home due to the nature of their duties are in the workplace.
- To minimize the risk of exposure to institutional staff, CSC has minimized the comings and goings into institutions.
- CSC institutions have reviewed their operations and adjusted their routines, where feasible, in order to reduce staffing demands and promote risk mitigation efforts.
- CSC has implemented mandatory employee self-isolation for 14 days for all returning international travellers and employees living with people who travelled internationally.
- CSC is reinforcing the importance of hand washing, social distancing, cough etiquette and other key public health messages.
- CSC has postponed all non-essential, in-person staff training. Exceptions will be assessed on a case-by-case basis.

Health Services

- CSC is working to increase capacity at health centres to manage more complex health needs.
- CSC is hiring additional health professionals where feasible to deliver essential health services.
- CSC is establishing clear protocols and procedures with local hospitals for when inmates will be transferred for care.
- CSC is expanding access to health care for inmates to address essential health care needs.
- CSC is working with inmates to review existing treatment plans with a focus on older offenders and those more vulnerable due to pre-existing underlying health conditions.
- When necessary, CSC is temporarily suspending some less urgent health services, consistent with community practice. This includes dental and optometry services, except urgent care.
- Where feasible, CSC is increasing telemedicine.
- CSC has established processes and procedures to disseminate key scientific and health literature specific to COVID-19 to all health professionals.
- CSC is consulting with medical ethicists to review clinical decision-making.

Infection **prevention** and **control**

- CSC has well-established infection prevention guidelines.
- CSC is educating staff and offenders on the prevention and spread of illness, including the importance of good hygiene practices.
- CSC is enhancing cleaning practices at all sites.
- CSC is working with an Infections Prevention and Control Specialist to continue to review our practices and procedures.

Offenders

- CSC has suspended visits to offenders, temporary absences (except for medical escorts) and work releases. CSC is supporting inmates staying connected to family and community by video visitation or telephone, as well as looking at additional measures to maintain the calm in institutions.
- CSC has waived telephone, accommodation and food deductions for inmates, and has provided additional minutes on their phone accounts. This will help them to continue connecting with family, friends, and support networks.
- All inter-regional and international transfers of inmates have been suspended.
- CSC is increasing supply of medication for offenders on release to reduce the burden of the health care system and provide offenders with more time before visiting a pharmacy or seeing their physician.
- CSC is actively screening offenders in CSC institutions upon arrival.
- CSC has asked legal counsel to postpone visiting institutions and maintain access by telephone. Case-by-case accommodation will be facilitated, where essential.

Community Operations

- Public safety is the foundation of everything we do at CSC.
- CSC has provided flexibility to parole officers and program officers to adapt their supervision strategies to minimize the risk of COVID-19 transmission, while continuing to supervise offenders.
- CSC has engaged its community partners, including Community-Based Residential Facilities, to address challenges currently being faced.
- CSC is communicating with victims through the Victims Portal, the CSC Web site page, and social media.
- CSC is also reaching out to victims to advise them of cancellations of UTAs, ETAs and Work Releases.
- Presently, CSC is meeting all obligations to provide services to victims.

CSC'S CORE MANDATE OF MAINTAINING PUBLIC SAFETY AND SAFELY MANAGING OFFENDERS CONTINUES DURING THIS PUBLIC HEALTH CRISIS.

This is **Exhibit "K"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

Prisons are "in no way equipped" to deal with COVID-19

Prisons are a hotspot for COVID-19. In theory, prisoners have the same right to health as anyone else, but the reality is very different. Talha Burki reports.

We will probably never know the extent to which coronavirus disease 2019 (COVID-19) has penetrated the world's prisons and detention centres. Testing capacity and the supply of personal protective equipment are already constrained, and inmates are rarely a priority. Nonetheless, at least one prison has done mass testing. The Marion Correctional Institution in Ohio, USA, holds around 2500 detainees. As *The Lancet* went to press, more than 2000 of them had tested positive for COVID-19.

According to the New York City Board of Correction, there are currently 378 cases of COVID-19 among inmates in the city jails, equating to an infection rate of around 10%. But this does not include those who contracted the virus in custody and have since been released or transferred, or have died. Hundreds of cases have been registered among prison and jail employees, who can obtain testing far more easily than prisoners, including almost 1000 in New York City alone.

"The prisons and jails in the USA that have reported high rates of the coronavirus are the ones who are doing the testing", points out David Patton, executive director and attorney-in-chief of the Federal Defenders of New York. "It is hard to imagine that the virus is not already rampant throughout the US penal system." Around 2·2 million individuals are incarcerated in the USA; no other country imprisons as many people.

In the UK, COVID-19 has been detected in the majority of prisons, and at least 15 prisoners and four members of staff have died after being infected. For much of the rest of the world, statistics on infection rates and mortality in prisons are hard to come by, but the danger that COVID-19 poses to such institutions can be discerned from another set of statistics.

> "'It is hard to imagine that the virus is not already rampant throughout the US penal system.' Around 2·2 million individuals are incarcerated in the USA…"

The global prison population is estimated at 11 million. At least 124 prisons worldwide exceed their maximum occupancy rates. The Philippines has imprisoned 215 000 people in a system designed for no more than 40 000. 92 000 inmates are thought to be scattered across Myanmar's 100 or so prisons and labour camps, served by a medical staff that is estimated to consist of 30 doctors and 80 nurses. A quarter of inmates in Canada are over the age of 50 years. The UK Justice Secretary, Robert Buckland, reckons that around 1800 prisoners in the UK would be especially susceptible to severe disease were they to contract COVID-19.

The situation in Latin America is particularly worrying. Haiti's prisons are running at 450% occupancy. 773 151 people are imprisoned in Brazil, in a system built to hold 461 026 people. "Conditions in the prisons in South America are ripe for coronavirus to spread", said Tamara Taraciuk Broner of Human Rights Watch (Buenos Aires, Argentina). "These places are typically very unsanitary and overcrowded and inmates do not always have access to running water." In such circumstances, regular handwashing and social distancing are impossible to achieve.

"Prisoners share toilets, bathrooms, sinks, and dining halls. They are mostly sleeping in bunk beds; in some countries they sleep crammed together on the floor", explains Frederick Altice of the Yale School of Medicine (New Haven, CT, USA). "These settings are in no way equipped to deal with an outbreak once it gets in." If an institution is already operating at far beyond its capacity, it is going to be very difficult to find areas where prisoners with suspected COVID-19 can be isolated. "If a prisoner knows he is going to be put in solitary confinement if he admits to being sick, which is usually a punishment, then there is a heavy disincentive to seek medical attention", adds Patton.

Prisoners tend to be in worse health than the wider population. "80–90% of people charged with a crime in the USA are too poor to afford legal counsel", notes Patton. "They have high rates of asthma, diabetes, and smoking". Prison itself is hardly a healthy environment. A lot of time is spent sitting around, and the food is typically poor quality. And in some places, even poor-quality food is in short supply.

Maria Tan/AFP/Getty Images

The occupancy rate for prisons in DR Congo is estimated at 432% of capacity, but food is budgeted on official capacity. That means a maximum of one meal a day. According to the UN peacekeeping mission in DR Congo, at least 60 people died from hunger at Kinshasa's central prison during the first 2 months of 2020. In Niger, those in pretrial detention, a cohort that makes up over half the prison population, are not provided with any food at all. If you cannot rely on family or friends to bring in supplies, you are in serious trouble.

International norms stipulate that prisoners should receive the same standard of health care as the wider community. The reality is very different. "First of all, if you are a prisoner, you cannot just choose to visit the emergency room; you have to go through the officers and that can be a huge obstacle", said Altice. "Almost no prisons have real hospitals within their walls, and the ratio of clinical staff to prisoners is extremely low; there is no true equivalence of care".

Sending prisoners for external medical care means seconding officers and transport. Prison administrators can be reluctant to expend such time and resources on a single inmate. "There is both a lack of ability to deal with health issues in-house, because of chronic understaffing, and disincentives to seek outside attention", said Patton. "It means that prisoners have to be in a very bad state before they get the treatment they need."

Reuters/Jim Vondruska

Matters are further complicated during a time of pandemic, when moving prisoners requires all kinds of additional precautions. "It is very likely that prisoners are not getting medical care or even assessments", said Altice. "Prisons do not usually have any way to manage patients when they start deteriorating or to triage people at higher risk; prisoners who do get shipped out for treatment are at a much later stage of disease because detection abilities are often limited."

"'Almost no prisons have real hospitals within their walls, and the ratio of clinical staff to prisoners is extremely low; there is no true equivalence of care.'"

The UN High Commissioner for Human Rights, Michelle Bachelet, has encouraged governments to release inmates who are especially vulnerable to COVID-19, such as older people, as well as low-risk offenders. "Imprisonment should be a measure of last resort, particularly during this crisis", she noted, in a statement on March 25, 2020. Experts believe that there is plenty of scope for prisoner releases. In at least 46 countries worldwide, the majority of prisoners have not been convicted of any crime. Rates of pretrial detention are high. A third of Brazil's sizeable prison population, for example, are in pretrial detention. More than one in six prisoners around the world are serving time for possession of drugs for personal use.

"Deincarceration has to be the foremost strategy here", said Altice. "Several countries, including the USA, have extraordinarily high levels of incarceration. It will certainly be possible to release prisoners and maintain public safety." He advocates diverting drug offenders to evidence-based treatment programmes. "You can take a lot of people out of the system by doing that, and these are people who are at increased risk of comorbidities such as HIV and hepatitis C, so there is an immediate public health benefit", said Altice.

Several countries have taken action. Iran announced the release of 85 000 prisoners in March. France and Italy have reduced their prison populations by 10 000 and 6000, respectively. Chile has let out 1300 low-risk offenders, and states across the USA are releasing varying numbers of prisoners. "There is absolutely no doubt that this crisis calls for reducing overcrowding and finding alternatives to prison for people in particular categories, definitely those in pretrial detention for non-violent offences", Broner told *The Lancet*. She gave the example of semiopen facilities in Brazil, where prisoners spend the day outside the institution and return in the evening. "That is a huge risk for transmission of COVID-19; it would be better to allow these prisoners to just remain outside", she said.

UK prisons are running at 107% capacity, which is modest by international standards. The government has pledged to release 4000 prisoners to alleviate the risk of COVID-19 transmission. However, the Prison Governors Association reckons that 15 000 inmates, representing almost a fifth of the prison population, would have to be let out if prisoners were to not share cells. Making a meaningful difference to overcrowding in prison systems elsewhere will require far larger measures. Whether governments are willing to release prisoners in the numbers necessary to truly cut the risk of COVID-19 from tearing through prisons remains to seen.

Talha Burki

This is **Exhibit "L"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

PRESS RELEASE: Corrections Announces Upcoming Transfer of Individuals Back to the Community

Released April 16, 2020

Contact Corrections' Joint Information Center, (425) 754-4939
Department of Corrections

TUMWATER – The Washington State Department of Corrections is planning for the transfer of incarcerated individuals back to their communities. The goal in transferring a limited number of individuals to the community is to provide more physical distancing within the state's correctional facilities.

The Department is implementing strategies to reduce the population in state correctional facilities, while also considering public safety. The strategies focus on individuals who are not currently incarcerated for violent or sex offenses and nearing the end of their incarceration.

It will be confirmed by correctional staff that individuals transferring to the community will have an established address and a current Washington State identification, and that the current sentence being served is for non-violent or drug/alcohol related offenses.

On April 15, 2020, Governor Inslee issued an emergency commutation to allow for the release of incarcerated individuals. The commutation is specific to those in custody whose judgment and sentences include only non-violent offenses or drug or alcohol offenses and whose projected release date (PRD) is prior to or on June 29, 2020. It authorizes their transfer from confinement within seven days of the order, or as soon as can be reasonably achieved thereafter.

In addition to the Governor's commutation, based on Governor's Proclamation 20-50 Reducing Prison Population , Secretary Sinclair will take additional measures to provide more physical distancing. The Rapid Reentry program allows incarcerated individuals an opportunity to serve an expanded portion of their sentence of confinement in the community on electronic monitoring (up to six months). Individuals are subject to their conditions of supervision and, if they violate those conditions, could be returned to confinement. Individuals are included who meet the Centers for Disease Control guidelines of those at higher risk for health complications related to COVID-19.

By the statutory furlough authority granted to Secretary Sinclair, he will be granting emergency furloughs to those incarcerated individuals in work release settings, as established through careful legal advisement and statutory reviews. Furlough means an authorized leave of absence for an eligible individual, without any requirement that the individual be accompanied by, or be in the custody of, any corrections official while on such leave. Furloughed individuals are subject to their conditions of furlough and, if they violate those conditions, could be returned to confinement.

The steps being taken this week represent the latest work in the agency's diligent efforts to preserve the health of institutions and all people – staff and incarcerated individuals.

This is **Exhibit "M"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

116TH CONGRESS
2D SESSION

H. R. 6400

To require the release of certain individuals in the custody of the United States because of their risk of exposure during a national emergency, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 26, 2020

Mr. JEFFRIES (for himself, Ms. BASS, Mr. NADLER, Mr. RICHMOND, Mrs. WATSON COLEMAN, Ms. JAYAPAL, Ms. NORTON, Mr. THOMPSON of Mississippi, Mr. GARCÍA of Illinois, and Mr. TED LIEU of California) introduced the following bill; which was referred to the Committee on the Judiciary

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A BILL

To require the release of certain individuals in the custody of the United States because of their risk of exposure during a national emergency, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Emergency Community Supervision Act".

SEC. 2. FINDINGS.

Congress finds the following:

(1) As of the date of introduction of this Act, the novel coronavirus has spread to all 50 States, the District of Columbia, and 3 territories.

(2) The Centers for Disease Control and Prevention have projected that between 160,000,000 and 214,000,000 people could be infected by the novel coronavirus in the United States over the course of the pandemic.

(3) Although the United States has less than 5 percent of the world's population, the United States holds approximately 21 percent of the world's prisoners and leads the world in the number of individuals incarcerated, with nearly 2,200,000 people incarcerated in State and Federal prisons and local jails.

(4) Studies have shown that individuals age out of crime starting around 25 years of age, and released individuals over the age of 50 have a very low recidivism rate.

(5) According to public health experts, incarcerated individuals are particularly vulnerable to being gravely impacted by the novel corona virus pandemic because—

(A) they have higher rates of underlying health issues than members of the general public, including higher rates of respiratory disease, heart disease, diabetes, obesity, HIV/AIDS, substance abuse, hepatitis, and other conditions that suppress immune response; and

(B) the close conditions and lack of access to hygiene products in prisons make these institutions unusually susceptible to viral pandemics.

(6) The spread of communicable viral disease in the United States generally constitutes a serious, heightened threat to the safety of incarcerated individuals, and there is a serious threat to the general public that prisons may become incubators of community spread of communicable viral disease.

SEC. 3. DEFINITIONS.

In this Act:

(1) COVERED HEALTH CONDITION.—The term "covered health condition" with respect to an individual, means the individual—

(A) is pregnant;

(B) has chronic lung disease or asthma;

(C) has congestive heart failure or coronary artery disease;

(D) has diabetes;

(E) has a neurological condition that weakens the ability to cough;

(F) has HIV;

(G) has sickle cell anemia;

(H) has cancer; or

(I) has a weakened immune system.

(2) COVERED INDIVIDUAL.—The term "covered individual" means an individual who—

(A) is 50 years of age or older;

(B) has a covered health condition; or

(C) is within 12 months of release from incarceration.

(3) NATIONAL EMERGENCY RELATION TO A COMMUNICABLE DISEASE.—The term "national emergency relating to a communicable disease" means—

(A) an emergency involving Federal primary responsibility determined to exist by the President under the section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5191(b)) with respect to a communicable disease; or

(B) a national emergency declared by the President under the National Emergencies Act (50 U.S.C. 1601 et seq.) with respect to a communicable disease.

SEC. 4. PLACEMENT OF CERTAIN INDIVIDUALS IN COMMUNITY SUPERVISION.

(a) AUTHORITY.—Except as provided in subsection (b), beginning on the date on which a national emergency relating to a communicable disease is declared and ending on the date that is 60 days after such national emergency expires—

(1) the Director of the Bureau of Prisons shall place in community supervision all covered individuals who are in the custody of the Bureau of Prisons; and

(2) the Director of the United States Marshals Service shall place in community supervision all covered individuals who are in the custody of the United States Marshals Service.

(b) EXCEPTION.—In carrying out subsection (a), each Director—

(1) may not place in community supervision any individual determined, by clear and convincing evidence, to be likely to pose a specific and substantial risk of causing bodily injury or using violent force against the person of another;

(2) shall place in the file of each individual described in paragraph (1) documentation of such determination, including the evidence used to make the determination; and

(3) not later than 180 days after the date on which the national emergency relating to a communicable disease expires, shall provide a report to Congress documenting—

(A) the demographic data (including race, gender, age, offense of conviction, and criminal history level) of the individuals denied placement in community supervision under paragraph (1); and

(B) the justification for the denials described in subparagraph (A).

(c) LIMITATION ON COMMUNITY SUPERVISION PLACEMENT.—In placing covered individuals into community supervision under this section, the Director of the Bureau of Prisons and the Director of the United States Marshals Service shall take into account and prioritize placements that enable adequate social distancing, which include home confinement or other forms of low in-person-contact supervised release.

SEC. 5. LIMITATION ON PRE-TRIAL DETENTION.

Notwithstanding section 3142 of title 18, United States Code, beginning on the date on which a national emergency relating to a communicable disease is declared and ending on the date that is 60 days after such national emergency expires, the Government may not seek to detain, and a judicial officer (as defined in section 3156 of title 18, United States Code) may not order the detainment of, any individual, unless the Government shows by clear and convincing evidence that the individual is likely to pose a flight risk or specific and substantial risk of causing bodily injury or using violent force against the person of another.

SEC. 6. LIMITATION ON SUPERVISED RELEASE.

Beginning on the date on which a national emergency relating to a communicable disease is declared and ending on the date that is 60 days after such national emergency expires, the Office of Probation and Pretrial Services of the Administrative Office of the United States Courts shall take measures to prevent the spread of the communicable viral disease among individuals under supervision by—

(1) suspending the requirement that individuals determined to be a lower risk of reoffending report in person to their probation or parole officer;

(2) identifying individuals who have successfully completed not less than 18 months of supervision and transferring such individuals to administrative supervision or terminating supervision, as appropriate; and

(3) suspending the use of incarceration as a sanction for violations of probation or parole that do not constitute a new felony offense.

SEC. 7. PROHIBITION.

No individual who is granted placement in community supervision, termination of supervision, placement on administrative supervision, or pre-trial release shall be re-incarcerated, placed on supervision or active supervision, or ordered detained pre-trial only as a result of the expiration of the national emergency relating to a communicable disease.

This is **Exhibit "N"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

116TH CONGRESS
2D SESSION

H. R. 6414

To amend the Omnibus Crime Control and Safe Streets Act of 1968 to establish the Pandemic Jail and Prison Emergency Response grant programs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 27, 2020

Mr. NADLER (for himself, Ms. BASS, and Mr. JEFFRIES) introduced the following bill; which was referred to the Committee on the Judiciary

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A BILL

To amend the Omnibus Crime Control and Safe Streets Act of 1968 to establish the Pandemic Jail and Prison Emergency Response grant programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "COVID–19 Correctional Facility Emergency Response Act of 2020".

SEC. 2. PANDEMIC CORRECTIONAL FACILITY EMERGENCY RESPONSE.

Title I of the Omnibus Crime Control and Safe Streets Act of 1968 (34 U.S.C. 10101 et seq.) is amended by adding at the end the following:

"PART OO—PANDEMIC CORRECTIONAL FACILITY EMERGENCY RESPONSE

"SEC. 3061. FINDINGS; PURPOSES.

"(a) IMMEDIATE RELEASE OF VULNERABLE AND LOW-RISK INDIVIDUALS.—The purpose of the grant program under section 3062 is to provide for the testing, initiation and transfer to treatment in the community, and provision of services in the community, by States and units of local government as they relate to preventing, detecting, and stopping the spread of COVID–19 in correctional facilities.

"(b) PRETRIAL CITATION AND RELEASE.—

"(1) FINDINGS.—Congress finds as follows:

"(A) With the dramatic growth in pretrial detention resulting in county and city correctional facilities regularly exceeding capacity, such correctional facilities may serve to rapidly increase the spread of COVID–19, as facilities that hold large numbers of individuals in congregant living situations may promote the spread of COVID–19.

"(B) While individuals arrested and processed at local correctional facilities may only be held for hours or days, exposure to large number of individuals in holding cells and courtrooms promotes the spread of COVID–19.

"(C) Pretrial detainees and individuals in correctional facilities are then later released into the community having being exposed to COVID–19.

"(2) PURPOSE.—The purpose of the grant program under section 3063 is to substantially increase the use of risk-based citation release for all individuals who do not present a public safety risk.

"SEC. 3062. IMMEDIATE RELEASE OF VULNERABLE AND LOW-RISK INDIVIDUALS.

"(a) AUTHORIZATION.—The Attorney General shall carry out a grant program to make grants to States and units of local government that operate correctional facilities, to establish and implement policies and procedures to prevent, detect, and stop the presence and spread of COVID–19 among arrestees, detainees, inmates, correctional facility staff, and visitors to the facilities.

"(b) PROGRAM ELIGIBILITY.—

"(1) IN GENERAL.—Eligible applicants under this section are States and units of local government that release or have a plan to release the persons described in paragraph (2) from custody in order to meet 80 percent of the rated capacity of a correctional facility, within 60 days of the declaration of a national emergency issued by the President, dated March 13, 2020, entitled 'Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID–19) Outbreak'.

"(2) PERSONS DESCRIBED.—A person described in this paragraph is a person who—

"(A) does not pose a risk of serious, imminent injury to a reasonably identifiable person; or

"(B) is—

"(i) 50 years of age or older;

"(ii) an individual with serious chronic medical conditions, including heart disease, cancer, diabetes, HIV, sickle cell anemia, a neurological disease that interferes with the ability to cough or breathe, chronic lung disease, asthma, or respiratory illness;

"(iii) a pregnant woman;

"(iv) an individual who is immunocompromised or has a weakened immune system; or

"(v) an individual who has a health condition or disability that makes them vulnerable to COVID–19.

"(c) AUTHORIZED USES.—Funds awarded pursuant to this section shall be used by grantees to—

"(1) test all arrestees, detainees, and inmates, and initiate treatment for COVID–19, and transfer such an individual for an appropriate treatment at external medical facility, as needed;

"(2) test for COVID–19—

"(A) correctional facility staff;

"(B) volunteers;

"(C) visitors, including family members and attorneys;

"(D) court personnel that have regular contact with arrestees, detainees, and inmates;

"(E) law enforcement officers who transport arrestees, detainees, and inmates; and

"(F) personnel outside the correctional facility who provide medical treatment to arrestees, detainees, and inmates;

"(3) curtail booking and in-facility processing for individuals who have committed technical parole or probation violations; and

"(4) provide transition and reentry support services to individuals released pursuant to this section, including programs that—

"(A) increase access to and participation in reentry services;

"(B) promote a reduction in recidivism rates;

"(C) facilitate engagement in educational programs, job training, or employment;

"(D) place reentering individuals in safe and sanitary temporary transitional housing;

"(E) facilitate the enrollment of reentering individuals with a history of substance use disorder in medication-assisted treatment and a referral to overdose prevention services, mental health services, or other medical services; and

"(F) facilitate family reunification or support services, as needed.

"SEC. 3063. PRETRIAL CITATION AND RELEASE.

"(a) AUTHORIZATION.—The Attorney General shall make grants under this section to eligible applicants for the purposes set forth in section 3061(b)(2).

"(b) PROGRAM ELIGIBILITY.—Eligible applicants under this section are States and units of local government that implement or continue operation of a program described in subsection (c)(1) and not fewer than 2 of the other programs enumerated in such subsection.

"(c) USE OF GRANT FUNDS.—A grantee shall use amounts provided as a grant under this section for programs that provide for the following:

"(1) Adopting and operating a cite-and-release process for individuals who are suspected of committing misdemeanor and felony offenses and who do

not pose a risk of serious, imminent injury to a reasonably identifiable person.

"(2) Curtailing booking and in-facility processing for individuals who have committed technical parole or probation violations.

"(3) Ensuring that defense counsel is appointed at the earliest hearing that could result in pretrial detention so that low-risk defendants are not unnecessarily further exposed to COVID–19.

"(4) Establishing early review of charges by an experienced prosecutor, so only arrestees and detainees who will be charged are detained.

"(5) Providing appropriate victims' services supports and safety-focused residential accommodations for victims and community members who have questions or concerns about releases described in this subsection.

"SEC. 3064. REPORT.

"Not later than two years after the date on which grants are initially made under this section, the Attorney General shall submit to Congress a report on the program, which shall include—

"(1) the number of grants made, the number of grantees, and the amount of funding distributed to each grantee pursuant to this section;

"(2) the location of each correctional facility where activities are carried out using grant amounts; and

"(3) the number of persons who have benefitted from early release, disaggregated by type of offense, age, race, and ethnicity.

"SEC. 3065. DEFINITION.

"For purposes of this part:

"(1) CORRECTIONAL FACILITY.—The term 'correctional facility' includes a juvenile facility.

"(2) COVID–19.—The term 'COVID–19' means a disease caused by severe acute respiratory syndrome coronavirus 2 (SARS–CoV–2).

"(3) DETAINEE; ARRESTEE; INMATE.—The terms 'detainee', 'arrestee', and 'inmate' each include juveniles.

"SEC. 3066. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated $1,000,000,000 for each of fiscal years 2021 and 2022 to carry out sections 3062 and 3063.".

This is **Exhibit "O"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

Ontario Stepping Up Measures to Limit the Spread of COVID-19 in Correctional System

March 20, 2020 1:45 P.M. | Ministry of the Solicitor General

TORONTO — Today, Christine Elliott, Deputy Premier and Minister of Health, and Sylvia Jones, Solicitor General, issued the following statement regarding regulatory changes to temporary absences and parole at Ontario's adult correctional facilities as a further precautionary response to COVID-19:

"As Ontario continues to act to slow the spread of COVID-19, we are making further changes to protect our frontline workers and our health care system from the burden an outbreak in our correctional system could cause.

On March 13, we announced measures to protect Ontario's adult correctional facilities from COVID-19 by granting intermittent inmates, who serve time on the weekends, temporary absences from custody, and temporarily halting personal visits. Intermittent inmates have already been deemed low-risk by the courts and remain in the community Monday to Friday to live and work.

Building on these changes, Ontario is implementing amendments to Regulation 778 under the *Ministry of Correctional Services Act* to allow senior corrections officials to expand the use of temporary absences and for the Ontario Parole Board to use alternatives to in-person meetings.

Going forward, correctional services will have the option to issue temporary absences beyond the current 72-hour maximum. This means those serving intermittent sentences, who have been granted a temporary absence will not have to report to a correctional facility every weekend, which will avoid cycling individuals back and forth between the community and a correctional facility.

In addition, the longer-term temporary absences will allow for early release of those inmates who are near the end of their sentence. To ensure public safety, inmates would be carefully assessed to ensure they are a low risk to reoffend. Those inmates who have been convicted of serious crimes, such as violent crimes or crimes involving guns, would not be considered for early release.

A second regulatory amendment will allow the Ontario Parole Board to conduct hearings by electronic or written means, rather than solely in-person, providing alternate options for hearings.

We continue to evaluate all options to limit the possible spread of COVID-19 within our correctional system. These regulatory amendments will help us preserve the integrity of our health care system, protect our frontline workers and help keep our communities safe."

Media Contacts

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- COVID-19: Get the **latest updates** or take a **self-assessment**.

This is **Exhibit "P"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

Vera Evidence Brief

For the Record

The Prison Paradox: More Incarceration Will Not Make Us Safer

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Summary*

Despite two decades of declining crime rates and a decade of efforts to reduce mass incarceration, some policymakers continue to call for tougher sentences and greater use of incarceration to reduce crime.[1] It may seem intuitive that increasing incarceration would further reduce crime: incarceration not only prevents future crimes by taking people who commit crime "out of circulation" (incapacitation), but it also may dissuade people from committing future crimes out of fear of punishment (deterrence).[2] In reality, however, increasing incarceration rates has a minimal impact on reducing crime and entails significant costs:

- Increases in incarceration rates have a small impact on crime rates and each additional increase in incarceration rates has a smaller impact on crime rates than previous increases.[3]
- Any crime reduction benefits of incarceration are limited to property crime. Research consistently shows that higher incarceration rates are not associated with lower violent crime rates.[4]
- Incarceration may *increase* crime in certain circumstances. In states with high incarceration rates and neighborhoods with concentrated incarceration, the increased use of incarceration may be associated with increased crime.[5]
- Incarceration is expensive. The United States is spending heavily on jails and prisons and under-investing in less expensive, more effective ways to reduce and prevent crime.[6]

* This brief uses the broad term "incarceration," which can encompass confinement in both prisons and jails. Much of the research conducted to date, however, examines imprisonment only, and not incarceration in America's jails.

Why won't more incarceration reduce crime?

Incarceration has a marginal impact on crime

There is a very weak relationship between higher incarceration rates and lower crime rates. Although studies differ somewhat, most of the literature shows that between 1980 and 2000, each 10 percent increase in incarceration rates was associated with just a 2 to 4 percent lower crime rate.[7] Since then, only one empirical analysis (a study that requires corroboration) has examined the relationship between incarceration and crime.[8] Overall, the increased use of incarceration through the 1990s accounted for between 6 and 25 percent of the total reduction in crime rates.[9] Since 2000, however, the increased use of incarceration accounted for nearly zero percent of the overall reduction in crime.[10]

This means that somewhere between 75 and 100 percent of

About these briefs

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the reduction in crime rates since the 1990s is explained by other factors. Research has shown that the aging population, increased wages, increased employment, increased graduation rates, increased consumer confidence, increased law enforcement personnel, and changes in policing strategies were associated with lower crime rates and, collectively, explain more of the overall reduction in crime rates than does incarceration.[11]

Incarceration has a diminishing impact on crime

The relationship between higher incarceration rates and lower crime rates is weak, and is getting weaker.[12] Research shows that each additional increase in incarceration rates will be associated with a smaller and smaller reduction in crime rates.[13] This is because individuals convicted of serious or repeat offenses receive prison sentences even when overall rates of incarceration are low. To continue to increase incarceration rates requires that prisons be used for individuals convicted of lower-level or infrequent offenses as well. Thus, since the early 1990s, the crime reduction benefits of additional prison expansion have been smaller and more expensive to achieve.[14] This diminishing impact of incarceration also explains the lack of crime reduction benefits of higher incarceration rates through the 2000s. Increases in correctional populations when incarceration rates are already high have less impact on crime than increases in populations when incarceration rates are low.[15]

Incarceration has little to no effect on violent crime

The weak association between higher incarceration rates and lower crime rates applies almost entirely to property crime.[16] Research consistently shows that higher incarceration rates are not associated with lower violent crime rates.[17] This is because the expansion of incarceration primarily means that larger numbers of individuals convicted of nonviolent, "marginal" offenses—drug offenses and low-level property offenses, as well as those who are convicted of "infrequent" offenses—are imprisoned.[18] Those convicted of violent and repeat offenses are likely to receive prison sentences regardless of the incarceration rate. Thus, increasing incarceration rates for those convicted of nonviolent, marginal offenses does nothing to impact the violent crime rate.[19]

Incarceration will increase crime in states and communities with already high incarceration rates

Although it may seem counterintuitive, research has shown that incarceration may actually increase crime. At the state level, there may be an "inflection point" where increases in state incarceration rates are associated with higher crime rates.[20] This state-level phenomenon mirrors a similar occurrence in specific neighborhoods, where communities may reach an incarceration "tipping point" after which future increases in incarceration lead to higher crime rates.[21] The argument is that high rates of imprisonment break down the social and family bonds that guide individuals away from crime, remove adults who would otherwise nurture children, deprive communities of income, reduce future income potential, and engender a deep resentment toward the legal system; thus, as high incarceration becomes concentrated in certain neighborhoods, any potential public safety benefits are outweighed by the disruption to families and social groups that would help keep crime rates low.[22]

At the individual level, there is also some evidence that incarceration itself is criminogenic, meaning that spending time in jail or prison actually increases a person's risk of engaging in crime in the future.[23] This may be because people learn criminal habits or develop criminal networks while incarcerated, but it may also be because of the collateral consequences that derive from even short periods of incarceration, such as loss of employment, loss of stable housing, or disruption of family ties.[24]

Incarceration is an expensive way to achieve little public safety

The United States incarcerated 1.2 million more people in prison in 2000 than in 1975 to achieve little public safety benefit. By 2000, the incarceration rate was 270 percent higher than in 1975, but the violent crime rate was nearly identical to the rate in 1975 and the property crime rate was nearly 20 percent lower than in 1975. Put another way, the United States was spending roughly $33 billion on incarceration in 2000 for essentially the same level of public safety it achieved in 1975 for $7.4 billion—nearly a quarter of the cost.[25] But the costs of high incarceration rates go well beyond the financial costs to government. Mass incarceration also imposes significant social, cultural, and political costs on individuals, families, and communities.[26] Incarceration reduces employment opportunities, reduces earnings, limits

economic mobility and, perhaps more importantly, has an intergenerational impact that increases the chances that children of incarcerated parents will live in poverty and engage in delinquent behavior.[27]

What can policymakers do to reduce crime without the use of incarceration?

Prior research indicates several factors associated with lower crime rates: aging population, increased wages, increased employment, increased graduation rates, increased consumer confidence, increased law enforcement personnel, and changes in policing strategies.[28] Policymakers have many tools at their disposal to address crime rates based on these factors in the long term. They can implement policies that require investment outside the criminal justice system to increase graduation rates, employment, income, or consumer confidence. But there are short-term solutions to reducing crime as well. Research points to several criminal justice practices that policymakers can adopt that are more effective and less expensive than incarceration at reducing crime.

Use community crime prevention strategies

Several policing and community-engagement strategies can reduce the incidence of crime in local jurisdictions.[29] Place-based problem-oriented policing approaches, for example, significantly reduce crime rates; such approaches involve carefully analyzing crime and disorder in small geographic areas and addressing such problems through tailor-made solutions, such as situational crime prevention measures (repairing fences, improving lighting, erecting road barriers) and community improvements (removing graffiti, nuisance abatement).[30] Similarly, several jurisdictions also have renewed efforts to implement and improve community policing approaches—such as working with business owners to identify neighborhood problems, conducting citizen surveys and outreach, and improving recreational opportunities for youth—in order to engage more closely with communities to identify and solve crime problems. Evaluations show that such programs can reduce both violent and property crimes.[31]

To address violent crime, several jurisdictions have implemented focused deterrence strategies that 1) identify high-risk individuals who are responsible for a disproportionate share of violent crime, 2) advise such individuals that they will be subjected to intensified enforcement if they continue to engage in violence, and 3) provide targeted individuals with access to social services. Evaluations of such programs have shown significant reductions in violent crime, including homicides and gun-related offenses.[32] Finally, several studies also have shown that jurisdictions working with residents to increase collective crime prevention techniques or to implement situational crime prevention techniques can reduce property crimes in targeted neighborhoods.[33]

Increase the availability and use of alternative-to-incarceration programs

Several types of alternative-to-incarceration programs that offer supportive services (like mental health, substance abuse, employment, housing, Medicaid, public benefits, and community health centers) can reduce criminal activity among participants.[34] For example, law enforcement-led diversion programs that divert individuals at the point of arrest and prosecution-led diversion programs that divert individuals either pre-charge or defer prosecution post-charge have been shown to reduce future criminal activity of program participants.[35] Several meta-analyses show that participation in drug courts—specialized courts that combine drug treatment with supervision to reduce drug use and drug-related crime—can significantly reduce recidivism among participants.[36] Research also suggests that other specialty courts may reduce criminal activity of targeted groups. Mental health courts, for example, combine treatment-oriented and problem-solving strategies to reduce recidivism and contact with the criminal justice system among individuals with mental health issues.[37] Juvenile diversion programs divert youth out of traditional criminal case processing and into a variety of alternatives, including restorative justice programs, community service, substance abuse treatment, skills-building programs, or family treatment.[38]

Employ community corrections approaches

Several community corrections approaches, which provide supervision and services to individuals in the community post-conviction, can reduce criminal activity among participants without the use of incarceration.[39] Reducing caseloads for probation officers and focusing on evidence-based practices like risk/needs assessments, separate specialized caseloads, intensive wraparound services, and comprehensive case management can significantly reduce re-arrest rates

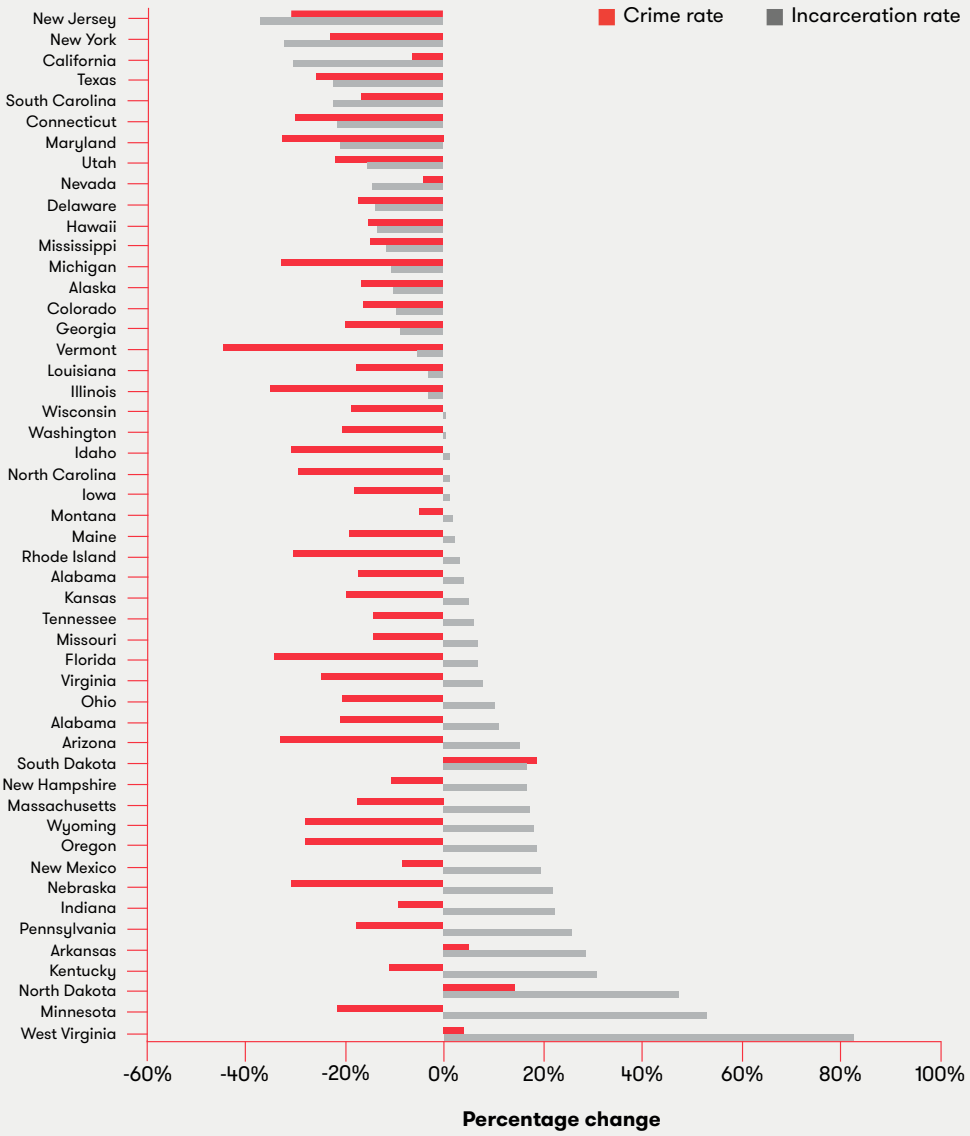
among high-risk probationers.[40] In addition, community supervision programs that target moderate- and high-risk adults and incorporate cognitive behavioral therapy have been shown to reduce recidivism rates among program participants.[41] Investment in reentry programs for those already incarcerated, such as pre-release programming and aftercare services, in-prison therapeutic communities, and transitional planning, can significantly reduce criminal activity of those released from incarceration.[42]

It is possible to reduce incarceration and crime

Experiences in several states offer evidence that policymakers can reduce crime without increasing imprisonment. In fact, 19 states reduced both imprisonment and crime rates over the last 15 years.[43] (See Figure 1 below.) These states represent a diverse cross-section of the United States, including large states like Texas and small states like Alaska; Northeastern states like Connecticut and Midwestern states like Michigan; Southern states like Louisiana and Western states like Hawaii. Socially liberal states like New York,

Figure 1

Percent change in state crime rates and imprisonment rates, 2000-2015.



wealthy states like Maryland, and states with low crime rates like Vermont simultaneously reduced incarceration and crime rates, but so did socially conservative states like Utah, economically distressed states like Mississippi, and states with high crime rates like Nevada.

The experiences across states also indicate that the relationship between incarceration and crime is neither predictable nor consistent. The state with the largest decrease in incarceration rates—New Jersey (with a 37 percent decrease between 2000 and 2015)—also experienced a 30 percent decrease in crime rates during the same period. The state with the largest increase in incarceration rates—West Virginia (with an 83 percent increase between 2000 and 2015)—also experienced a 4 percent increase in crime rates. Among the 10 states with the largest decreases in crime rates between 2000 and 2015, five also reduced incarceration rates.[44] Indeed, the state with the largest decrease in crime rates—Vermont—also reduced incarceration rates. Between 2000 and 2015, only four states—Arkansas, North Dakota, South Dakota, and West Virginia—experienced increases in crime rates, and all four also experienced increased incarceration rates.

The practices and programs adopted at the state and local levels in many of these states—community-based crime prevention, innovative policing strategies, diversion, and community corrections programs—likely explain these disparate trends in incarceration rates and crime rates over the last 15 years. As national policymakers call for increased incarceration and many state and local policymakers feel pressure to introduce measures to keep crime rates low, officials would do well to look toward states that have reduced both incarceration and crime for examples of innovation.

Conclusion

After 25 years of consistently declining crime rates, policymakers continue to feel pressure to introduce measures to address even small upticks in crime. This is understandable—policymakers should seek solutions to the problems of violence and embrace practices and policies that can keep crime rates low. Filling the nation's prisons is not one of them. The impact of incarceration on crime is limited and has been diminishing for several years. Increased incarceration has no effect on violent crime and may actually lead to higher crime rates when incarceration is concentrated in certain communities. Instead, policymakers can reduce crime without continuing to increase the social, cultural, and political costs of mass incarceration by investing in more effective and efficient crime reduction strategies that seek to engage the community, provide needed services to those who are criminally involved, and begin to address the underlying causes of crime.

Resources

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Endnotes

1 The crime rate is defined as the number of crimes reported to police per 100,000 people, based on the Uniform Crime Reports produced annually by the Federal Bureau of Investigation. When analysts or the media refer to the "crime rate," they generally mean the index crime rate, which is based on a set of seven violent and property crimes—murder and non-negligent manslaughter, forcible rape, aggravated assault, robbery, burglary, larceny-theft, and motor vehicle theft. Analysts may also use the violent crime rate (which is based only on the crimes of murder and non-negligent manslaughter, forcible rape, aggravated assault, and robbery) or the property crime rate (which is based only on the crimes of burglary, larceny-theft, and motor vehicle theft). See Federal Bureau of Investigation, "UCR Offense Definitions," https://perma.cc/SF7A-SM9F. Violent and property crime rates both declined roughly 50 percent between their peak in 1992 and 2015. For crime rates through 2013, see Federal Bureau of Investigation, "Uniform Crime Reporting Statistics, State and National Estimates by Year," https://perma.cc/LHV6-2G3R. For crime rates in 2014 and 2015, see Federal Bureau of Investigation, "2015 Crime in the United States," Table 1, https://perma.cc/BW2M-JBC6. For a review of state sentencing and corrections reforms aimed at reducing the size of state prison populations, see Rebecca Silber, Ram Subramanian, and Maia Spotts, *Justice in Review: New Trends in State Sentencing and Corrections 2014-2015* (New York: Vera Institute of Justice, 2016), https://perma.cc/RX3U-K9R3; Ram Subramanian, Rebecka Moreno, and Sharyn Broomhead, *Recalibrating Justice: A Review of 2013 State Sentencing and Corrections Trends* (New York: Vera Institute of Justice, 2014), https://perma.cc/L2D2-YUAA; Ram Subramanian and Rebecka Moreno, *Drug War Détente? A Review of State-level Drug Law Reform, 2009-2013* (New York: Vera Institute of Justice, 2014), https://perma.cc/N2SF-LH86; and Christine S. Scott-Hayward, *The Fiscal Crisis in Corrections: Rethinking Policies and Practices* (New York: Vera Institute of Justice, 2009), https://perma.cc/AMT6-6U44. For policymaker statements on crime, see, e.g., Jeff Sessions, "Being soft on sentencing means more violent crime. It's time to get tough again," *Washington Post*, June 16, 2017 (arguing for the use of mandatory sentences and prison for drug offenses), https://perma.cc/7GJA-A6ZU; see also Rachel Weiner and Sari Horwitz, "Sessions Vows Crackdown on Drug Dealing and Gun Crime," *Washington Post*, March 15, 2017, https://perma.cc/Z28L-Y8TR; Office of the Attorney General, Memorandum for All Federal Prosecutors, "Department Charging and Sentencing Policy," May 10, 2017 (directing federal prosecutors to "charge and pursue the most serious, readily provable offense…[defined as] those that carry the most substantial guidelines sentence, including mandatory minimum sentences" and requiring prosecutors to "disclose to the sentencing court all facts that impact the sentencing guidelines or mandatory minimum sentences"), https://www.justice.gov/opa/press-release/file/965896/download.

2 For a review of research examining the incapacitative and deterrent effects of incarceration, see Jeremy Travis and Bruce Western (eds.), *The Growth of Incarceration in the United States: Exploring Causes and Consequences* (Washington, DC: The National Research Council, 2014), https://perma.cc/D2Q6-7HEJ.

3 The incarceration rate is defined as the number of sentenced persons in prison per 100,000 people. Analysts use either the national incarceration rate (the number of sentenced persons in state or federal prison per 100,000 U.S. population) or state incarceration rates (the number of sentenced persons in a particular state's prisons per 100,000 state population). By definition, this figure does not include the nation's jail populations. For more information about the U.S. jail population, see Bureau of Justice Statistics, "Data Collection: Annual Survey of Jails," https://perma.cc/D7QZ-CM46. For the impact of increased incarceration rates on crime rates, see, generally, James Austin and Tony Fabelo, *The Diminishing Returns of Increased Incarceration: A Blueprint to Improve Public Safety and Reduce Costs* (Washington, DC: JFA Institute, 2004), https://perma.cc/N9K7; Jenni Gainsborough and Marc Mauer, *Diminishing Returns: Crime and Incarceration in the 1990s* (Washington, DC: The Sentencing Project, 2000), https://perma.cc/HV5E-J4YQ; Steven Raphael and Michael A. Stoll, *A New Approach to Reducing Incarceration While Maintaining Low Rates of Crime* (Washington, DC: The Hamilton Project, 2014), https://perma.cc/46B2-6G4M.

4 For reviews of studies examining the relationship between incarceration and crime in the 1990s, see Don Stemen, *Reconsidering Incarceration: New Directions for Reducing Crime* (New York: Vera Institute of Justice, 2007), 4 (describing studies that showed no relationship or a very weak relationship between incarceration rates and violent crime rates through the 1990s), https://perma.cc/T8PJ-QBCD; Oliver Roeder, Lauren-Brook Eisen, and Julia Bowling, *What Caused the Crime Decline?* (New York: Brennan Center for Justice, 2017) (analyzing incarceration rates and crime rates through 2015 and showing no relationship between incarceration rates and crime rates in the 2000s), https://perma.cc/NTL9-5Z24.

5 For a review of research on the effects of incarceration at the local level, see Todd R. Clear, "The Effects of High Imprisonment Rates on Communities," *Crime and Justice* 37, no. 1 (2008), 97-132 (describing several studies that find high incarceration rates associated with higher crime rates at the neighborhood level), https://perma.cc/5L73-2DGT; see also Raymond V. Liedka, Anne Morrison Piehl, and

Bert Useem, "The Crime-Control Effect of Incarceration: Does Scale Matter?" *Criminology & Public Policy* 5, no. 2 (2006), 245-76.

6 John J. Donohue III, "Assessing the Relative Benefits of Incarceration: The Overall Change over the Previous Decades and the Benefits on the Margin," in *Do Prisons Make Us Safer? The Benefits and Costs of the Prison Boom*, edited by Steven Raphael and Michael Stoll (New York: Russell Sage Foundation, 2009) (arguing that "social spending" on programs such as preschool and early-childhood education, family therapy, programs for juvenile delinquents, and labor-market interventions could generate greater reductions in crime at a lower social cost than incarceration).

7 See Don Stemen, *Reconsidering Incarceration* (2007); and Oliver Roeder, Lauren-Brook Eisen, and Julia Bowling, *What Caused the Crime Decline?* (2017).

8 Ibid. Roeder, Eisen, and Bowling, 2017.

9 William Spelman, "The Limited Importance of Prison Expansion," in *The Crime Drop in America*, edited by Alfred Blumstein and Joel Wallman (Cambridge, England: Cambridge University Press, 2000) (finding that 25 percent of the decrease in index crime rates in the 1990s was explained by higher incarceration rates); in contrast, see Oliver Roeder, Lauren-Brook Eisen, and Julia Bowling, *What Caused the Crime Decline?* (2017), 23 (arguing that once the diminishing returns of incarceration are accounted for, only 6 percent of the decrease in property crime rates and 0 percent of the decrease in violent crime rates in the 1990s were explained by higher incarceration rates; however, the authors note that even for property crime, higher incarceration could account for anywhere from 0 to 12 percent of the decline).

10 Ibid. Roeder, Eisen, and Bowling, 2017, 23 (stating that "increased incarceration accounted for less than one one-hundredth of the decline of property crime in the 2000s…[and] had no observable effect on the violent crime decline … in the 2000s").

11 For reviews of studies examining the relationship between these factors and crime, see Don Stemen, *Reconsidering Incarceration* (2007). For a review and reanalysis of these factors see Oliver Roeder, Lauren-Brook Eisen, and Julia Bowling, *What Caused the Crime Decline?* (2017) (finding that lower unemployment rates, higher per capita income, higher consumer confidence, lower alcohol consumption, aging population, and the introduction of COMPSTAT were associated with lower crime rates). For the results of specific studies, see, e.g., Hope Corman and H. Naci Mocan, "A Time-Series Analysis of Crime, Deterrence, and Drug Abuse in New York City," *American Economic Review* 90, no. 3 (2000), 584-604 (finding a significant effect of increased numbers of law enforcement officers on lower burglary and robbery rates); Steven D. Levitt, "Using Electoral Cycles in Police Hiring to Estimate the Effect of Police on Crime: Reply," *American Economic Review* 92, no. 4 (2002), 1244-50 (finding a significant effect of increased numbers of law enforcement officers on property and violent crime rates), https://perma.cc/XZ87-5849; Steven Raphael and Rudolf Winter-Ebmer, "Identifying the Effect of Unemployment on Crime," *Journal of Law and Economics* 44, no. 1 (2001), 259-83 (finding that higher unemployment rates were associated with higher property crime rates and that higher per capita income was associated with lower violent crime rates); Steven D. Levitt, "Alternative Strategies for Identifying the Link between Unemployment and Crime," *Journal of Quantitative Criminology* 17, no. 4 (2001), 377-90 (finding that higher unemployment rates were associated with higher property crime rates); Raymond V. Liedka, Anne Morrison Piehl, and Bert Useem, "The Crime-Control Effect of Incarceration" (2006) (finding that higher per capita income was associated with lower crime rates); Richard Rosenfeld and Robert Fornango, "The Impact of Economic Conditions on Robbery and Property Crime: The Role of Consumer Sentiment," *Criminology* 45, no. 4 (2007), 735-69 (finding that increased consumer confidence was associated with lower rates of robbery, burglary, larceny, and motor vehicle theft rates); Sara Markowitz, *An Economic Analysis of Alcohol, Drugs, and Violent Crime in the National Crime Victimization Survey* (Cambridge, MA: National Bureau of Economic Research, 2000) (finding that increases in the number of alcohol distribution outlets is associated with increased probability of assault), https://perma.cc/4XUB-L3A4; Lance Lochner and Enrico Moretti, "The Effect of Education on Crime: Evidence from Prison Inmates, Arrests, and Self-Reports," *American Economic Review* 94, no. 1 (2004), 155-89 (finding that increases in individuals' education levels are associated with lower crime rates).

12 This is generally referred to as the "diminishing marginal returns" of incarceration. See, e.g., James F. Austin and Tony Fabelo, *The Diminishing Returns of Increased Incarceration* (2004); Jenni Gainsborough and Marc Mauer, *Diminishing Returns* (2000); Steven Raphael and Michael Stoll, *A New Approach to Reducing Incarceration* (2004); Franklin Zimring and Gordon Hawkins, *Crime Is Not the Problem: Lethal Violence in America* (Oxford, England: Oxford University Press, 1997).

13 See, e.g., Oliver Roeder, Lauren-Brook Eisen, and Julia Bowling, *What Caused the Crime Decline?* (2017), 18-19 (the authors look across states and demonstrate the diminishing marginal returns of increases in incarceration over time); see also Steven D. Levitt, "Understanding Why Crime Fell in the 1990s: Four Factors that Explain the Decline and Six that Do Not," *Journal of Economic Perspectives* 18, no. 1 (2004), 163-90; Ilyana Kuziemko and Steven D. Levitt, "An Empirical Analysis of Imprisoning Drug Offenders,"

Journal of Public Economics 88, no. 9-10 (2004), 2043-66; Raymond V. Liedka, Anne Morrison Piehl, and Bert Useem, "The Crime-Control Effect of Incarceration" (2006); Anne Morrison Piehl and John J. Dilulio, "'Does Prison Pay?' Revisited" *The Brookings Review* 13, no. 1 (1995) (findings indicate that when those convicted of drug offenses are included in calculations, continued prison expansion is not cost effective); Tomislav V. Kovandzic and Lynne M. Vieraitis, "The Effect of County-Level Prison Population Growth on Crime Rates," *Criminology & Public Policy* 5, no. 2 (2006), 213-44; Washington State Institute for Public Policy, *The Criminal Justice System in Washington State: Incarceration Rates, Taxpayer Costs, Crime Rates, and Prison Economics* (Olympia, WA: Washington State Institute for Public Policy, 2003) https://perma.cc/WP6A-XN3J; William Spelman, "Jobs or Jails? The Crime Drop in Texas," *Journal of Policy Analysis and Management* 24, no. 1 (2005), 133-65.

14 Washington State Institute for Public Policy, *The Criminal Justice System in Washington State* (2003). Washington State, for example, concluded that while more incarceration had led to less crime in the state in the 1990s, the benefits of additional prison expansion would be smaller and more expensive to achieve. Specifically, the state concluded that an increase in the incarceration rate in 2003 prevented considerably fewer crimes than did previous similar size increases in the state's prison population. The state further concluded that while incarcerating individuals convicted of violent and high-volume property offenses continued to generate more benefits than costs, each additional person incarcerated for these crimes would result in fewer prevented crimes than previous persons. Washington even found that increasing the incarceration rate for people convicted of drug offenses in the 1990s actually cost more than the average value of the crimes prevented by their imprisonment and was, thus, no longer cost-effective.

15 Raymond V. Liedka, Anne Morrison Piehl, and Bert Useem, *The Crime-Control Effect of Incarceration* (2006) (finding that increases in prison populations in states with already large prison populations have less impact on crime than increases in states with smaller prison populations; states experience "accelerating declining marginal returns"—meaning that the percent reduction in crime gets ever smaller with larger prison populations. The authors concluded that increases in incarceration rates are associated with lower crime rates at low levels of imprisonment, but the size of that association shrinks as incarceration rates get bigger).

16 See, e.g., Oliver Roeder, Lauren-Brook Eisen, and Julia Bowling, *What Caused the Crime Decline?* (2017) (re-analyzing data from previous studies and analyzing data from 2000 to 2015; finding either no relationship between incarceration rates and violent crime rates or a very small relationship).

17 See, e.g., Thomas B. Marvell and Carlisle E. Moody, "Prison Population Growth and Crime Reduction," *Journal of Quantitative Criminology* 10, no. 2 (1994), 109-40 (finding that higher incarceration rates were generally related to lower index crime rates but had little or no impact on murder, rape, or assault); Steven D. Levitt, "Alternative Strategies for Identifying the Link between Unemployment and Crime" (2001) (finding a very modest association between incarceration rates and property crime rates but no association between incarceration rates and violent crime rates); Robert H. DeFina and Thomas M. Arvanites, "The Weak Effect of Imprisonment on Crime: 1971-1998," *Social Science Quarterly* 83, no. 3 (2002), 635-53 (finding that higher incarceration rates were associated with lower crime rates for burglary, larceny, and motor vehicle theft, but not for murder, rape, assault, or robbery), http://www.antoniocasella.eu/nume/DeFina_Arvanites_2002.pdf; Tomislav V. Kovandzic and Lynne M. Vieraitis, "The Effect of County-Level Prison Population Growth on Crime Rates" (2006) (finding no association between incarceration rates and crime rates); Oliver Roeder, Lauren-Brook Eisen, and Julia Bowling, *What Caused the Crime Decline?* (2017).

18 See, e.g., Franklin Zimring and Gordon Hawkins, *Crime Is Not the Problem* (1997). Zimring and Hawkins argue that by the late 1980s U.S. prisons already housed those convicted of the most serious, violent offenses and did not need to expand to get more such individuals off of the streets; the prison expansion since the 1980s resulted in nothing more than the imprisonment of large numbers of people convicted of nonviolent, "marginal" offenses. Thus, the authors argue that increasing incarceration rates does nothing to impact the crime rate since those convicted of the most serious offenses were already incarcerated.

19 Ibid.

20 Raymond V. Liedka, Anne Morrison Piehl, and Bert Useem, "The Crime-Control Effect of Incarceration" (2006). Liedka, Piehl, and Useem argue that there is an "inflection point" where increases in incarceration rates are associated with higher crime rates. According to the authors, this inflection point occurs when a state's incarceration rate reaches some point between 325 and 429 inmates per 100,000 people. In other words, states with incarceration rates above this range can expect to experience higher crime rates with future increases in incarceration rates.

21 For a theoretical discussion of this phenomenon, see Dina R. Rose and Todd R. Clear, "Incarceration, Social Capital, and Crime: Implications for Social Disorganization Theory," *Criminology* 36, no. 3 (1998), 441-80. For empirical studies confirming an association between higher incarceration rates and higher crime rates, see, e.g., Todd R. Clear et al.,"Coercive Mobility and Crime:

A Preliminary Examination of Concentrated Incarceration and Social Disorganization," *Justice Quarterly* 20, no. 1 (2003), 33-64; Brian C. Renauer et al.,"Tipping the Scales of Justice: The Effect of Overincarceration on Neighborhood Violence," *Criminal Justice Policy Review* 17, no. 3 (2006), 362-79. For a review of empirical research confirming these findings, see Todd R. Clear, "The Effects of High Imprisonment Rates on Communities" (2008) at 118-20.

22 See generally Todd R. Clear, "The Effects of High Imprisonment Rates on Communities" (2008).

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29 For a list of community crime prevention programs that have been evaluated and reviewed to be effective, see National Institute of Justice, Office of Justice Programs, CrimeSolutions.gov, https://www.crimesolutions.gov.

30 Such approaches fall under the general category of "hot spots" or place-based policing. However, place-based policing can involve either traditional policing strategies, such as increased patrols and aggressive enforcement, or problem-oriented policing approaches, which involve efforts by police to address the underlying causes of crime in targeted areas by relying on non-traditional problem-solving policing strategies. Research indicates that place-based problem-oriented approaches are much more effective than place-based traditional policing approaches. For a meta-analysis of 10 hot spot policing programs, see, Anthony A. Braga, Andrew V. Papachristos, and David M. Hureau, "The Effects of Hot Spots Policing on Crime: An Updated Systematic Review and Meta-Analysis," *Justice Quarterly* 31, no. 4 (2014), 633-63. Braga et al., found that problem-oriented policing approaches (police-led efforts to change the underlying conditions at hot spots that lead

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39 For a list of community corrections programs that have been evaluated and reviewed to be effective, see National Institute of Justice, Office of Justice Programs, CrimeSolutions.gov.

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This is **Exhibit "Q"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

Strategies for Reducing Prison Populations

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Abstract

There is a growing U.S. national consensus that with proper attention to the policies that drive the size of prison populations, these populations can be reduced. As several states have reduced prison populations, there is an accumulating record of strategies that reduce prison populations—but little in the way of proven cause and effect based on research or evidence of the degree to which these gains can be sustained and replicated. Concurrently, the current fiscal crisis has created enormous pressure to reduce prison populations, with a first-in-decades showing of political support. This article provides information about the various prison-reduction strategies, with examples of successful initiatives and an eye toward implementing rigorous evaluations.

Keywords

prison population-reduction strategies, rearrest rates, prison programming

If the standard is one of "rigorous research underlying evidence-based policy," we must admit that we know shockingly little about effective ways to reduce prison populations.[1] Although there has been a great deal of policy activity trying to reduce the size of prison populations, especially in the last few years, very little of this activity has received rigorous evaluation. This means that those who want to reduce the number of people behind bars can

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avail themselves of plenty of strategic thinking, but little in the way of "proven" direction based on research. As several states have actually reduced their prison populations rather dramatically, there is practical knowledge on how it can be done. However, the degree to which these gains can be sustained in their locations and replicated elsewhere—and exactly why they were successful—is largely unknown.

This lack of "scientific" evidence is unfortunate because the current fiscal crisis has created enormous pressure to reduce prison populations that has never been more intense—or politically supported. States across the nation are into their third consecutive year of rapidly declining federal, state, and local revenues (following several years of stagnant revenue levels at best for most states). Saving correctional dollars by reducing costs to run state prison systems is a major item on the fiscal table. Many state leaders are looking for "evidence-based" approaches to address the problem of prison costs (Vera Institute of Justice, 2010). There is evidence that we can bring to bear on this question—and we describe much of that evidence in this article—but a deep literature of evaluation studies that can guide the policy maker does not yet exist. It is our hope that this article will increase the likelihood that rigorous evaluations will come with time.

That said, there is a rich *experiential* literature based on the states that have successfully reduced their prison systems. Most notable among these are Michigan, which closed more than 20 prisons, and New Jersey and New York (which have so far closed only one prison each in the face of the powerful politics involved in prison closings). Indeed, these and other prison population-reduction initiatives now underway as part of the work being done by the Pew Center for the States, the Council of State Governments, the Vera Institute of Justice, the Public Welfare Foundation, the Constitution Project, and the Northpointe Institute for Public Safety offer valuable guidance regarding strategies that can yield substantial results.

What Makes Prison Populations Change?

We begin with the hydraulic question about prison populations: What determines the number of prisoners? Although there is no natural law at work, there are factors that systematically influence changes in prison populations. The great variation in state-level incarceration rates—and the small correlation between state-level crime rates and incarceration rates (King, Mauer, &Young, 2005)— demonstrate elastic nature of prison populations. Crime has something to do with it, of course, but it is really quite astonishing how limited the crime rate is as a factor in the number of prisoners.

The mathematics of prison populations is not complicated. The size of the prison population is entirely produced by two numbers: (a) how many people go to prison and (b) how long they stay there (Clear & Austin, 2009). The corollary is that prison populations change when either the number of people going to prison changes, their length-of-stay (LOS) changes, or (for the most dramatic and immediate effect) both. Intake and LOS are the levers of prison populations.

Embedded in this simple formula are numerous policies, practices, and programs—and funding—that affect those numbers. For example, we think that judicial sentencing policy drives the number of people who go to prison, but sentencing policy is far from the sole factor. Community corrections acts that exist in about half the states (Clear, Cole, & Reisig, 2009) promote prison diversion efforts with some level of fiscal incentives that help drive the prison population down. Likewise, for many states, the number of people going to prison is deeply affected by policies for the supervision of those who leave prison. High rates of community supervision failure lead to larger cohorts entering prison, regardless of judicial sentencing policies.

Similarly, LOS is not simply a factor of sentencing policies. Release policies are very important in determining LOS, and this is especially so in the past several years as rates of parole release have diminished (Travis & Lawrence, 2002). Yet we know little about the potential impact of what happens *inside* prisons on LOS. That is ironic because what happens inside prisons is connected to how long people stay in prison. Release authorities pay considerable attention to the programming a person receives and how much impact it has on prisoner behavior. Similarly, how prisoners' grievances and discipline are handled has enormous implications for the earning of good time and as a consequence the overall LOS (see Lawrence, 2009).

Thus, although prison entry rates and LOSs are the two numbers that completely determine the size of a prison population, these two factors in turn are a consequence of an array of policies, practices, and programs that are complex and interactive. The implication is that changes in any (or some combination) of these policies will result in changes in the overall prison population by changing either the number of people who go to prison or how long they stay. Therefore, the major policy question is how does a state go about reorienting this array of policies so as to reduce prison intake and/or reduce LOS?

In this article, this policy question will be considered from not only a research perspective but also in light of the operational successes in the country by states that have actually reduced their prison population. What we have learned is that most individual pressure points on prison intake and LOS have only a small separate impact on those rates. As a result, a state

policy apparatus need not make the choice *between* one and the other of these two policy approaches, rather a state will most likely have to pursue *all* available strategies.

Strategies Relating to the Prison Intake Rate

People come into prison from two streams. The most commonly thought of stream is judicial sentencing: a judge imposes incarceration as the punishment for a crime. A less commonly considered, but just as critical, stream is from community-based supervision: people who fail in noncustodial settings (primarily probation and parole) and are remanded to custody as a failure to meet the "technical" conditions of their supervision—such as weekly or monthly reporting, attending programs, maintaining gainful employment, and so forth.

These are not equivalent streams. States will vary in the rate of flow from these streams. In California, for example, more than half of the incarceration intake comes from the latter, noncustodial sources. In other places, the community-based failure rate is much smaller. The obvious point is that in a place like California, considerable reductions in prisoners could be achieved by reducing the rate of intake from noncustodial sources. This is affirmed by the experience in states like Michigan, New York, and New Jersey that have had double-digit reductions in prison populations. In these locations, the stream from probation and parole failures was more like a river, outstripping direct sentences from the court by as much as 15%. These probation and parole violations represented "low hanging fruit" as policy strategies for population reduction efforts, and new policies there resulted in immediate impact. However, in places where technical revocation rates are low, the gains from a focus on technical failure will be at best quite small. So the first point is that a prison-reduction strategy focused on intake must begin by analyzing the streams that produce the intake. The relative importance of focusing on one or more of the specific strategies which follow should reflect the degree that the target populations create prison intake.

The Sentencing Stream: Diversion From Prison to Probation

There are three general methods to divert people from prison: strengthening probation, creating fiscal incentives for community corrections, and reducing or eliminating mandatory penalties that tie judges' hands by reducing their discretion to sentence on a case-by-case basis.

Method No. 1: Strengthening Probation. For much of the 1980s and 1990s, probation systems sought to stake their claim as sentencing alternatives by strengthening the supervision they provided. For the most part, this meant an increased emphasis on surveillance and control. Probation departments added intensive supervision units and electronic monitoring capacity in the hopes that they would prove a more credible sentencing option than prison for judges to consider. Probation also sought to induce probationers to "tow the line" so that fewer of them would fail and be resentenced to prison. In addition to, or instead of, increased surveillance, an increased emphasis on services and programming was also intended to strengthen probation. Each of these are examined below.

Surveillance-based probation. From the standpoint of reducing prison flow, the results have been extremely disappointing. Many intensive supervision units have provided expanded surveillance to cases that would have otherwise been on probation rather than cases that would have gone to prison. This, by definition, fails to affect prison population; instead, it constitutes "net widening" (Krisberg & Austin, 1982). For many (if not most) of these intensive programs, the result was *increased* numbers of persons sent to prison, not reductions. The classic example is provided by the RAND study of probation in California, which found that intensive supervision did not reduce arrest rates but instead increased significantly the rate of technical failures, thereby resulting in *more* people ending up in prison rather than fewer (Petersilia, Turner, Kahan, & Peterson, 1985).

The result for intensive surveillance models is so consistently disappointing that in their meta-analysis of this approach, Dowden and Andrews (2000) argue that the overall effect of this approach is now *expected* to be negative. Dowden and Andrews (2000) finding is repeated for *all* forms of control-based/surveillance enhancement models of community supervision, including boot camps. In this dark review, there is but one bright spot, a recent study of electronic monitoring in Florida that found a significant effect on diversions from prison overall (Padgett, Bales, & Blomberg, 2006). Here is the major point: If this method is desired (and expected) to have a positive impact on the size of the prison population, specific offender targeting techniques must be employed.

These techniques are not so difficult to design but they are not so easy to implement. Straightforward data analysis of past sentencing practices can identify a pool of likely prison-bound offenders. The difficulty lies in using this information to actually target offenders so that sentencing courts focus on alternatives to prison for only the truly prison bound is very difficult to

implement. Some of the "likely" prison cases would have received a nonprison sanction anyway. However, more to the point, courts have often been reluctant to divert large numbers of these prison-bound cases to community penalties.

Service-delivery probation. Intensive supervision is not the only way probation can be enhanced. Various strategists have suggested that probation can become a more viable sentencing alternative by implementing evidence-based supervision policies, which will result in a lower probation failure rate. Preventing new arrests is an extremely attractive option because by doing so the community is also made safer from crime. For this reason, many attempts to control prison populations have strong recidivism-reduction components.

The belief that new arrests can be reduced substantially is based on a host of studies providing an overview of evidence-based practice (EBP; Sherman, Farrington, MacKenzie, & Welsh, 2006). The approaches to these studies vary, but most use some form of meta-analysis to summarize what we know about the effects of programs. The effect size they suggest varies but most come in range of 20% to 30% reductions in rearrests. This is no small matter, for we should all welcome a reduction in criminality of this scope. Indeed, service-delivery strategies have worked in some states. Michigan increased funding for local court- and prosecution-based programs in the early 1990s to significantly reduce admissions to prison.

The overall conclusion we can draw from probation enhancement strategies is that they have played a significant role in the control of prison populations in only isolated instances. However, in these cases, the effects have been significant. If a policy were taken to invest in this area, it would need to be carefully constructed.

Method No. 2: Creating Fiscal Incentives for Community Corrections. More than half the states have created fiscal incentives for local jurisdictions to develop programs that are capable of retaining people who are convicted of crimes in the locally funded correctional systems rather than sending them to the state's prison system. The most recent example is the California Community Corrections Performance Incentive Program (California Penal Code, 2009) which allocates US$45 million annually to the counties to enhance probation supervision. Under this new legislatively allowed policy, local county probation chiefs (who are appointed by the local chief judge) form advisory councils who are engaged in the development of specific ways to reduce prison admissions through the *mandated* use of evidenced-based approaches. The counties are rewarded through a formula that is directly tied to a reduction in admissions to prison. The California approach is noteworthy in that it has quite a bit of direction within it regarding implementation. Without proper

offender targeting according to risk and needs, counties will undoubtedly fail to meet the expectations of this new voluntary law.

The idea has appeal. If the local corrections system can be incentivized to reduce its use of state penal resources, prison populations will drop. However, studies of community corrections incentives systems do not bear this out and point to the need for specificity for proper offender targeting as well as resource allocation. The study of the original California Probation Subsidy (Lemert & Dill, 1978) found that local corrections systems placed most of the subsidy cases in local confinement (jail) and used the money to defray the costs of probation. The subsidy costs money and yet did not result in a reduction of the use of confinement. This is evidence of poor planning, a poor connection between research and program design and poor implementation.

So, although the ideal has appeal and there is some operational evidence that incentives can work if carefully planned and implemented, there is no available rigorous study anywhere showing that community corrections incentives *reduce* prison populations significantly. There is, however, a strong base of experience. The main problem appears to be that it is extremely difficult to know for certain who is prison bound. The implementation work in Michigan certainly proves this point—proper offender targeting drove the process and still does. Most observers believe that community corrections subsidies enhance the capacity of local correctional services, but this may not translate into significant reductions in incarceration.

This is not to say that a front-end enhancement strategy that moves money to community corrections for keeping people locally *cannot* work; there is evidence that it has. In principle, and theoretically, a fiscal incentive that supplements local correctional costs would be a powerful tool for pressuring local officials to use state prison as a last resort. The problem is that there is no current evaluation of this approach that proves that it has worked at reducing prison costs or controlling prison growth, the experience in several states notwithstanding.

Method No. 3: Reducing or Eliminating Mandatory Penalties. Mandatory sentencing—restrictions on the use of probation—has been blamed for much of the increase in prison populations. The argument goes that allowing judges to sentence offenders to probation more frequently will reduce the use of prison. Again, this is an appealing argument with no strong empirical foundation. Indeed, at least one study of sentencing during the heyday of prison growth in the late 1980s has found that mandatory sentencing reform did *not* explain growth in prison populations (Stemen & Rengifo, 2011). The implication is that judges just got tougher.

All front-end diversion strategies are limited in their upper end impact by the fact that they generally apply to less serious offenses, which (it follows) are subject to less severe punishments. If, for example, a drug diversion program is entirely successful in diverting people convicted of drug possession (a problematic assumption) into community sanctions, that seems like a major accomplishment (and it would be) but the impact may still be smaller than one would expect. For example, if 20% of the prison intake is drug possession cases, and they serve an average of 6 months (LOS), then the effect of diverting *all of them with no failures* will be to reduce the prison population by 10%. The fact is that if these front-end diversion efforts are to be successful, they must attempt to not only focus exclusively on prison-bound offenders but must also focus on those crimes that are associated with those prison-bound offenders.

The "Recycling Rate" of People Released From Prison

The second way to try to affect prison intake is through slowing down the rate that former prisoners—usually those on parole—recycle back into the prison system. There are two reasons that former prisoners are returned to prison: first, they have been rearrested for a new crime and, second, they have failed to abide by the rules of their release and are returned to prison as a result of what is usually called a "technical violation."

New arrests. Numerous studies have examined the nexus between parole release, conditions of that release, and the impact on parolees' rearrest rates (for reviews of this material, see Petersilia, 2003; Travis, 2005).

It is possible to change the rearrest rates of people leaving prison. In Michigan, for example, even while the number of adult parolees grew by 27% from 2004 to 2009, the number of parolees rearrested for new crimes remained fairly constant (approximately 1,900 per year) because the rearrest *rate* dropped from 10% to 9.4% from 2004 to 2009. The question, then, is what aspects of correctional programming produce these reductions in rearrests—and to what degree can a prison-based programmatic effort help achieve them?

Prison programming and rearrest rates. Most recently, a major initiative in the United Kingdom hopes to demonstrate the cost savings associated with reductions in recidivism for people who receive treatment in prison (Social Finance, 2010). There is no doubt that this is an increasingly popular target population and intended impact area as a result of the focus on prisoner reentry over the past 10 years, but how promising is it? The answer to this question can be found by initially answering two questions: how much can recidivism be reduced and how much will this affect prison populations?

We already discussed the limitations of program-based strategies for prison population reduction, using effect sizes in the range of a 20% to 40% reduction in rearrest rates. The effect sizes for these programs are smaller when they operate in the prison setting, sometimes considerably so. To illustrate how important this smaller effect size is, if we were to cut an expected 30% reduction in recidivism in half to reflect the fact that the program is being offered in the prison instead of in the community, a "successful" program means that a 40% failure rate drops only to 34%.

The evidence-based practice (EBP) studies are also narrowly prescribed. They look at specific programs targeted to subsets of the client population. For example, many programs that have proven effective focus on high-risk clients with substance abuse problems or some other specific difficulty. Custodial programs in general do not affect the general population, but even if they do, they are not widespread. In today's custodial world, it is estimated that only about 10% of people behind bars get the programs they need (Taxman, Perdoni, & Harrison, 2007) Let us say, then, that a given prison is able to expand its programs to scale such that half of its population gets the treatment it needs. Under these circumstances, the prisons recidivism rate for rearrests would go from, say, 40% to 37%. Moreover, that is only the case if the program is truly an EBP.

This analysis helps us answer the second question in this way: Based on what we know about programs that work, any reasonable expansion of prison-based programs cannot be expected to have a large impact on reducing returns to prison.

Technical violations/revocation to prison. Another fertile area for reducing prison recycling is technical failures on probation or parole. These can be considerable in number. For example, in California, as we have noted, more than half the persons who are admitted to prison have failed on parole (or probation). As the parolees have not been convicted of a new crime, is it not reasonable to expect that a strategy to keep them from returning to prison might affect prison admissions?

However, to be in a position to benefit from a technical revocation-oriented initiative, a state must have a reasonably high technical failure rate to begin with. This is not always the case. In Florida, for example, very few of those who enter prison are technical failures of community supervision, mostly as a consequence of the virtual elimination of parole in that state, along with the low technical failure rate on probation. States such as Florida offer limited potential value for a strategy focusing only on technical community supervision failure. (Glaze, Bonczar, & Zhang, 2010).

However, even in states with significant technical failure rates, the potential impact of a strategy focused on these cases has a ceiling that is worth noting. If, say, 50% of a state's prison intake comes from probation and parole, and half of these are technical failures, then the total population in play is 25% of prison entries. However, even here, some of the technical failures are actually cases that experienced an arrest but the arrest charges were dropped in light of the plan to revoke supervision on a technicality. Petersilia (2008) has estimated that in California, this is true for 80% of technical revocations. In Michigan, it is estimated that 70% of technical violations were for cases that were associated with some type of criminal behavior—the potential for an acquittal notwithstanding, this is a high percentage. If these cases are excluded (as they sometimes are), then we would be dealing with only about 12% of the entries. Most new initiatives are selective in the cases they involve in the revocation diversion process. For sake of argument, if only half the relevant cases were brought into the program, we would be down to 6% of prison intake.

This effect size—6%—would be meaningful; it would amount to an annual decrease in prison admissions, using such a program, and would be an immediate (and, as long as the program stayed stable, permanent) reduction in prison intake. Over time, the number would grow, of course, as the effect of diverted cases would increase in future cycles of ever-smaller intake. In addition a focus on probation and parole seems a reasonable strategy overall because as many as 570,000 of the 675,000 prison admissions are coming from probation or parole systems. (compare West, Sabol, & Greenman, 2010 with Glaze et al., 2010).

Recently, Hawaii's Project Hawaii Opportunity Probation with Enforcement (HOPE) is a promising new way to approach the issue of probation revocation (Kleiman, 2009). In this model, strict, rapid enforcement is coupled with random drug testing to strengthen the deterrent impact of short stays in jail. In the initial study of this approach, prison days were reduced by about a third.

Strategies Related to LOS

There are two kinds of strategies focused on LOS: programs that release prisoners before their maximum length of stay and sentencing changes that reduce sentences across the board. The term "early release" is being carefully avoided here. Indeterminate sentencing structures allow for parole before the maximum term allowed by law, generally after they serve a minimum term. Letting offenders out after the minimum term that the judge

said was appropriate is not an "early" release—it is a release before the maximum. When cases "go bad," local elected and appointed criminal justice officials may rail against a parole board's decision for allowing an "early release" when, in fact, the first possible release date was established as a result of plea bargaining in the local system and agreed on by the judge and the defense attorney with at least the implicit approval by the prosecutor. The demonization of parole boards in the press—driven by high-profile cases—is one of the reasons that nonstatutory policies to reduce prison populations are fraught with political peril.

Longer stay prisoners create a problem for LOS reduction strategies when they are a main source of growth (as they are in most state prison populations). This point can be illustrated by looking at the most extreme long termers: life without parole. A single life-without-parole sentence for a 25-year-old (who will live to 65) turns out to be 40 years LOS. That person is the equivalent of a 2-year time-served sentence every other year for two decades. Those 2-year sentences can be altered at the margin without affecting very much the average population over that 40-year period. If one more life-without-parole sentence is added to the mix, it makes the adjustments in the shorter sentences all the less meaningful. Long sentences create a permanent prison population base that becomes increasingly impervious to changes in the short termers.

Release Strategies

Method No. 1: Parole. About two thirds of the states have indeterminate sentencing structures of some form. For these states with indeterminate sentencing structures where parole boards make the release decisions, rates of parole release represent one of the most rapid levers that can be used to reduce LOS. Each state represents a different statutory challenge in speeding up parole, but most states have been reluctant to release people at their first parole eligibility. A state that has the routine practice of denying parole at the initial hearing for nearly all cases, setting a new hearing a year later, would reduce LOS for parole-eligible cases by at least a year, overall, if it eliminated this practice. This would result in an immediate and permanent sizeable reduction in the prison population.

This is the method that is being used by states when they focus on improved prisoner reentry and it pays dividends, over time, when system-wide improvements take place. When improved parole practices include education and training of parole board members, a greater array of community-based options for their consideration on a case-by-case basis but uniformly available across the state—particularly in urban areas—and a concerted effort by

the agency that supervises parole to improve transition planning before release and case management afterward, parole approval rates will go up. With improved transition plans and improved supervision techniques, more former prisoners will succeed with fewer returns for new crimes and fewer returns for technical violations.

Method No. 2: Special Early Release. Early release programs used as temporary measures to ease correctional population pressures cannot make any long-term reductions in prison costs. Prison populations are produced by a set of decision dynamics external to the prison system. If a cohort is released early, but nothing else changes, then the pressures producing the prison population reconstitute it. That is, if the cohort is released an average of 3 months early, the population returns to what it would have been in about 3 months. These types of policies, however, are eschewed by politicians and are often controversial if not devastating.

Across-the-board release policies do better—both operationally and politically. For example, a new good time provision that adds a day a week of earned credit off the maximum term will result in systemic earlier releases. If everyone earned all that additional good time, and nothing else changed, the prison population would reach a new stability at about 85% of its earlier level. That does not mean the population will drop to a new level. If the population had been increasing at a rate of 4% a year, the effect of early release on the stock population will be replaced by growth in about the third year. If the average length of stay is about 3 years, and the underlying growth rate is 4%, the populations will be roughly stable for 3 years, then return to growth.

Because of this, several states have experimented with across-the-board LOS strategies to reduce prison populations. One mechanism is to increase the amount of "good time" (or earned release time) a person can receive. This can be a promising (and low-profile) strategy. For example, an increase in good time of 5 days per month could reduce overall LOS quite dramatically; for example, a state with an average LOS of 30 months would drop up to 5 months off that average. For example, a recent evaluation of the earned release time statute in Washington State found that the law had been effective in reducing costs and recidivism, it is difficult to estimate its impact on the size of prison population. (Drake & Barnoski, 2008)

Sentencing Change Strategies

Method No. 1: Targeted Sentence Reduction. Using a policy approach to across-the-board sentencing reductions can also result in a quite dramatic impact.

One of the main engines of prison population growth has been the Federal government's "truth in sentencing" program (enacted under President Clinton) that gave states financial incentives to meet a goal of 85% time served for "serious and violent" felons. By the time the incentives ended, states had already changed their sentencing laws to correspond to the federal expectation and the laws remain on the books. Several states moved to an 85% rule while a few went to 100%. These policies have, of course, a broad and long-term impact on increasing prison populations and are in some states largely responsible. Moreover, given the politics of imprisonment, state legislatures have been extremely reluctant to change these laws back.

In addition, the impact of targeted sentencing changes can be vast. By redefining what constitutes the label "serious and violent," states can realize substantial potential reductions in LOS for large numbers of people. Mississippi, for example, reformed its stringent truth-in-sentencing laws, allowing nonviolent offenders parole eligibility after serving 25% of their sentences. Parole eligibility turned on evidence-based risk assessments, leading to a strikingly low recidivism rate of parolees under the new law, and the state saved an estimated US$200 million it would have spent on new prison beds.

Method No. 2: Offense-Specific Statutory Changes. Changes in sentencing have much potential to alter the underlying prison population. For a prison population that has an average LOS of 30 months, an across-the-board reduction in prison LOS of 10% (3 months) would reduce the prison population by 10% in about 30 months, similar to the "good time" example above.

However, legislatures almost never alter sentencing in this way. (They alter other government services in across-the-board manner, such as school and pensions, but not prisons.) Instead, specific offense groups are targeted. The impact of these changes is proportional to the size of the offense group in the prison population. Roughly speaking, if the sentence reduction above is applied to, say, people serving time for drug possession, and they constitute 10% of the prison population but serve 20 months, then the impact will be an average of about .2 months across the population. In the example cited above, with average LOS of 30 months for the prison system, the average will drop to 29.8 months, a drop that will be almost unnoticeable in the face of the existing prison population hydraulics.

Method No. 3: Recidivism Statutes. One significant source of much recent prison growth has been the predominance of recidivism statutes. Here, there is much variation from state to state, but the general scenario is that a person

who is convicted of a second serious felony within a particular window of time will have an automatic sentence enhancement of a particular level.

The effect of eliminating these enhancements is straightforward; peoples' sentences return to the base for the original crime. The calculation of the impact of this change on prison populations is a bit more complex because it cannot be done without knowing the mix of people serving time under recidivism statutes. To illustrate, let us assume a simple prison entry cohort of 1,000 people. Twenty (2%) are serving life without parole and will stay in the prison until they die (an average of 40 years). One hundred and ninety (19%) are serving short sentences, with an LOS of 1 year. Six hundred (60%) are serving "normal" sentences with an average LOS of 2 years. Two hundred (20%) are serving "recidivist" sentences that are doubled, an average of 4 years. This entry cohort will serve 2,980 years (a hefty if realistic 30 months per person). If the recidivist statute is eliminated, the group will instead serve 2,580 years (a bit more than 2 years per person, a significant reduction of 14%). Most people would think of this as a meaningful reduction in the prison population.

A final consideration. As the potential effects of some of the LOS strategies are more significant than most intake strategies, there is a temptation to emphasize them. Except for immediate emergency release approaches (which have no long-term value), there is a problem with these strategies in that they take time to have impact. Policies that change the expected LOS for an entering cohort, and do not apply to the existing stock (sentencing changes), will have a slowly growing impact on prison populations. In the recidivist example above, no changes in the prison population will be felt for 2 years, but the change will be gradual between Year 2 and Year 3 and will be permanent (all else being equal). Usually, however, a change of this magnitude is called for because the system is in such crisis and a 2-year wait is unthinkable.

Program-Based Strategies

We have already made the point about the limited capacity of program-based strategies to reduce prison populations in the discussion above, but these strategies are sufficiently popular that it is worth giving them a separate, if a bit redundant, discussion. The upshot of this discussion is that correctional programming has a low ceiling of possible impact on correctional populations; and whatever its long-term impact may be, the effect will be gradual. This low ceiling occurs for four reasons:

1. Programming's effects only apply to people who would ordinarily recidivate without the programming, and this is but a fraction of the overall prison populations;
2. The effect on recidivism is at the margins, and systems starting out with lower recidivism rates will have the smallest gains;
3. Programming's effects are known to be greatest in higher risk people in the system; the effects with moderate-risk people are diminished and low-risk people are zero—thus, expected overall program effects are further diminished by the true size of the target group; and
4. It is not easily conceivable that programs can be brought to scale so that all high-risk (and most moderate-risk) people will be exposed to the programs they need.

To this list of limitations must be added the fact that any effects of treatment will be felt gradually over time, as people exposed to the program are released and return at a diminished rate. There will still be a high rate of returns to prison under any plausible program assumptions. None of this is to suggest that programs are neither important nor worth their costs. Every study of LOS ever done on effective treatment proves their value (see Dowden & Andrews, 2000 for a summary). This is merely to say programs are not a main strategy for reducing prison populations.

Prison Populations and Public Safety

The final issue is an examination of the public safety implications of a reduction in the prison population. Much is expected of prison as a vehicle for public safety. It is expected to confine "dangerous" citizens so that they cannot commit crimes against the at-large public. It is expected to convince those who are wavering in their criminal decision making to resist the temptations of crime. It is expected to shape the decision making of those who taste the prison to resist those temptations as well. What is prison's track record with respect to these expectations?

Diversion and Crime

A handful of studies have compared the recidivism rates of those who go to prison with those who do not. These comparisons are hazardous because clearly those who go to prison are different for those who do not, in important (and presumably recidivism-related) ways. So those differences have to

be controlled. Recently, the size of databases and the sophistication of methods have grown to the point that such comparisons can be made with decent assurances that the baseline differences between those who go to prison and those who do not have been ruled out through mathematical design. Either matched cases are found, or the factors that make one go to prison instead of probation are statistically controlled, or (in the strongest designs) both. Three recent studies have been completed (Nagin, Cullen, & Jonson, 2009) and they are completely consistent in their findings. People who are placed on probation instead of prison are not more likely to be arrested, and may be a bit less likely to be arrested, than those who go to prison.

One of the problems with the diversion comparisons is that, in general, prison sentences are too long to get a fair chance to deter more than probation. That is the implication of the new and popular strategy, called Project HOPE (Kleiman, 2009), which replaces prison stays for high-risk probationers with very short, immediate consequences such as a couple of days in jail.

So it may be that diverting people from prison does not increase their criminality but rather simply moves it to an earlier period of time. It may equally be that there are sanctioning strategies that can significantly reduce the public safety threat, but only in the context of diversion from prison. It is a bit early in the life of these innovations to draw strong conclusions. However, if the findings from the original study of Project HOPE hold up in the replications, this will certainly be a fair conclusion.

With what we now know, it is at a minimum clear that people can be diverted from prison without affecting their rate of new criminality.

LOS and Crime

A more complicated story is told regarding LOS. Again, there are the methodological problems inherent in the selection for these sentences: People who earn long stays in prison are different than those who earn shorter stays, and some of these differences show long termers to have higher likelihood of recidivism. Yet there is also the countervailing point that long termers are older when they leave prison, automatically resulting in lower risk due to age alone.

Thus, no comparisons can be made regarding LOS within a strong design to cancel out these confounding selection factors. A few studies have been done. The differences in recidivism rates between short and shorter prison sentences appears to be near zero, although one recent study in the United Kingdom (Gonçalves, 2008) finds a slight advantage for a 2-year sentence over a 1-year sentence (mostly due to the availability of treatment programs,

they conclude). Those who serve very long sentences may be of a significantly lower risk than more typical sentences. With those caveats, it is fairly clear from the studies that adding a few months to a given sentence does not increase its deterrent capacity in a way that results in lower recidivism rates. By contrast, a study in the United States (Green & Winick, 2010) found that changes in LOS on *both* probation and incarceration have no impact on rates of recidivism.

Thus, we can conclude that longer LOSs merely postpone recidivism rather than reduce it.

Incapacitation Effects

The most controversial (and least subject to consensus) findings regarding the impact of incarceration on public safety have to do with incapacitation: the idea that people who are locked up do not commit crimes in the general public while they are locked up. Indeed, it may be that a person's rate of new criminality is not significantly affected by whether a prison term is imposed, nor is it affected by the length of that term. However, during that term, crimes are being prevented.

We will not include here an extended discussion of incapacitation as that discussion has been provided exhaustively by other authors (Spelman, 1994). Several conclusions can be drawn from the existing literature:

1. There is no settled estimate of the amount of crime prevented through incapacitation; estimates vary from as high as 287 crimes averted per year per person incarcerated (Zedlewski, 1987) to as low as less than 1 crime for every new person added to the prison population (Western, 2006). A likely estimate of the overall impact of the size of the prison population in crime is that the growth in incarceration reduced crime by about 10% to 15% (Stemen, 2007);
2. Earlier estimates were quite high, but as the designs became more sophisticated and the incarceration rate got higher, the estimated amount of crime averted through incapacitation declined (Clear, 2007; Zimring, 2006).
3. Criminal replacement and the high degree of co-offending (Andresen & Felson, 2009) explain why overall crime rates have not been affected by the removal (and subsequent incapacitation) of many individuals through incarceration;
4. A strong case can be made that the current high levels of incarceration go well beyond what is needed to maximize the efficiency of incapacitation (Useem & Piehl, 2008).

Although these studies provide a useful view of the value of prison as an incapacitation device, none of them give firm estimates of how much crime would be changed by a substantial drop in the size of the prison population. The research of two Villanova economists is suggestive in this regard (DeFina & Hannon, 2009). Their data show that the incapacitation effects of prison growth last for a few years and then are canceled out by the effects of growing rates of reentry. It is also the case that community penalties also avert crime through a kind of soft incapacitation (DiLi, Priu, & MacKenzie, 2000), so the question is not how much crime does prison avert but rather how much crime is averted by prison compared with other options. The total incapacitation effect is understandably, then, not large.

In summary, then, all things taken together, the link between the size of the prison population and public safety is weak. Going to prison instead of being placed on probation has little impact on the likelihood of new criminality. Likewise, the length of the sentence has little effect. There is a small incapacitation effect. So it is reasonable to look on reductions in the size of the population in prison as a change more in the timing of crimes rather than their number. Prison is, in this view, like a black box. The people who go into prison (or do not) are responsible for a certain amount of crime. Studies (Geerken & Hayes, 1993) estimate that fewer than 15% of all arrests are of people on probation or parole and, from this, they conclude that this group accounts for approximately 15% of crime. This amount of crime is not made larger or smaller by the size of the prison population. A policy of releasing people earlier or not placing them in prison means primarily that those who are going to commit crimes do so earlier rather than later. The smaller stock population of prisoners due to changes in prison entries or LOS would also result in a small reduction in the number of crimes the prison system is averting through incapacitation each day.

In terms of crime patterns, a reduction in prison populations would likely be felt as an initial small increase in crime, as recidivism events that would have occurred later are pushed to an earlier point in time. However, then the system would rapidly reach its prior level of systemic homeostasis (that is, fluctuations would be due to factors independent of the prison system's size), when the new prison population becomes a stable fact. Any changes in crime rates that happen as a result of the downsizing of the prison system should occur only in the short term as crimes that would have occurred later are moved to an earlier time.

Conclusion

From this review, it can easily be seen why so many states have struggled to contain their prison populations. There are few proven strategies to do so and only a handful of states have managed to effect reductions. The practical approaches that these states have taken have not been scrutinized by rigorous research, so much of the specific reason behind the impact is somewhat unclear, not only in terms of why the impact occurred but also how it occurred over time. Are these changes in prison population in these states sustainable?

Taken one at a time, the most desirable strategies appear to have very limited prospects to make sizeable reductions in the number of prisoners. Adding new rehabilitation programs and making emergency releases, two of the more prominent strategies, are shown to have limited payoff. Likewise, enhancing probation alternatives and strengthening community-based incentives, while promising on their face, have not shown a track record of success. The kinds of sentencing reforms that are often discussed—drug crime and the "nonviolent offender"—have low ceilings of possible effects on prison population reductions. Trying to reduce incarceration by reducing recidivism also has a low ceiling of possibility.

However, as states like Michigan, New York, and New Jersey have shown, when these strategies are used in concert with each other, drops in prison populations occur and, so far, appear to be sustainable, the lagging of research to more clearly understand this notwithstanding.

This review does suggest that a focus on broad-scale sentencing reform has promise. Across-the-board reductions in LOS, either through sentencing reform or through sped-up release mechanisms, will have a slow-developing but long-range and significant impact on the number of prisoners. Targeted sentencing reforms, such as elimination of mandatory minimums and recidivist enhancements, may, under certain circumstances, prove beneficial.

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Note

1. There has been only one randomized field trial involving persons released from prison, conducted a generation ago and written as a government report (Berecochea & Jaman, 1981). There has also been one major randomized field trial of diversion from prison to probation (Petersilia et al., 1985), conducted more than 20 years ago. Two aging studies do not make a foundation.

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Bios

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This is **Exhibit "R"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

ICPS
International Centre for Prison Studies
A partner of the University of Essex

A Human Rights Approach to Prison Management

Professor Andrew Coyle
International Centre for Prison Studies
University of Essex

A presentation to the European Federation of Public Service Unions conference
Athens, 12 May 2011

I am honoured to have been invited to address you all today at this important conference organised by the European Federation of Public Services Unions (EPSU) in partnership with the Federation of Greek Prison Staff Unions.

This conference, of course, is taking place immediately before the 12th Congress of the European Trades Union Confederation which will have the theme "Mobilising for Social Europe", a theme which is meant to underline the need for increasing efforts to secure more employment and quality jobs, equality and social justice. These are very worthy ambitions at this time when there is increasing unemployment in many countries in the European region, when there is increasing inequality between different groups of citizens and when there is evidence of increasing social injustice in many areas.

The theme of this conference is the role which trade unions of prison staff should play in ensuring that there are “better prison services in Europe”. This is also a worthy ambition because prisons can make an important contribution to public safety and security. My theme today is to describe the key role that can be played by a well-trained and professional prison staff. Before I do that I would like to make a few introductory remarks.

First of all, I would like to explain my own professional background. For the last 14 years I have worked in the International Centre for Prison Studies and until my retirement last year I was also professor of Prison Studies in the University of London. But I had another life before becoming an academic. For almost 25 years I was a prison director in the United Kingdom. During that period I was in charge of two high security prisons in Scotland and for six years I was governor of one of the main prisons in London. I was also chairperson of the trade union which represented prison governors. So, I have experienced life at the sharp end.

Secondly, I would like to say something about the use of imprisonment today. As we sit here this morning there are almost ten million men, women and children in prisons around the world. Half of them are in three countries: Russia, China and the United States of America.

The United States has less than five per cent of the total population of the world – it has 23%, almost a quarter, of all prisoners – with around 2.3 million people in prison. The last thirty or so years have seen a massive expansion in the use of imprisonment in many countries. This increase has occurred in democratic countries and in totalitarian states; it has happened in rich countries and in poor; it has happened in countries in the northern hemisphere, in the south, the east and the west.

Let me give you a few examples. Rates of imprisonment are usually quoted per 100,000 of a country's population. The world average is around 145 per 100,000. The average in Western Europe is just over 100. I do not wish to overwhelm you with statistics. However, it is worth taking just a moment to contrast rates of imprisonment between neighbouring countries. The rate of imprisonment in France is 96 per 100,000 of the population, while that in neighbouring Spain is 163; so quite a significant difference. The rate in England and Wales is 154, while that in Germany, a country which has many similarities, in overall population and in other respects, is 88; almost half the rate in England. How are we to explain these large differences in imprisonment rates?

The first thing to say is that it cannot be explained by reference to crime rates. It is notoriously difficult to compare crime rates internationally for a variety of reasons, including the different definitions of crime and the different way in which data is collected. However, we can safely say that the difference in rates of imprisonment between France and Spain, between Germany and England, between Canada and the United States cannot be explained by differences in levels of crime. Rather, we have to look for other explanations which are more to do with matters such as social equality, social trust, consensus politics and a balanced political economy, a responsible media and a set of criminal justice structures which separate law from party politics and guarantee a judiciary which is independent from political and populist pressure.

In all countries people who commit serious crimes, murder, rape, other serious crimes of violence, invariably go to prison if they are found guilty. But what has happened in recent years is that many countries have increasingly used prison as a place to hold all sorts of groups who are at the margins of society: the mentally ill, drug addicts, the homeless; and, a recent development, foreign nationals and illegal immigrants. This change in the profile of prisoners has a significant effect on the way that prisons are managed and on the task of prison staff. Let me express that in personal terms. When I was director of the most high security prison in Scotland I was very clear what my task was. Everyone who was in that prison had been convicted of a very serious crime. There was no argument that each of them required to be deprived of their liberty as a punishment for the crimes they had committed and for the protection of the public. Working in that prison was very challenging for the staff, but their responsibility was clear. It was to hold these men securely in conditions which were as human and as decent as possible.

A few years later I found myself in charge of one of the main prisons in London. There, the challenge was quite different. A small number of the 1,200 men in that prison required to be held in high security conditions. But there were also large numbers of other people. There were over 300 men who were mentally ill; people who should have been in secure hospitals rather than in a prison. There were many people who had chaotic lifestyles caused by drug or alcohol abuse or simply an inability to cope with our highly pressurised modern, materialistic society. In a way, the challenges facing staff in that prison were much more complex than that in the high security prison. Staff were being asked to deal with men who were being ignored by other

institutions in civil society and had ended up in prison by default. I imagine that Dr Lars Moeller of the WHO will tell us more about these issues when he speaks later.

What this implies is that in many countries prison are being used in an inappropriate manner. They are being used as the safety net for civil society, into which are cast a wide variety of people who would be dealt with much more appropriately in other settings. One immediate consequence of this increased use of prison is that in many countries there is gross overcrowding in many prisons. The latest available figures for Greece, for example, show that prison capacity is overcrowded by 30 per cent; in Belgium it is 20%; in Spain overcrowding is at 38% and in Cyprus it is 48%.

All of these factors have grave consequences for prisoners and they way they are treated. They also have grave consequences for prison staff and the way they carry out their responsibilities. And that brings me to my main topic for today, which is the role and the responsibility of prison staff. Let us be quite clear from the outset that you as prison staff carry out one of the most important of public services. You are charged with protecting society from the actions of some of its most dangerous and difficult members. In all countries in the region of greater Europe imprisonment is the most severe penalty that can be imposed by any court. To be responsible for the custody and care of those whom courts have deprived of their liberty is a heavy public duty.

Unfortunately in many countries the public does not recognise the work which prison staff carry out on their behalf. Prison staff do not have the high public profile of other players in the world of criminal justice, such as the police, prosecutors and judges. The high walls of our prisons do not only shield prisoners from public view, they also mean that the work which staff do is hidden and not understood. In many jurisdictions prison staff are badly paid, they are inadequately trained and they are given little public respect.

So, how can we begin to change those perceptions? How can we set about increasing the respect that the public has for the difficult task that prison staff carry out on their behalf? How can we improve the professional standing of prison staff and ensure that they are properly trained and supported and given the resources that they need. Obviously your trade unions and staff associations have a key role to play in these matters and you will be discussing some of these issues this afternoon. What I would like to do now is to suggest to you some important features which set you apart from all others who work in public services, features which underpin the work which you do on a daily basis and which demand of you high levels of professionalism.

The first is the need to remember at all times the particular context within which you are working. Let me explain what I mean. When people talk about prisons they generally start from their physical aspects: walls, fences, buildings with locked doors and windows with bars. However, the reality is that the most important aspect of a prison is its human dimension, and the two most important groups of people within it, who are the prisoners and the staff who look after them. The daily experience of life for prisoners is determined by their relationship with first line prison staff, the men and women who unlock them first thing in the morning, who will be with them throughout the day, and who will lock them up at the end of the day. The dynamics of a prison are defined by the relationship between prisoners and front line staff.

I have already referred to the demanding nature of prison work and to the way that has changed in recent years. Prisoners are not a homogenous group. Some will be a threat to the public; some will be dangerous and aggressive; others may try very hard to escape. Others are

likely to be mentally disturbed, to suffer from addictions, to have poor social and educational skills and to come from the minority groups in society. The vast majority of prisoners will be adult males and national prison regulations are generally drafted with this majority in mind. However, there are other groups who have specific and different needs; they include, for example, women and young prisoners. In many European jurisdictions the traditional profiles of prisoners have been changing in recent years. For example, foreign nationals now constitute a significant proportion in several member states, in some instances making up over half of the entire prisoner population. Another new challenge relates to the management of prisoners who require to be held in conditions of very high security.

As they go about their daily work prison staff must always bear in mind that all prisoners are persons. No matter what crime they may be accused or convicted of, they remain human beings, entitled to respect. This principle is articulated in the United Nations International Covenant on Civil and Political Rights, Article Ten:

> All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

This principle should influence prison staff in the way they carry out all their duties. It is also the foundation stone of good prison management. The need to operate within the context enshrined in Article 10 of the ICCPR is universal and is one of the defining features of good prison management. By observing this there can be an assurance that torture and inhuman or degrading treatment under any form will always be prohibited and that staff will give priority to treating all prisoners and detainees with humanity and respect.

Another way of expressing this is to say that prison staff must always carry out their work within an ethical context. This principle applies to all those who work in the public sector and especially those who work within the field of criminal justice. All of us here come from countries which are members of the Council of Europe, a body which has taken the lead in advocating that that all public servants should observe the highest standards in their professional work. In the year 2000 the Council adopted a recommendation on Codes of conduct for public officials and since then it has been particularly active with regard to public officials who are involved in the criminal justice field, most commonly in encouraging individual member states to develop codes of ethics for specific groups, such as prosecutors, the judiciary and the police. It is currently drafting a Code of Ethics for Prison Staff.

This Code will be based on European Prison Rule 72, which states as follows:

1. Prisons shall be managed within an ethical context which recognises the obligation to treat all prisoners with humanity and with respect for the inherent dignity of the human person.
2. Staff shall manifest a clear sense of the purpose of the prison system. Management shall provide leadership on how the purpose shall best be achieved.
3. The duties of staff go beyond those required of mere guards and shall take account of the need to facilitate the reintegration of prisoners into society after their sentence has been completed through a programme of positive care and assistance.
4. Staff shall operate to high professional and personal standards.

The Commentary which accompanies the European Prison Rules includes the following explanation for Rule 72:

- This Rule underlines the ethical context of prison management. Without a strong ethical context the situation where one group of people is given considerable power over another can easily become an abuse of power. This ethical context is not just a matter of the behaviour of individual members of staff towards prisoners.
- Those with responsibility for prisons and prison systems need to be persons who have a clear vision and a determination to maintain the highest standards in prison management.
- Working in prison therefore requires a unique combination of personal qualities and technical skills. Prison staff need personal qualities which enable them to deal with all prisoners in an even-handed, humane and just manner.

It is important to note that these rules and regulations stress not only the obligations of front line prison staff. They also require that those who manage prison systems must show strong leadership and have a clear sense of purpose. They also stress that prison staff need to be given proper levels of support, of training and of development.

The European Prison Rules follow on from an earlier recommendation of the Council of Europe in 1997 about what were called "Staff concerned with the implementation of sanctions and measures", that is prison staff. This Recommendation confirms the key role played by prison staff at all levels. The Explanatory Memorandum which accompanies the Recommendation lays out general principles:

- In every prison system there should be a formal set of regulations covering all aspects of recruitment and selection, training, status, management responsibilities, conditions of employment and mobility.
- This policy should emphasise the ethical nature of corporate and individual responsibilities and particular reference should be made to national adherence to human rights instruments.
- The policy should be formulated in consultation with the staff and their professional representatives.
- And finally, that adequate financial resources should be allocated in the budget of the service for the carrying out of these policies.

So, this is very much a two way process. There are obligations on prison staff and there are obligations on prison management.

Let me now turn briefly to the work which prison staff do and to their responsibilities to the public and civil society. I have already suggested that in some respects the prison system can be described as the most forgotten element of criminal justice. Very few members of the public know, or indeed care very much, about what goes on behind the high walls of its prisons. Yet prison work is a very important part of the public service. Prison staff have three main responsibilities and the relationship between each of them can be complex.

The first responsibility is the safety and security of the public. Prison staff contribute to public safety by detaining large numbers of persons who have broken the criminal law, some of whom pose a real danger to other people. This means that security must always be an important consideration. Staff have a duty to make sure that prisoners, especially those who are dangerous, do not escape.

The second responsibility of prison staff is to ensure that there is good order within prisons. Prisons should be safe places for everyone who is involved in them. This includes prisoners, prison staff and everyone else who has reason to visit a prison. Most prisons are large, anonymous establishments, where groups of people, mostly young men, many of them with mental health or social problems, are held against their will with limited opportunities to take part in positive activities. In this sort of environment it is a challenging responsibility to maintain a positive atmosphere and to prevent sporadic unrest or even violence.

Thirdly, prison staff have a responsibility to assist prisoners to reintegrate into society after they have completed their sentences. Prisons should not be places merely of detention. Instead, while they are detained prisoners should be given every opportunity to develop their skills and personal relationships in a way which will make it less likely that they will re-offend again after they are released. Helping prisoners to achieve these aims demands great commitment from prison staff.

Maintaining a proper balance between these three sets of responsibilities presents a professional challenge to prison staff. The three duties of ensuring public safety, maintaining good order and encouraging rehabilitation can be regarded as the three legs of a stool. If the balance is not maintained, the stool of good prison management will topple over. For example, this is liable to happen if there is not enough control and also if control is too repressive. It is the achievement of this balance which makes the task of the prison officer one of the most important of public services. It takes a very special person to be a professional prison officer.

Let me now say a few words about the recruitment, training and support of prison staff. In the first place prison administrations must have a clear understanding of the role which they want prison staff to undertake and then to set standards which will ensure that they recruit staff who have the potential to carry out this public service. It is not sufficient, as still happens in some regions of the world, to use conscripts who are undertaking one or two years of compulsory military service as prison guards. The same care should be exercised in recruiting prison staff as is taken in recruiting other public servants such as policemen, teachers and nurses.

Having made sure that the staff who are recruited are of proper quality, the next requirement is to give them appropriate training. It is not sufficient to send them immediately to work in a prison and to expect them to learn on the job from more experienced staff. Most European prison administrations now have some form of training for new recruits, although the length and quality of this training varies significantly. The length of initial training varies from a few weeks, as in England and Wales, to two years, as in Denmark. In some jurisdictions, particularly in Eastern Europe, training for junior prison staff is still linked very closely with that of the police and often concentrates on military matters such as drilling and use of weapons. In other countries, in contrast, the curriculum for training prison staff is linked closely to that of other institutional workers, such as those in psychiatric hospitals and youth care centres.

In undertaking their difficult work, prison staff need to have ongoing support from senior management. Throughout the course of their career, staff should be given regular opportunities to enhance their skills and to learn about new professional developments, technical advances and comparative international experiences. For example, in recent years

staff have had to learn more about how to manage prisoners who require to be held in conditions of very high security, about how to manage the increasing number of prisoners who are foreign nationals and who may speak a wide variety of languages. In the European context, staff now have to be aware of reports, findings and judgements of bodies such as the European Court of Human Rights and the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. There is an increasing amount of case law about prisons emanating from the European Court of Human Rights. In addition, the Committee for the Prevention of Torture, the CPT, has now developed a comprehensive set of standards which it expects to be observed in all the prisons which it visits. In respect of Greece, the CPT took the very unusual step in March of this year of issuing a public statement expressing concern about what it considered to be "persistent lack of action" on the part of the Greek authorities to deal with unacceptable conditions in prisons. Prison staff need to be given regular development training about all of these matters.

Let me draw to a conclusion. I have emphasised that prison staff are key public servants, that they are entitled to respect by the public and by their employers for the difficult public duty which they carry out. I have emphasised that government and prison management have a duty to respect prison staff, to ensure that they are properly remunerated and that they are properly trained and support.

My final word is to you as trade union leaders, who represent your members. Your primary duty, as with any trade union leadership is to represent your members and to ensure that they have proper conditions of employment. However, I would like respectfully to suggest to you that your duty goes further than that. It is also your duty to make sure that the public is aware of the public service which your members undertake. It is your duty to participate in and to encourage public debate about the use of imprisonment and to speak out when you think it is being overused or is being used inappropriately. It is your duty to ensure that the professional status which your members deserve is reflected in the way that they and you go about your work. It is your duty to support all attempts to ensure that the ethical context of the work involved in depriving other human beings of their liberty is always in the minds of your members as they go about their daily work.

I wish you every success in your difficult and important work.

This is **Exhibit "S"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

Large scale releases and public safety

Can governments safely release hundreds or thousands of people from prison? We offer 14 historical examples to show that, in fact, they already have.

by Peter Wagner, April 9, 2020

To protect the American public from COVID-19, schools have closed, non-essential stores have been shuttered, people with desk jobs have started working from home, and public gatherings have been prohibited. But the prison system continues to hum along as though nothing has changed: Prisons have done virtually nothing to reduce the population density that puts both incarcerated people and staff at grave risk.

To justify their lack of action, criminal justice officials and elected leaders imply that saving the lives of people behind bars is not worth the inevitable public safety cost of releasing them. This talking point is as old as time. It's also out of step with history.

Large-scale releases have been common throughout U.S. and international history for a variety of legal, political and health reasons. Below is a partial and non-exhaustive summary of some notable examples in U.S. and international history. (These examples were originally collected for a different project with Leah Sakala in 2014.)

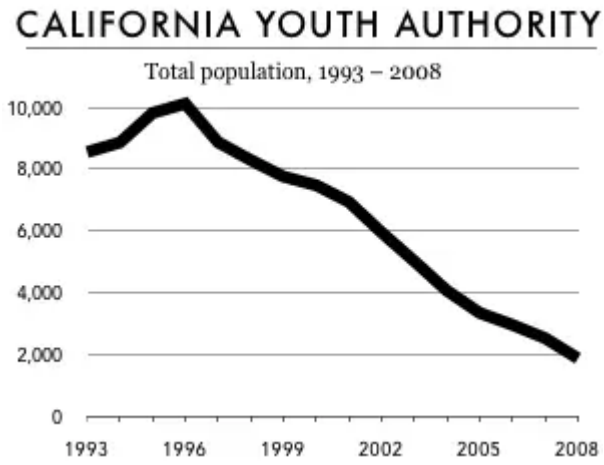
If the places where these releases took place became hotbeds of crime, we'd know about it already. But they didn't. In fact, in many cases, the inverse happened — and the academic literature about these experiences prove it.

SELECTED HISTORICAL DECARCERATION EXAMPLES

U.S. examples

California (adults, 1968 – 1972)
Between 1968 and 1972, while Ronald Reagan was the tough-on-crime Governor of California, the state's incarceration rate dropped from 146 to 96 per 100,000. The historical record suggests that the decrease was largely due to a state program to incentivize local probation departments to decrease commitments to state facilities, as well as an increased use of parole.

California (youth, 1996 – 2009)
Although California is currently struggling politically with reducing its adult population, that state is a national leader on reducing its incarceration of kids. Previously, the Youth Authority was a "catch-all" for even the lowest-level offenders. Among other reforms, the state has created financial disincentives for counties to send kids to the state system while rewarding them if they kept the kids in local programs.



Compiled from the California Department of Corrections & Rehabilitation report, A Comparison of the Division of Juvenile Justice's Facility and Parole Populations, released by the Division of Juvenile Justice annually from 1993-2008.

California (currently)
Beginning in 2006 and accelerating in 2009, the California prison population has been dropping. Spurred in part by the Supreme Court's order in Plata, major changes are underway (although far less than most of us hoped and far less than most of our opponents feared.) Some of the drop in the prison population is the illusory result of "Realignment," a legislative change that sends people who would previously have gone to state prison to local jails. The California prison population drop is still notable because the state's prison population is dropping faster than the jail population is increasing, but the actual decline in the number of people incarcerated in California is not as large or as quick as the Supreme Court ordered.

Florida (1963 – 1965)
On the heels of the Supreme Court's Gideon v. Wainwright decision, Florida had to give thousands of incarcerated people new trials, this time with court-appointed lawyers. For some people, the evidence was too flimsy or dated to withstand a proper legal defense, so over 1,000 people were released in a very short time period.

Illinois (1980 – 1983)
Concerned that the 1978 legislative switch to "determinate" sentencing would lead to prison overcrowding, the Department of Corrections instituted a special program of the parole board awarding extra good time credits. In sum, over 21,000 people, or 60% of all prison releases, were released an average of 105 days early.

Massachusetts (youth, 1969)
Massachusetts, under Republican Governor Frank Sargent and newly-appointed Department of Youth Services Commissioner Jerome Miller, closed its training schools for kids and decarcerated nearly 900 children. The state paroled some children directly home while a new system of community-based alternative programs were developed.

New York & New Jersey (~1999 – present)
A mix of reforms — including policing, sentencing reform and parole — have allowed these

two states to radically reduce both the number of people entering prison and how long they are incarcerated. Governors of both parties implemented these reforms at a time when the prison population was still rising nationally. In fact, much of the national prison drop in recent years is the result of these two states plus California.

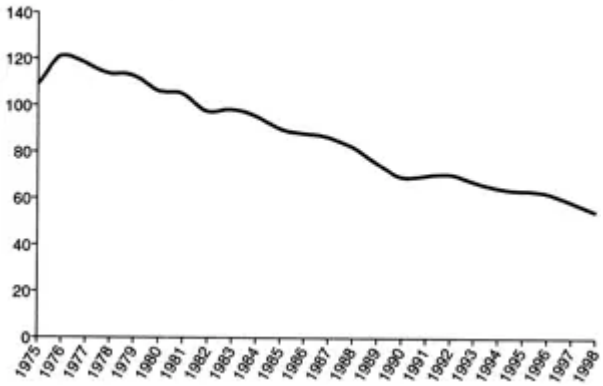
Washington State (1979-1984)
Over 1,600 people were released early in six different periods over the course of five years.

International examples

Czech Republic (2013)
Outgoing President Václav Klaus gave a mass amnesty/pardon to over 6,000 people, approximately one third of the incarcerated population, as a way to both respond to an overcrowding crisis and to mark the anniversary of Czech Independence. “The president pardoned all convicts with prison terms under one year. The amnesty… also includes people sentenced for non-violent crimes to up to two years in jail, and seniors aged at least 70 whose prison terms do not exceed three years and those aged at least 75 with terms of up to 10 years.”

Finland (1976 – present)
Finland used to have one of the highest incarceration rates in Europe. Finland made a long series of policy changes — including decreasing sentence lengths — to radically lower their use of the prison, and that country now has one of the lowest incarceration rates in the entire world.

Diagram 4.4-2. Prisoners per 100,000 inhabitants in Finland 1975–1998



Source: Nils Christie, Crime Control as Industry.

Israel (1967)
The Israeli Knesset passed an Amnesty Law that released 501 incarcerated people and closed 15,376 criminal investigations.

Italy (2006 and 1990)
In 2006, to respond to prison overcrowding, the Italian government released 22,000 people, generally those serving three years or less, except for those convicted of Mafia-related crimes, terrorism, sexual violence or usury. An earlier mass pardon in 1990 released 8,451 people out of the total incarcerated population of 26,000.

Russia (numerous, late 1990s through present)
Russia has repeatedly issued large-scale amnesties, used both to manage the populations and to celebrate key events like the 20th anniversary of the constitution. Some amnesties also applied to people with pending charges. One notable and major large-scale amnesty was in 1999, when incarcerated people were released to help control a tuberculosis epidemic that was incubating in the prisons and then spreading to the rest of the country.

Peter Wagner is Executive Director of the Prison Policy Initiative. (Other articles | Full bio | Contact)

This is **Exhibit "T"** referred to in the
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A Commissioner, etc

Article

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Penal reform 'Canadian style': Fiscal responsibility and decarceration in Alberta, Canada

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Abstract
To fulfil a political promise to eliminate the provincial fiscal deficit, the (conservative) Premier of Alberta cut all budgets by roughly 20 per cent in 1993–1994. As an unanticipated by-product, this political solution to a political problem resulted in a 32 per cent decrease in provincial imprisonment between 1993 and 1997. Economic imperatives created the catalyst for changes in imprisonment policies. However, the types of change and the mechanisms for achieving them reflected Canada's specific history, culture and politico-legal structures. Decarceration was consistent with core Canadian values rooted in the long-standing belief in the need for restraint in the use of imprisonment and a lack of faith in its effectiveness as a crime control strategy. On the surface, this case study is yet another example of decarceration. However, the interactive and multifactorial explanatory model underlying Alberta's reduction in its prison population raises questions about not only single factors or simple additive models as explanations for changes in penal policies but also uni-dimensional solutions to jurisdictions in need of fiscal restraint. The historical and cultural embeddedness of Alberta's decarceration alerts us to its country-specific nature and the need to situate imprisonment in a broader set of concerns.

Keywords
Canada, decarceration, values

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In discussing US mass incarceration, Gottschalk (2009: 467) concluded that 'Criminal justice is fundamentally a political problem, not a crime and punishment problem. The real challenge is how to create the political will and political pressure to pursue and implement . . . [penal reform] policies.' Similarly, Von Hofer (2003) argued that imprisonment rates derive from political decisions and cultural pressures rather than crime rates or other social/economic factors. These conclusions are echoed elsewhere (e.g. Barker, 2009; Loader, 2010; Simon, 2007; Snacken et al., 1995). Loader (2010: 359) notes that 'those societies which have effected reductions in the use of prison and/or sustained relatively mild penal systems have done so through acts of political will'. More broadly, Lappi-Sappälä (2011: 318) concludes that 'prison rates (and social policies) are an outcome of policy choices and political actions, taken within a given political culture'.

However, this focus on the 'primacy of politics' is not suggesting that imprisonment policies are functions of simple single-dimension political orientations. Party politics cannot adequately account for American increases since the early 1970s: Incarceration rates more than doubled in every state in the past 40 years (Doob and Gartner, 2011). In Canada, despite relatively stable imprisonment rates since 1950, the political parties in power repeatedly changed over this period. In fact, right-leaning parties do not necessarily favour high imprisonment policies. For instance, England's Margaret Thatcher was 'not especially sanguine about the prospect of increased overcrowding and pursued a number of means of limiting the prison population' (Newburn, 2007: 434). Incarceration levels did not rise during her term in office largely because – as Gottschalk (2006: 105–108) explains – she saw imprisonment as counterproductive. Similarly, New York's imprisonment reduction between 1999 and 2009 was largely due to less repressive drug laws introduced under a Republican governor (Greene and Mauer, 2010).

While simple 'left–right' political orientation may not be helpful in explaining imprisonment policies, this conclusion does not mean that *politics* are unimportant. As Gottschalk (2006: 256–257) notes,

> If the comparative history of incarceration teaches us anything, it is that political leadership, not expertise alone, has been responsible for major decarcerations elsewhere. But politicians have to be pushed. In short, the public has to be mobilized and organized to undo the carceral state.

Though we agree that politicians need to be 'pushed', we suggest that what 'pushes' them need not have to do with carceral policies or public opinion. In this article, we analyse an example of decarceration that took place without public pressure, originating solely from the need to fulfil an election promise. While the political system provided the pressure, the pressure was unrelated to criminal justice policies.

The 'setting' of this article is Alberta – Canada's fourth largest and most conservative province. We focus on how a Conservative[1] premier, Ralph Klein, presided over a dramatic decrease in imprisonment in the mid-1990s. The catalyst was

a political promise to balance his province's budget (which had been running a deficit under the prior – also Conservative – government) by cutting expenditures. Accomplishing this task was seen as critical to maintaining or increasing public support in his political party. Klein slashed expenditures in almost all departments, including the justice ministry. In response, justice experts effected policy changes that reduced, by approximately 32 per cent in four years, that portion of the imprisoned population under provincial responsibility.

Notably, the impetus for this change had nothing directly to do with imprisonment, crime or criminal justice. We found no evidence that Alberta's relatively high incarceration rate prior to 1993 was even noticed by anyone in power. The goal was *not* decarceration; it was expenditure reduction. Or, as Gottschalk (2006, 2009) might have put it, decarceration was a political solution to a political problem, not a criminal justice problem. However, we argue that a sole focus on politics misses the complexities of the phenomenon. An examination of the process (versus the catalyst) of decarceration highlights the fact that the type of changes chosen and the mechanisms to achieve change are deeply embedded in wider Canadian history and culture. Alberta's reduction in its prison population reflected the broader culture of restraint in the use of imprisonment and underlying core values of tolerance and reintegration that have characterized Canadian criminal justice policy for decades.

Part I describes several decarceration experiences elsewhere. Part II traces the genesis of this story, highlighting the wider political and economic events which set the stage for Alberta's decarceration. Part III examines the evidence corroborating Alberta's reduction in its provincial prison population. While Part IV presents the (immediate) mechanisms that contributed to Alberta's decarceration, Part V discusses the wider factors which are important in understanding it. Concluding comments consider general lessons for those jurisdictions searching for strategies to reduce prison populations.

Part I – Decarceration: Examples from elsewhere

Between 1945 and 1973, the Netherlands prison population decreased from approximately 70 to 20–25 inmates per 100,000 residents. Downes (1988) and Downes and Van Swaaningen (2007) identified a number of interacting – yet distinct – factors that contributed to decarceration. Closing prisons, the adherence to a policy of one prisoner per cell, the development of waiting lists for admissions, home leave and the use of parole and pardons as 'shields' against prison overcrowding and expansionism were collectively important. More broadly, the suffering of members of the Dutch underground in German prisons during the Second World War set the stage for a reconsideration of the role of prisons which were henceforth to be governed by minimalist and humane policies. This change was coupled with a general liberalization of Dutch social policy and the influence of academics and policy makers who advocated substituting rehabilitation for retribution as the principal objective governing prisons.

Similarly, Finland's imprisonment rate dropped from 150 per 100,000 residents in 1960 to 60 in 2000 as a result of numerous policy changes. Specifically, the extensive list of law reforms 'supports the conclusion that the decrease . . . was the result of a conscious, long-term, and systematic criminal justice policy strategy' (Lappi-Seppälä, 2007: 239). Central was the strong political will and consensus to decrease the Finnish prison population, rooted in the conviction (shared by both politicians and experts) that Finland's high imprisonment rate (particularly in comparison with the other Nordic countries) was a disgrace (Lappi-Seppälä, 2000). Criminal justice policy was also developed primarily by criminology-trained experts – a characteristic also prevalent among judges and prosecutors who were equally receptive to liberal criminal policies. Further, the Finnish media 'retained a sober and reasonable attitude toward issues of criminal policy', sparing Finland from 'low-level media populism' (Lappi-Seppälä, 2007: 241).

Finally, Republican Governor Ronald Reagan proudly presided over a 34 per cent drop in California's imprisonment rate between 1968 and 1972 (Gartner et al., 2011). This decarceration did not involve a principled reduction of imprisonment. Though it was partly enabled by Reagan's desire for a balanced budget, it occurred because state officials were allowed to implement policies that were seen at the time as sensible. Gartner et al. (2011) suggest that a particular constellation of events (including existing legislation) enabled this reduction to occur smoothly and without controversy or major legislative changes.

Within the context of the current study, the value of these examples of decarceration is twofold. Most obviously, they remind us that the Alberta story is not unique. However, they also provide us with 'sensitizing concepts' (Blumer, 1954) – potential factors that might be relevant in understanding the Alberta experience. First, decarceration can be the result of several diverse (local and national) mechanisms. Second, it is context-specific. As Melossi (2001: 407) reminds us, 'Punishment is deeply embedded in the national/cultural specificity of the environment which produces it'. Third, decarceration is multi-dimensional – in its mechanisms and players, and also in its objectives and catalysts. Finally, we are forewarned that additive explanatory models – whereby each factor 'contributes' a small amount to decarceration – may not be especially useful in understanding decarceration. Rather, an interactive model examining the interplay of multiple factors may more accurately capture the reality under study.

Part II – Decarceration 'Alberta style': The story

Method

In constructing an account of the events surrounding the dramatic drop in Alberta's imprisonment rate between 1992 and 1997, we relied on several different types of data. We started by examining provincial and national statistics on crime, imprisonment and the operation of the principal criminal justice agencies. These data – taken from Statistics Canada's website – provided a detailed picture of

both the decrease in Alberta's imprisonment and its uniqueness in Canada. This information allowed us to examine criminal justice mechanisms that could account for this change, including police policies and practices, prosecutorial decision making, sentencing patterns and correctional programmes.

This picture was complemented by its contextualization within a wider framework. First, we drew from economic and political analyses written about the so-called 'Klein Revolution' in which Ralph Klein (Alberta's premier) cut expenditures. They provided insights into the catalysts driving the decrease in imprisonment. Second, we surveyed legislative bills related to crime and criminal justice introduced prior to and during the period under study. It was within this legislative framework that the key criminal justice players acted. Third, federal and provincial electoral results in Alberta were compiled from 1945 to 2012, providing a sense of Alberta's political orientation.

Further, we incorporated archival material and secondary sources into our analysis. Records of government operations, including copies of reports issued by the government (e.g. annual reports from Alberta's Solicitor General, a report on the budget deficit from Alberta's Treasurer, a report on the deficit from an Alberta 'think tank') and, more importantly, the debates in the provincial legislature (Alberta Hansard) were consulted. Articles pertaining to Ralph Klein, crime, imprisonment and the Justice Ministry as well as stories about the budget and justice issues from the province's major newspapers – the Edmonton *Journal* and the Calgary *Herald* – were also compiled and analysed. These sources were important in identifying what were (and were not) seen as important issues.

Finally, we interviewed a small number of key informants. Semi-structured interviews were conducted with the then Deputy Minister of Justice, a senior correctional official and a member of the opposition in the provincial legislature at the time. In each case, specific questions were formulated relating to each person's knowledge and understanding. These interviews often elicited answers which led us to examine new areas (and documents) and provided us with supplementary details related to some of the events. In effect, they served as a final point of triangulation. Although no account of historical events is ever complete, by using a number of diverse data sources and several different research methods, we attempted to construct a comprehensive picture of the drop in Alberta's imprisonment rate in the early 1990s and various (immediate and broader) factors accounting for it.

The context

Alberta is almost certainly Canada's most politically conservative province. Since 1945, Alberta consistently sent a higher proportion of conservatives[2] to the federal Parliament than the country as a whole. In 18 of 21 federal elections between 1949 and 2011, 80 per cent or more of Alberta's representatives in the federal Parliament were conservatives during a period when federal Conservatives formed a majority

government only four times (14 years). The same holds for the provincial government. In 18 elections (1948–2012), conservatives always won at least 60 per cent of the seats.

In 1993 (the beginning of our study period), Albertans were slightly more likely than those elsewhere in Canada (80 per cent versus 77 per cent) to view sentences as being too lenient (Statistics Canada, 1994). Legislative debates also contain numerous 'tough on crime' references, including regular calls for harsher sanctions. Predictably, the government supported criticisms expressed in the provincial legislature that penalties for impaired driving were too light (Alberta Hansard, 7 May 1990, 1061: 37). Similarly, Conservative Stockwell Day (later Klein's first Minister of Labour) proposed forming 'citizens committees' in 1992 to review youth justice legislation whereby ordinary Albertans would meet to recommend legislative changes. These citizens would discuss their concerns *without* 'the professionals and the academics . . . involved in the legal and justice system' and '[i]f they happen to agree . . . then as legislators we have no option but to fix it'. Notably, this proposition ignores the fact that these matters were in federal jurisdiction.

However, there were also statements in the legislature by Alberta Conservative ministers that do not sound traditionally pro-incarceration. When providing budget information in May 1990 on correctional expenditures (three to four years prior to the decarceration period), Alberta's Solicitor General expressed the hope that his proposals would 'lead to significant reductions in the numbers of native people in custody' (Alberta Hansard, 7 May 1990, 1050: 16). He was also concerned with the number of young offenders remanded to custody, 'not because of the seriousness of their offence but due to the fact that a suitable placement in the community cannot be found' (Alberta Hansard, 7 May 1990, 1050: 16). Similarly, when presenting his department's financial estimates to a legislative committee in May 1992, this Minister expressed 'concern with rising crime rates' but also with 'the dramatic increase in the number of Albertans on probation or in custody' (Alberta Hansard, 20 May 1992, 1000: 15). Subsequently, he discussed how 'there is no single simple solution' to these problems, stating that he intended to 'look at measures that will provide more opportunities for young offenders and in particular native young offenders, to avoid incarceration . . . Custody should only be used as a last resort for young offenders' (Alberta Hansard, 20 May 1992, 1000: 17).

Beyond politics per se, Alberta's decarceration experience is also framed by economic policies. Prior to Klein's 1992 assent as premier, Don Getty – his Conservative predecessor – had become unpopular, in part because Alberta had been running a deficit. Given that Alberta was considered a wealthy province with the country's lowest individual tax rate, Getty was seen as a poor economic manager (Martin, 2002: 105). The problem – politically – was that there was concern about the future of Alberta's Conservative party. Polls showed that opposition Liberals were ahead, largely by successfully criticizing the Conservatives' fiscal policies and the province's rapidly rising debt (Martin, 2002: 105–106). As one deputy minister expressed: 'The government has lost much of its credibility in

the way it has managed the province's finances since the 1989 election' (Martin, 2002: 117).

Getty resigned as premier and Ralph Klein was selected in late 1992 as Conservative leader (and, therefore, premier) in part because of his promise to balance the budget. Choosing Klein had not been easy because there were deep divisions within the party and the province. He was seen as needing to re-brand his party which had lost public confidence. In early 1993, Klein promised to eliminate Alberta's deficit if his party won the next election. Fulfilling this objective was seen as central to their continued success. This promise responded to the achievement of Laurence Decore – the Alberta Liberal Party leader – in eliminating, in 1993, Edmonton's (Alberta's capital) deficit as its mayor. Klein's Conservatives were re-elected in June 1993 with a smaller majority than in any of the 12 previous elections.

The events

Klein's decarceration begins with his 1993 promise to balance the budget. However, consistent with his 'small government' philosophy, he made it clear that the deficit would be eliminated by cutting spending, not raising revenue. In Klein's own words, 'We have a spending problem, not a revenue problem' (Martin, 2002: 123). He could have raised revenue as Alberta had the country's lowest personal income tax rate and was the only province without a provincial sales tax. However, given that the opposition Liberals also favoured expenditure cuts, Klein's choice is unsurprising. From 1993 onwards, it was clear that serious cuts in government expenditures would occur.

The government's May 1993 budget proposed to eliminate the deficit by 1996/1997 – requiring a cut of approximately 20 per cent (Bruce et al., 1997: 1). Moreover, spending cuts would not follow the traditional approach. As Mansell (1997: 58) suggests, government cutbacks in spending are normally accomplished selectively: specific constituencies deemed by government to be less important or less deserving feel the pain; others do not. In contrast, Klein's expenditure cuts were across the board: no sector or ministry was exempt. He felt that big government departments – health and education – could not be expected to be solely responsible for budget cuts unless the smaller ministries also received comparable cutbacks. As the provincial Treasurer (an elected member of the legislature) said, 'I remember Ralph [Klein] saying everyone's got to be touched by this. Everybody's got to feel some pain. Don't single out one group' (Martin, 2002: 135).

As a senior civil servant (the Deputy Minister of Justice) explained, 'In order to eliminate the deficits, all departments were asked to look at [cuts of] 20 per cent . . . or . . . 40 per cent . . . to [their] budget . . . That was the choice, and there were no other choices.' This approach was strategic. As Mansell (1997: 58) notes,

> It would appear that this broad sharing of the pain has played an important role in minimizing any widespread opposition to the cuts. Put simply, it is difficult for any

> one group to form major opposition to cuts when they will be revealed as a 'special interest' by the willing sacrifices of other groups in the common interest. In addition . . . there is a greater tendency for all groups to more clearly recognize the existence of an aggregate budget constraint.

Nonetheless, this strategy met considerable resistance. Understandably, certain cuts were more salient than others. For instance, health and education are, largely, provincial responsibilities and accounted for 53.6 per cent of provincial expenditures in 1992/1993. One can easily see that cuts to the health budget ($4.174 billion for 1992/1993) were more relevant to Albertans than cuts to the justice budget ($426.03 million). However, Klein was determined to cut all departments. Martin (2002: 136–137) reports a story circulating at the time of the budget deliberations which captures Klein's approach:

> The defining showdown came in the fall of 1993 during pre-budget discussions. Social services officials appeared before the treasury board to warn that, due to rising welfare rolls, they couldn't possibly meet their budget reduction target. Dinning [the Provincial Treasurer] recalls a silence around the table as the officials waited for cabinet to begrudgingly approve the required increase. 'Well' he said, 'what are you going to do about meeting your commitments?'
>
> The officials exchanged knowing looks. They'd heard this tough talk before and knew just how to deal with easily spooked politicians. 'Perhaps we'll have to slash the widows' pension or reduce the Alberta Income for the Severely Handicapped,' one official warned, his shoulders sagging . . . [in] reluctant horror . . ..
>
> 'I got some nods from around the table, so I [Dinning] said, 'Okay, we accept your recommendations. Now come back a week from now with a communication plan for your minister to announce these reductions'. The bureaucrats in the room went noticeably pale because they knew they'd gone too far . . . A week later, they came back and said they'd rethought how they were going to tackle the problem and proposed alternatives.
>
> After [these social services officials left], Klein burst into laughter and pounded the table. 'That's exactly how they did it at city hall' he said . . . [Klein had been Mayor of Calgary, Alberta, before entering provincial politics.] It was a turning point for the Klein Tories. Word spread throughout the bureaucracy from deputy minister to deputy minister: this cabinet is different, this cabinet has balls. Either that or it's nuts.

Whether 'true', embellished or completely fabricated, this story (as it circulated around the government) set the tone for every Ministry in terms of the inevitability of expenditure cuts. Although the size varied, all but one Ministry (Community Development) took substantial cuts in dollar amounts and/or percentages.

Justice was not immune. When faced with a 20 per cent or 40 per cent budget cut, the Deputy Minister explained that '... [We] laid out [during the summer of 1993] the consequences of a 40 per cent cut which we thought would cripple the justice sector completely. We said that the 20 per cent cut we could live with.' In fact, Justice received a 1997/1998 target cut of 16.85 per cent. Notably though, Justice officials were allowed to decide how to accomplish it. When asked whether imprisonment was an issue when identifying justice sector cuts, the former deputy answered:

> Only to the extent that in order to reach the goal we had to [cut] various departments across the whole organization ... I'm not saying that we cut 20 per cent out of each part of the department. Some got more [of a cut] than others, some less. But the corrections [cut] probably came in at close to 20 per cent and in order to do that, we had to close some of our prisons.

In the end, Justice accomplished its cuts and Alberta experienced a dramatic drop in its prison population – a reality not naturally associated with a conservative government. Further, Klein would unlikely be described as a liberal on criminal justice matters.[3] Illustratively, he agreed with his justice minister's 1995 proposal to institute chain gangs[4] and reportedly favoured the death penalty for certain youths.

Part III – Decarceration 'Alberta style': Evidence

Canadian provinces – like US states – do not act in isolation of one another. Hence, the Canadian context is important in verifying that a demonstrable change in imprisonment had occurred in Alberta relative to national trends. Notably, Canada's overall imprisonment rate has been relatively stable since 1950 (Figure 1, top line).

However, Canadian incarceration has two components. Provinces are responsible for prisons – housing offenders sentenced to < 2 years and those awaiting trial (Figure 1, middle line). The federal government has responsibility for penitentiaries – housing those sentenced to two years or more (Figure 1, bottom line). Both show stability during the mid-1990s.

In contrast, Alberta shows a drop of 32 per cent in its provincial prison population rate between 1993 and 1997 (Figure 2). The average daily count dropped from 102 in 1993 to 69 in 1997. This decrease occurred because of changes in the number of sentenced prisoners, not the remand population (until about 2001).

Figure 3 contrasts Alberta's imprisonment rate with those of the other large Canadian provinces (Quebec, Ontario, British Columbia) and the two other Prairie provinces (Saskatchewan and Manitoba). None show the same dramatic drop between 1993 and 1997.

This reduction was – in numbers – non-trivial. There were 23,771 sentenced admissions to provincial correctional institutions in 1992. In 1997, this number decreased to 14,467 – a 39 per cent decline. Alberta witnessed a decrease from

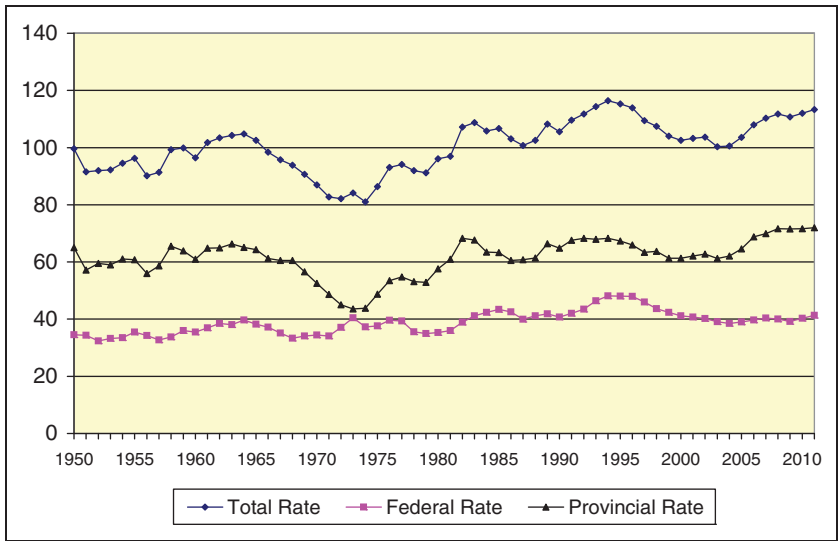

Figure 1. Total, federal and provincial adult imprisonment rates per 100,000 residents.

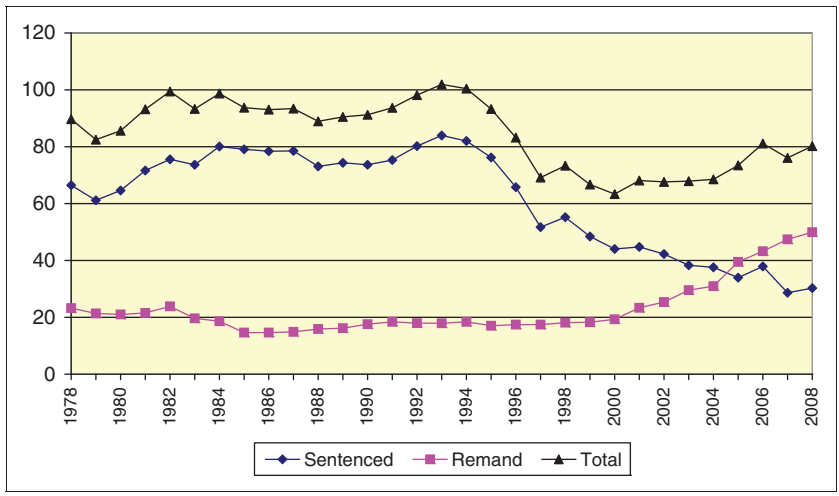

Figure 2. Alberta adult imprisonment per 100,000 residents.

903 to 511 admissions per 100,000 residents (Figure 4). This reduction is larger than changes in any of Canada's other large provinces.[5]

Clearly, something unique occurred in Alberta between 1992 and 1997. While it is tempting to think that Alberta's drop was simply due to its relatively high

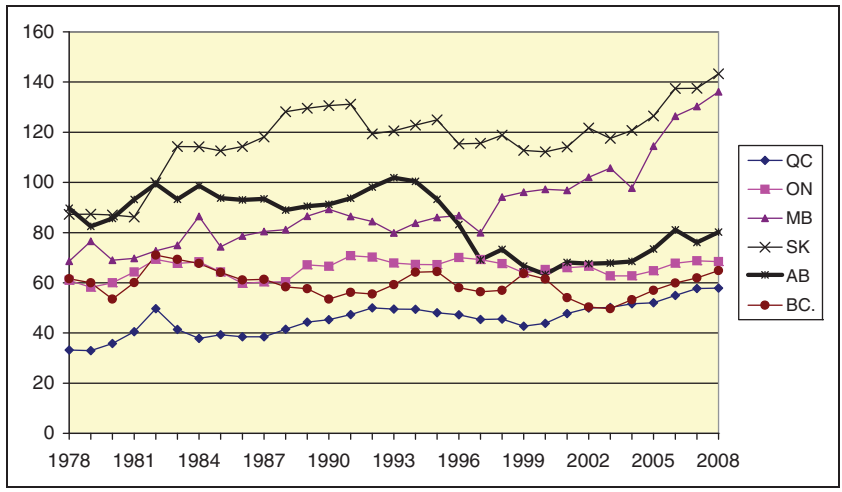

Figure 3. Adult provincial imprisonment rates per 100,000 residents.

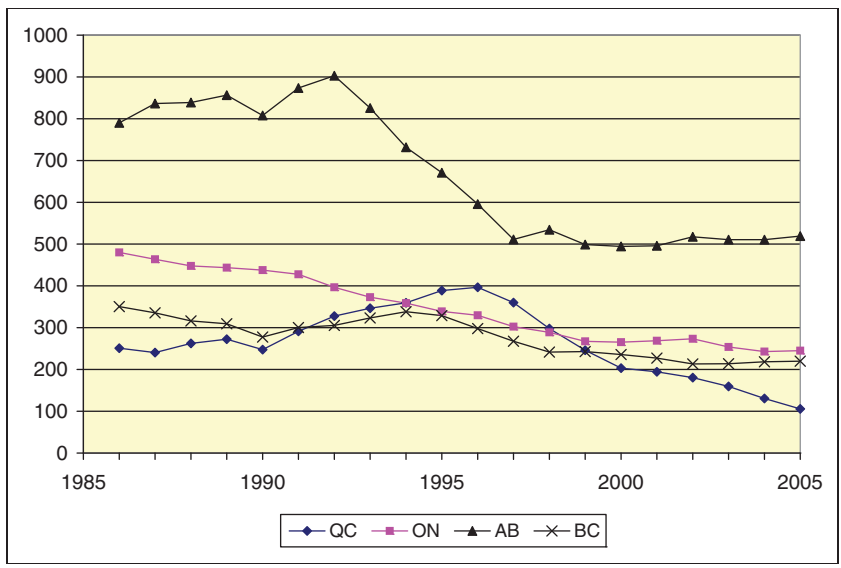

Figure 4. Sentenced adult admissions rate per 100,000 residents.

imprisonment levels prior to 1993, the data (Figure 3) do not support this hypothesis. Although Alberta's provincial imprisonment rate was higher than those of British Columbia, Ontario and Quebec, it was comparable to those of the other two provinces in the Prairie region (Manitoba and Saskatchewan). Similarly, the federal elections of 1993 – the beginning of the period under study – in which the Liberals

took over power from the Conservatives might also intuitively emerge as a compelling factor facilitating Alberta's dramatic drop in its imprisonment rate. However, no obvious change in criminal justice policy accompanied the change in the federal government (Webster and Doob, 2012: 86–90).

A possible explanation might be that the drop in provincial incarceration was the result of displacement to federal penitentiaries. Conceivably, those ordinarily given severe 'provincial sentences' (i.e. close to the two-year breakpoint between provincial and federal institutions) could be elevated into the federal system (e.g. with sentences of two years or more). Unfortunately, counts of prisoners in federal penitentiaries reported by province of sentencing are unavailable, nor do adequate provincial sentencing data on the length of custodial sanctions exist. Further, counts (number of prisoners on an average day) are only broken down by the region in which the prison is situated, which is not helpful for our purposes since inmates are moved across regions.

However, regional *admissions* constitute a useful proxy as the region in which offenders enter federal penitentiary is generally where they were sentenced. Since Alberta's 1994 population constituted 56 per cent of the Prairie region, substantial movement from provincial into federal institutions would appear as increases in Prairie federal admissions. Yet, the data suggest the opposite. The high point, in this period, for admissions to federal penitentiaries from the Prairie provinces was 1992–1993; admissions thereafter dropped. Specifically, there was an average of 1371 federal (sentenced) admissions in 1992–1993 in the Prairie region, but under 1300 admissions each year in the following four years, ruling out any 'displacement' explanation.

Consistent with other research suggesting that imprisonment and crime rates are essentially independent (Lappi-Seppälä, 2008; Young and Brown, 1993), Alberta's drop in its prison population was also not due to changes in reported crime. Like Canada overall, crime declined in Alberta, beginning in the early 1990s. Notably, imprisonment decreased dramatically in Alberta in the mid-1990s. On the surface, these observations seemingly provide some support for the notion that the drop in Alberta's crime rate accounts for the decrease in imprisonment. However, this conclusion ignores two contrary pieces of evidence. First, an earlier increase in Alberta's crime rate (mid-to-late-1980s) was *not* associated with a rise in imprisonment. Second, patterns of crime and imprisonment in Canada's other three large provinces do not support this argument. Specifically, while crime rates decreased during the 1990s in all three jurisdictions, their incarceration rates show diverging trends. Imprisonment levels remained stable in Ontario but varied during this period in British Columbia and Quebec.

Finally, Alberta's decline in its imprisonment rate cannot be attributed to changes in (federal) criminal law. The only relevant criminal justice legislation introduced in this period was the 'conditional sentence of imprisonment' – which permitted an eligible offender to serve a custodial sentence of <2 years in the community rather than prison. Although this sanction was available nationally,

only Alberta showed a dramatic drop in imprisonment. Second, it was only implemented in September 1996, after most of Alberta's decrease had occurred. Third, its rate of use in Alberta was fairly constant (averaging 42 admissions to supervision per 100,000 population) from 1996 to 2008 and was not accompanied by reduced prison admissions (averaging 515 admissions per 100,000 for 1996–2008).

Part IV – Decarceration 'Alberta style': Mechanisms

While Alberta's decreased use of imprisonment finds empirical support, its cause(s) proves more elusive. Explanations cannot be located in the 'usual suspects' – changes in crime, criminal jurisdiction of prisoners, or criminal law (a federal responsibility). Rather, it is necessary to look more 'locally' (Barker, 2009; Lynch, 2011; Miller, 2011). Alberta's deficit and the decision to end it via expenditure cuts are central to understanding what occurred.

Whether it was necessary for the decarceration to take place that Alberta had a conservative government at this time is difficult to determine. Less conservative governments might have balanced the books with revenue increases, not spending decreases. Had that occurred, Alberta's imprisonment rate would likely not have decreased. But being conservative likely helped. As Gartner et al. (2011) note regarding California's decarceration under (Republican) Governor Ronald Reagan, some liberal changes are more easily made by political conservatives. Similarly, England's Margaret Thatcher was able to question the value of general deterrence strategies and to stall increases in imprisonment rates during her period in office (Newburn, 2007: 436–437). Klein – like Margaret Thatcher – was not pressured to look tough as a Liberal might have been.

Alberta's Conservatives received little political opposition to reducing prison populations. Justice Minister Brian Evans is quoted in an article entitled 'Alberta wants non-violent inmates out of jail, back to work' that:

> there are other ways of dealing with some of the criminal activity . . . that are more effective than putting a person in jail. Our . . . correctional facilities should be used, for the most part, for people who have committed serious and violent crime and therefore are a substantial risk to society. (Gold, 1996: A3)

The Liberal justice critic was cited as agreeing. In fact, we found *no* evidence that the Liberals were critical of government proposals designed to reduce prison populations.

This political consensus supporting decarceration of certain types of offenders can be juxtaposed with political opposition to other projected justice sector changes. For example, the Justice Minister announced cuts to transfers to municipalities for police. The opposition Liberals were mildly critical of this proposal, raising concerns that 'when policing agencies are trying to make [the transition to community policing] . . . on what basis was it made that their financing could be pulled away from them, that they could be . . . left to fend for themselves?'

(Howard Sapers, Alberta Hansard, 3 March 1994: 405). Sapers also expressed concern that the Minister's proposal to expand 'house arrest' might be used 'to expand the network of social control in a way that we wouldn't be happy with' (Alberta Hansard, 3 March 1994: 406).

Little political opposition was coupled with little public opposition. Justice sector cuts were relatively invisible – not because the government hid them but because they were only a small part of the overall change occurring during the 'Klein Revolution'. The targeted reductions (in nominal spending and, more dramatically, in real per capita spending) between 1992/1993 and 1997/1998 across the 18 provincial ministries showed reductions in 17 of them. While justice cuts totalled $71.79 million, the two largest ministries – health and education – experienced cuts of $530.21 and $290.76 million respectively. Even smaller ministries faced non-trivial cuts (Bruce et al., 1997: 2).

Further, cuts of this magnitude involved matters almost certainly of higher concern than justice. There were hospital closures, cuts (17 per cent) to Colleges and Universities, and a 50 per cent reduction in the number of government funded kindergarten classroom hours. As one journalist reported, he did not recall 'justice matters having the same kind of overall effect on people as education, health, and the state of government finances' (Mark Lisac, personal communication, 3 February 2009). Similarly, the Deputy Justice Minister told us that for the public, 'there were so many bigger fish to fry that nobody was concerned with what [Justice was] doing'.

Justice cuts also received little media attention. As one commentator noted, 'Seventeen departments had been asked to reinvent everything they did at once. The department planners and cabinet ministers and the businessmen acting as unelected advisors had produced too many proposals to track' (Martin, 2002: 198–199). Moreover, all final cutbacks for all Ministries were announced simultaneously (18 January 1994). The result – one journalist explained – was that '[w]ith so many consequences, so many victims and so much potential opposition we couldn't possibly do justice to all that needed covering in what was clearly a strategic carpetbombing of bad news' (Martin, 2002: 138–139). Our count of newspaper stories in the main newspaper in Alberta's capital (Edmonton *Journal*) supports this view. On the day after the announced cutbacks, 139 stories were published,[6] 18 of which related to budget cuts. The only reference to justice issues was one sentence related to possible cuts to the Edmonton police.

But Justice matters were not ignored completely. Public attention was drawn to decisions to close two prisons. The correctional union – described by the Deputy Minister as being 'very aggressive, calling us all frauds and things of that nature' – was the most vociferous. The union vice-president suggested that correctional closures would mean that people imprisoned 'for domestic assault are going to private camps and halfway houses . . . Spousal assault is being viewed as a minimum security offence, otherwise they can't get enough people for prison camps and halfway houses' (Danylchuk, 1994a: B3). He was also quoted as saying that for cost reasons, prisons were releasing offenders early despite judicial orders to serve

full sentences (Danylchuk, 1994b). Notably, Canadian judges do not have the power to issue such orders.

Government officials responded by celebrating prison closures. The Justice Minister explained that this decision was part of an overall 'rationalization of our system . . . [whereby] the management of offenders who would normally be incarcerated . . . reflect[s] a cost-effective and progressive approach to corrections while ensuring the protection of the public and the deterrent effect of sentencing' (Alberta Hansard, 3 March 1994: 402). Further, the government reminded the public of its 'tough on crime' approach to criminals. Lisac (1995: 195–196) notes that the government 'was trying to present a law-and-order front by whipping up public interest in bringing back the death penalty. They also reacted to public concern about crime by holding hearings on the [federal law governing young offenders]'. These strategies are notable because neither was within provincial jurisdiction, nor a provincial money issue. Rather, they served as 'insurance' against charges that closing prisons and implementing more selective prosecutorial policies showed them to be 'soft on crime'.

This combination of little political opposition and low public interest in justice issues gave the civil servants in Justice considerable freedom when designing strategies to reduce expenditures. The Deputy Minister told us that while he had no flexibility in accomplishing the required budget cut, he and his colleagues determined how it was done. Considering inflation and increases in population, the real per capita justice expenditures decreased 21 per cent between 1992/1993 and 1994/1995, with a decrease of 31 per cent by 1997/1998. While a 5 per cent salary decrease for all provincial employees (except judges) helped, the challenge was non-trivial.

Proposed strategies were largely limited only by structural factors. Within the government itself, Klein reduced the number of Ministries. The responsibilities located in Alberta's Ministry of the Solicitor General (policing and corrections) were folded into Justice. One deputy was reassigned, leaving the other fully responsible for all justice expenditures and for meeting the budget cut.

Further, Justice expenditures were constrained by Canadian constitutional divisions. As criminal law in Canada is a federal responsibility, the law could not be changed. However, the administration of justice is largely a provincial responsibility. Hence, provinces are responsible for police, courts, most prosecutions, community corrections, pre-trial detention prisoners and those sentenced to <2 years in prison. The federal government is responsible for the administration of sentences of two years or longer. Further, most provinces – including Alberta – contract with the federal government to provide certain policing services from the Royal Canadian Mounted Police (RCMP).

For our purposes, two parts of this constitutional complexity are important. First, provinces are responsible for most prisoners. In 1995, 94.5 per cent of prison *admissions* were housed in provincial institutions. Second, 91 per cent of accused people in Alberta in 1994 were prosecuted by provincial prosecutors. Consequently, provinces control prosecutorial processes and policies, and by

implication, prison intake. Furthermore, provinces control the portion of provincial prison sentences that offenders actually serve in custody. Alberta also had a small indirect power over police budgets through grants to the larger municipalities and by being responsible for negotiations for RCMP services.

Strategies to reduce justice expenditures were developed within this context. Several rural courts were closed and a hiring freeze on prosecutors and judges was implemented, creating pressure to reduce the number of cases prosecuted. However, this 'piecemeal' approach only succeeded in chipping away at outer layers of the justice expenditures. The most important line of attack was rooted in a more holistic strategy crafted by civil servants in the Ministry, particularly those in corrections. Recruited from the 1970s onwards for management or policy positions and typically possessing graduate degrees in criminology/social science, these public servants were described by our key informants as 'progressive'. Budget cuts provided them with opportunities to implement – or expand – programmes that would simultaneously reduce costs, reduce imprisonment and be sensible from a criminological perspective. Further, these 'Corrections' staff had considerable autonomy. As a senior corrections official noted, 'All anyone knew . . . was that we were broke. We needed a change. And downsizing and restructuring was the solution. Klein stayed away from Corrections.'

The combination of this 'freedom' to craft policy and the liberal orientation of the civil servants was central in decreasing Alberta's prison population. Decarceration was accomplished through a concerted, multi-factor approach involving multiple players, mechanisms and entrance and exit points. Most obviously, prisons were targeted. Privatization, though not part of adult incarceration in Canada, was discussed (March 1994) in a legislative committee. However, public servants were reported to have studied it and convinced their political masters that it would not reduce expenditures. Rather, the decision was made to close prisons. Notably, this choice to target prisons did not reflect any concern with imprisonment levels. As the then Deputy Minister said, Alberta's incarceration rate 'did not stand out as a significant issue'. The goal was to cut expenditures and prisons are expensive to run.

The largest closure was the 300-bed provincial prison in Grande Cache. Perhaps because it was the town's largest employer, Alberta offered it to the federal government for what the deputy described as 'a very small amount on the basis that they would continue [employing] the [provincial] correctional officers and move them into their staff'. Though closing this correctional facility made news, the Deputy indicated that it did not receive the public outcry that cuts in health and education received. Similarly, the Ministry closed a few other smaller correctional facilities without any serious public opposition.

Consequently, prisons had reduced capacity. To avoid overcrowding, other strategies were introduced which focused on alternatives to custody. This approach to reduce expenditures was consistent with the 'progressive' orientation of the justice civil servants. As the member of the provincial legislature told us, 'there was this notion [within the civil service] about not using incarceration

and . . . working with the courts and doing different things in terms of sentence administration'. He added that many of the senior provincial officials 'believed in community corrections'.

A central element of this 'front-end' approach was the 'Serious and Violent Crime Initiative', proposed by the Deputy Minister, in conjunction with his prosecutors. He was blunt about the reasons for this initiative:

> First . . . it was done for economic reasons, but also – and perhaps more importantly – it was an initiative that a number of us had felt was long overdue . . . I used to [say that we give] the same attention to somebody who has broken a noise bylaw as somebody who has committed a mass murder, and so we've got to start to distinguish between those two extremes . . . The key selling point was that . . . we're treating [serious and violent crime] seriously, but at the other end . . . we're letting some people get a break early on in the process. . . . [O]n that basis we cleared up the number of people actually being rotated through the courts.

This initiative proposed a bifurcated imprisonment policy whereby the government would be tough on the small number of violent cases while showing more leniency – in the form of non-custodial sanctions, or diversion from the court process – for the much larger number of minor cases.

We found no evidence suggesting that Alberta politicians were nervous about advocating this policy. In fact, a newspaper article on the expansion of community-based programmes under this new initiative quotes the justice minister as saying:

> [the bifurcation policy] is much more effective in changing behaviour than just having someone for a minor offence being put in jail. If they are spending their time doing community service work, they're much more likely to be thinking about the impacts of what they've done . . . The issue is how effective is prison and are there alternatives which are better for less serious . . . criminal activity. (Gold, 1996: A3)

The Liberal justice critic supported the justice minister: 'We have to recognize that jail is absolutely the most expensive way and arguably the least effective way to deal with a whole range of offences and offenders.'

The Justice Minister was quoted as reporting that to make room for violent offences, those normally receiving short sentences would be eligible for an alternative measures programme (Laghi, 1996). The median provincial prison sentence in 1996 was 30 days. By giving prosecutors and police the licence to look for alternatives for those likely to be awarded prison sentences of up to 90 days, this strategy could significantly reduce the number of sentenced offenders entering prison. One need only recall similar policies intended to abolish short prison sentences implemented in West Germany in 1969 and 1975 which contributed to its drop in imprisonment levels (Weigend, 1997). The suggested elimination of short custodial sentences in Alberta was made in the context of the minister indicating that prosecutors would request the imposition of longer parole ineligibility periods

for the rare cases for which this is possible (i.e. certain serious offenders with long sentences).

In practice, Alberta was largely successful in avoiding the 'perverse effects' (Snacken et al., 1995: 33) often associated with a bifurcation policy. Both the police and the prosecution embraced it. Anecdotally, the Deputy Minister noted:

> I think that the impact on the jails was this. Those that were in there spent longer in jail than they had before . . . but fewer people went in. I think the reason for that is the police reacted to . . . the cuts, and pulled back on some of their enforcement but, more importantly, I think they probably reacted to the . . . Initiative in the right way, in that I think they probably gave breaks. There was probably a fair amount of diversion that was at the discretion of the police prior to even coming into the system. And so those that had otherwise been arrested and held for bail hearings sometimes over a weekend were no longer going into the prison system; and the short, sharp jail terms to straighten people up . . . probably were significantly reduced . . . [The police] may have been legitimately trying to work with the system that we had developed.

Figure 5 supports this interpretation. After 1992, the rate of adults charged dropped much more in Alberta than elsewhere. Further, the decrease is dramatic, with 79,192 adults charged in Alberta in 1992 but only 59,786 in 1995 – a 24.5 per cent decrease. Moreover, the number of adults charged for violent offences dropped only about 10 per cent. This finding is consistent with increased police discretion whereby non-violent offences were less likely to be brought into the formal system. Further, this change is unlikely to have been caused by a reduction in police services: police officers per capita in Alberta dropped by nearly the same percentage (8 per cent) between 1992 and 1997 as in Canada as a whole (8.9 per cent).

Similar conclusions emerge regarding increased prosecutorial discretion. While the rate of findings of guilt for 'serious violence' (all violent cases except common assault) increased, it decreased for common assault. This difference is unlikely due to changing reporting patterns to police. The number of both common and serious assaults reported to the police either stayed the same or increased between 1994 and 1997.

Community corrections and diversion programmes were also expanded. A fine-default programme was broadened. Further, more offenders were apparently released early from prison. Although hard data are unavailable, Corrections' 'temporary absence' programmes were expanded to accommodate more prisoners. A community alternative – referred to as 'Surveillance Supervision' for those sent to prison – allowed prison officials to release offenders on ordinary sentences relatively early (i.e. prior to the 2/3 point in their sentences when they are generally automatically released). Through 'temporary absence' passes, these inmates were allowed to complete their sentences in the community, subject to conditions (e.g. 'house arrest').

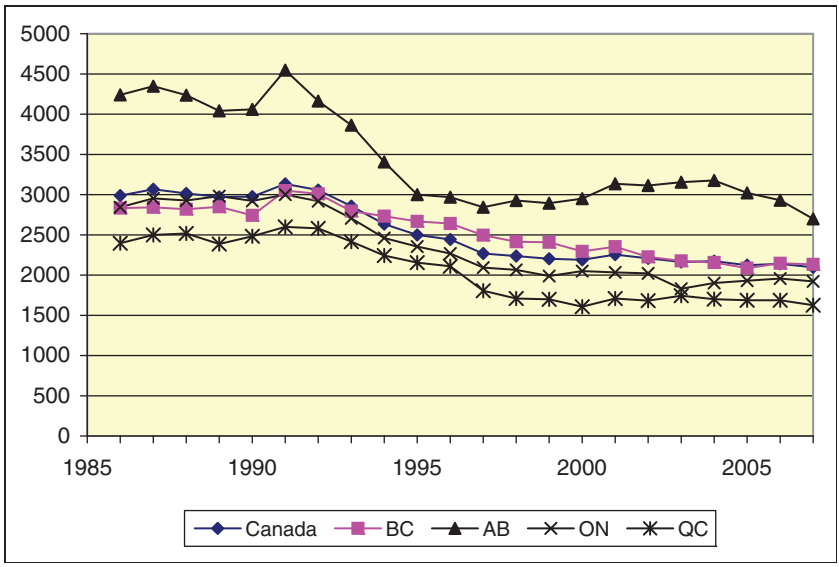

Figure 5. Rate of adults charged per 100,000 residents (all offences).

Part of the 'surveillance supervision' package was a system of 'attendance centres', replacing prisons that had closed. For those then working in the system, these programmes were unambiguously seen as cost savings measures that made correctional sense. As a senior Alberta correctional official indicated, this strategy of reducing the prison population ensured that they could '[h]andle many more prisoners per dollar spent'. However, from his perspective as someone aware of correctional research, community sanctions were also more effective than prison in promoting reintegration.

'Surveillance supervision' was subsequently expanded to include intermittent sentences. Those sentenced to serve prison sentences on weekends were 'released' to their homes on temporary absence passes and ordered to do community programmes (often at attendance centres) or community work during the day. The attendance centres – we were told – were seen as being consistent with the focus on 'intermediate punishments'.

Taken together, the new and expanded mechanisms to reduce justice expenditures, introduced throughout the system and embraced by multiple justice players, constituted a new way of 'doing business'. While cost-cutting was fundamental in stimulating this change in culture, its role was restricted to providing correctional officials with the opportunity to introduce what they believed to be sensible policy. Given that 'corrections' was generally ignored by politicians, these civil servants were largely left alone on issues affecting the size of the prison population.

Even in those rare occasions in which correctional staff were not 'left alone to do their work', these intrusions had little consequence to the overall decarceration

project. Several examples come to mind. Later in the 1990s, colour TVs were replaced with black-and-white sets. An attempt – albeit short-lived – was also made to reduce the amount of food given to prisoners. Politicians examined, but rejected, a boot camp model (Coulter, 1993). Further, prisoners' pay for work was first cut and then eliminated (Danylchuk and Thacyk, 1993) and weight training equipment was removed from the prisons for political, not correctional, reasons. Finally, prisoners – wearing orange jump suits – picked up trash on highways, with signs posted nearby announcing 'Alberta Inmates Working for Albertans'. While obviously constituting annoyances and additional punishments, these changes did not affect imprisonment rates.

Part V – Decarceration 'Alberta style': Broader issues

Gottschalk (2006, 2009) states that to understand imprisonment policies, one needs to understand politics. This lesson finds support in this case study. While simple political ideology is not a useful predictor on its own of punishment policies, politics – which, in this case, is inseparable from economic policy – is central to this conservative province's decarceration. Decarceration was the result of a political problem rooted in Klein's need to restore public confidence in his government. This objective was achieved largely by balancing the budget, accomplished through substantial reductions in expenditures across all sectors, including justice. Decarceration contributed to attaining this goal.

Within this context, Alberta's experience with decarceration was an act of political will. However, different from other political decisions to decarcerate, the catalyst for this change had nothing to do with *social* policies. The reduction in imprisonment was – at the political level – disconnected from either principled questions of punishment or concerns with crime or levels of incarceration. We found no evidence that anyone in power had even noticed, let alone been concerned with, Alberta's relatively high imprisonment rate prior to 1993. Klein's objective was solely expenditure reduction, with no real interest in how this goal was achieved.[7] Decarceration constituted – from a political perspective – simply a means to an end but never an end in itself.

For those who suggest that fiscal crises and the need for financial austerity may be important catalysts for decarceration (e.g. Clear, 2011), this study may provide some optimism. The impetus for change was entirely driven by economics. Reductions in imprisonment do not necessarily have to be motivated by criminological or social policy issues/concerns. Further, Alberta's decarceration emerged under a conservative government and during a period of high and increasing imprisonment rates in the USA and elsewhere (e.g. Britain, New Zealand, Australia) (see Webster and Doob, 2007: 309–310).

However, such optimism may reflect only half the story. The limitations – and dangers – of the power of fiscal crises (and the economic burden of the carceral state) to bring about decarceration have been discussed elsewhere (e.g. Gottschalk, 2009; Loader, 2010). The reliance solely on economic imperatives to change

imprisonment rates risks the adoption, instead, of more repressive or austere measures related to a prisoner's quality of life (e.g. cuts to medical care, correctional programmes or overcrowding). Even when employed to decrease expenditures, decarceration – as a politico-economic strategy – may be short-lived, with imprisonment rates returning to pre-existing levels once the economic crisis has passed (Tonry, 2011).

Notably, neither situation occurred in Alberta. First, the vast majority of criminal justice policies and practices adopted to reduce justice expenditures had no obvious important negative impacts on offenders. Second, the provincial imprisonment rate not only showed a dramatic decline but also remained low for at least a decade (Figure 2). The 2008 rate of incarceration was still lower than it had been 15 years earlier, and the recent increase is largely rooted in the growth of remand prisoners – a general problem in Canada (Webster et al., 2009).

Hence, the question becomes one of how Alberta avoided the risk factors associated with 'playing the Treasury card' (Loader, 2010) – that is, promoting penal reductionism for fiscal reasons. We suggest that Alberta's success resides in the rest of the story. Though balancing the budget was the catalyst for change, it did not determine the types of changes introduced. Said differently, Klein's decision to impose 'across the board' expenditure cuts created the political will and the space for change. But the manner in which Justice achieved its cost reduction was not driven primarily by economic factors (except to ensure that budget cuts were met).

Lurking behind the economic imperative were civil servants who were eager to implement what they saw as sensible policies and politicians who were happy to celebrate the successes of these policies in reducing imprisonment. We have suggested elsewhere (2007) that until recently Canada has had a long tradition of relying on civil servants and non-governmental experts – not politicians – in developing criminal justice reforms. Since they generally remain in their positions independent of changes in government, they are largely insulated from wider pressures towards punitive approaches. Further, as experts in their areas, they provide an awareness and understanding of relevant research. Hence, it is unsurprising that strategies were adopted that simultaneously reduced imprisonment and expenditures with what was seen as good policy.

However, it was not simply a question of civil servants' commitment to sensible policy. Rather, decarceration strategies were supported and embraced simultaneously by multiple sectors of the system. Police were discouraged from charging in cases of minor offences; prosecutors were encouraged to screen out minor cases and request non-custodial sentences in less serious cases; correctional workers were encouraged to release inmates early. While the reduction of prison populations may have begun – albeit indirectly or unintentionally – as a top–down process, its strength and expansion resided at a more local level. In practical terms, a new 'way of doing business' was created (Lynch, 2011). Without legislative changes, new procedures were developed, restructuring the ways in which the system operated. In contrast with decarceration experiences rooted in court-ordered releases or

sporadic amnesties (Lévy, 2007), the creation of a new working culture ensured that staff hired subsequent to the 'Klein Revolution' were trained within these new parameters, promulgating and perpetuating lower levels of incarceration as the normal way of operating.

But above and beyond these local mechanisms lies the story's most central element. Underlying – and configuring – the entire decarceration experience is the question of values. Canadian criminal law and the numerous formal statements of criminal justice policy addressing the issue of criminal sanctions over the past 50 years describe Canada's tradition vis-à-vis its imprisonment policies. The predominant leitmotif running through these documents – which have reflected, defined and structured criminal justice reform – is that of an official culture of restraint in the use of incarceration (Doob and Webster, 2006; Webster and Doob, 2007, 2012). In contrast to the USA or post-Thatcher England, Canada has consistently shown deep scepticism about imprisonment as an appropriate response to crime. This perception of prison as a necessary evil whose use should be minimized has been shared – until recently – by Liberals and Conservatives alike.

More broadly, value structures of Canadians and Americans differ in several fundamental ways. Adams (2003) characterizes Canadians as less violent and more communitarian in their core values than Americans, whose values are seemingly more individualist in nature. Arguably, these underlying normative beliefs and attitudes may have defined and guided Canada's response to crime and criminals for decades. The perception of offenders as still deserving of hope, redemption and being considered as full citizens – justifying a focus on their reintegration (versus segregation) – likely finds its translation in Canada's rejection of such exclusionary policies as capital punishment, the disenfranchisement of offenders and sentences of 'life without parole'. While Canada may not have adopted the 'widely held Scandinavian normative belief that imprisonment is in its nature undesirable' (Tonry, 2011: 646–647), an over-reliance on incarceration was perceived (until recently) to be a 'Bad Thing'.

Within this context, Alberta's adoption of strategies – at the operational level – to reduce its prison population and their support – at the political level – are unsurprising. Decarceration does not challenge long-standing Canadian values as expressed in many government criminal justice policy statements during this period (Webster and Doob, 2012). Even in Canada's most conservative jurisdiction, the culture of restraint in the use of imprisonment was still firmly embedded. Illustratively, when imprisonment rates rose slightly in the 1990s, the federal government and *all* provinces (including Alberta) agreed to try to contain prison populations (Working Group, 1996).

Conclusion

Decarceration in Alberta in the mid-1990s could be described as an unintended by-product of expenditure cuts, having nothing to do with criminological matters.

More simply, it was a political solution to a political problem. However, this assessment challenges – rather than supports – any over-simplified notion that 'left–right' political orientation is a major determinant of penal policy. Alberta's decarceration experience provides a richer, more nuanced account of the importance of politics. Reductions in prison populations are achieved through acts of political will, suggesting that decarceration – like increasing incarceration – requires an understanding of politics.

But even this 'roadmap' to explaining Alberta's dramatic reduction in imprisonment is more complex. Decarceration may be a political solution to a political problem but even politics are context-specific. Political decisions are not made in a vacuum and to understand them, they need to be placed in a historical as well as a political, economic and cultural context.

The immediate context of this story is political. The political decision to balance the budget through expenditure cuts provided the catalyst. In its absence, decarceration would not have occurred. Economic policies opened up opportunities for changes in imprisonment policies that had not previously existed.

The wider context is cultural. Canada's criminal justice culture largely determined the type of 'political solution' and the mechanisms for achieving it. Contrary to other jurisdictions whose deficits have also created a political willingness to decarcerate but have had difficulty achieving real change, Alberta brought about a dramatic – and sustained – drop in its prison population. The difference – we argue – is that the cultural values which promote and sustain decarceration are often missing. As Tonry (2011: 647) reminds us, '[i]n countries in which imprisonment is widely believed to be a Bad Thing, policy makers will work to restrain its use'.

Alberta's decision to adopt strategies favouring reduced criminal justice involvement in Canadians' lives was not accidental. The criminal justice culture which produced it reflected – and perpetuated – core Canadian values rooted in a long-standing belief in the need for restraint in the use of imprisonment and a lack of faith in its effectiveness. From the Deputy on down, there was an understanding that reducing both the number of full prosecutions of minor criminal matters and the size of the prison population made sense. While the Conservative government – and arguably the general public – of the time are unlikely to have supported decarceration as a political goal, it is likely that they would not have been antagonistic to decarceration as a solution to a political problem. Indeed, decarceration was compatible with the wider culture of restraint in the use of imprisonment and underlying core values of tolerance and reintegration. Further, this generalized support of lower incarceration as good policy and not just necessary policy (because of fiscal constraints) was likely important to its sustainability.

From a methodological perspective, this 'contextualization' of our object of study suggests that research focusing solely on political or economic typologies (e.g. Cavadino and Dignan, 2006; Lacey, 2008) to explain imprisonment rates are inadequate in that they provide little understanding of *changes* such as those

in Alberta (with no apparent change in political-economic orientation). As Gottschalk (2006: 244) warns us in the context of decarceration:

> No single factor explains [the rise in imprisonment rates], and no single factor will bring about its demise. This should prompt us to be sceptical of claims that any single new development, such as mounting economic pressures, will undo the carceral state.

It is not so much that these simple approaches rely on a limited number of factors but that they do not place the political decisions about imprisonment policies in a political, social, historical or even economic context. Indeed, this study suggests that simple additive models of explanation in which several different factors – each with its own independent effects – are added together to predict the occurrence of a policy are equally likely to fall short of capturing and understanding a jurisdiction's penal landscape. We suggest that penal policies and practices are a product of a range of forces which uniquely interact, reflecting and reproducing the defining elements of a country's specific history, culture and politico-legal structures – described by Lappi-Seppälä (2011: 324) as 'country-specific exceptionalism'.

Unquestionably, this conceptualization becomes increasingly more complex when one considers the sophisticated model of (internal, external and intermediate) factors which affect imprisonment rates proposed by Snacken et al. (1995). Based on Alberta's experience, one might be tempted to add to this schematic the wider core cultural values of a jurisdiction as yet another explanatory factor – albeit one which would be superimposed over the entire model to reflect its overarching effect. Borrowing Melossi's (2001) notion of cultural embeddedness, the Alberta case study suggests that Canada's long-standing culture of restraint not only influenced the decarceration process itself but may also have helped to fashion or shape – on a much broader level – other factors related to imprisonment rates. Canada's federal system (with criminal law as a federal responsibility), its electoral procedures (whereby judges and prosecutors are appointed, rather than elected), the central responsibility of experts in the development and management of criminal justice policies and the role of government in both promoting moderate responses to crime/criminals and leading (rather than following) public opinion have significantly limited (until recently) the politicization of criminal justice issues (and its contribution to increased punitiveness).

Within this methodological context, politics – in the form of fiscal imperatives – played a central role in Alberta. However, an exclusive focus on the 'catalyst' to decarceration and not on the process itself would have missed the real story. An understanding of Alberta's decarceration requires an interactive, multi-factor model that is attentive to both the historical and cultural embeddedness of the phenomenon as well as its local meanings. Such a model also alerts us 'to the difficulties of translation and the dangers of simple-minded lesson-drawing' (Loader, 2010: 358). The decarceration experience in Alberta should not be read as a 'roadmap' to reducing prison populations but, instead, as a cautionary tale concerning the necessity to situate imprisonment in a broader set of concerns.

Optimistically, Alberta's experience with decarceration is still a story about promise. Decarceration is possible, even during 'punitive times' and under conservative governments. It can be achieved without political fallout or soaring crime rates. Further, multiple mechanisms exist for achieving this goal. Even the need for fiscal restraint may hold part of the key to reducing prison populations in some jurisdictions. Certainly for initiatives like the US 'Right On Crime' project whose mantra is to be tough on both crime and criminal justice spending, the Alberta case study holds some promise in creating the political will to decarcerate.

More pessimistically, the lesson from Alberta is that reductions in imprisonment rates are the result of concerted, simultaneous, somewhat independent, but interacting actions. As Melossi (2001) noted in his comparison of the USA and Italy, the way in which cultural values, politics and history interact to create imprisonment rates is hardly mechanical. On the surface, it might appear that Alberta's reduction in incarceration was strictly about money. However, the actual process constituted a complex set of interactions involving both the 'internal factors' of the criminal justice system and the wider political and public spheres. And interwoven throughout this process are the underlying core values which have defined Canadians for decades. Decarceration – as a political solution – was largely successful because it reflected the beliefs and normative principles of Albertans.

For jurisdictions looking to reduce imprisonment but whose cultural values may not be receptive, Alberta's experience would suggest that economic imperatives – even with the corresponding political will – may not be enough. Prior examples of successful decarceration seem to provide some support for this pessimistic view. For example, the substantial reduction in the prison populations of both Finland (1960–2000) and the Netherlands (1945–1973) would appear to coincide with changes in cultural attitudes whereby high imprisonment was seen as disgraceful (Finland) or inhumane (Netherlands). On the surface, the case of California (1968–1972) is more promising, given that its catalyst was predominantly political in nature (i.e. desire for a balanced budget). However, it cannot be forgotten that the cultural values of this era – particularly within criminal justice circles – favoured restraint in the use of imprisonment. It also may not be coincidental that the dramatic reversal of California's incarceration rates after 1977 coincides with an increasing hardening of societal attitudes and beliefs vis-à-vis crime/criminals across the USA. While we are not suggesting a model of cultural determinism, these examples of substantial reductions in imprisonment would appear to corroborate the importance of core beliefs and attitudes (particularly those generating deep scepticism towards the value and effects of incarceration) in any decarceration experience.

This is not to say that economic imperatives cannot create the political will to decarcerate. Particularly in hard economic times, policy makers have been able to effect modest changes to their sentencing and correctional policies in some American states (Tonry, 2011). However, Tonry (2011: 638) reminds us that these reductions 'have mostly nibbled at the edges and are inherently unstable'. We would suggest that part of the problem is rooted in their lack of cultural correspondence.

Without the underlying belief that high imprisonment rates are morally wrong, any decarceration attempt will likely produce only modest and transient reductions. While changing cultural values is certainly a tall order, the deep-seated belief in the culture of restraint in the use of imprisonment by Albertans provided the framework within which Alberta achieved substantial and sustained decarceration.

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Notes

1. Formally known as the Progressive Conservative Party, but referred to, hereafter, as simply 'Conservative'.
2. The characterization of political parties as 'conservative' does not coincide perfectly with party names (federally or provincially), as often the conservatives were to be found in various 'right of centre' parties. We classified all 'right of centre' parties (right of the Liberal Party) as 'conservative'.
3. Some who knew Klein were not convinced that – on social policies – he would be very far to the right, given his apparent support of the Liberals in the early 1980s when he was a mayor.
4. The proposal was subsequently rejected after debate by Klein's party's caucus. The justice minister indicated that 'many Albertans were worried the program would have focused too much on punishment and not enough on rehabilitation' (Tibbetts, 1995: A-11). There were also concerns that since Alberta's prisoners were disproportionately Aboriginal, the Aboriginal makeup of chain gangs 'would attract major, and controversial coverage on North American television' (Martin 2002:141).
5. The reduction in sentenced admissions elsewhere – most clearly Ontario – is likely due to an increase in the remand population (Webster et al., 2009). As offenders get 'credit' for this time, the number sentenced to 'time served' increases, (artificially) decreasing sentenced admissions.
6. What constitutes a 'story' is problematic. We counted each 'letter to the editor' as well as 'boxes' or 'sidebars' as separate stories.
7. While we did not interview Klein, those who knew him suggested that he would have been unaware of the effects of his policies on Alberta's imprisonment rates.

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This is **Exhibit "U"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

Subjects
Aboriginal Corrections
Chaplaincy
Citizen Advisory Committees
Community Corrections
Ethnocultural
Families of Offenders
Health Services
Media
Research
Restorative Justice
Victims of Crime
Volunteers
Working at CSC
Careers in Corrections
Resources
Our Organization
Acts and Regulations
Facilities and Institutions
Forms
CSC in the World
Programs
Publications
Speakers Bureau
Educational Resources
Access to Information and Privacy
Reporting to Canadians
Completed Access to Information Requests
Proactive Disclosure

Public Health Strategy for Offenders

Health Services Vision: *Improved offender health that contributes to the safety of Canadians.*

Objective of CSC's Public Health Program: *To provide public health services to federal offenders in order to prevent and control disease and promote good health within federal institutions.*

TABLE OF CONTENTS

THE PURPOSE OF A PUBLIC HEALTH STRATEGY FOR CORRECTIONS

The penitentiary environment inherently presents the potential for the transmission of diseases, given the high number of persons in close confinement and the daily movement of staff, visitors and others from the community in and out of the penitentiary.

The potential for transmission of air-borne, sexually transmitted and blood-borne pathogens is heightened by the generally poorer levels of health among inmates, many of whom also have a history of high-risk behaviours such as injection drug use, sex work, and unprotected sex with high-risk partners, and by the compromised health of those with chronic diseases. For example, in the area of infectious disease, at year-end 2008, 219 inmates or 1.69% of the total inmate population were known to be living with HIV and 3,903 or 30.2% of the total inmate population were known to be Hepatitis C Virus positive.

Over the course of the past 15 years the Correctional Service of Canada (CSC) has progressively implemented public health services in its institutions. Some of these services, such as tuberculosis (TB) prevention and control and immunizations against hepatitis A and

B, were established and strengthened as resources were made available to CSC, while other services such as special treatments were introduced in response to the emergence of new public health challenges such as HIV and Hepatitis C. In short, public health services in CSC have grown incrementally as a result of various opportunities and influences. A strategic approach to identifying, aggregating and planning for the public health needs of the inmate population is now timely, given the establishment of a dedicated public health branch in CSC (2007) and the considerable growth in capacity and expertise within CSC that has developed across the past decade. A strategy will provide CSC with a framework to guide the development of public health activities, including the collaboration that will be required with internal partners and external stakeholders. In addition, it will provide a stronger focus for public health activities, along with expressed goals for improving offender health in order to contribute to the safety of Canadians.

This Public Health Strategy for CSC will be implemented across five years, beginning in fiscal year 2010-2011. It will strengthen and build upon current public health activities. As well, it identifies areas for enhancement and expansion of the scope of public health activities if additional resources become available. While the Strategy speaks to high-level goals for seven strategic areas, an action framework has been developed to detail activities within those strategic areas, track progress, report results, and ensure ongoing alignment and congruence with corporate plans and priorities. Annex A outlines how the Strategy links to CSC's strategic priorities.

LEGISLATIVE CONTEXT

Section 86(1) of the *Corrections and Conditional Release Act (CCRA*) requires that every inmate be provided with essential health care as well as reasonable access to non-essential mental health care that will contribute to successful rehabilitation and reintegration into the community. Section 86 (2) states that the provision of health care under subsection (1) shall conform to professionally accepted standards. In addition, section 70 requires that CSC take all reasonable steps to ensure that the penitentiary environment and the living and working conditions of inmates are safe and healthy.

Section 4 (h) of the *CCRA* sets out the principle that corrections policies, programs and practices [shall] respect gender, ethnic, cultural and linguistic differences and be responsive to the special needs of women*and Aboriginal peoples, and the needs of other groups of offenders with special requirements. Accordingly, public health activities must be tailored to achieve the most appropriate, meaningful and most likely to succeed approaches for those groups.*

This is the legal framework within which CSC provides public health services to offenders.

OBJECTIVE OF PUBLIC HEALTH PROGRAM

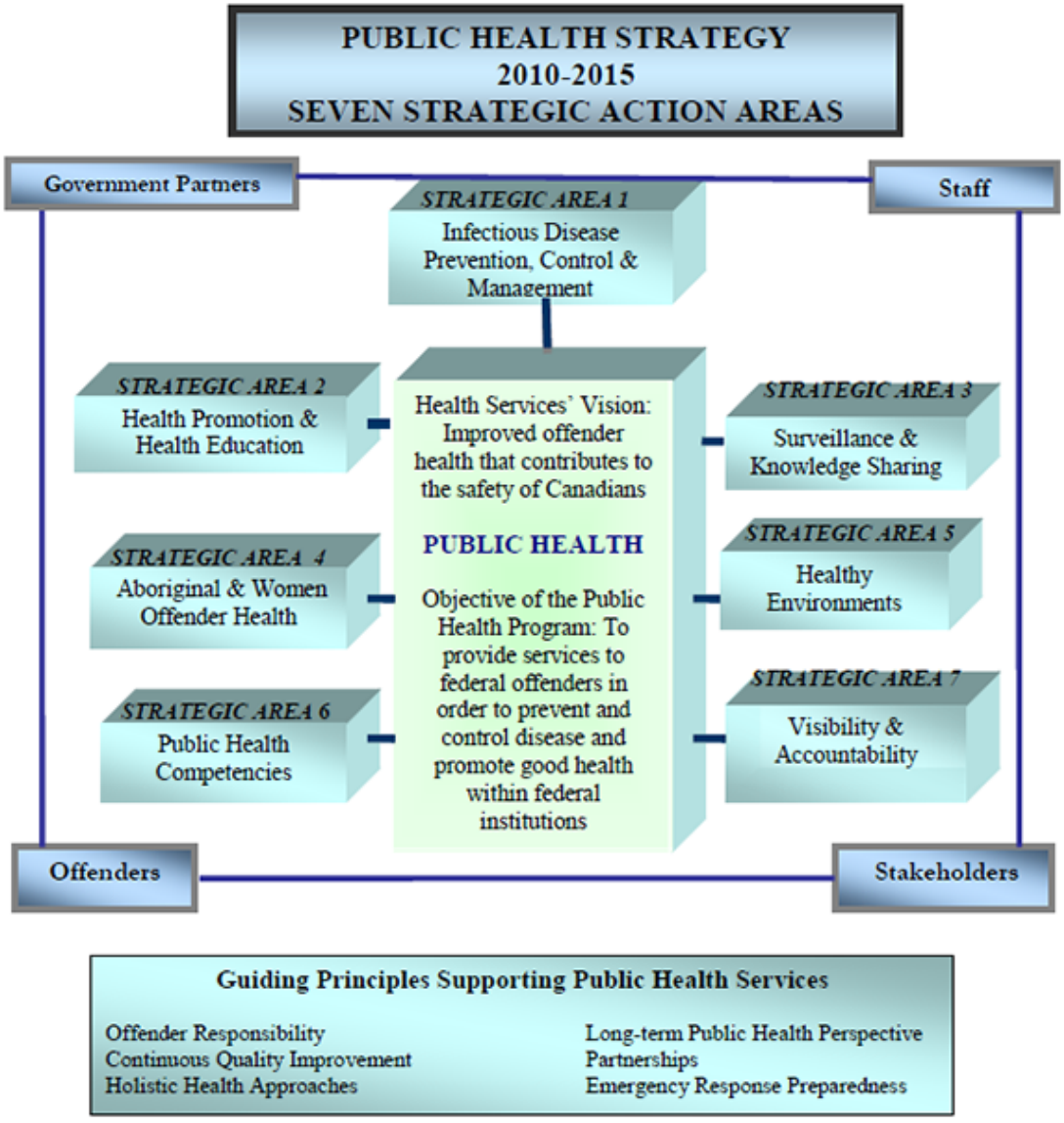
The objective of CSC's Public Health Program is to provide public health services to federal offenders in order to prevent and control disease and promote good health within federal institutions.

GUIDING PRINCIPLES

The way forward in implementing the Strategy is illuminated by a set of Guiding Principles for the delivery of public health services in CSC.

- ***Offender responsibility****:* Offenders must be involved both in taking responsibility for behaviours that affect their health and in being proactive in order to safeguard their health.
- ***Long-term public health perspective***: The provision of public health services to offenders has the potential to lessen the burden of health care on society as a whole. By endeavouring to improve offender health during the period of incarceration, public health services in federal penitentiaries may contribute to the reduction of the downstream costs of health care for the community after offenders are released.
- ***Continuous Quality Improvement***: CSC is committed to ongoing improvement in the quality and delivery of health services to offenders. Public health services must meet or exceed national accreditation standards.

- ***Partnerships***: Public health activities will be strengthened through internal and external partnerships.
- ***Holistic health approaches***: Holistic approaches to meeting the public health needs of offenders will be developed and implemented over time, as resources permit.
- ***Emergency response preparedness***: Public Health staff will work collaboratively with all sectors to develop contingency plans and protocols for timely, effective and efficient responses to infectious disease outbreaks and other health challenges in CSC institutions.



THE PUBLIC HEALTH STRATEGY FRAMEWORK

Seven strategic areas along with corresponding goals provide the framework for the Strategy and its implementation through annual work plans.

Strategic Area #1: Infectious disease prevention, control and management

The goal is to ensure consistency and sustainability in infectious disease prevention, control and management, and to consider enhancements if more resources become available.

Management measures include community standard treatments for infectious diseases such as HIV, Hepatitis B/C, sexually transmitted infections, influenza A and Tuberculosis. CSC

currently offers a range of prevention, control and management measures including: screening and testing at reception; immunizations; counselling and education on infectious diseases and how to prevent their acquisition and/or transmission; discreet access to harm reduction devices and information (bleach, condoms, dental dams, instructions on cleaning syringes and tattooing materials); discharge planning to ensure continuity of care upon return to the community; and planning for outbreaks of disease such as Influenza A.

The national office will continue to ensure that the necessary infectious diseases screening and testing, care, treatment and support guidelines and protocols are in place to guide public health staff at the regional and institutional levels.

A key initiative within Strategic Area #1 is the ongoing implementation of the enhanced harm reduction strategy (2007) which is based on recommendations made by the Health Care Advisory Committee to CSC. The findings of the analysis of the National Inmate Infectious Diseases and Risk Behaviours Survey of 2007 also provide a reference for the reinforcement of public health activities.

With respect to discharge planning, more information sharing between Health Services staff and parole officers would expedite the transition from institutional to community health care upon the offender's release. This is particularly important for offenders with complex infectious disease treatment needs and other complicated physical health problems. Dialogue needs to take place at various levels of the organization in order to implement an appropriate process to share information that addresses issues regarding privacy and sharing of medical information with persons outside the circle of care.

The recent experience in dealing with H1N1 has underscored the need for CSC to remain "on top" of the evolving policy for pandemic influenza planning and response. Public health has been working in partnership with stakeholders within and outside CSC, has formed specialized working groups, and has developed tools, procedures and guidelines to enhance pandemic response.

The development of protocols to delineate the roles and responsibilities of branches and sectors within CSC and external partners such as PHAC in dealing with both enteric and respiratory issues is essential. Collaborative work with internal and external partners will be required to produce comprehensive protocol documents.

Strategic Area #2: Health promotion and health education

The goal is to ensure dissemination of health promotion materials to all offenders; and to broaden their content to include healthy lifestyle behaviours, risk factors for chronic diseases, and health needs specific to certain groups.

Public health program managers are leading on the development of material and information reflecting best practice in health promotion, and regional health promotion nurse positions have been established to oversee and facilitate institutional program delivery. The content of current health promotion materials is being expanded to include healthy lifestyle choices and prevention of chronic diseases such as Type 2 diabetes, heart disease and obesity. In addition, health promotion materials are being developed for specific groups or situations, e.g. offenders with mental health needs; private family visits that include children.

Offenders generally rely on health care staff to direct their health-related behaviours and maintain their health. A key element of this strategic direction is the encouragement of offenders to take responsibility for adopting healthy behaviours and to support their efforts through health education programs.

A mid- to long-term enhancement in this strategic area would be to develop broader and more holistic health education programs in such areas as chronic disease prevention and include a greater focus on wellness. Its implementation would require the participation of other sectors and significant additional resources.

Strategic Area #3: Surveillance and knowledge sharing

CSC currently has an effective infectious diseases web-based surveillance system which enables us to understand the prevalence of specific diseases in the offender population and leads to the identification of groups at risk as well as to emerging areas of risk such as local outbreaks.

The goal is to inform the development of evidence-based measures in the prevention, control and management of infectious diseases and other risks to offender health, through enhanced, co-ordinated surveillance efforts and knowledge sharing

In order to monitor public health issues within the overall offender population, the focus and scope of surveillance activities should be broad and data collection, analysis and evaluation inclusive of all offender groups including women, Aboriginal peoples, ageing offenders and offenders with chronic and other diseases. Information should also be gathered about co-morbidities within the offender population. An expanded surveillance system, which would require additional resources, would assist health professionals to understand the diverse health characteristics of the offender population and to target appropriate interventions.

The Policy Sector conducts research on an ongoing basis in the area of offender demographics. This work could be linked directly to public health activities in order to target relevant issues that need to be explored. In addition, knowledge sharing is imperative within CSC to ensure that the analytical work in epidemiology and research is disseminated throughout various levels of the organisation and to other governmental partners and stakeholders.

Strategic Area #4: Aboriginal and women offender health

The goal is to ensure sustained emphasis on addressing the public health issues affecting Aboriginal and women offenders.

Two separate strategies have been developed to address the needs of Aboriginal and women offenders, many of whom, having been disadvantaged according to the social determinants of health, are at increased risk of compromised health.

While there is a need for more complete information about the health profile of Aboriginal offenders, what is clearly known is that programming that includes traditional culture, spiritual practices and ceremonies appears to be effective. In response, the Public Health Branch has developed, in partnership with the Aboriginal Initiatives Directorate, an Aboriginal Health Strategy (2009-2012) to take into account the health needs of Aboriginal offenders and culturally-appropriate-specific approaches to meeting these needs. The Aboriginal Health Strategy is intended to address Aboriginal health from a holistic perspective, taking into consideration the physical, mental, emotional and spiritual aspects of the offender, and thereby incorporating a range of areas within Health Services (e.g. infectious diseases, mental health, and clinical issues).

Given the high prevalence of infectious diseases among federal women offenders, and recognizing the importance of women-centered programming, the Public Health Branch has developed the Infectious Disease Strategy for Women Offenders (2008-2013) to provide a framework for infectious disease prevention, care, treatment and support for women offenders. In the short term, the Public Health Branch is working with other CSC sectors to support and enhance the delivery of health information currently being offered in the context of women's programming.

In the longer term, the development of a more holistic approach to women's health needs will take significant time to research, formulate/develop and implement. This process will be guided by a multi-sector working group established within CSC.

Strategic Area #5: Healthy Environments

The goal is to ensure that public health activities contribute to and support healthy environments.

In the future, the Public Health Program could play an advisory role in areas related to infrastructure, water and air quality, cleanliness, physical activities and nutrition for inmates.

In terms of environmental health, this area falls under the purview of Technical Services and is not currently part of public health activities within CSC. However,in the related area of cleaning of facilities, the Public Health Program is working in partnership with Technical Services in the development of cleaning and disinfection guidelines for CSC's Health Centres.

Strategic Area #6: Public Health competencies

The goal is to ensure that staff has the requisite public health skills and knowledge.

The Public Health Agency of Canada has identified 36 core competencies (essential knowledge, skills and attitudes) necessary for the practice of public health which can be used as a baseline for CSC public health staff.

Health Services has highly skilled health professionals who work to deliver optimal public health results for offenders and the communities to which they return. Ongoing learning opportunities for existing and new staff are important to ensure that they have the right mix of competencies to deliver on the Strategy.

Strategic Area #7: Visibility and accountability

The three goals are (1) to secure collaboration from internal and external partners and stakeholders; (2) to broadly communicate the Strategy and the results of its implementation; and (3) to have in place updated performance measurement indicators and an evaluation framework

It is essential that all branches of Health Services - clinical, mental health, public health, and policy, planning and quality improvement -- work in collaboration. Reinforcing the close relationship with our colleagues in clinical services and mental health services will help weave health promotion and health education into their activities. Quality improvement and accreditation partners will assist in ensuring that the quality of public health services meets or exceeds national accreditation standards. This collaboration must take place at all levels of CSC: national, regional, and institutional.

Second, it is imperative that public health activities have strong horizontal linkages, where appropriate, to other sectors of CSC such as Policy, Security, Corporate Services, Human Resources, Correctional Operations and Programs, Aboriginal Initiatives and the Women's Sector. These linkages must be both strategic and practical, i.e. serve to improve the effectiveness of public health services in the institutions.

The Public Health Branch at National Headquarters has existing external partnerships with federal departments such as the Public Health Agency of Canada (PHAC), Health Canada (particularly the First Nations and Inuit Health Branch), and Public Safety Canada. A Memorandum of Agreement with PHAC for the provision of expert advice and technical support with respect to the prevention, control and management of infectious diseases has been in place since 2003. This MOU will be replaced in 2010 by an Interdepartmental Letter of Agreement that enables the expansion of collaborative activities of mutual interest, reflecting CSC's increasing public health competence and capacity.

In addition, the Public Health Branch liaises on a regular basis with the Federal/Provincial/Territorial Working Group on Health, the Health Care Advisory Committee, the Federal Health Care Partnership and numerous non-governmental organisations that have an interest in public health issues affecting offenders.

With the introduction and implementation of the Public Health Strategy, we will continue to rely on the support and advice of our external partners and to share best practices. There may also be opportunities to work together on horizontal government health issues and to participate in joint funding ventures that are of mutual benefit. Such partnerships will be encouraged at the regional and local levels with public health authorities and community-based service organizations, for example.

In addition, it will be important to determine the overall effectiveness of the Public Health Program through an evaluation. A Performance Measurement Strategy (PMS) will be developed and will include the following: (1) a program profile (2) expected results along

with a logic model and accountabilities and (3) monitoring and evaluation information that provides on-going performance measurement as well as an evaluation strategy.

Performance information will ensure that there is accountability for results and that senior management of CSC is aware of them. The evaluation of the Public Health Program is targeted for 2014.

CONCLUSION

It is intended that the Public Health Strategy for CSC will have a positive impact on the public health program. It is expected to contribute to more effective and efficient public health services and, in the long term, to the reduction of health costs for offenders, healthier communities, and better public safety. It is a collaborative approach to providing public health services to offenders from the date of admission to penitentiary through to their release to the community that will draw upon the expertise of a national network of internal and external partners and stakeholders.

ANNEX A Link to CSC's Strategic Priorities

The Public Health Strategy has linkages to the five CSC strategic priorities in the following manner:

(1) Safe Transition of Eligible Offenders into the Community: The core public health activities that are maintained in the Strategy attempt to maximize offenders' health which in turn contributes to their successful reintegration and the health of communities. The focus on health promotion/education activities assists offenders in becoming more aware of the factors that affect their health and encourages them to adopt healthy lifestyles. In addition, the new focus on individual responsibility for health will empower offenders to be proactive to safeguard their health for the benefit of themselves and their families.

(2) Safety and Security for Staff and Offenders in our Institutions: The Public Health Strategy reinforces the requirement for screening, prevention control (including vaccinations) and treatment of infectious diseases which will have the ultimate outcome of reducing the transmission of these diseases amongst the offender population. The development of department-wide protocols assists in stabilizing the institutional environments in cases of outbreak of communicable and non-communicable diseases.

(3) Enhanced Capacities to Provide Effective Interventions for First Nations, Métis and Inuit Offenders: The Public Health Strategy recognises the necessity to work on issues affecting Aboriginal offenders, and an Aboriginal Health Framework has been developed in consultation with the Aboriginal Initiative Directorate.

(4) Improved Capacities to Address Mental Health of Offenders: There is an indirect link to this strategic objective in the Public Health Strategy as health promotion material will be adapted to offenders with mental health disorders. The Public Health Branch will work closely with the community and institutional mental health specialists to ensure that this information meets these offenders' needs and is accessible to them.

(5) Strengthening Management Practices: The Public Health Strategy will improve internal communications with respect to public health activities through the strengthening of internal linkages among CSC staff. It will also strengthen human resource management by identifying the appropriate mix of competencies and assisting staff in re-orienting their tasks to deliver on public health outcomes. As well, the collection of performance information supports accountability and reporting on the delivery of outcomes. The Public Health Branch will develop and implement a performance measurement framework and an evaluation approach based on the Strategy.

This is **Exhibit "V"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

CORRECTIONAL SERVICE CANADA

CHANGING LIVES. PROTECTING CANADIANS.

EVALUATION REPORT

CSC's Health Services

MARCH 2017

FILE #394-2-96

Correctional Service Canada | Service correctionnel Canada

Canada

SIGNATURES

EVALUATION OF CSC'S HEALTH SERVICES

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Commissioner

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Date

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Brigitte de Blois
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The evaluation team would like to express its appreciation to all those who participated in the collection of data at various CSC institutions and contributed valuable information, including Regional Directors, Wardens, District Directors, institutional and community staff members, and staff at NHQ. The evaluation team would like to extend their gratitude to all offenders who contributed to the evaluation by participating in interviews and sharing their overall experiences regarding health services throughout the continuum of care.

We would also like to thank the many branches and sectors of CSC who helped provide data for this evaluation, including the staff in Financial Management Services in the Comptroller's Branch who provided financial data and staff from Strategies, Planning, Measurement and Reporting who provided human resource data.

Finally, the evaluation team would like to thank everyone else who contributed to this evaluation, whose names do not appear here.

EXECUTIVE SUMMARY

According to section 86(1) of the *Corrections and Conditional Release Act* (CCRA), CSC is mandated to provide essential health care, and reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community. [i]

Compared to the Canadian population, offenders demonstrate a higher prevalence of mental and physical health concerns. As well, CSC's offender population is aging. In 2014-15, 24% of federal offenders were 50 years or older and the number of offenders over the age of 50 at admission has risen over the last ten years. [ii] In 2014-2015, Health Services accounted for approximately 11% of CSC's total direct program spending. CSC's Health Services represent an important opportunity to address offenders' diverse health care needs throughout the continuum of care, which includes: intake, incarceration, and pre-release and community supervision.

The evaluation focuses on the relevance and performance of CSC's mental, clinical, and public health services. Evaluation questions examine the following areas: relevancy of CSC's health services, effectiveness and efficiency of the intake assessment process, offender access to care and services throughout incarceration, public health education and harm reduction, institutional mental health services, pre-release and community health services and the management and coordination of health services. Given the breadth and complexity of health services within CSC, the evaluation is organized into seven findings in focus for evaluation (FIFEs).

Evaluation Results:

Overall, the evaluation found that CSC's Health Services are relevant and meet the needs of federal offenders. Positive impacts were found regarding institutional mental health care where offenders' had a reduced likelihood of incidents, serious charges and involuntary segregation following treatment. Several key areas were identified for service improvements and recommendations were made to support decision makers with improving the efficiency and effectiveness of CSC's Health Services. Program managers responded to these recommendations. The major recommendations and their associated management responses are outlined below.

- ***Maintain productive relationships with partners who support individuals with mental health disorders.*** CSC is responsible for providing health services to federal offenders; there is an ongoing need for partnerships to effectively and efficiently deliver these services to offenders.
    - **In response:** CSC will strengthen partnerships to support the delivery of mental health services for federal offenders and will share information and practices related to mental health through the Federal Provincial Territorial Working Group on Health/Mental Health.
- ***Ensure offenders are referred to the appropriate mental health services.*** CSC has developed a *Mental Health Need Scale* to assess offenders' mental health need and determine the appropriate level of care required in accordance with its new refined model of mental health care (primary, intermediate, psychiatric hospital). The validity and reliability of this scale are yet to be assessed.
    - **In response:** CSC will assess the validity and reliability of the *Mental Health Needs Scale* and will strengthen the process for recording and maintaining offender level of need data.
- ***Adopt measures to support a continuum of health care for offenders during their transition from CSC Health Services to provincial/territorial health coverage. Specifically, obtaining health cards and payment for community health services.*** Procedures in obtaining provincial/territorial health cards vary across regions and depend on provincial/territorial health authority requirements. CSC may cover the cost of some medical expenses in the community if offenders are not covered by provincial/territorial health insurance or other provincial/territorial plans (e.g., disability benefits, drug plans).
    - **In response:** CSC will develop guidelines to obtain, track and store ID at intake; work with Canadian provinces and territories to determine how offenders can better access health care services and disability benefits following their release; and, clarify national guidelines regarding CSC payment for health services in the community.
- ***Increase the efficiency of health-related intake assessments processes.*** Health services intake assessment tools and processes are effective in identifying offender health needs; however, duplication of offender health information collected through intake assessment processes results in inefficiencies in assessing offenders' health care needs.
    - **In response:** CSC will eliminate the requirement for repeated administration of health assessments and unnecessary repetition of health information between assessment tools.

CSC will also ensure health referrals are appropriately recorded and monitored electronically.

- ***Ensure offenders have timely access to health education programs and harm reduction products.*** Health education programs, particularly those aimed at infectious disease, are associated with increased offender health-related knowledge and related behavioural changes (e.g., reduced risk-taking behaviours). Results of a review indicated that bleach was not always available as required in all CSC institutions and no recent data were available to confirm the accessibility of other harm reduction products (e.g., condoms).
    - **In response:** CSC will provide clear direction and accountability for delivery and tracking of health education programs; monitor the distribution of harm reduction products; and, address any identified accessibility issues.
- ***Continue to implement and report on the Chronic Disease Management Strategy.*** CSC has implemented policies, guidelines and strategies to address the special health care needs of women and Indigenous offenders. Additional support related to the chronic disease needs of older offenders is required.
    - **In response:** CSC will continue to implement the Chronic Disease Management Strategy and will report on progress against expected results to track and identify gaps in service.

This evaluation will assist CSC in improving the delivery of health services for all offenders across the continuum of care.

LIST OF FINDINGS

FINDING 1: NEED FOR HEALTH SERVICES
There is a continued need for delivery of clinical, public and mental health services to CSC offenders.
FINDING 2: ALIGNMENT WITH PRIORITIES AND FEDERAL ROLES AND RESPONSIBILITIES
CSC Health Services are aligned with federal government priorities. CSC is responsible for providing health services to federal offenders, but there is an ongoing need for partnerships to effectively and efficiently deliver services to offenders.
FINDING 3: EFFECTIVENESS OF HEALTH SERVICES INTAKE ASSESSMENT
The overall health services intake assessment tools and processes are effective in identifying offender health needs.
FINDING 4: EFFICIENCY OF HEATH SERVICES INTAKE ASSESSMENT PROCESS
Duplication of offender health information collected through CSC health services intake processes and tools results in inefficiencies in assessing offenders' health care needs.
FINDING 5: ACCESS TO CLINICAL, PUBLIC, AND MENTAL HEALTH CARE
CSC offenders have access to clinical, public, and mental health care to address their needs. The majority of offenders receive initial mental health services according to established time-frames; clinical health services are not tracked electronically. Health Services is in the process of implementing an Electronic Medical Record.
FINDING 6: ACCESS TO COMMUNITY HEALTH CARE SPECIALISTS
The provision of community health care specialist services for offenders for non-urgent care is subject to wait times in the community. CSC uses telemedicine (where provincial telemedicine programs are available) to address procedural issues associated with health care specialist appointments in the community. CSC does not systematically collect data regarding referrals to specialist services (in-person or telemedicine).
FINDING 7: TRANSFERS
Health services staff and offenders reported challenges to continuity of care and information sharing or documentation during transfers were identified. Inaccurate information sharing may be a result of incomplete documentation in the Health Services Transfer Summary forms.
FINDING 8: INFORMATION SHARING
Some CSC personnel reported a lack of understanding of the guidelines for sharing of personal health information, and the sharing of health information could be improved. There are opportunities to implement electronic medical records to enhance information sharing.
FINDING 9: HEALTH EDUCATION DELIVERY
CSC's health education programs and initiatives target many of the significant health needs of the offender population, but offender access to and voluntary participation in some programs is limited.

FINDING 10: IMPACT OF HEALTH EDUCATION AND HARM REDUCTION INITIATIVES
Health education programs, particularly those aimed at infectious disease, are associated with increased offender health-related knowledge and related behavioural changes (e.g., reduced risk-taking behaviours). Results of a review indicated that bleach was not always available as required in all CSC institutions, but no recent data were available to confirm the accessibility of other harm reduction products, such as condoms, dental dams, and lubricants.
FINDING 11: INSTITUTIONAL MENTAL HEALTH CARE OUTCOMESS
Institutional mental health care provided in CSC mainstream institutions and RTCs was associated with positive impacts on offenders' behavioural stability following treatment, such as reduced likelihood of incidents, serious charges, and involuntary segregation.
FINDING 12: LEVEL OF CARE BASED ON NEED
The Health Services Sector developed a *Mental Health Need Scale* to assess the level of mental health need and determine the appropriate level of care required in accordance with the new refined model of mental health care (primary, intermediate, psychiatric hospital). The validity and reliability of this scale have not been assessed, and electronic data on offender scale results have not been consistently recorded.
FINDING 13: REGIONAL COMPLEX MENTAL HEALTH COMMITTEES
Regional Complex Mental Health Committees have been established to assist and support institutions in providing an effective continuum of care to offenders with complex mental health needs. The degree to which funds were expended relative to those allocated at the regional level could not be accurately determined because funding was not fully tracked in the financial system.
FINDING 14: ROUTINE DISCHARGE PLANNING AND OFFENDER IDENTIFICATION
Processes to assist offenders in obtaining provincial health cards vary across regions and are dependent on provincial/territorial health authority requirements. Procedural challenges associated with assisting offenders to obtain provincial/territorial health cards exist (e.g., prerequisite for a birth certificate, fee requirements, releases to different provinces).
FINDING 15: PAYMENT FOR COMMUNITY HEALTH SERVICES
According to CSC policy, CSC may cover the cost of some medical expenses in the community if offenders are not covered by provincial/territorial health insurance or other provincial/territorial plans (e.g., disability benefits, drug plans) and have no personal means to pay. Medical expenses covered by CSC in the community vary across regions, which may be related in part to variations in provincial health coverage.

FINDING 16: COMMUNITY MENTAL HEALTH SERVICES AND CLINICAL DISCHARGE PLANNING
Community mental health specialists services provided to offenders were associated with lower rates of recidivism; whereas, clinical discharge planning services alone did not appear to have an impact. The number of offenders receiving clinical discharge planning services could not be determined due to inconsistencies in data recording; providing continuity of care is challenging when offenders who receive discharge planning services are released to locations with limited CSC community mental health staff.
FINDING 17: COORDINATION OF CSC'S HEALTH SERVICES
Following changes to the health services governance structure, there has been greater standardization and integration of health services.
FINDING 18: INFECTIOUS DISEASE TREATMENT: HEPATITIS C VIRUS
CSC expenditures for Hepatitis C Virus (HCV) medication more than tripled from 2013-2014 to 2015-2016 due to a new Canadian approved standard of care. New treatment is more costly, but has resulted in an increased cure rate for individuals with the disease, also reducing the risk of spread of HCV to others.
FINDING 19: HEALTH SERVICES FOR SPECIFIC POPULATIONS
CSC has implemented policies, guidelines and strategies to address the special health care needs of women and Indigenous offenders. Additional support related to the chronic disease needs of older offenders is required.

LIST OF RECOMMENDATIONS

RECOMMENDATION 1: MENTAL HEALTH DIVERSION

That CSC maintains productive relationships with partners who support individuals with mental health disorders.

RECOMMENDATION 2: EFFECIENCY OF HEALTH SERVICES INTAKE ASSESSMENT TOOLS AND PROCESSES

That CSC Health Services endeavour to increase the efficiency of health-related intake assessment processes by considering the following:

- Eliminating the requirement for repeated administration of health assessments;
- Optimizing and eliminating unnecessary repetition of health information between assessment tools; and,
- Ensuring health referrals are appropriately recorded and monitored.

RECOMMENDATION 3: ACCESS TO COMMUNITY HEALTH CARE SPECIALISTS

That CSC Health Services collect data on wait times to access selected specialists services for non-urgent care; and implement strategies (for example increased use of telemedicine where appropriate) if wait times exceed available Canadian benchmarks.

RECOMMENDATION 4: INFORMATION SHARING

That CSC Health Services improve the understanding of information sharing requirements and limitations, as elaborated in their guidelines, in accordance with privacy laws and other relevant legislation. That CSC Health Services improve timely access to relevant and accurate medical records for Health Care staff. These will be accomplished by:

- Finalizing the implementation of electronic medical records to improve accessibility and consistency of health information;
- Enhancing awareness of information sharing procedures and "need-to-know" principle among CSC personnel, including concrete examples of where and how the principle should be applied; and
- Conducting a review of information sharing issues identified in board of investigation incidents to contribute to existing lessons learned and to inform procedural/policy changes if necessary.

RECOMMENDATION 5: HEALTH EDUCATION AND HARM REDUCTION

That CSC Health Services ensure that offenders have timely access to health education programs and harm reduction products by:

- Providing clear direction and accountability for delivery and tracking of health education programs; and
- Monitoring the distribution of harm reduction products (bleach, condoms, dental dams, and lubricants) and addressing any identified accessibility issues.

RECOMMENDATION 6: LEVEL OF CARE BASED ON NEED

That CSC Health Services ensure offenders are referred to the appropriate mental health services by:

- Implementing effective management practices to ensure that current information on offender level of need is recorded electronically and that previous records are retained;

and

- Assessing the validity and reliability of the Mental Health Need Scale.

RECOMMENDATION 7: REGIONAL COMPLEX MENTAL HEALTH COMMITTEES

That CSC Health Services:

- Track nationally and report on activities and expenditures of funds released to regions through RCMHCs; and
- Provide information to institutional staff regarding the role of RCMHCs and identified best practices.

RECOMMENDATION 8: RELEASE PLANNING AND OFFENDER INDENTIFICATION

That CSC adopt measures to address challenges related to offenders accessing health care in the community by retaining or obtaining offender ID (including health cards); and to clarify the policy, guidelines and procedures pertaining to coordinating access to medication while transitioning to the community.

- Develop guidelines to support the retention of offenders' ID including health cards;
- Establish mechanisms to obtain key ID at intake; and,
- Clarify existing release policy related to the requirements for medication at release and provide consistent communications to staff.

RECOMMENDATION 9: ACCESS TO AND PAYMENT FOR COMMUNITY HEALTH SERVICES

That CSC improve access to community health services to ensure a continuum of health care for offenders during the transition to provincial/territorial health coverage, by:

- Improving partnerships with provincial and territorial health authorities to determine how offenders can better access health care services and disability benefits; and,
- Clarifying and communicating policies and procedures related to CSC's coverage (i.e., payment) for health services in the community and requirements for medication at release.

RECOMMENDATION 10: CLINICAL DISCHARGE PLANNING AND COMMUNITY MENTAL HEALTH SERVICES

That CSC:

- Review the model of community mental health service delivery to ensure that community mental health services are being provided to offenders with the greatest mental health needs.
- Ensure that clinical discharge planning activities are tracked in electronic information systems.

RECOMMENDATION 11: SPECIFIC POPULATIONS OF OFFENDERS

That CSC Health Services continue to implement the Chronic Disease Management Strategy, with reference to any special needs/requirements for older, women, and Indigenous offenders, and methods for tracking impacts.

MANAGEMENT ACTION PLAN OVERVIEW

In response to the recommendations identified throughout the evaluation, CSC has developed Management Action Plans to strengthen the provision of health services across the continuum of care. The Management Action Plans are summarized below, for a copy of a full plan, contact CSC's Evaluation Division.

MANAGEMENT ACTION PLAN FOR RECOMMENDATION 1:

- Strengthen partnerships and collaborative efforts in support of the delivery of mental health services to federal offenders by guiding the implementation of CSC's *Integrated Engagement Strategy*.
- Share information and practices relating to mental health through the Federal Provincial Territorial Working Group on Health/Mental Health and for consideration of the Heads of Corrections.

MANAGEMENT ACTION PLAN FOR RECOMMENDATION 2:

- Modify health services processes for health care requirements for 24-hour and 14-day assessments.
- Streamline health services intake assessment tools to reduce unnecessary repetition of physical health information.
- Review of mental health assessment tools to determine if they can be revised/streamlined to eliminate unnecessary duplication of information while maintaining effective identification of offenders with mental health needs.
- Implement a new electronic health information system to record information electronically on assessments and referrals.

MANAGEMENT ACTION PLAN FOR RECOMMENDATION 3:

- Implement a national approach to tracking offender referrals and services for selected community specialist services.

MANAGEMENT ACTION PLAN FOR RECOMMENDATION 4:

- Implement an Electronic Health Information System.
- Improve clarity and understanding of information sharing requirements and understanding of "need-to-know" principle (among all Health Services staff, and between Health Services and operations staff).
- Identify common issues and lessons learned, and best practices across Boards of Investigations, related to health related information sharing issues.

MANAGEMENT ACTION PLAN FOR RECOMMENDATION 5:

- The Regional Directors Health Services and the Director General Clinical Services and Public Health are responsible for ensuring that offenders have timely access to health education programs and harm reduction products.
- Streamline and integrate delivery of health education and awareness programs to facilitate delivery and tracking.
- Monitoring harm reduction product distribution.

MANAGEMENT ACTION PLAN FOR RECOMMENDATION 6:
• Conduct analysis to verify the validity and reliability of the Mental Health Needs Scale. • Strengthen the process for recording and maintaining offender level of need data.
MANAGEMENT ACTION PLAN FOR RECOMMENDATION 7:
• Implement a national approach to track and monitor outcomes associated with RCMHC activities in each region. • Ensure accurate recording of expenditures related to RCMHCs in CSC's financial system.
MANAGEMENT ACTION PLAN FOR RECOMMENDATION 8:
• Ensure the retention of offenders' ID (e.g., birth certificate, health card) at intake through the development of storage and tracking procedures. • Develop guidelines and procedures to ensure that offenders obtain ID at intake (e.g., birth certificate, health card). • Clarify existing release policy related to the requirements for medication at release and communicate the policy updates to staff.
MANAGEMENT ACTION PLAN FOR RECOMMENDATION 9:
• Improving partnerships with provincial and territorial health authorities to remove barriers to accessing health care and disability benefits. • Clarifying and communicating policies and procedures related to CSC's coverage (i.e., payment) for health services in the community and requirements for medication at release.
MANAGEMENT ACTION PLAN FOR RECOMMENDATION 10:
• Review CSC's model for community mental health services. • Ensure that clinical discharge planning activities are tracked in electronic information systems.
MANAGEMENT ACTION PLAN FOR RECOMMENDATION 11:
• Continue to implement CSC's Chronic Disease Management Strategy.

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LIST OF ACRONYMS

ADHD	Attention Deficit Hyperactivity Disorder
APEC	Aboriginal Peer Education Course
BBSTI	Blood Borne and Sexually Transmitted Infection
BOI	Boards of Investigation
CCC	Community Correctional Centre
CCRA	Corrections and Conditional Release Act
CD	Commissioner's Directive
CDP	Clinical Discharge Planning
CHIPs	Choosing Health in Prisons
CMH	Community Mental Health
CMHI	Community Mental Health Initiative
CMHS	Community Mental Health Services
CMT	Case Management Team
CoMHISS	Computerized Mental Health Screening System
CORR	Compliance and Operational Risk Report
CPO	Community Parole Officer
CRF	Community Residential Facility
CSC	Correctional Service of Canada
DBT	Dialectical Behaviour Therapy
ETA	Escorted Temporary Absence
FASD	Fetal Alcohol Spectrum Disorder
FIFE	Finding in Focus for Evaluation
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HCV	Hepatitis C Virus
HSPMR	Health Services Performance Measurement Report
IFMMS	Integrated Financial and Materiel Management System
IIS	Intensive Intervention Strategy
IMHT	Institutional Mental Health Team
IPO	Institutional Parole Officer
ISAPW	Inmate Suicide Awareness and Prevention Workshop
LTBI	Latent Tuberculosis Infection
MAP	Management Action Plan
MHNS	Mental Health Needs Scale
MHTS	Mental Health Tracking System
MMTP	Methadone Maintenance Treatment Program
MRSA	Methicillin-resistant Staphylococcus Aureus
NCMHC	National Complex Mental Health Committee
NHQ	National Headquarters
OHIS-EMR	Offender Health Information System-Electronic Medical Record
OMS	Offender Management System
OST	Opiate Substitution Therapy
OTN	Ontario Telemedicine Network
PEC	Peer Education Course
PSR	Psychosocial Rehabilitation
RAP	Reception Awareness Program

RCMHC	Regional Complex Mental Health Committee
RDHS	Regional Director of Health Services
RHQ	Regional Headquarters
RTC	Regional Treatment Centre
SIB	Self-Injurious Behaviour
SLE	Structured Living Environment
SMT	Suboxone Maintenance Treatment
STI	Sexually-Transmitted Infection
TB	Tuberculosis
TBS	Treasury Board of Canada Secretariat
TOR	Terms of Reference
WebIDSS	Web-Enabled Infectious Disease Surveillance System
WED	Warrant Expiry Date

1.0 INTRODUCTION

In accordance with the *Five-Year Departmental Evaluation Plan*, the Correctional Service of Canada (CSC) conducted an evaluation of health services. As per the Treasury Board Secretariat's (TBS) *Policy on Evaluation (2009)* and the *Policy on Results (2016)*, the evaluation focused on two core objectives: 1) the continued relevance of health services, including the need for health services offered as part of the continuum of care, and their alignment with departmental and government priorities, as well as federal roles and responsibilities; and 2) CSC's performance in delivering health services, as demonstrated through implementation, effectiveness, efficiency and economy.

CSC delivers health services throughout the continuum of care including intake, incarceration and pre-release and community supervision and focuses on the areas of: mental health, public health and clinical services. By delivering efficient and effective health services, CSC encourages offenders to take responsibility for their own health, promotes healthy reintegration, and ultimately contributes to safe communities.[iii] These objectives are aligned with four of CSC's corporate priorities:[iv]

- Safe management of eligible offenders during their transition from the institution to the community, and while on supervision;
- Effective, culturally appropriate interventions for First Nations, Métis and Inuit offenders;
- Effective and timely interventions in addressing mental health needs of offenders; and,
- Efficient and effective management practices that reflect values-based leadership in a changing environment.

The results and recommendations included in this evaluation report will guide CSC's senior management with future strategic policy and decision-making regarding CSC's health services.

1.1 BACKGROUND

Federal offenders experience many of the same health issues as the general Canadian population. However, compared to the Canadian population, offenders demonstrate a higher prevalence of mental health concerns (e.g., antisocial personality disorder, anxiety disorders, self-injurious behaviour) and physical health concerns (e.g., diabetes, cardiovascular conditions, HIV/AIDS, Hepatitis C).[v] Studies have indicated that individuals entering the correctional system already suffer from poor health due to risky lifestyle behaviours, such as intravenous drug use.[vi] Further, once they are incarcerated, an individual's health concerns may be aggravated.[vii] This may be attributed to a number of characteristics related to the institutional setting, such as shared accommodations, which may expose offenders to new physical health risks, and present opportunities for engaging in high-risk activities that may result in transmission of infectious disease.[viii] Moreover, CSC's offender population is aging. In 2014-15, 24% of federal offenders were 50 years or older compared to 45% of the Canadian population and the number of offenders over the age of 50 at admission has risen over the last ten years.[ix] With this general increase in the number of older offenders, CSC is likely to experience increased demand to address health needs attributed to aging, such as chronic conditions, cardiovascular conditions, and diabetes.[x]

Offenders require access to health services to meet their diverse health care needs throughout their continuum of care. Studies have shown that health services in institutions have positive impacts on offenders' health. One study demonstrated that prison health education had significant long-term effects on offenders' knowledge of the transmission of infectious diseases.[xi] Given that the majority of offenders will be released, their prevalent health concerns could have an impact on the communities in which they are released.[xii] As such, CSC's health services represent an important opportunity to address offenders' health needs.

1.2 POLICY AND LEGISLATION

The delivery of health services for Canadians is a shared responsibility between the federal, provincial and territorial governments. CSC is mandated through federal legislation and corporate requirements to provide health services for federal offenders. Section 86(1) of the *Corrections and Conditional Release Act* (CCRA) states that CSC is obligated to provide every inmate with "essential

health care; and reasonable access to non-essential mental health care that will contribute to the offender's rehabilitation and successful reintegration into the community."[xiii]

In addition to the CCRA, CSC is guided by a series of internal Commissioner's Directives (CDs) that support legislative obligations. CDs specific to health services include the following:[1]

CD 800 – Health Services: focuses on procedures related to health services delivery, including assessments occurring at intake, responsibilities during medical emergency situations, involuntary admission and treatment at Regional Treatment Centres and childbirth arrangements for pregnant offenders.

CD 843 – Management of Inmate Self-Injurious and Suicidal Behaviour: outlines procedures for assigning suicide watch observational levels, including screening for the risk of suicide, descriptions of high and modified suicide watch and mental health monitoring. Also included are procedures for the use of restraint equipment including reporting requirements, application to pregnant offenders and assessment and monitoring.

CD 578 – Intensive Intervention Strategy in Women's Institutions: provides procedures for Structured Living Environments (SLEs) including admission requirements, assessments, use of the therapeutic quiet room, discharge process and outreach support. The Secure Unit procedures are also presented, including rules and expectations, the role of interdisciplinary teams, treatment planning and movement.

1.3 PROGRAM DESCRIPTION

According to the *National Essential Health Services Framework*, health services are defined as physical and mental health services, which include health promotion, disease prevention, health maintenance, patient education, diagnosis and treatment of illnesses. In accordance with CSC's program structure, health services are delivered in three areas:[xiv]

1. Clinical Services: "assessment, diagnosis and treatment of acute and chronic physical illnesses."
2. Public Health: "services and resources on a variety of topics (mental health, wellness, infectious diseases, etc.) provided to inmates related to health promotion and education; disease prevention,

[1] A comprehensive list of CDs that involve a health related component can be found in Appendix A.

control and management of infectious diseases and discharge planning for community reintegration."

3. Mental Health: "assessment, intervention, treatment and support services and discharge planning provided to inmates with mental health needs in the areas of emotion, thinking and/or behaviour."

1.3.1 INTAKE ACTIVITIES

During the intake process, offenders undergo health needs assessments, screening and testing and intervention for immediate mental, clinical and public health care needs. Offenders are also provided with disease prevention initiatives along with health promotion and educational activities. Ongoing surveillance and analysis of offender health needs is initiated at intake and continues throughout incarceration.

1.3.2 INCARCERATION ACTIVITIES

As per CSC's mandate, essential health services are provided to offenders during incarceration. This includes ongoing screening and assessment as required, and various mental, clinical, and public health interventions. Disease prevention measures, health promotion and education, as well as surveillance and analysis of offender health needs, which were initiated at intake, continue throughout the incarceration period.

Mental Health Services: A range of institutional programs and services are available to address offenders' mental health needs. Primary mental health services consist of individual and group interventions (e.g., sleep hygiene, stress management, counselling), as well as crisis intervention as needed. Offenders who require intermediate mental health care may access high or moderate intensity levels of service, women offenders may also access the SLE. Offenders with acute needs that cannot be addressed within the institution may receive treatment at a RTC.

Clinical Services: Offenders are offered primary care (e.g., dental services, pharmacy services) and chronic disease management. Offenders also have access to community specialists if necessary. In addition, CSC offers infectious disease management including the opiate substitution therapy (OST) program which is made available to offenders with substance abuse problems.

Public Health Services: CSC provides a number of public health educational activities to address infectious diseases, such as the Peer Education Course (PEC), which aims to train offenders as peer counsellors and to provide information on infectious diseases. Offenders may also access harm reduction initiatives (e.g., needle exchange programs, bleach kits, condoms).

1.3.3 PRE-RELEASE AND COMMUNITY ACTIVITES

During pre-release, CSC provides routine discharge planning to prepare offenders for transitions in care, including release to the community.[2] Offenders with significant mental health needs may be referred for clinical discharge planning. This process aims to ensure that offenders receive continuity of care by establishing comprehensive plans and transitional services.

In the community, CSC offers essential physical health services for offenders residing in Community Correctional Centres (CCCs) where provincial coverage is unavailable. This may include appointments, dental care, eyewear, and/or equipment and medical devices. In some regions, CSC may provide additional coverage for medication. CSC provides limited community mental health services in select locations to provide support for offenders with significant mental health needs. These services are provided by mental health professionals, and may include monitoring and assessment, education, clinical accompaniment support, mobile services, and community capacity building.

[2] Transitions in care also include transfers between CSC institutions.

2.0 EVALUATION METHOD

2.1 SCOPE OF THE EVALUATION

The scope of the evaluation was determined through a number of activities aimed at identifying evaluation priorities, including:

- Pre-evaluation consultations with approximately 80 CSC key informants from National Headquarters (NHQ), Regional Headquarters (RHQ), institutions and the community. Consultations were conducted in person, by telephone or by videoconference.
- Site visits were conducted at Millhaven Institution and Joyceville Institution to gain a better understanding of the intake assessment process from health services staff members.
- Review of documentation including CSC priorities and risks as well as research, audit, evaluation, accreditation and other performance reports.
- Risk was assessed at the outset with mental health services representing the highest area of risk for the organization, primarily due to the direct link with corporate risk and priorities and the high sensitivity of this area.

The scope of the evaluation was further refined through ongoing consultations with the Office of Primary Interest (OPI), the Health Services Sector, and key stakeholders which assisted in organizing the health services evaluation into three periods: intake, incarceration and pre-release and community supervision. These three periods reflect the continuum of care provided to offenders by CSC and examines clinical, public and mental health services. A brief description of each period is provided below.

2.1.1 INTAKE

The evaluation questions related to intake concentrated on intake screenings and assessment tools, as well as specific health services interventions, health promotion activities, and access to health information. The continued need for CSC health services, alignment with government priorities and federal roles and responsibilities were also explored. Specific questions were included in regards to meeting the health care needs of women offenders, Indigenous offenders and older offenders at intake.

2.1.2 INCARCERATION

The evaluation questions associated with incarceration examined the integration and continuity of health care services, including any challenges or improvements with the new governance structure, health services planning and coordination, and gaps related to accessing health care professionals and health promotion activities. Specific questions were included related to meeting the needs of women offenders, Indigenous offenders and older offenders during incarceration.

2.1.3 PRE-RELEASE AND COMMUNITY SUPERVISION

The evaluation questions for pre-release and community supervision focused on routine and clinical discharge planning and community mental health services. Challenges in regards to offender identification and payment for essential health services were also examined. Specific questions were included in regards to meeting the health care needs of women offenders, Indigenous offenders and older offenders during pre-release and community supervision.

2.2 APPROACH

The evaluation of CSC's health services used a mixed-method research design, incorporating both quantitative and qualitative methodologies. Several lines of evidence were used to address the evaluation issues and questions, including:

2.2.1 LITERATURE AND DOCUMENT REVIEW

An extensive examination of peer-reviewed literature and internal and external documents was conducted, including:

- CSC and other governmental documents and reports (e.g., legislation, policies and regulations, evaluation reports, research reports, audit reports, board of investigations, and other corporate and operational documents);
- A review of Canadian public health initiatives;
- A review of community health roles and responsibilities;
- A review of the prevalence of health issues in the Canadian population and in the offender population;

- A review of the methods of diversion for mental health needs from the criminal justice system; and,
- An environmental scan of health services in other correctional jurisdictions.

2.2.2 QUALITATIVE DATA[3]

Interviews with Offenders: Intake and Incarceration

Offender interviews for intake and incarceration were conducted during institutional visits between November 2014 and January 2015. An interview guide was developed using open-ended and closed-ended questions (such as 5-point Likert-scales, dichotomous and categorical multiple choice questions). Criteria to participate in the intake questionnaire included offenders who were admitted to CSC within the previous 3 to 12 months. The criteria for the incarceration questionnaire included offenders who were incarcerated for a minimum of 15 months or more at CSC at the time of the evaluation. In total, 104 offenders participated in the intake interviews and 149 offenders participated in the incarceration interviews.

The data collected through both questionnaires was entered into Snap Survey software and exported into SPSS and Microsoft Excel. The Evaluation team analyzed qualitative data obtained through open-ended questions using the iterative and inductive[4] process to identify relevant themes. Qualitative data obtained through closed-ended questions were analyzed using descriptive analysis techniques. Frequencies and percentages were calculated based on the number of valid responses to the questions.

Interviews with Offenders: Regional Treatment Centre

Offender interviews were conducted at RTCs located in the Quebec and Prairie regions between January 26 and 29, 2015. An interview guide was developed using open- and closed-ended questions (dichotomous questions and one categorical multiple choice question). In total, 32 offenders participated in the interviews. They were incarcerated for a minimum of 2 months to a maximum of 108 months.

[3] The federal government has transitioned from using the term Aboriginal to describe First Nations, Inuit and Métis peoples to the term Indigenous. The transition took place during the evaluation. The data collection instruments used the term Aboriginal; however, the evaluation report has replaced this with Indigenous where applicable.
[4] An iterative and inductive qualitative analysis process identifies emerging themes and meaning from data through a repetitive reflexive process (see Srivastava & Hopwood, 2009 and Patton, 1980).

Electronic Questionnaires with Staff

Four electronic questionnaires were developed using Snap Survey software and administered through CSC's Intranet site (InfoNet). The questionnaires solicited the views and experiences of health services and non-health services staff in regards to the delivery of health services to offenders throughout the continuum of care. Respondents were representative of all security levels, regions, genders, and facilities across Canada. In addition, an electronic consultation was developed using Microsoft Word and was sent through Outlook. Data were analyzed using the same process and procedures as used for the offender interviews.

Intake and Incarceration

- *Intake*: this questionnaire was launched in October 2014 and solicited responses from health services staff and managers involved in the delivery of health services during intake. A total of 116 participants responded,[5] all regions participated in the questionnaire.
- *Incarceration*: this questionnaire was launched in August 2015 and solicited responses of health services staff members involved in the delivery of health services to offenders during the incarceration period. A total of 196 participants responded[6] with representation from all regions across CSC.
- *General Staff – Incarceration and Intake:* this questionnaire was launched in July 2015 and solicited responses pertaining to general staff and management experiences with health care services during incarceration. A total of 167 participants responded,[7] all regions participated in the questionnaire.

[5] The majority of respondents were from the nursing (53.9%, n = 62) and psychology (18.3%, n = 21) groups. The remaining respondents included: social work (7.8%, n =9), clerical (6.1%, n = 7), administrative services (4.3%, n = 5), pharmacy (2.6%, n = 3), welfare programs (2.6%; n = 3), and others.

[6] The largest percentage of respondents were from the nursing (46.4%, n = 89) and psychology (24.0%, n = 46) classifications. In addition, questionnaires were completed by respondents in the administrative services (8.9%, n =17), clerical (7.3%, n = 14), pharmacy (3.6%, n = 7), social work (3.1%, n =6), engineering and scientific support (2.6%, n = 5), executive and welfare programs (1.6%, n = 3) classifications.

[7] The majority of respondents worked in the institutions (94.5%, n = 156) while a small proportion were from Regional Headquarters (RHQ; 5.5%, n = 9). The majority of respondents worked in men's institutions (80.1%; *n* = 125) while a few (19.8%, n = 31) indicated working in women's institutions. The highest proportion of respondents (38.9%, n = 63) were educators followed by correctional officers (21.6%, n = 35) and employees who work in welfare Programs (19.1%, n = 31). A few respondents worked in administrative services (12.3%, n = 20), the executive group (3.7%; n = 6) and other groups (4.3%, n = 7).

Pre-Release and Community Supervision

- *Pre-Release and Community Supervision*: this questionnaire was launched in August 2016 and solicited responses from institutional and community health services staff as well as managers involved in the delivery of health services to offenders at pre-release and during community supervision. A total of 291 participants responded,[8] all regions participated in the questionnaire.
- *Regional Directors, Health Services*: this consultation was launched in August 2016 and solicited responses from Regional Directors respecting the responsibilities and processes related to offender provincial health cards, payment of fees and essential health services coverage. All regions participated in the consultation.

2.2.3 QUANTITATIVE DATA

Automated data

Various sources of automated data were used for the Evaluation, such as:

Offender Data: Data pertaining to mental health referrals, assessments, and services were obtained from the Computerized Health Intake Screening System (CoMHISS) and the Mental Health Tracking System (MHTS) and analyzed using Statistical Analysis System (SAS) software. Additional data related to sub-population profiles, offender characteristics and correctional outcomes (e.g., institutional incidents) were extracted from the Offender Management System (OMS) and analyzed using SAS.

Human Resource Data: Data extracted from the Human Resource Management System (HRMS) database were provided by CSC's Human Resources Management Section. Data on staff classifications, positions and location, as well as data specific to Aboriginal perceptions training were retrieved for FY 2014 to 2016.

[8] There were mainly two distinct categories of respondents. The largest percentage of respondents was from case management team (57%, n = 165). About half were community parole officers (53%, n = 87), and a small number institutional parole officers (22%, n = 36), parole office supervisors (13%, n = 21). The other category was health services staff (39%, n = 112). Some of the health services staff were institutional nurses (34%, n = 38), community mental health nurses (26%, n = 29), and a small number of clinical social workers (14%; n = 16). There was a remaining small number of uncategorized respondents (5%, n = 14).

Financial Data: Financial data for health services expenditures was retrieved from the Integrated Financial & Material Management System (IFMMS) for FY 2012-13 to 2015-16 and were analyzed using Excel.

2.3 MEASURES

Analysis of Qualitative Data

The following scale was used throughout the current report to indicate the weight of emerging qualitative themes[9] and to facilitate the interpretation of evaluation results.

- *A few/a small number of interviewees* = less than 25%;
- *Some interviewees* = 25% to 45%;
- *About half of interviewees* = 46% to 55%;
- *Many interviewees* = 56% to 75%;
- *Most interviewees* = over 75%; and,
- *Almost all interviewees* = 95% or more.

2.4 LIMITATIONS AND MITIGATION STRATEGIES

Evaluations face constraints that may have implications for the validity and reliability of the evaluations findings and recommendations. The following table outlines the limitations encountered along with the impact experienced and the mitigation strategies put in place to ensure decision makers have confidence in evaluation the findings and recommendations.

Limitation	Impact	Mitigation Strategy
Missing or unreliable data (e.g., health referrals, wait times, program participation, level of need, financial expenditures, offender identification, clinical discharge planning activities).	Inability to report on the effectiveness, efficiency and/or economy of the health services evaluation.	Unreliable data was excluded from our analyses and recommendations were made to track and record pertinent information.
Sample size too small to conduct analyses and/or draw conclusions: - Older offenders (e.g., health services intake assessment	Comprehensive information for specific populations of offenders is not complete. Inability to analyze the effectiveness and efficiency of	Older offender health requirements and services were assessed in other components of the evaluation where possible (e.g., health services for specific

[9] This scale has been adapted from Employment and Social Development Canada.

Limitation	Impact	Mitigation Strategy
screening tool) -Women and Indigenous offenders (e.g., impact of mental health treatment on correctional outcomes in mainstream institutions and RTCs)	services for specific populations (e.g., women and Indigenous offenders) independently.	populations). Women and Indigenous offenders were included in the overall analyses.
Correctional outcomes (e.g., institutional incidents) could be the result of time passing (i.e., outcomes more likely to occur later in an offender's sentence) or participation in mental health treatment.	Difficult to determine the construct validity of the analysis.	A random sample of offenders was selected as a comparison group and arbitrary treatment timelines were implemented to compare results.
During mental health treatment, offenders may demonstrate heightened emotional instability, resulting in correctional outcomes (i.e., institutional incidents).	Difficult to determine if treatment has any significant impact on correctional outcomes during treatment.	Results will be presented to identify that outcomes during treatment are to be interpreted with caution.
A small number of RTC interviews were completed.	Experiences reported only represent a small subset of the population.	Other lines of evidence were used to substantiate and provide further information on data received in interviews.

3.0 FINDINGS

The key findings of the Evaluation on Health Services are presented under the following seven FIFEs:

- FIFE #1: Relevance of CSC's Health Services
- FIFE #2: Effectiveness and Efficiency of CSC's Health Services Intake Assessment Process
- FIFE #3: Offender Access to Care and Services
- FIFE #4: Public Health Education and Harm Reduction
- FIFE #5: Institutional Mental Health Services
- FIFE #6: Pre-Release and Community Health Services
- FIFE #7: Management and Coordination of Health Services

FIFE #1: RELEVANCE OF CSC'S HEALTH SERVICES

The first FIFE focuses on the continued relevance of mental, clinical and public health services, including the need for health care services, and alignment of health services with departmental and government priorities and federal roles and responsibilities. This section provides a broad overview of offenders' health care needs. Specific health care needs of offenders (including needs for special populations) in the context of services provided will be reviewed in more detail during subsequent phases of the evaluation as we progress to an examination of the effectiveness and efficiency of health services provided to offenders. The findings, supporting evidence and implications for the relevance of health care services are presented below along with next steps, which are meant to guide decisions in the development of a MAP.

3.1 NEED FOR HEALTH SERVICES

FINDING 1: NEED FOR HEALTH SERVICES

There is a continued need for delivery of clinical, public and mental health services to CSC offenders.

There is a demonstrated need for health services within Canadian federal institutions. Although federal offenders have many of the same mental, clinical, and public health issues as the general Canadian population, the prevalence of certain health issues is significantly higher among federal offenders compared to the general public. Offenders often enter the correctional systems in poor health and have had limited contact with the health system.[xv] Compared to the Canadian population, offenders have more lifestyle risk factors associated with poor health (such as history of injection drug use, employment problems), and have higher rates of substance abuse, communicable diseases and mental illnesses upon arrival to the correctional institution.[xvi] In addition, studies have found that factors related to the prison environment, such as shared accommodations, can exacerbate existing health conditions (especially conditions related to stress) or contribute to new health issues, particularly with respect to infectious disease transmission.[xvii]

The following section provides an overview of some of the most prevalent health care needs of offenders in CSC (see Appendix B for more specific information on specific populations).

Evidence:

There is a significant need for clinical health services for offenders, which is expected to grow with an aging offender population.

- CSC is responsible for providing health service screening, referral and treatment to inmates including emergency and urgent health care.[xviii]
- In addition to ongoing acute physical needs that require more immediate and urgent attention (such as treatment of falls, broken limbs), many offenders have chronic clinical health care needs (e.g., central nervous system illnesses, cardiovascular illnesses, and respiratory illnesses)[10] that require continuous care and/or monitoring.
- Among newly admitted federal offenders, the most prevalent self-reported current or past clinical health conditions for men and women offenders are head injuries (34% and 23%, respectively), back pain (19% and 26%), and asthma (15% and 16%).[11] [xix] For women offenders, menopause is also a prevalent condition (19%).[xx]
- Prevalence of some conditions was higher among CSC offenders than the general population (e.g., asthma).In addition, although the rates of diabetes (8%) and obesity (23%) are high among CSC offenders; the rates are comparable to those of the general Canadian population.[xxi]
- CSC offenders are aging. According to a 2014 research study, the proportion of incarcerated offenders over the age of 50 years has increased since 2006 and is expected to continue to increase over the next five years, with the most prominent increase projected to occur among non-Indigenous men offenders.[xxii] Furthermore, certain chronic illnesses (e.g., high blood pressure, high cholesterol) increase with age, and will consequently increase the need for chronic care among CSC's older offenders.[xxiii]

Communicable diseases (e.g., HCV, HIV) are more prevalent among federally incarcerated offenders than the general Canadian public.

- The most frequent public health issues (i.e., communicable diseases) among the federal offender population are Hepatitis C Virus (HCV), Latent Tuberculosis Infection (LTBI), and the Human Immunodeficiency Virus (HIV).

[10] Some of the chronic physical health needs can also result in acute episodes (e.g., heart attack).
[11] These rates were based on self-report of current or past head injury and may therefore include a broad range of injuries. A review of health files found that 2% of offenders had evidence of current or recent brain injury. See Correctional Service Canada. (2015). *Estimates of chronic disease prevalence among CSC inmates.* Ottawa, ON: Health Services.

- According to CSC Health Services data, the prevalence of HCV, LTBI, and HIV were 17%, 17%, and 1%, respectively.[xxiv] Rates of HCV and HIV are higher among the federal offender population in comparison to the Canadian population (1% and 0.3% respectively).[xxv]
- The self-reported prevalence rates of HCV and HIV are consistently higher among Indigenous offenders than non-Indigenous offenders and among older offenders than young offenders.[xxvi]
- In addition, HIV and Acquired Immunodeficiency Syndrome (AIDS) are key risk factors for Tuberculosis (TB). Within the Canadian population, the prevalence of TB is disproportionately higher among Indigenous peoples (19.9 per 100,000) than non-Indigenous peoples (0.6 per 100,000).[xxvii]

Mental disorders are among the most frequent conditions affecting federal offenders.[xxviii] Among the most commonly identified mental health issues were anxiety disorders and antisocial personality disorder.

- According to the 2012 Canadian Community Mental Health Survey,[xxix] approximately one in ten Canadians meet the criteria for a current (i.e., within past12 months) mental or substance use disorder.
- Comparisons between the offender population and the general Canadian population on rates of mental health disorders are difficult due to the use of different definitions and samples, but evidence indicates that mental health issues are at least as prevalent, and more so for specific disorders, among the offender population.
- Mental disorders are among the most frequent chronic conditions affecting federal offenders. According to the treatment-based definition utilized by CSC Health Services, 28% of incarcerated offenders have mental health needs.[12] This includes 57% of women offenders (26% of men offenders), and 32% of Indigenous offenders (26% of non-Indigenous).[xxx]
- The most prevalent mental health disorders among federal offenders are:[xxxi]
    - Men offenders: anxiety and mood disorders with current prevalence rates of 30% and 17%, respectively.[13]

[12] Mental health need is determined by having at least one mental health treatment-oriented service or stay in a treatment centre in the previous six-months.
[13] This refers to a one-month prevalence rate [the prevalence rate for current disorders (i.e. disorders that were present in the month prior to the study)].

  - Women offenders: anxiety disorders (e.g., prevalence rates of 31% for post-traumatic stress disorder, 18% for specific phobia, and 16% for generalized anxiety disorder) and attention-deficit/hyperactivity disorder (17%).[14]

- Personality disorders, which are characterized by stable and consistent expression of pathological personality traits that cause impairment to the individual or interpersonal functions,[xxxii] are also common among federal offenders.
  - The lifetime prevalence of antisocial personality disorder for men and women offenders were 44% and 83%, respectively.[15]
- Self-injurious behaviour (SIB)[xxxiii] occurs for both men and women offenders, but for different reasons. A research study examining incidents of SIB within a 30-month period found that women more frequently engaged in SIB whereas men's SIBs were more likely to result in more serious bodily harm. The difference in bodily harm may be related to the different types of SIB committed by men and women offenders. Specifically, the researchers noted that women offenders were more likely than men offenders to engage in head banging behaviour, which is less likely to result in visible physical injuries. In comparison, men offenders were more likely than women offenders to cut themselves, overdose, threaten to harm themselves, and open wounds.

3.2 ALIGNMENT WITH PRIORITIES AND FEDERAL ROLES & RESPONSIBILITIES

FINDING 2: ALIGNMENT WITH PRIORITIES AND FEDERAL ROLES & RESPONSIBILITIES

CSC Health Services are aligned with federal government priorities. CSC is responsible for providing health services to federal offenders, but there is an ongoing need for partnerships to effectively and efficiently deliver services to offenders.

[14] This refers to a one-year prevalence rate [the sample's continued experiences with an active disorder (i.e. in the year prior to the study)].
[15] A lifetime prevalence rate refers to the proportion of a population that has experienced a condition at some point in their life. Such rates are used for personality disorders because they involve enduring patterns of behaviour.

Evidence:

The priorities of CSC's Health Services are aligned with CSC corporate priorities and ultimately to federal government priorities and legislation related to health service.

- Health Services provide services that contribute to four of CSC's six corporate priorities.
  - Health Service contributes to safe management of eligible offenders during their transition from the institution to the community, and while on supervision by providing essential health care and reasonable access to non-essential mental health care.
  - Health Services contributes directly to addressing the mental health needs of offenders through timely assessment, effective management, appropriate intervention, relevant staff training and rigorous oversight.
  - Health Services supports CSC's corporate priority, to provide "[e]ffective, culturally appropriate interventions for First Nations, Métis and Inuit offenders"[xxxiv] through its commitment to "[i]mprove capacity to address the health needs of Indigenous offenders, aging offenders and offenders with mental health disorders".[xxxv]
  - Health Services contributes to CSC's corporate priority of "[p]roductive relationships with diverse partners, stakeholders, victims' groups, and others involved in public safety",[xxxvi] for example, by engaging national and regional or local partners to assist in the transition of offenders with mental health needs to the community.
- In addition, CSC's Health Services contributes more broadly to the Government of Canada's Mental Health Action Plan for Federal Offenders [xxxvii] and aligns with the federal government's priority to support the health and well-being of all Canadians.[xxxviii] The Minister of Public Safety and Emergency Preparedness has also been given the mandate to work with other Ministers to address gaps in services to those with mental illness throughout the criminal justice system.[xxxix]

The delivery of health services for Canadians is a shared responsibility between the federal, provincial, and territorial governments. CSC retains ultimate responsibility for the health care of federal offenders although partnerships play an important role in service delivery and facilitating continuity of services.

- In general, the delivery of health services falls under the jurisdiction of the provincial government.[xl]

- However, the federal government is responsible for the provision of health services for specific groups: First Nations and Inuit peoples (Health Canada); veterans (Veterans Affairs Canada); members of the Canadian Forces (Department of National Defence); members of the Royal Canadian Mounted Police (RCMP); refugee claimants (Citizenship and Immigration Canada); and, inmates in federal correctional facilities (CSC). According to section 86(1) of the *Corrections and Conditional Release Act* (CCRA), CSC is mandated to provide "essential health care; and reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community".[xli]
- A review of potential alternative models for the delivery of health services for federal offenders reaffirmed the role of CSC in the delivery of health services to federal offenders. The review examined legislation concerning health service delivery in Canada, existing health service delivery arrangements for provincial/territorial correctional populations, practices in some international jurisdictions, and feedback from external stakeholders and partners.[xlii] Additionally, it was concluded that improvements to service delivery should be explored through new partnerships.
- Partnerships with other levels of government (e.g., provincial and territorial governments[16]) and non-governmental stakeholders are established to ensure continuity of services from admission to a federal institution, throughout the period of incarceration, release to community supervision, and finally after warrant expiry particularly in light of the different roles and responsibilities of the partners prior to, during, and after the completion of an offender's sentence.[17]

CSC Health Services is involved in mental health diversion for offenders after they enter the federal correctional system by facilitating re-entry into the community and support for offenders supervised in the community.

Mental health diversion within the criminal justice context refers to "an option to divert persons with mental disorders to appropriate treatment, supports and corrections systems in order to address the mental issue contributing to the offending behaviour" and may be offered at various points along the continuum of involvement with the criminal justice system.[xliii]

[16] CSC is part of the Federal, Provincial, Territorial Heads of Corrections Working Group on Health and Mental Health.
[17] CSC partners with governmental and non-organizations across the country that provide supports to offenders with mental health needs, at both the national and provincial levels (e.g., Mental Health Commission of Canada, Canadian Mental Health Association, National Aboriginal Health Organization, etc.).

Diversion can occur before (pre-contact) or after (post-contact) initial contact with the criminal justice system (see Appendix C for more information).

Pre-contact diversion occurs prior to an individual's first contact with the criminal justice system (i.e., prior to encounter with police)

- Pre-contact diversion initiatives focus on crime prevention through interventions that target an individual's mental health risk factors before crime occurs.

Post-contact diversion occurs after an individual's first contact with the criminal justice system (i.e., upon contact with police or later)

- Post-contact diversion is for individuals already engaged with the criminal justice system and has been described using the Sequential Intercept Model.[xliv] The model identifies five points (intercepts) at which individuals with mental health needs could be diverted:
  - **Intercept 1:** First interactions with law enforcement and emergency services (e.g., police-based);
  - **Intercept 2:** Post-arrest (pre-trial): initial detention/hearing or pretrial services;
  - **Intercept 3:** Court-based diversion (e.g., mental health courts);
  - **Intercept 4:** Re-entry planning from jails, prisons, and forensic hospitalization; and
  - **Intercept 5:** Community corrections and community support.
- CSC is primarily involved in post-contact mental health diversion at intercepts 4 and 5:[xlv]
  - Intercept 4: (Re-Entry Planning): CSC clinical social workers develop discharge plans for offenders to facilitate the transition from the institution to the community.[18]
  - Intercept 5: (Community Corrections & Community Support): CSC community mental health specialists provide support to offenders supervised in the community to ensure continuity of services.[19]

[18] This involves collaboration with case management staff members (e.g., institutional/community POs) to assess the psychosocial needs of offenders with mental disorders, identify and develop linkage to community resources, and formulate comprehensive discharge plans to facilitate continuity of mental health services into the community.
[19] Services include comprehensive assessment & intervention planning, direct service provision such as individual counselling, consulting with case management staff to assist in managing offenders in the community, and advocacy for offenders with mental health needs.

Effective earlier mental health diversion strategies could result in: cost savings and improved public safety outcomes.

Cost Savings:

- Research shows that mental illness often begins during childhood or adolescence.[xlvi] Investment in pre-contact diversion initiatives targeting the mental health of children and youth could lead to long-term economic impacts. For instance:
  - A study in the UK estimated that £230,000 ($365,000) per person could be saved in the areas of criminal justice, health and increases to individual earnings through early prevention of conduct disorders.[20] [xlvii]
  - A systematic review by the Washington State Institute for Public Policy of evidence-based options to reduce costs to the criminal justice and correctional systems found that Multisystemic Therapy (MST)[21] demonstrated a net savings of $18,213 in victim and criminal justice costs per participant[xlviii] or approximately a savings of $5.27 for every dollar spent on MST.
  - There is some evidence that crime prevention programs are cost-effective. For example, an evaluation of the cost effectiveness of the crime prevention program Stop Now and Plan (SNAP) implemented in Edmonton found that for every dollar spent there was a savings of four dollars (in costs for police, courts, incarceration, probation, etc). [xlix] Although the implementation of SNAP in Edmonton was not specific to youth with mental health issues, there is a model of the program that specifically targets youth with mental health needs. A more recent study examining another SNAP program found savings of $2.05 to $3.75 for every $1 spent on the program based on data on convictions.[l]

Improved Public Safety Outcomes:

- Diversion initiatives may contribute to reductions in recidivism. For example, mental health courts have been associated with fewer arrests and jail days (e.g., an average of 3 days instead of 23 days), a significant to moderate effect on reducing recidivism.[li]

[20] Conduct disorders in children and youth have been identified as a precursor of antisocial personality disorder in adults, which is a particularly prevalent disorder in the offender population. (Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23000 prisoners: A systematic review of 62 surveys. *The Lancet, 359*(9306), 545-550).

[21] MST is a program model that targets youth with serious behavioural issues by addressing the systems or settings related to the problematic behaviour. (MST Services, Inc. (2015). *Multisystemic therapy*. Retrieved from http://mstservices.com/what-is-mst/what-is-mst.).

- Diversion initiatives may also contribute to cost-savings to criminal justice (e.g., costs associated with serving time in jail, encounters with police, and court) [lii] and correctional systems.
- Although costs saved to the correctional system by post-contact diversion initiatives may be displaced to the health system, the costs may nevertheless be offset by savings associated with emergency responses such as ambulance services and hospitalization and criminal justice costs such as arrest and ultimately incarceration.[liii] [22]
- In addition, several community-based prevention programs for at-risk youth have been shown to improve short-term outcomes such as knowledge and attitudes towards substance abuse and violent/aggressive behaviour, as well as reduction in problematic behaviours (e.g., substance abuse, limited attachment to school, associations with delinquent peers, violent/aggressive tendencies, early contact with the justice system, etc.), and contacts with the police.[liv]

Next Steps for CSC:

CSC could strengthen its involvement in mental health diversion activities through engagement with governmental and non-governmental partners and stakeholders.

- CSC is engaged in several initiatives with a focus on mental health partnerships, including:
  - An Integrated Community Engagement Strategy, in which one of the areas of focus is mental health; and,
  - A sub-committee comprised of Assistant Deputy Ministers on Mental Health (with one of the areas of focus is outreach to partners, including mental health prevention and diversion).
- It is through strong partnerships that opportunities may arise to collaborate and contribute to referrals to appropriate, timely services for individuals with mental health needs.
- At a broad level, opportunities exist for CSC and federal partners (e.g., Health Canada and Public Safety Canada) to engage other national stakeholders (such as the Canadian Mental Health Commission and others) in prevention and intervention efforts in order to address mental

[22] For instance, among participants in *Streets to Homes* (a program in Toronto that offers help in finding long-term housing for homeless people), just under one half of sampled participants had mental disorders. Furthermore, the number of arrests and jail admittances were reduced by 56% and 68%, respectively (City of Toronto, 2009), as cited in Centre for Addiction and Mental Health, & Canadian Council on Social Development. (2011). *Turning the key: Assessing housing and related supports for persons living with mental health problems and illness.* Calgary, AB: Mental Health Commission of Canada.

illness or provide other supports outside of the criminal justice and correctional systems (e.g., housing for persons with mental disorder).

- In addition, CSC could engage in other partnerships and activities to intervene at earlier intercepts in the Sequential Intercept model, to divert individuals from entering CSC jurisdiction. Activities may include:
  - Liaising with local police services, first responders, crisis response sites and subsequent mental health service providers (intercept one).
  - Case management staff participation in post-arrest (pre-trial) diversion in order to divert parolees from incurring additional sentences for relatively minor infractions (intercept two).
  - Providing subject matter expertise on effective case management to therapeutic courts to contribute to both public safety and therapeutic results (e.g., integrating correctional case management practices to address both criminogenic needs and mental health needs - intercept three).
- Emerging research on mental health diversion also suggests benefits with respect to public safety results and cost-savings. Persons with significant mental health needs will require mental health treatment, either within the correctional environment or in the community. From a humanitarian perspective, it may be more appropriate to treat some offenders in the community, particularly those who are low risk, but who have high needs, and whose criminal behaviour is likely the result of having a mental illness.[lv]

RECOMMENDATION 1: MENTAL HEALTH DIVERSION

That CSC maintains productive relationships with partners who support individuals with mental health disorders.

FIFE #2: EFFECTIVENESS AND EFFICIENCY OF CSC'S HEALTH SERVICES INTAKE ASSESSMENT PROCESS

The following section focuses on assessment of offenders' health service needs and referral to appropriate health care services during the intake period. The effectiveness and efficiency of the offender intake assessment tools and process are examined. The findings, supporting evidence and implications for the relevance of health care services are presented below along with next steps, which are meant to guide decisions with regards to the development of a management action plan.

Overview: Health Services Main Intake Assessment Tools

During the intake period, offenders are offered voluntary assessments, including physical and mental health screening and assessments.[23] CSC Health Services administers four main tools to assess offender health at intake: the 24-Hour Health Intake Assessment, the 14-day Health Intake Assessment, Infectious Disease Screening, and the Computerized Mental Health Intake Screening System (CoMHISS).

The *24-Hour Health Status Intake Assessment* is a tool administered by a nurse within 24 hours of an offender's admission to an institution. This assessment includes questions about offenders' immediate mental (e.g., suicidal or self-harming behaviour) and physical health needs (e.g., current physical health issues, allergies, and medications).[24]

The *14-Day Health Status Intake Assessment* is an assessment tool completed by a nurse within the first two weeks of the offender's admission to the institution. At the time of the evaluation, this tool involved a series of questions about the offender's mental (e.g., stress management, etc.) and physical (e.g., diabetes, etc.) health. It is similar to the 24-Hour Health Status Intake Assessment, but is more detailed and addresses both the offender's immediate health needs and medical history. This assessment also involves measurement of height, weight, and vital signs (e.g., blood pressure).[25]

[23] Although this document refers to "assessments," note that assessment processes and tools also comprise a screening component.
[24] Falls risk screening is also completed as part of the 24-hour intake assessment. If the screening criteria are met, offenders are referred for the Morse Falls Scale to determine whether fall prevention interventions should be implemented.
[25] The Health Status Admission Assessment is also completed as part of the 14-day intake assessment for those who are 50 or older or those with self care needs, to identify any special health care needs for these populations. Note, as of August, 2015, the Health Status at Admission Assessment is completed for those who are 65 years or older or anyone with self-care needs.

The 14-day Infectious Disease Screening is performed by a nurse within 14 days of an offender's admission to the institution. This assessment includes questions concerning the offender's immunization/vaccination history and any tests for infectious diseases (e.g., sexually transmitted diseases, tuberculosis, and hepatitis). During this assessment, the nurse also discusses risk factors for infectious diseases with the offender, such as tattoos, drug use, and body piercing.

Computerized Mental Health Intake Screening System (CoMHISS) is an offender self-administered assessment tool that specifically assesses mental health needs. It is completed within 3 to 14 days of admission and is used to identify offenders who are experiencing any mental health symptoms that may require further assessment and intervention. The assessment includes questions related to past or present mental health symptoms, diagnoses, medications or treatments, suicidal ideations, attention deficit hyperactivity disorder (ADHD), as well as cognitive deficiencies and intellectual abilities.

3.3 EFFECTIVENESS OF HEALTH SERVICES INTAKE ASSESSMENT

FINDING 3: EFFECTIVENESS OF HEALTH SERVICES INTAKE ASSESSMENT

The overall health services intake assessment tools and processes are effective in identifying offender health needs.

Evidence: Effectiveness of Intake Assessment

Health intake assessment tools and processes are effective in identifying offender health needs.

No significant challenges with the intake assessment tools and process in identifying offender health care need were observed based on a comprehensive review of health-related documents, reviews, and investigations.

- All offenders admitted to CSC must be offered the opportunity to participate in the health service intake assessment, including the 24-hour assessment, 14-day assessment, infectious disease screening, and CoMHISS.[26]
    - According to Health Services performance measurement data, most offenders complete these assessments and many are completed on time in accordance with health services guidelines. Rates of timely completion of intake assessments for fiscal year 2013/2014: 24-

[26] The types of offender admission pertaining to each assessment are described on p.31 of this report.

Hour Assessment (96%), 14-day Assessment (67%), 14-day infectious disease screening (65%),[lvi] and CoMHISS (80%).[lvii]

- Similarly, almost all of the offenders interviewed for the evaluation during the intake period indicated that they completed the health status intake assessments.[27]

- CSC's health services intake assessment process was explicitly identified as a strength in the 2014 CSC Health Services Accreditation report.[lviii] Specifically,
  - The Pacific Region was acknowledged for strengths in "intake assessment and medication reconciliation process on admission, transfer and release" (p. 42) and exemplary "falls prevention program and alert identification of inmates at risk" (p. 43).
  - In the Ontario Region, the accreditation team noted that extensive assessments were "consistently applied across all the institutions visited during the on-site survey" (p. 43) and "all requests for health care are triaged by a nurse, with response and further action communicated to the inmate" (p. 44).
- Examination of Mortality Reviews and health-related Boards of Investigation[28] available at the commencement of the current evaluation[29] did not find any evidence that the intake assessment tools and process was a contributing factor to the incident. Although a few intake assessments were completed after the timeframes outlined in guidelines, there was no evidence that the timing of the assessments had an impact on the incidents.[30]

[27] Percentage of offenders interviewed during intake period who reported that they had completed each of the following intake health assessment tools: 24 hour and 14 day 95% (n=95), infectious disease screening 95% (n=93), and CoMHISS 89% (n=57).

[28] CSC conducts Boards of Investigations (BOIs) when significant incidents occur as well as Mortality Reviews in the cases on deaths by natural causes. Only health-related BOIs were reviewed for this investigation including: assault of a staff member, assault of an inmate, suicide of an inmate, attempted suicide of an inmate, attempted suicide and subsequent death, self -inflicted injury of an inmate, overdoes interrupted, hostage-taking on an inmate, injury of inmate, death by unknown cause of an inmate.

[29] The evaluation examined reports available at the time the evaluation commenced, which included reports that were convened and completed in fiscal year 2012-2013.

[30] In most cases where a health intake assessment was completed late, it was the 14-day assessment, all of which were ultimately completed, and there was no evidence within the reports to suggest that the timing of the assessments had an impact on the incident. In one investigation, the Health Status Admission Assessment for offenders who are 50 or older was not completed; however, there was no evidence to suggest that its non-completion had an impact on the incident.

- Finally, few health services staff members reported challenges related to the accuracy of the tools or challenges related to the referral process in identifying offender health needs based on results of the 24-hour, 14-day, or infectious disease assessment tools.[31]

The majority of offenders were satisfied with the health intake assessment and most staff and offenders agreed that intake assessments were completed at an appropriate time to identify offender health needs.

- The majority of offenders interviewed were extremely or very satisfied that the health intake and screening assessment processes identified existing mental (78%, n=74), physical (63%, n=62), and public health care needs (i.e., infectious disease needs; 84%, n=76) upon their arrival at CSC.[32]
    - Among those who reported lower levels of satisfaction, a few offenders reported they had unidentified physical health needs (n=7), or that their mental health assessment had not been through enough (n=7);
    - Offenders suggested that health intake and screening process could be improved by: reviewing previous medical records from the community or from the provincial correctional system (n=6), or by modifying the intake process (e.g., to take more time to complete the assessments or include more one-on-one assessment for CoMHISS; n=12).
- Most offenders also reported that they received follow-up on referrals. Specifically, the majority of offenders, 74% (n=64) indicated that they were advised by a nurse that a referral for a follow-up appointment would be made to address their health needs, of which 89% (n=57) reported receiving the follow-up appointment with a health care professional.
- Few staff or offenders reported that they disagreed with the timing of the health intake assessments to identify offender health needs.[33]

[31] Less than one-quarter of health services respondents familiar with the tools identified any challenges to accuracy of the 24-hour (23%, n=13), 14-day (22%, n=11), or infectious disease assessment (14%, n=6). Few health services staff reported experiencing challenges referring offenders to health services based on the results of the 24-hour (24%, n=13), the 14-day (20%, n=10), or the infectious disease screening (10%, n=4). Note that number of respondents for each assessment tool varied, due to the fact that only staff members familiar with each of the assessment tools were asked to respond to these questions.
[32] Based on interviews with a sample of offenders recently admitted to CSC (within 3 to 7 months of admission).
[33] The following percentages of offenders interviewed at intake disagreed with the timing of intake assessments (14%, n=15). For staff questionnaire respondents, percentage disagreement was: 24-hour (13%, n=8), 14-day (20%, n=11), Infectious Disease Screening (20%, n=9), CoMHISS (32%, n= 7).

CoMHISS[34] is generally effective in identifying offender mental health needs, but may somewhat over-identify offenders requiring mental health treatment.

According to data analyzed as part of the current evaluation (i.e., selected from all offenders admitted to CSC in FY 2013-2014 and FY 2014-2015), among the sample of offenders who completed CoMHISS assessment:[35]

- 26% (n=2034) were flagged for mental health follow-up;
- 20% (n=1524) were assessed as unclassified;[36] and,
- 54% (n=4188) were screened out.[37]

To examine the effectiveness and sensitivity of CoMHISS, the percentage of offenders who received mental health treatment among offenders who were flagged and screened out by CoMHISS was examined. Offenders were considered to have received mental health treatment if they received a mental health treatment-oriented service resulting from a referral generated within 4 months of admission[38] or if they were admitted to a Regional Treatment Centre.[39]

CoMHISS effectively *screens out* most offenders who do not require mental health treatment:

- Most offenders (79%; n=3309 of 4188) screened out by CoMHISS did not receive mental health treatment.
- Few offenders (21%; n=879) screened out by CoMHISS received mental health treatment.

[34] Note that the effectiveness and over-identification of needs could not be examined for all intake mental health assessment tools since information on referral from other intake tools is not tracked electronically.
[35]CoMHISS identifies three groups of offenders: (1) Flagged: offenders require mental health follow-up; (2) Unclassified: offenders have a moderate need for mental health services and mental health staff are required to conduct at least a file review to determine whether or not an offender required follow-up mental health assessment or services; and, (3) Screened out: offenders do not require follow-up mental health services.
[36] Among offenders who were unclassified, 39.5% (n=602, including 44 offenders admitted to a regional treatment centre) received mental health treatment and 60.5% (n=922) did not receive mental health treatment.
[37] These percentages are comparable to those reported by Martin et al (2013) who examined the scoring model utilized in the current version of CoMHISS for all offenders admitted to the Pacific Region over a 15-month period from October 2006 to December 2007. See Martin, S., Wamboldt, A., O'Connor, S., Fortier, J., & Simpson, A. (2013). A comparison of scoring models for computerised mental health screening for federal prison inmates. *Criminal Behaviour and Mental Health, 23*(1), 6-17.
[38] In order to examine the intake period, treatment-oriented services were only included if they were linked to a referral that was made within 4-months of the offender's admission. Treatment-oriented services included: group or individual counselling; group or individual mental health counselling; psychiatric clinic; skills training, self-care or activities of daily living; suicide or self-injury intervention; and, treatment planning.
[39] Date of admission to a regional treatment centre was between the offender admission date in fiscal year 2013-14 or 2014-15 to the data extraction date in September, 2015.

- Among those offenders screened out who did receive treatment, mental health need may have been identified through other intake assessments[40] particularly since research indicated that each of the three mental health intake assessment tools uniquely identify offenders requiring mental health follow-up.[lix]Alternately, the referrals and treatment may have been required as a result of an urgent or emerging need within the intake period.

CoMHISS may be over-sensitive in that some offenders *flagged* for further mental health assessment did not receive mental health treatment:

- Many offenders (60%; n=1222 of 2034) who were flagged by CoMHISS received mental health treatment.
- A few offenders (2.5%; n=50) flagged by CoMHISS refused services.[41]
- Some offenders (37.5%; n=762) flagged by CoMHISS did not receive any mental health treatment for a referral made during admission, suggesting that the tool may be over-sensitive.
- This finding is consistent with results from staff questionnaires:
  - Many (75%, n=14) health services staff familiar with the administration of CoMHISS reported challenges with respect to the accuracy of CoMHISS in identifying offender health needs. The most commonly noted issue was that there were a number of "false positives" or that the tools screened in offenders for further assessment who did not have a mental health need.
  - About half (53%, n=10) of health services staff respondents also reported challenges making referrals based on results of CoMHISS, most commonly noting that that offenders were unnecessarily screened-in for further assessment.
- The current version of CoMHISS includes assessment of ADHD as well as cognitive deficits.[42] Although offenders with these conditions may be flagged by CoMHISS, they may not necessarily be referred for treatment but rather results would be taken into consideration in assessing programming needs.

[40] This information was not available, since the sources of other referrals for mental health treatment (other than CoMHISS) are not tracked electronically.
[41] 1 offender refused the referral and 49 offenders refused at least one mental health service. The service may have been a treatment-oriented service or another service (such as an assessment that may have led to a future treatment-oriented service). Therefore all were included as refusals in this analysis.
[42] Other issues may have impacted on these results, including the possibility that CoMHISS referrals or treatment were delayed beyond the initial intake period, or that data entry errors occurred in MHTS.

Health services intake assessment tools are generally responsive to the needs of specific offender populations. However a minority of staff members indicated that there may be communication or cultural challenges to the administration of health services intake assessment tools for Indigenous and visible minority offenders.

- Information for the intake assessment period was reviewed (where available) for the following groups of offenders: Indigenous offenders, visible minority offenders, older offenders, and women offenders.
- Based on the available information from staff questionnaires, offender interviews, and health services performance measurement data, the assessment tools were reported to be generally responsive to the needs of these specific offender populations (see Appendix D for more detailed information for specific populations).
- However, a few challenges to the intake assessment process were reported for Indigenous and visible minority offenders.
    - Although most health service staff respondents did not report any challenges for specific populations, a few reported that there were communication or cultural challenges[43] in completing intake assessments for Indigenous (n=10) or visible minority offenders (n=15).
- Most health services staff (61%, n=34)[44] and Indigenous offender respondents[45] (78%, n=18) reported that Elders were rarely involved in completion of intake assessment tools, but many Indigenous offenders interested in following a traditional healing path reported that having an Elder present would have been helpful (n=11).[46]

[43] Communication and cultural challenges include language barriers and barriers with the assessment not identifying offenders' mental health issues due to cultural differences surrounding beliefs about mental health.
[44] Percentages for staff ranged from 61% for 14-day intake assessment to 73% for COMHISS or infectious disease screening (see Appendix D for more information).
[45] This represented the percentage of Indigenous offenders interested in following a traditional healing path who reported that they did not have an Elder present during health intake assessments.
[46] The presence of Elders during health intake assessments is not specified in health services guidelines with the exception of CoMHISS where, according to the *National Guidelines: Version 2.2* (June 2014), offenders may request the presence of an Indigenous advisor during the CoMHISS assessment.

3.4 EFFICIENCY OF HEALTH SERVICES INTAKE ASSESSMENT PROCESS

FINDING 4: EFFICIENCY OF HEALTH SERVICES INTAKE ASSESSMENT PROCESS

Duplication of offender health information collected through CSC health services intake processes and tools results in inefficiencies in assessing offenders' health care needs.

Evidence: Assessment Process

Health services intake assessment policies and guidelines result in repeated administration of health service intake assessments, particularly for the 24-hour intake assessment.

- According to CSC health services guidelines, at admission, all offenders arriving at a CSC institution must be offered a health assessment, including: *24-hour Intake Health Status Assessment; 14-day Intake Health Status Assessment, 14-Day Infectious Disease Screening; and Computerized Mental Health Intake Screening System*.
- Furthermore, there exist additional guidelines for the administration of these four health intake assessments at various points along an offender's sentence:
  - 24-hour assessment: must be conducted following a court return, an inter- or intra-regional transfer and/or a warrant of suspension.[lx]
  - 14-day assessment: must be offered to offenders who are re-admitted to CSC following a period of release to the community for more than twelve months and those who resided in the community for less than twelve months but have had significant changes in their health status within that period.
  - Infectious disease screening: must be offered to offenders who are re-admitted to CSC following a period of release to the community for more than twelve months and those who resided in the community for less than twelve months but have had significant changes in their health status within that period.
  - COMHISS assessment: may be offered to offenders re-admitted to the institution on suspension, revocation or transfer at the institution's discretion.[lxi]
- When asked about the appropriateness of the criteria for the intake assessment tools, health services staff members reported that there was repetition within the assessment process:

- 24-hour assessment: About half (53%, n=31) of health services staff members reported that they disagreed with the requirement to conduct the assessment after a brief absence from the institution. Respondents agreed that this criterion was unnecessary as some offenders only go out for a few hours, for example to go to court (n=22), and that an alternative form/assessment should be developed for this population (n=13).
- 14-day assessment: Some (30%, n=17) health services staff reported that they disagreed with the criteria for the 14-day assessment. They suggested that conducting the assessment is unnecessary for all offenders returning from the community (n=15).
- Infectious Disease screening: Few (13%, n=6) health services staff reported that they disagreed with the criteria.
- COMHISS assessment. Few health services staff (18%, n=4) reported that they disagreed with the criteria.

Evidence: Assessment Tools

There is repetition of information collected across health related intake assessment tools, particularly concerning mental health information.

Duplication of information between health services intake assessment tools:

- Mental health information is collected by three of the four health services assessment tools: the 24-hour assessment, 14-day assessment, and CoMHISS.[47] Duplicate information on suicide/self-injurious behaviour, medication for mental health disorder, depression/sadness, and mental health diagnosis, assessment, or treatment is collected through at least two of these tools.
- Physical health information, at the time of the evaluation, is collected by three of the four intake assessment tools: the 24-hour assessment, 14-day assessment, and infectious disease assessment. Duplicate information on current physical health needs, infectious diseases, and use of tobacco is collected by at least two of these tools.
- Many health services staff members agreed that there was unnecessary duplication of health information across the health services intake assessment tools (69%, n=40).

[47] These assessment tools are administered through different sources, formats and timeframes. For example the 24-hour assessment is administered early, it assesses offenders' immediate needs, and it is administered by a nurse. CoMHISS is administered after the 24-hour assessment, collects a broader scope of mental health information (including ADHD and cognitive deficiencies), and it is self-administered by the offender on a computer.

- Most commonly, health services staff members reported that the 24-hour assessment and the 14-day assessment were repetitive of one other (n=14) and CoMHISS was identified as being repetitive with other intake assessment tools (n=4).
- Health services staff identified mental health and suicide/self-injury risk information as being repeated across various assessment/screening tools (n=19).

Duplication of information between health services intake assessment tools and other CSC health-related assessment tools:

- In addition to the four health specific intake assessment tools identified above, (which are administered by health services personnel), several other CSC health-related assessment tools may also be administered at intake by other personnel (e.g., correctional officers, parole officers, correctional program officers). Several of these tools also collect health-related information:
  - Offender Intake Assessment: in addition to information related to criminal history and risk, the Offender Intake Assessment collects information related to substance use and coping;
  - Immediate Needs Checklist – Suicide Risk: used by non-clinical staff to identify offenders who may be at risk for suicide; and,
  - Computerized Assessment for Substance Abuse, Specialized Sex Offender Assessment, Spousal Assault Risk Assessment: these assessments collect mental health information related specifically to the topic of the assessment tools (e.g., substance use, sexual deviance, risk for family violence, etc.).
- Most health services staff members (82%, n=37) and some other staff members[48] (31%, n=11) reported that there was unnecessary duplication of health information between health services intake assessment tools and other assessment tools completed at intake.
  - The most commonly noted issue was duplication of mental health information (including suicide risk) across multiple assessment tools (health services staff, n=23; other staff, n=8).
  - Some health services staff members mentioned sources of duplication, reporting that the Immediate Needs Checklist – Suicide Risk and the 24-hour assessment were the most repetitive (n=5) followed by the Immediate Needs Checklist – Suicide Risk and CoMHISS (n=3).

[48] Note that many non-health services staff members reported that they did not know whether there was duplication or not. Percentages here are reported out of those staff members who were knowledgeable about the issue.

Efficiency of health services intake assessment tools:

- In addition to the repetition of information collected through intake assessment tools, these tools were also reported to be too lengthy.
  - Health services staff members reported that they experienced challenges in the efficient administration of: the 24-hour assessment (30%, n=16), the 14-day assessment (43%, n=23) and COMHISS assessment (62%, n=13).[49]
  - The most commonly noted issue was that there was repetition of information collected through the tools (n=21).
  - Some staff also reported that the assessments were too lengthy (n=10).

The duplication of information between assessment tools leads to duplication of health referrals.

Mental Health Referrals:

- Offenders undergo multiple assessments, any or all of which may identify a need for a mental health referral, resulting in multiple referrals for mental health follow-up and inefficiencies in the referral process.[50]
- Most health services staff members reported that at least occasionally, multiple referrals were submitted for an offender for the same mental health care service[51] (85%, n=78).
  - Specifically, multiple referrals occurred between *different health services intake assessment tools:* Health services staff most commonly reported duplicate mental health referrals between the 14-day and 24-hour (54%, n=27), between the 14-day and CoMHISS assessments (46%, n=17); and between the 24-hour and CoMHISS assessments (36%, n=18).
  - Multiple referrals also occurred between *health services intake assessment tools and other CSC health-related assessment tools:*[52] About half of health services staff reported duplicate mental health referrals between other health related assessments conducted at intake and: the 24-hour (52%, n=26), 14-day (51%, n=19), and CoMHISS assessments (53%, n=19).

[49] Few staff members (9%, n=4) identified challenges in the efficient administration of the infectious disease screening.
[50] Referrals may also be submitted as a result of offender self-referral or staff observation.
[51] For duplication of mental health care referrals: occasionally (21%), frequently (60%), always (4%).
[52] Health services staff also reported that duplicate referrals came from health services intake assessment tools and staff referrals or offender self-referrals. Health services staff also noted that duplicate referrals are sometimes received from multiple different staff members (e.g., nurses, correctional officers).

- Analysis of data in Health Services' Mental Health Tracking System (MHTS; which includes information on offender referrals and services) also indicates that multiple referrals for offenders are made for offenders early in their sentence.[53]
- Specifically, 61% of offenders in the sample (n=5643) were referred for a mental health service within the first month of admission to the institution, and 35% (n=3275) had multiple referrals during the first month.[54]
- However, only a few of these offenders (n=68) had a referral that was cancelled because there were duplicate referrals prior to assigning them to a mental health professional.[55]
- Based on the data in the MHTS, it was not possible to determine which assessment tools (if any) were more likely to result in a duplicate referral.[56]
- However, results of a file review conducted by CSC's Research Branch indicated that 21% of offenders had multiple referrals for further mental health assessment that were generated from some combination of the 3 intake assessment tools that collect mental health data (i.e., 24-hour assessment, 14-day assessment, COMHISS).[57] [lxii]
- The same file review also found that each tool uniquely identified some offenders in need of mental health follow-up that the other tools did not (i.e., CoMHISS uniquely identified 13% of offenders; 24-hour assessment: 5%; 14-day assessment: 5%).[lxiii]
- Therefore, it is not possible based on these results, to determine whether any one tool (or set of tools), could effectively identify mental health needs in a more efficient manner.

[53] Once an offender has completed an intake assessment and is determined to require a mental health referral, forms are completed and subsequently reviewed by the Chief Psychologist (or delegate) to determine the appropriate follow-up action. The evaluation team examined mental health services data for a two-year admission cohort (FY 2013-2014 and FY 2014-2015) of all federal offenders admitted with a warrant of committal to a federal institution. It is important to note that offenders admitted to a regional treatment centre are considered to have the highest level of mental health need and their mental health service information are not consistently entered into MHTS. Therefore, referrals within MHTS pertaining to offenders who were admitted to a regional treatment centre were excluded from analysis because the data would not be comprehensive for these offenders.

[54] Of all offenders who had at least one referral (n=5643), 42% (n=2368) had only one referral and 58% (n=3275) had multiple referrals (32% received two referrals and 26% received three or more referrals).

[55] These 68 offenders accounted for 75 of the referrals cancelled as duplicate referrals. Those referrals that are assigned to a mental health professional may subsequently result in further treatment, or the referrals could be cancelled by the mental health professional for reasons that could include cancellations due to duplicate referrals.

[56] MHTS tracks by whom the referrals were made (e.g., mental health staff, health staff, parole officer, offender), but it does not identify the assessment tool from which the referral was made.

[57] 5% were referred based on all 3 tools; an additional 8% had referrals from both CoMHISS and the 24-hour assessment; 5% had referrals from both CoMHISS and the 14-day assessment; and, 3% had referrals from both the 24-hour and the 14-day assessments.

Physical Health Referrals:

- Most health services staff members reported that at least occasionally, multiple referrals were submitted for an offender for the same physical health care service[58] (81%, n=58).[59]
- Health services staff reported duplicate referrals: between the 14-day and 24-hour assessments (57%, n=24), between the 14-day and infectious disease assessments (52%, n=17), and between the 24-hour assessment and infectious disease screening (31%, n=13).[60]

Implications:

- **Workload:** Many health services staff members reported that the duplication of physical (62%, n=28) and mental health referrals (51%, n=26) is problematic, noting that multiple referrals for the same service causes an increase in workload for health services staff (n=34). Staff described increased workload resulting from issues such as:
  - Duplication of administrative tasks (n=10);
  - Duplication of services provided directly to offenders (n=6); and,
  - Confusion among staff concerning the status of a referral (n=8).
- **Correctional Setting:** Most health services respondents (82%, n=64) also reported challenges in completing health intake assessment/screening as a result of working in a correctional environment, including:
  - Operational issues impacting on access (e.g., lockdowns, movement/incompatibility issues, n=45);
  - Adequate and confidential work space (n=26);
  - Staffing resources such as sufficient staff/escorts to facilitate offender access for assessments (n=9); and,
  - Offender competing priorities/commitments (n=7).
- **Timeliness:** Results also indicate that there are challenges to complete some of the intake assessment tools on time, particularly the 14-day intake assessment (67%) and the 14-day

[58] For duplication of physical health care referrals: occasionally (26%), frequently (46%), always (8%).
[59] Information on physical health referrals is not currently tracked electronically. Therefore, it was not possible to assess the degree to which multiple referrals for physical health care may be made for offenders through any source of physical health data.
[60] Note that a small percentage of staff also reported duplication between each of the four main health services assessment tools and *other* health related tools conducted at intake. However, respondents did not specifically identify which of the other health related tools included duplicate physical health information.

infectious disease screening (65%), which were implemented within the timeframes outlined in health services guidelines less than 70% of the time.[lxiv]

Next Steps:

- Health services staff members had several suggestions for improving efficiency and reducing duplication of health services tools or processes, including:
  - Reviewing, streamlining, and combining health-related intake assessment forms (n=30);
  - Identifying the most effective intake assessment tools and eliminating the others (n=8);
  - Implementing a centralized electronic health care record (n=36);
  - Implementing a tracking/monitoring system for referrals (n=11); and,
  - Facilitating access to pre-existing offender health information (e.g., community hospital records, n=21; provincial correctional facility records, n=16).
- **Intake Assessment Process:** CSC Health Services is implementing changes to the guidelines concerning Health Care Requirements on Reception and Transfer, in order to reduce the repetition of health services assessment tools within short time frames.
- **Assessment Tools – Physical Health:** CSC Health Services has made changes to the assessment of offender physical health by eliminating repetitive physical health information in the 24-hour, 14-day, and infectious disease assessments, and combining the information into one assessment of physical health to be completed within the first 24 hours of admission.
- **Assessment Tools – Mental Health:**
  - CSC requires more information on the tools to ensure an effective and efficient screening process.[lxv] There is repetition of mental health information collected through health services assessment tools (i.e., 24-hour, 14-day, CoMHISS), and through other assessment tools collected at intake (e.g., Immediate Needs Checklist – Suicide Risk), and also duplication of mental health referrals. Results of recent research[lxvi] also suggest some degree of overlap as well as uniqueness among three health services intake assessment tools (24-hour, 14-day, CoMHISS) in identifying offenders for further mental health follow-up.
    Additional research will be required to determine which mental health assessment tool (or combination of tools) will effectively identify offender mental health needs in the most efficient manner.

RECOMMENDATION 2: EFFICIENCY OF HEALTH SERVICES INTAKE ASSESSMENT TOOLS AND PROCESSES

That CSC Health Services endeavor to increase the efficiency of health-related intake assessment processes by considering the following:

- Eliminating the requirement for repeated administration of health assessments;
- Optimizing and eliminating unnecessary repetition of health information between assessment tools; and,
- Ensuring health referrals are appropriately recorded and monitored.

FIFE #3: OFFENDER ACCESS TO CARE AND SERVICES

The following section provides an overview of offenders' access to clinical, public, and mental health care during incarceration. We also examined specific activities where challenges and opportunities were identified related to: provision of specialist services, offender transfers, and health information sharing.

3.5 ACCESS TO CLINICAL, PUBLIC, AND MENTAL HEALTH CARE

FINDING 5: ACCESS TO CLINICAL, PUBLIC, AND MENTAL HEALTH CARE

CSC offenders have access to clinical, public, and mental health care to address their needs. The majority of offenders receive initial mental health services according to established time-frames; clinical health services are not tracked electronically. Health Services is in the process of implementing an Electronic Medical Record.

Evidence: Access to Care and Services – Clinical, Public, and Mental Health

- CSC has a responsibility to provide health services as prescribed by the Corrections and Conditional Release Act (CCRA): "The Service shall provide every offender with: essential health care and reasonable access to non-essential mental health care that will contribute to the offender's rehabilitation and successful reintegration into the community".[lxvii]
- Within CSC, the Health Services Sector provides clinical (including medical and dental), mental, and public health services for offenders.
- CSC's National Essential Health Services Framework outlines the procedures required to access essential and non-essential health services, the coverage available, and the guiding principles used by staff to determine eligibility for essential and non-essential clinical, public, and mental health services. Offender requests are reviewed and prioritized according to urgency and services are provided by a health care provider.[lxviii]
- Incarcerated offenders may access health services by:[lxix]
    - Self-referral - submitting an offender request to Health Services, or
    - Institutional staff referral – health services staff or any staff member in the institution, or
    - Health Care Centre drop-in hours (where available).

Clinical and Public Health

Assessment, screening, and treatment for clinical and public health needs occur on an ongoing basis throughout incarceration. Wait times for clinical and public health services are not tracked electronically, although some offenders reported clinical health services were not received in a reasonable timeframe.

Clinical Health: Acute and Chronic Issues

Clinical services refer to "assessment, diagnosis and treatment of acute and chronic physical illnesses." [lxx] Through clinical health services, offenders receive medical and dental care. Essential clinical health services include services such as: diagnostic services and treatment, assistive devices and mobility aids (e.g., wheelchairs, canes, hearing aids), vision care, and dental care (with a focus on pain relief and management of infection, disease management, and education on good or proper oral hygiene). [lxxi, 61]

- Most of the offenders sampled reported (92%, n=136) that over the last year they had made requests to see a health care professional for general clinical health care issues, and most reported (89%, n=120) that the requests resulted in an appointment.[62]
    - Among the few offenders (11%, n=15) who reported that requests did not result in an appointment, 9 indicated that they were waiting to see a medical professional (e.g., dentists, doctors, optometrists).

Public Health: Infectious Diseases

Through public health services, CSC provides treatment, screening and testing for infectious diseases. Initial screening and testing is offered to all offenders upon admission, regardless of their risk profile.[lxxii] Throughout incarceration, testing is also available at the offender's request, upon recommendation by health services staff, or following an incident where exposure to infection may have occurred. Testing for tuberculosis (TB) is offered to all inmates one year post-admission and every two years thereafter. Not all inmates request health-related testing during their incarceration; all testing is voluntary.

[61] Non-essential clinical health services may consist of orthotics, respiratory devices, chiropractic services, and fluoride treatments. Such services are at the offender's expense; Health Services may assist in coordinating the offender's access to these services.

[62] Clinical health related appointments within the last year: 90% (n=122) of offenders reported having had an appointment with a doctor, 61% (n=83) with a nurse and 32% (n=44) with a dentist.

- Rates of screening and testing that occurred among inmates throughout their incarceration (post-admission) in 2014-15 were:
  - Blood borne and sexually transmitted infection assessment: 31%[lxxiii]
  - TB assessment: 82%[lxxiv]
  - Human immunodeficiency virus (HIV) test: 24%[lxxv]
  - Hepatitis C virus (HCV) test: 23%[lxxvi]
- Following infectious disease screening, offenders with an infection are offered treatment. For example, in the calendar year 2014:[lxxvii]
  - The average monthly number of offenders receiving treatment for HIV nationally was 156, representing 91% of the average monthly number of active cases (N=171);[63]
  - The number of offenders treated for HCV nationally was 151.
- Among offenders sampled (34%, n=49) who reported that they had made requests to see a health care professional for infectious disease issues over the last year, most (86%, n=42) reported that the requests they made resulted in an appointment.
  - Among the offenders (14%, n=7) who reported the requests had not yet resulted in an appointment, 4 indicated that they considered the wait time for treatment to be long. Time between referral for infectious disease treatment and treatment is not tracked, so average times between referrals and appointments could not be determined. According to health services guidelines, offender requests are reviewed and prioritized according to urgency.[lxxviii]

Timeliness of Service:

- According to *Commissioner's Directive (CD) 800: Health Services*:[lxxix]
  - The Institutional Head will ensure that a process is in place to allow offenders to submit in confidence a request for health services and to facilitate access to these services;
  - All institutional staff/contractors will relay an offenders' request for health services to a health care professional in a timely manner;

[63] "Offenders in CSC who are known to be infected with HIV are offered treatment for infection. Decisions on starting the treatment and remaining on treatment due to side effects, resistance or response are clinical decisions made by the treating infectious disease expert and the patient." (p.14)

  - The current Commissioner's Directive for Health Services does not include a timeframe for response to a request. However, the previous *Commissioner's Directive 800: Health Services* (2011) stated that offender requests must be dated and a signed response must be provided to offenders within 15 days.
- Most health services staff (78%, n=83) and many general staff (60%, n=71) agreed that offenders have access to clinical health care in a timeframe that is appropriate for their level of need.
- Many offenders reported (58%, n=69) that the appointments they received for their clinical health care issues were within a reasonable timeframe.
  - Among those who disagreed (42%, n=50), they reported long wait times for services such as: dental care, specialists/community practitioners, and optometry services. However, wait times for specialist services also exist in the community, and offender access to community specialists is also dependent on community wait times. Time between referrals and clinical services, including specialist services, is not tracked, so average times between referrals and appointments could not be determined.
- Most offenders reported (78%, n=31) the appointment(s) they received for their public health (infectious disease care) needs occurred within a reasonable timeframe.
- Clinical health services are not recorded electronically. However, CSC is currently in the process of implementing an Electronic Medical Record which will allow greater access to clinical health information.

Mental Health

Assessment and treatment for mental health care needs occurs as required throughout incarceration. The majority of initial institutional mental health services were provided within 7 days of referral. Access to mental health services occurs in a timely fashion according to most offenders interviewed.

Mandated under the CCRA, CSC is responsible to "provide every inmate with essential health care and reasonable access to non essential mental health care".[lxxx] Essential mental health services are needed and provided when an offender has significant mental health needs in the areas of emotion, cognition and/or behaviour indicative of a mental health disorder.[lxxxi] Furthermore throughout

incarceration, an offender can access primary mental health care, intermediate mental health services[64] and specialized services in the form of intensive care at Regional Treatment Centres.[lxxxii]

- Of the total institutional flow-through population[65] in 2014-15 (n=20,657), 45%, (n=9,371) of offenders received at least one mental health service in the institution; and in total, there were 18,872 initial institutional mental health services provided. [lxxxiii, 66]
- Among offenders (36%, n=52) who reported that they had asked to see a mental health professional over the last year, most reported (85%, n=44) that their requests resulted in an appointment.[67]
    - Among the few offenders (15%, n=8) who reported that requests did not result in an appointment, the most common reason was being waitlisted to see mental health professional (e.g., psychologists, psychiatrists) (n=4).

Timeliness of Service:

- A total of 3,983 offenders were screened by the Computerized Mental Health Intake Screening System (CoMHISS) in 2014; of those, 27% (n=1,081) were identified as requiring mental health follow-up care, and, of those, 95% received a service within the designated timeframe of 50 days from admission or 40 days from referral.[lxxxiv, 68]
- In 2014-15, 60% (n=11,405) of initial institutional mental health services were provided within 7 working days and 84% were provided within 28 working days of being requested.[lxxxv]
- Many health services staff (72%, n=88) and about half of general staff (51%, n=56) agreed that offenders have access to mental health care in a timeframe that is appropriate for their level of need.
- Most offenders reported the appointment(s) they received for their mental health needs occurred within a reasonable timeframe (80%, n=35).

[64] Intermediate mental health services were not included in the scope of this evaluation due to the fact that intermediate mental health care was not fully implemented in CSC institutions at the commencement of the evaluation.
[65] Flow-through population refers to the number of offenders that have been in an institution over a given time period.
[66] Mental h**e**alth services may include counselling, crisis intervention, and skills training.
[67] Mental health related appointments within the last year: a few offenders reported having had an appointment with a psychiatrist (24%, n=33), psychologist (21%, n=29), or social worker (3%, n=4).
[68] Percentage of flagged offenders who received a follow-up service by region in 2014: Atlantic 99% (n=207); Quebec 98% (n=212); Ontario 99% (n=270); Prairies 93% (n=286); and, Pacific 73% (n=53). Offenders are to receive a follow-up service within 50 days of admission or 40 days from referral.

Challenges to Health Services Delivery and Areas of Opportunity

A review of CSC documents such as Boards of Investigations (BOIs), Mortality Reviews, Accreditation Reviews, Compliance and Operational Risk Reports (CORR) was conducted to identify any specific challenges or common themes. Staff members and offenders were also asked for their input and suggestions. Finally, a scan of the literature in the area of correctional health delivery was conducted to determine any good practices, and any areas of opportunity for CSC to improve access to quality and timely care.

3.6 ACCESS TO COMMUNITY HEALTH CARE SPECIALISTS

FINDING 6: ACCESS TO COMMUNITY HEALTH CARE SPECIALISTS

The provision of community health care specialist services for offenders for non-urgent care is subject to wait times in the community. CSC uses telemedicine (where provincial telemedicine programs are available) to address procedural issues associated with health care specialist appointments in the community. CSC does not systematically collect data regarding referrals to specialist services (in-person or telemedicine).

Evidence: Community Health Care Specialists

CSC provides specialist services to offenders in the areas of mental, clinical, and public health. Staff reported challenges in facilitating offender access to health care specialists in the community.

- CSC provides general health care services through health care professionals such as nurses and psychologists employed by CSC and doctors contracted to provide general care. Appointments with physicians/specialists and other health care professionals occur according to need and institutional operational requirements. When offenders are referred to community medical/psychiatric services, they are subject to the same waiting periods as the general Canadian population.[lxxxvi]
- Multiple specialist services are provided in the areas of clinical, public, and mental health, but electronic data was unavailable to provide reliable statistics on the number of various specialist services accessed or the time required accessing them. The Mental Health Tracking System (MHTS) could not be used to consistently track the number and timeliness of psychiatric

services offered to offenders. However, the implementation of the Offender Health Information System- Electronic Medical Record (OHIS-EMR) will allow psychiatrists to use the system to record their appointments with offenders, enabling more reliable tracking of these services.

- Procedural challenges (availability of security escorts, security clearance for contractors) were reported by health services staff and general staff related to heath care contractors and specialists coming into CSC to provide services (health services staff 64%, n=58; general staff 46%, n=29) and to offenders going out into the community for specialist services (health services staff 62%, n=55; general staff 29%, n=20).
- Procedural issues related to requirements for Specialist Services may include:
  - Wait Times:
    - Staff reported wait times and limited hours to access specialist care (health services staff: n=17; general staff: n=19).
  - Escorts:
    - Staff reported challenges associated with security escorts (e.g., resources required, availability of escorts, etc.) for appointments in the community (health services staff n=20; general staff n=9).
  - Recruitment:
    - Staff reported challenges in the recruitment and retention of community specialists (e.g., their willingness to work with offenders, or to work in a correctional environment) (health services staff n=13; general staff n=5).
  - Administrative/Logistical:
    - Obtaining security clearances for community specialists (health services staff n=9; general staff n=2).
    - Administrative requirements and scheduling challenges (health services staff n=9; general staff n=3).
    - Correctional environment and limited space for delivery of health services (health services staff n=10; general staff n=4).

Telemedicine has been implemented in some institutions within CSC regions with the goal of increasing offender access to essential health services including community specialists.

Telemedicine is the delivery of health care services and information using telecommunication technologies. Through live interactive video and electronic diagnostic equipment inmates can be seen remotely by specialists for assessment, consultation and ongoing treatment monitoring. The use of telemedicine is in its infancy in many jurisdictions across Canada. CSC's use of telemedicine mirrors the availability of the required infrastructure within individual provinces. For example, the province of Ontario has put in place a comprehensive telemedicine infrastructure network and reports significantly higher rates of service delivery than other provinces.[69, lxxxvii] Supported by the availability of telemedicine in the province of Ontario, CSC's Ontario region is the most advanced in terms of using this technology. CSC uses telemedicine to access a range of specialty services detailed below. Telemedicine is an important mechanism for effectively and efficiently accessing services for inmates (e.g., timely access and avoid costly medical escort).[lxxxviii]

- Results of the Health Services Accreditation Report (2014) noted that there were opportunities to increase the use of telemedicine in CSC, particularly for the Atlantic, Quebec, and Prairie regions.[lxxxix]
- Telemedicine was implemented in CSC in the Ontario region in 2008. CSC's partner in Ontario is the Ontario Telemedicine Network (OTN). OTN provides technical and operational supports for telemedicine delivery; it is an independent, not-for-profit organisation funded by the Ontario Government.[xc] A new partnership agreement between CSC and OTN was re-negotiated and signed in 2015. Currently, all CSC Ontario institutions use Telemedicine.
- Objectives for use of telemedicine in CSC include:[xci]
    - Increased access to essential health services for offenders, including access to specialists
    - Faster patient care/decreased wait times
    - Cost savings related to reduced number of medical ETAs
- In 2015, telemedicine was being used in all 5 regions in different capacities (e.g., after-hours care, specialist services) and to different degrees across institutions. Implementation across CSC's 5 regions differs based on available provincial technology infrastructure and progress in addressing issues related to provincial health professional college guidelines/licensing, physician

[69] Note that there may be some differences in reporting practices across provinces.

reimbursement, etc. It is possible that CSC's telemedicine infrastructure growth will be commensurate with provincial infrastructure expansion. By the fall of 2015, the following was reported regarding usage of telemedicine across CSC:

- Telemedicine for Specialist Services:[xcii]
  - Atlantic: Telemedicine provides access to a variety of specialists in some institutions including; infectious disease, urologist, surgeons (pre-admission and surgical follow-up) and respirology.
  - Quebec: Telemedicine consultations are offered with microbiologists for offenders with HCV and psychiatrists for offenders at Port Cartier institution.
  - Ontario: Telemedicine is used to provide a variety of specialist services in some institutions, some of which include; cardiology, diabetes clinic, dietician, orthopedic/pain clinic, congestive heart failure clinic, urology, psychiatry and infectious disease, general surgery, methadone, rheumatology, dermatology.
  - Prairies: Telemedicine is used in some institutions for the following clinics; infectious disease, dermatology, neurology, dietician, palliative care, oncology, and psychiatry services.
  - Pacific: no specialist services available via telemedicine.
- Telemedicine for After-Hours Care:
  - Most regions (Pacific, Ontario, Prairie, and some Atlantic institutions) support access to CSC Regional Hospitals outside of regular business hours, using telemedicine.

Impact of Telemedicine in CSC:

- Telemedicine in CSC is not currently available in all institutions for reasons described above (provincial infrastructure; provincial health professional guidelines/licensing etc), and the types of services vary across institutions and regions. However, some preliminary evidence regarding the impacts and offender satisfaction with telemedicine were available from the Ontario Region.
- Results of a 2011-2012 Ontario telemedicine satisfaction survey conducted with offenders who had used telemedicine to access health services indicated that:
  - Most offenders (79%, n=122) were satisfied or very satisfied with their telemedicine experience;

  - Most offenders (81%, n=126) felt comfortable talking to the doctor using telemedicine technology; and,
  - Most offenders (80%, n=122) felt they received enough information about the telemedicine appointment and the equipment used and felt comfortable asking questions about their appointment.
  - Although overall level of satisfaction was relatively high, some offenders who responded to the survey suggestion (n=14) reported a preference to see a doctor in person.
- The Ontario Region reported some preliminary evidence of the impact of telemedicine on access to after-hours services:
  - Between January and July 2015, the Ontario Regional Hospital received 61 "after hours" phone calls through telemedicine: 22/61 calls were sent to outside hospital and 33/61 were recommended to follow-up with an institutional nurse the next day.[70]

Telemedicine has also been successfully utilized in some US correctional systems to increase access to community specialists.

- Telemedicine has also been used to facilitate increased access to community specialists in other jurisdictions such as the United States (US).[xciii] Several US correctional systems[71] reported benefits of telemedicine, including:
  - <u>Increased Access and Reduced Escorts to Community:</u> Telemedicine has the potential to improve access to doctors and specialists and reduce escorts to the community, for example:[xciv]
    - Some prisons were able to obtain services through telemedicine that would have otherwise been unavailable. For example, Pennsylvania prisons were able to obtain services from an infectious disease expert to care for HIV positive prisoners through telemedicine.
    - Psychiatrists were accessible more often via telemedicine resulting in more effective medication management and monitoring of offenders with psychiatric illness; this was thought to stabilize patients and avoid crisis.

[70] The statuses of the other 6 calls were: 1 individual was admitted to the Regional Hospital, 2 individuals refused care and 3 were disposition unknown.
[71] Under the U.S. Department of Justice, the U.S. correctional systems included in the review were federal prisons in: Colorado, Pennsylvania, Louisiana, Wyoming, and Texas.

    - The use of telemedicine allowed correctional facilities to avoid 35 trips to outside specialists.
  - Wait times: While using telemedicine, the time between a prisoner's initial referral and the appointment with the specialist decreased. Before telemedicine the average wait time to see a specialist was 99 days, after telemedicine the average wait time was 23 days.[xcv]
  - Recruitment: More health professionals may be willing to work with offenders through telemedicine as specialists no longer have to travel and it provides easier access.[xcvi]

Community health care specialist services are delivered in the context of the Canadian health care system and offenders are subject to similar wait times for specialist health care services as the general Canadian population. Usage of telemedicine varies across Canadian provincial health systems.

Health Care in the Canadian Context:

- When offenders are referred to community medical services, they are subject to waiting periods for specialist health care services, similar to the general Canadian population.[xcvii]
- In 2014 and 2015, the Canadian national median wait time for a referral by a general practitioner to an appointment with a specialist was approximately 8.5 weeks. The national median wait time from an appointment with a specialist to treatment was just under 10 weeks.[xcviii]
  - The longest wait time for a referral from a general practitioner to an appointment with a specialist was in Prince Edward Island (28.3 weeks) while the shortest were in Saskatchewan and Ontario (6.7 weeks and 6.8 weeks).
  - The longest wait time between appointments with a specialist to treatment was in Newfoundland & Labrador (20.5 weeks) while the shortest was in Saskatchewan (6.9 weeks).
- In 2004, the Government of Canada developed the 10-Year Plan to Strengthen Health Care, which involved committing $5.5 billion to reduce wait times to quality health care by training and hiring more health care professionals, addressing backlogs, and expanding treatment and services.[xcix]
- Telemedicine is being used in Canada as an alternative method of health services delivery. It can be used to reach individuals in rural or remote locations and is used to provide home-care, clinical and educational services.

- CSC's access to telemedicine is driven by its use in the provincial health care system relevant to the CSC region and institution. Comparing telemedicine programs within Canada is complicated due to the differences in telemedicine programs and the program data that are available.[c]
- The availability of telemedicine to Canadians varies in terms of where it is offered, how it is offered and what services are offered. For example, there are different types of technology used (e.g., connection through video camera, use of digital stethoscopes, and robots), types of services available (e.g., psychiatry services, paediatrics, infectious disease services) and telemedicine can be community or hospital-based. In 2012, the three most common types of services delivered by telemedicine in Canada were:[ci]
  - *Mental Health (Psychiatry and Psychology)*
  - *Cardiology, Diabetes, Genetics, Oncology*
  - *Chronic Pain, Neurology, Rehabilitation (Occupational Therapy), Rehabilitation (Physiotherapy)*
- The structure of telemedicine programs also differ between provincial/territorial jurisdictions, for example: telemedicine is coordinated by a single provincial program in Ontario, Manitoba and Newfoundland and Labrador; whereas, in British Columbia, New Brunswick and Nova Scotia, telemedicine programs are regional or health authority based; telemedicine programs can also be hospital based.[cii] Ontario has the largest usage of telemedicine in Canada and has experienced growth rates of approximately 30% per year over the last few years yet makes up less than 0.1% of the provincial health budget.[ciii]
- Physician reimbursement, funding for equipment, training for health practitioners, increased bandwidth and improved comfort levels with technology by health practitioners are all areas where there is opportunity for improvement if the use of telemedicine is to spread across Canada.[civ]

RECOMMENDATION 3: ACCESS TO COMMUNITY HEALTH CARE SPECIALISTS

That CSC Health Services collect data on wait times to access selected specialists services for non-urgent care; and implement strategies (for example increased use of telemedicine where appropriate) if wait times exceed available Canadian benchmarks.

3.7 TRANSFERS

FINDING 7: TRANSFERS

Challenges to continuity of care and information sharing or documentation during transfers were identified. Inaccurate information sharing may be a result of incomplete documentation in the Health Services Transfer Summary forms.

Evidence: Transfers

Transfers for federal offenders can occur within the same region (intra-regional) or to a different region (inter-regional) for numerous reasons, such as penitentiary placement, for access to a service or treatment (e.g., cultural program, intensive mental health treatment), to be closer to home or a community, or be security-related. Transfers can also occur on a voluntarily, involuntarily, or emergency basis.[cv]

Health services staff and offenders reported challenges to continuity of care and information sharing related to transfers. Incomplete documentation of health information in the Health Services Transfer Summary form is currently being addressed through regional health services action plans.

- Many health services staff reported experiencing challenges in ensuring the continuity of health care services and treatments when offenders were transferred between institutions in different regions (59%, n=60) and between institutions in the same region (49%, n=50).
    - The most commonly noted challenges related to medication management issues (n=26), delayed, outdated or incomplete health information (n=20), a lack of communication and preparation regarding transfers (n=12) differing service and treatment models (n=19), lack of available staff and resources (n=9), and language barriers from a lack of translation of health information (n=7).
- Twenty-five percent (25%, n=36) of offenders interviewed reported having been transferred between institutions within the past year.
    - A few offenders who had been reporting ongoing health care at the time of transfer[72] suggested that health care services were different across institutions (physical health: n=12;

[72] Of those, n=19 reported receiving ongoing health care for clinical heath, n=10 for mental health, and n=4 for infectious disease at the time of their transfer.

mental health: n=6), but the number of responses were too small to analyze for any common themes.

Documentation:

- According to policy CD 710-2 (Transfer of Inmates), the Health Services Transfer Summary form (0377-01) is completed by the sending institution and translated if necessary into the language of the receiving institution. This ensures that key health information, such as medical and psychological reports and intake assessments, are reviewed and any relevant health care services and treatments are maintained.
- In 2013-14 and 2014-15, a review of Boards of Investigations (BOIs) indicated that 4% of BOI cases included issues related to documentation of the Health Services Transfer Summary.
- A review of compliance related to the Health Services Transfer Summary form in the fall of 2015 (CORR) identified that sections of the transfer form were not fully completed in all regions, for example: sections related to major mental health problems and methadone/Suboxone section.

Next Steps:

- In order to ensure accurate information sharing during transfers, the Health Services Transfer Summary form must be completed accurately prior to transfer. Incomplete transfer summary documentation was identified as an issue through CORR. Action plans to achieve compliance and risk mitigation strategies were developed by Health Services in each region to deal with areas of non-compliance. Compliance has been achieved in 2 out of 4 regions (Prairie and Quebec are not yet compliant).[73] Health Services continues to monitor progress towards compliancy. In April 2016, Health Services began the implementation of an Offender Health Information System that includes an Electronic Medical Record system (OHIS-EMR). As of July 2016 the OHIS-EMR has been fully implemented in 4 regions (Atlantic, Quebec, Ontario, and Pacific). Full implementation in the Prairie region is expected by the end of September 2016. The electronic medical record allows real time access to offender medical records by all regions.

[73] For all five CSC regions included in the CORR monitoring, non-compliance was found in the Atlantic, Quebec, Prairie and Pacific regions.

- CSC's Internal Audit Sector is currently conducting an audit of the transfer process. Issues identified related to transfers and health services will be addressed through Audit recommendations and action plans.

3.8 INFORMATION SHARING

FINDING 8: INFORMATION SHARING

Some CSC personnel reported a lack of understanding of the guidelines for sharing of personal health information, and the sharing of health information could be improved. There are opportunities to implement electronic medical records to enhance information sharing.

Evidence: Information Sharing

According to CSC policy, "the sharing of information should be carried out in a way that upholds an individual's rights to privacy and confidentiality, while still ensuring that relevant parties have access to appropriate information in order to address the risks and needs of the offender".[cvi] Appropriate sharing of personal health information with those who have a "need-to-know", is a key element in the provision of quality and timely care to offenders.[cvii] Information sharing, among health services staff and between registered health care professionals and other institutional staff (i.e., case management and operations), must respect professional obligations of health professionals.[74] Protecting client privacy and confidentiality is part of the standards of practice for licensed health professionals (e.g. nurses, physicians, psychologists, social workers etc), whereby individuals have a professional obligation to understand and follow applicable legislation governing privacy and the collecting and sharing of information.

Within CSC, the *Guidelines for Sharing Personal Health Information* outline information sharing protocols. In addition, CSC offers the Fundamentals of Mental Health Training, which is mandatory training for parole officers and correctional officers, and includes a component on the sharing of

[74] Two groups of health services staff were surveyed for the evaluation: those working with offenders at intake and those working with offenders during incarceration (after penitentiary placement). The information reported in this section was collected from health services staff working with offenders during the incarceration period. However, some general questions related to access to care and information sharing were also asked of health services staff working at intake. Responses of intake staff were scanned for commonality or differences of themes and issues. Overall, the pattern of responses for staff working with offenders at intake was similar to those working with offenders during the incarceration period.

personal health information. It outlines references to relevant legislation, policies and guidelines and defines the "need-to-know" principle "information that is pertinent and necessary to an individual performing his/her current duties."[cviii, 75] Discussions take place in small groups on various scenarios with respect to information sharing.

Most CSC clinical health information is currently documented in paper files, and mental and public health information is managed through a combination of paper and electronic records. CSC Health Services is currently implementing an Electronic Medical Record system.

- The importance of effective documentation is emphasized in the Accreditation Report (2014) which identified the use of manual documentation of health related information as an issue, as it poses a significant risk for missing and inaccurate information. The Accreditation Report identified opportunities to implement electronic health records in CSC to better track health related information and mitigate risks.
- Presently, most offender health care information is maintained in paper files, including institutional health care records, regional psychiatric centre records and psychology mental health files. In addition, specific health related information is tracked electronically for mental health in MHTS and for public health in the Web-Enabled Infectious Disease Surveillance System (WebIDSS), although these systems are currently in transition. The key elements of the latter two electronic systems will be incorporated into the OHIS-EMR.
    - Many health services staff agreed that they had access to the appropriate offender databases/records required for them to perform their duties during the incarceration period (70%, n=103). The most common database/records that health services staff had access to include: OMS, the offender's institutional health care record, and Psychology/Mental Health files.
    - Health services staff and general staff reported the following communication mechanisms to be effective in sharing offender health-related information: in-person information meetings/phone calls (86%, n=125, 85%, n=116 respectively); paper records/reports (84%, n=122; 39%, n=52 respectively); and formal meetings (72%, n=105; 50%, n=68 respectively).

[75] For example, a correctional officer may not "need-to-know" the specific medications an offender is taking; however, they may need to know symptoms related to the medication relating to mobility or behaviours that could affect security or case management.

Good Practice - Implementation of Electronic Medical Records:

A review of research literature was conducted to determine effective and efficient options to support information sharing and management. The use of electronic medical records was commonly discussed as an effective tool for information management in correctional settings and in the community. Electronic medical records (EMRs) are computer-based medical records that contain demographic information, medical and drug history, and diagnostic information such as laboratory results and diagnostic imaging.[cix] Benefits of using EMRs include: [cx]

- Reduced redundant care
- Increased speed of patient treatment
- Improved patient safety
- Increased efficiencies in workflow and laboratory and diagnostic test management
- Communication and quality of care: Centralized patient information gives health care providers better access to information and allows different health care providers to access the same information
- Reduced inaccuracies: EMRs keep information centrally located reducing the risk of losing documents

Health Services staff reported higher levels of understanding of the Guidelines for Sharing Personal Health Information compared to general staff.

CSC has developed *Guidelines for Sharing Personal Health Information*, which provides staff with information on the types of offender health information that may be shared, with whom, and in what context.[cxi] Personal health information should only be shared with those who have a "need-to-know", which includes only information that is pertinent and necessary to an individual performing his or her current duties. The purpose of the guidelines are to ensure that staff members have the information necessary to perform their duties to address offenders' risks and needs, while maintaining offenders' right to privacy and confidentiality.

- Many health services staff and some general staff agreed that the guidelines provided clear direction regarding:
    - *What* type of information can be shared (health services staff: 70%, n=91, general staff 57%, n=50);

- With *whom* information can be shared (health services staff: 73%, n=93, general staff 53%, n=47); and
- *How* information can be shared (health services staff: 70%, n=89, general staff 51%, n=43).

The sharing of personal health information, particularly between health services staff and operational personnel could be improved.

A review of CSC documents indicated that the sharing of personal health information does not always occur as it should. Among BOIs, information sharing issues were identified in 2013-14 (37% out of 86 BOI cases) and 2014-15 (19% out of 96 BOI cases).[76] Information sharing issues identified through these investigations included information sharing between a variety of different groups, including information sharing with offenders, operations, and health services. The following section provides an overview of the specific information sharing issues related to health in 2013-14 to 2014-15 BOIs.

Information Sharing within Health Services:

- A small percentage (3%) of 182 BOI cases from 2013-14 and 2014-15 represented issues of information sharing within health services.
- Many health services staff (67%, n=97) agreed that there is sufficient information sharing with other health services staff.

Information Sharing between Health Services and Other Institutional Staff:

- A review of 182 BOI cases in 2013-14 and 2014-15 identified information sharing issues between health services staff and:
  - Operational staff (7% of BOI cases); and,
  - Case management staff (1% of BOI cases).
- Some health services staff and general staff members reported that they would like access to more information than what is currently shared; however, it is not clear if the information that they would like access to falls under the "need-to-know" criteria established by the guidelines.

[76] Note that these included all BOIs for investigated incidents at the Tier I and II levels in 2013-14 and 2014-15 that had been investigated and completed. Not all 2013-14 and 2014-15 BOI cases had been completed at the time the data was obtained.

- Many health services staff (61%, n=81) agreed that there is sufficient information sharing with other general staff.
- Some general staff agreed (34%, n=41) that health information is shared to enable them to perform their duties. It was suggested that more information be shared concerning:
  - Health conditions that can impact offenders participation in work/school/correctional plan (e.g., receive notification if an offender is sick and unable to attend school, if a medical condition can affect their classroom performance, any health conditions that would interfere with offender completing their correctional plan n=14);
  - Health information to address an emergency/maintain safety (e.g., have a basic health profile, pre-existing conditions available in case of emergency n=6);
  - Public health (e.g., infectious diseases n=12);
  - Mental health (e.g., suicide risk, stress, diagnoses that may affect behaviour in programs n=12); and,
  - Medication (n=10).

Next Steps:

Documentation of Health Information:

- In 2016, CSC began the implementation of the National Offender Health Information System which consists of two components, an Electronic Medical Record (OHIS-EMR) and an electronic Pharmacy system (OHIS-PHARM).[77]
- As of July 2016 the OHIS-EMR has been fully implemented in 4 regions (Atlantic, Quebec, Ontario, and Pacific). Full implementation in the Prairie region is expected by the end of September 2016. The electronic medical record allows real time access to offender medical records by all regions.
- It is anticipated that OHIS-EMR will improve the quality of health care delivery and patient safety by facilitating integration of health information, information sharing among health services staff.

[77] Implementation in all institutions in Ontario and Pacific, and one institution in remaining regions, is scheduled to begin in September 2016, with full implementation to all institutions scheduled for March 2017.

Guidelines for Sharing Personal Health Information:

- In November 2015, CSC updated the *Guidelines for Sharing Personal Health Information*. The guidelines, which now apply to all staff, have been clarified in terms of references to legislation and policy, include additional examples to assist staff in making informed decisions about information sharing and understanding the need-to-know principle, and reference the use of electronic information sources.[cxii]
- Changes to the guidelines seem to have addressed some of health services staff and general staff suggestions. In order to improve the *Guidelines for Sharing Personal Health Information*, staff suggested:
  - Modifying format/content of guidelines (e.g., make the wording less vague; provide examples, better understanding of what information can be shared with outside agencies; health services staff n=6).
  - Providing staff with ongoing training regarding the guidelines (e.g., in relation to the parameters of the need-to-know principle; health services staff n=2; general staff n=4).

Health Information Sharing Practices:

- To enhance the management and sharing of health related information, health services staff and general staff suggested the following:
  - Enhance communication and information sharing practices between staff members through various mechanisms (e.g., brief daily meetings, greater involvement of general staff to attend institutional mental health team (IMHT) meetings, sending emails; health services n=8, general staff n=8).
  - Implement the electronic health care record (health services n=18).
  - Establish consistent protocols to share information (e.g., standardized practices across the organization, develop form for absence from work/school; general staff n=9).

RECOMMENDATION 4: INFORMATION SHARING

That CSC Health Services improve the understanding of information sharing requirements and limitations, as elaborated in their guidelines, in accordance with privacy laws and other relevant legislation. That CSC Health Services improve timely access to relevant and accurate medical records for Health Care staff. These will be accomplished by:

- Finalizing the implementation of electronic medical records to improve accessibility and consistency of health information;
- Enhancing awareness of information sharing procedures and "need-to-know" principle among CSC personnel, including concrete examples of where and how the principle should be applied; and
- Conducting a review of information sharing issues identified in BOI incidents to contribute to existing lessons learned and to inform procedural/policy changes if necessary.

FIFE #4: PUBLIC HEALTH EDUCATION AND HARM REDUCTION

CSC provides numerous public health programs to offenders. To reduce and eliminate the transmission of bloodborne and sexually transmitted infections among inmates while incarcerated, CSC Health Services offers numerous programs and services that range from screening and testing, treatment, vaccinations, health education and awareness, distribution of harm reduction materials, and staff education and training. The following section focuses on health education and awareness programs and harm reduction measures. The degree to which CSC health education and harm reduction programs are targeted to address prevalent health needs of offenders, overall delivery of these services including offender access, and impacts of health education programs and initiatives are examined.

3.9 HEALTH EDUCATION DELIVERY

FINDING 9: HEALTH EDUCATION DELIVERY

CSC's health education programs and initiatives target many of the significant health needs of the offender population, but offender access to and voluntary participation in some programs is limited.

Evidence: Health Education Programs: Offender Needs and Access

CSC offers health education initiatives that are intended to address the most prevalent health needs of our offender population.

Within CSC, the Health Services Sector provides public health services to federal offenders in order to prevent, control disease and promote good health within federal institutions.[cxiii] During intake and throughout incarceration, numerous bilingual health education and information materials are available to offenders, which include: the Reception Awareness Program (RAP), the Inmate Suicide Awareness and Prevention Workshop (ISAPW), the Peer Education Course (PEC) and the Aboriginal Peer Education Course (APEC), as well as other materials, such as monthly fact sheets and PowerPoint presentations on specific health topics (see Appendix E).

Health education programs and initiatives target numerous health needs of the offender population in the areas of clinical, public, and mental health.

Clinical Health: Acute and Chronic Issues

- Health education materials related to acute and chronic health issues are shared with offenders in CSC institutions primarily through the development of fact sheets:
  - National fact sheets are developed on specific health topics and are distributed in paper format or displayed on monitors in CSC institutions. Recent topics include many prevalent chronic health needs of the offender population, such as heart health, back pain, asthma, healthy eating, and diabetes.[cxiv]

Public Health: Infectious Diseases

- To address offender health care needs in the area of infectious diseases, Health Services provides a variety of education and information-based programs and materials throughout an offender's sentence which are intended to increase an offender's knowledge of prevalent infectious diseases, such as human immunodeficiency virus (HIV) and hepatitis C virus (HCV).
  - RAP is offered to all offenders during intake. It provides information on infectious diseases, such as HIV, HCV, and sexually-transmitted infections (STIs). Topics covered include means of transmission, such as methods to clean injecting, tattooing and piercing equipment, using harm reduction materials like condoms and dental dams and substance abuse programs and treatments (e.g., Opiate Substitution Therapy (OST) or methadone).
  - PEC is offered in most CSC institutions. Its purpose is to train offenders to become peer support workers for other offenders and to provide information on a wide variety of topics, including information on infectious diseases [e.g., HIV, HCV, tuberculosis (TB), STIs] and harm reduction.[78]
  - APEC provides information on infectious diseases and harm reduction and trains offenders to use a culturally-sensitive approach in providing information and peer support to Indigenous offenders.[cxv]
  - Fact sheets are developed that provide information on infectious diseases, such as HIV/AIDS, TB, HCV, and Methicillin-resistant Staphylococcus Aureus (MRSA).[cxvi]

[78] For women, PEC and the Peer Support Program for Women have recently been integrated into a new program called the Peer Mentorship program which is anticipated to be implemented in 2016-2017.

Mental Health

- In support of promoting mental health, health promotion is centred on general mental health well-being, awareness of signs and identification of symptoms, as well as where and how to seek support.
    - ISAPW provides information on the identification of signs and symptoms of suicide risk, tips on helping others who are exhibiting suicidal behaviour, and suggestions for who to contact in the institution for support.[cxvii]
    - RAP is primarily focused on delivering information related to infectious diseases and offers some general information on mental health, such as the availability of institutional support services and tips for managing stress.
    - PEC and APEC also offer general information in recognizing symptoms of stress and its management.
    - Fact sheets are also available on topics such as suicide prevention.[cxviii]

CSC offers a range of health education programs to address offender's needs related to physical health, chronic and infectious diseases and mental health. Many of these programs are targeted at addressing the high prevalence of infectious diseases among our population, and the ability of infectious diseases to spread easily within a closed environment. Consistent with CSC's focus on health education for infectious disease, results of a literature review on correctional health promotion found that the majority of offender specific health education initiative studies concentrated on infectious diseases, particularly HIV prevention and risk reduction.[cxix]

Offender Perceptions:

- Some offenders mentioned that health education should include more information on specific topics, such as what services are available, nutrition, hygiene, mental health, Alzheimer's, heart disease, fetal alcohol spectrum disorder (FASD) and cancer (n=25).
- Most offenders reported that the health information and materials that they had received over the course of incarceration (89%, n=124) and also at intake (89%, n=80)[79] met their individual needs related to factors such as areas of culture, gender, language, age.

[79] Health information and materials are presented both during the intake period (most commonly RAP, ISAPW) and throughout incarceration after penitentiary placement (most commonly PEC/APEC, fact sheets). Two sets of interviews

- Among offenders who participated in health education initiatives, most indicated that they would recommend the program/initiative to other offenders (PEC 100%, n=19; RAP 95%, n=36; ISAPW 95%, n=36).

Evidence: Health Education Delivery

Offender participation in health education programs and initiatives is moderate, and health education and awareness programs are not offered consistently.

According to CSC policy *Intake Assessment Process and Correctional Plan Framework,* the Assistant Warden, Interventions, is responsible for the intake assessment process and the correctional planning of the sentence and will ensure the provision of pre-treatment and awareness programs such as suicide awareness and prevention.[cxx]

Reception Awareness Program:

- *The Health Services Performance Measurement Report 2012-2013* states that RAP is offered to all new admissions during the intake period.[cxxi]
- RAP is delivered in a classroom setting in all regions except the Atlantic region where it is delivered one-on-one by a nurse during the initial blood borne and sexually transmitted infections (BBSTI) assessment. This accounts for the greater number of sessions in the Atlantic region.
- In 2013-14, the following number of RAP sessions were delivered across the provinces: Atlantic (n=414), Quebec (n=7), Ontario (n=55), Prairie (n=77), Pacific (n=18).[cxxii]
- About half of health services staff (51%, n=31) reported that RAP was offered at their institutions.
- Offender participation:
    - In 2014-2015, CSC reported that a total of 37% of newly admitted offenders participated in RAP.[cxxiii] The proportion of participants varied by region with Atlantic having the highest rate of participation (85%, n=483) followed by the Prairies (60%, n=916), Pacific (39%, n=135), Ontario (27%, n=337) and Quebec (2%, n=20).[cxxiv]

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were conducted with two different groups of offenders: at intake and during incarceration (after pen placement). Results in these sections are presented from either of these samples when and where applicable.

- Similarly, 40% (n=38) of offenders interviewed for the evaluation reported that they participated in RAP.

Peer Education Course/Aboriginal Peer Education Course:

- The *Public Health Performance Measurement Report 2013-2014* produced a summary of regions and institutions where the program is intended to be delivered.[cxxv]
- In 2013-2014, PEC was expected to be offered in a total of 41 of 55 institutions across Canada.[80] However, only 35 institutions offered PEC.[81,cxxvi]
- In 2013-2014, APEC was expected to be offered in 26 of 55 institutions across Canada.[82] In total, 23 institutions offered APEC.[83,cxxvii]
- Most health services staff reported that PEC (79%, n=62) and APEC (72%, n=46) were offered by trained PEC support workers that were available at their institution.
- Offender participation:
  - Many offenders (64%, n=89) indicated that they knew how to access the services of the PEC/APEC support worker.
  - Of the offenders who were interviewed, a few reported that they used the services offered through a PEC or an APEC support worker (12%, n=18 and 3%, n=5, respectively).[84]

Inmate Suicide Awareness and Prevention Workshop:

- According to *Commissioner's Directive 843: Management of Inmate Self-Injurious and Suicidal Behaviour* Institutional Heads are responsible for ensuring ISAPW is available on a regular basis and that offenders have access.[cxxviii]
- Currently, there is no reliable tracking of ISAPW sessions being offered or offender's attendance rate.

[80] The expected locations of PEC did not include maximum security, RTC/RPCs, receptions centres and the healing lodge.
[81] Not all expected institutions had an active PEC program across the regions, with 4/5 in Atlantic, 7/9 in Quebec, 10/11 in Ontario, 7/9 in Prairie and 7/7 in Pacific.
[82] The expected locations of APEC were more in areas with a high population of Indigenous offenders such as Prairie region and in healing lodges.
[83] Not all expected institutions had an active APEC program across the regions, with 2/2 in Atlantic, 2/4 in Quebec, 4/4 in Ontario, 10/11 in Prairie and 5/5 in Pacific.
[84] Of the offenders who were interviewed, 14% (n=21) participated in PEC and 7% (n=11) participated in APEC to become PEC or APEC support workers, respectively. A few (n=8) offenders reported that they were currently a PEC/APEC support worker/volunteer.

- Many health services staff (66%, n=40) reported that the ISAPW was offered at their institution.
- Some offenders (38%, n=38) reported participating in ISAPW.

Reasons for non-participation:

- Across programs, the most common reasons for non-participation reported by offenders included:
  - Lack of awareness /availability of the program (ISAPW n=24; PEC/APEC n=11; RAP n=29)
  - Perceptions that they did not require the services or need to participate (ISAPW n=10; PEC/APEC n=30).

CSC health education programs and promotional materials are delivered in a variety of formats and at various time periods during an offender's sentence.

Format: CSC delivers health education programs in a variety of formats and at various levels of intensity. RAP can be delivered one-on-one or in a group, most often facilitated by a nurse.[85] ISAPW can be delivered in a group or individually by health services staff and peer support is delivered by PEC/APEC support workers who are trained by health services staff. Offenders also receive promotional materials (i.e., written materials) providing information on various health care issues.

- Many health services staff agreed that health education programs were being delivered in an appropriate format (RAP 69%, n=25; PEC/APEC 64%, n=32; ISAPW 62%, n=13).
- The majority of offenders agreed that health education programs were being delivered in an appropriate format. Of those who participated in health education programs through a group setting, most liked that they were presented this way: RAP (84%, n=26), PEC/APEC (94%, n=17), and ISAPW (94%, n=33).[86]

Timing: CSC provides health education programs during the intake period such as RAP and ISAPW and throughout incarceration like PEC and APEC.

- Some health services staff reported that RAP (55%, n=21) and ISAPW (43%, n=9) were commonly delivered within the first month of admission within their institution.

[85] Additionally, the narrated version of RAP can be run via monitors in the Health Services waiting room.
[86] Most offenders also reported that materials delivered through RAP (97%, n=37), PEC/APEC (95%, n=18), and ISAPW (92%, n=35) were easy to understand.

- Many health services staff agreed that health education programs were being delivered at an appropriate time in the offenders' sentence (RAP 71%, n=25; PEC/APEC 62%, n=24; ISAPW 59%, n=13).
- The majority of offenders agreed that health education programs were being delivered at an appropriate time in their sentence (RAP 92%, n=35; ISAPW 89%, n=33).

Suggestions regarding format and timing:

- RAP could be delivered through other staff or formats (e.g., non-nursing staff, PEC/APEC support workers, video monitor or offender TV channel) (health services staff n=7).
- Health education programs/materials should be delivered in different formats to correspond to offenders literacy levels (e.g., video) (health services staff n=4; offenders n=10).
- Programs should be delivered by Health Services in smaller groups and individually to allow for more interaction (offenders n=4).
- Make health education information readily available in terms of quantity and location (e.g., pamphlets on range, more brochures in maximum) (offenders n=24).
- Programs, particularly RAP and ISAPW, should be delivered earlier within the intake period (e.g., within first week or two of admission) (health services staff n=5).

3.10 IMPACT OF HEALTH EDUCATION & HEALTH REDUCTION INITIATIVES

FINDING 10: IMPACT OF HEALTH EDUCATION & HARM REDUCTION INITIATIVES

Health education programs, particularly those aimed at infectious disease, are associated with increased offender health-related knowledge and related behavioural changes (e.g., reduced risk-taking behaviours). Results of a review indicated that bleach was not always available as required in all CSC institutions, but no recent data were available to confirm the accessibility of other harm reduction products, such as condoms, dental dams, and lubricants.

Evidence: Impact of Health Education Programs

Health education programs and initiatives increase offenders' health-related knowledge.

Results of current surveys with CSC staff and offenders along with previous studies on health education and harm reduction (2010) suggest that CSC health education programs increase offender health related knowledge:

- **Infectious disease prevention:** Most health services staff and offenders perceived that health education programs had a positive impact on offenders' knowledge of infectious diseases.
  - Most health services staff and offenders reported that RAP (81%, n=30; 84%, n=31, respectively) and PEC/APEC (72%, n=34; 89%, n=17, respectively) increased offenders' knowledge of infectious disease prevention. Many general staff (69%, n=33), also agreed that education programs/materials overall increased offenders knowledge about maintaining their health in prison.
  - Most (90%, n=17) offenders agreed that after participating in PEC/APEC training to become a PEC/APEC support worker, their knowledge of infectious diseases increased. In addition, results from a pre-post training survey 2010-2011, indicated that 87% of participants increased their knowledge following the completion of the APEC training program.[cxxix]
  - Results of a previous research study (2010) of CSC offenders on infectious diseases demonstrated that offenders who participated in a health services education programs such as RAP, PEC, and Choosing Health in Prisons (CHIPs) materials, had higher knowledge of HIV[87] and HCV[88] compared to offenders who had not attended health services education programs.[cxxx]
- **Knowledge of suicide signs, symptoms, and where to seek support:** Many health services staff and offenders reported that participation in the ISAPW increased offenders' knowledge about: suicide signs, symptoms, and stressors (91%, n=21; 66%, n=21, respectively), and where to go for support if they needed it (92%, n=23; 94%, n=34, respectively).

[87] HIV: Men and women offenders who attended health education programs were more knowledgeable about HIV (83%; 86%) than men and women offenders who did not attend education programs (78%; 80%).
[88] HCV: Similarly, men and women offenders who attended health education programs were also more knowledgeable about HCV (73%; 78%) compared to men and women offenders who did not attend education programs (68%; 68%).

- **Availability of health services and how to access them:** Most health services staff and offenders indicated RAP had provided information on types of health services available and how to access them (82%, n=31; 97%, n=37, respectively).[89]

Health education programs and initiatives are associated with offender behavioural change.

Results of a previous research study (2010) of CSC offenders on infectious diseases demonstrated that knowledge of HIV and HCV risk factors were associated with less risky behaviour and/or use of harm reduction practices to reduce risk associated with their behaviour.[cxxxi]

- Offenders who were knowledgeable about the risks associated with contracting HIV and HCV were ***less likely*** to engage in risky behaviour.
    - Among men offenders responding to the 2007 Inmate Survey, those who were aware of the risks associated with contracting HIV by injecting drugs with needles that had previously been used by others were less likely to report having injected drugs during the previous 6-months in prison compared to offenders who were unaware of the risks.
- Among offenders who continued to engage in risky behaviour, such as injection drug use, unsafe sex, piercing, those who were knowledgeable about the risks were ***more likely*** to use harm reduction practices.
    - Among men offenders responding to the 2007 Inmate Survey who reported injection drug use within the previous 6-months, those who were aware of the risks associated with needle sharing were more likely to report cleaning their needle with bleach the last time they injected (73%) compared to those who were unaware of the risks (46%).

Implications:

Correctional health promotion programs can impact overall knowledge and behaviours, which can impact the overall health of offenders.

- Results of a recent literature review (2016) suggest that various formats of correctional health promotion were associated with some level of improvement to health related knowledge (e.g., increase in HIV/AIDs knowledge), more proactive attitudes towards behaviours that protect/promote one's health (e.g., more positive attitudes towards condom use) and greater

[89] Many general staff also agreed that education programs/materials in general had a positive impact on offenders' awareness of health services and programs in CSC and how to access them (67%, n=30).

compliance with recommended health behaviours (e.g., getting tested for HIV), for example:[cxxxii]

- The use of educational videotapes and comic book style pamphlets resulted in increased knowledge of communicable disease among offenders. A systematic review on the effectiveness of peer education programs for prisoners found peer education programs have a positive impact on attitudes, knowledge, and behavioural intentions for HIV risk behaviour.
- In a self-directed intervention for HIV, offenders were given a single session with a "talking lap top". The computer used offender responses to assess their perceived interest in behaviour change, as well as potential obstacles for achieving behaviour change. Based on responses, a computer was used to present specific intervention videos to participants that assessed their perception of infectious disease. On follow-up, offenders who had received the intervention were significantly more likely to report they had been tested for HIV than offenders who had not received the intervention.
- Lastly, an eight-session pre-release workshop intervention for HIV positive offenders involving presentations and discussions was associated with significantly greater self-reported use of community resources and less unsafe sexual and drug-related risk behaviour in the months following release.

Infectious diseases can result in significant treatment costs and prevention programs can be cost-effective.

- HIV: A recent study estimated that the combined direct and indirect costs[90] of HIV in Canada are approximately 1.3 million per person and can range from $4.03 to $5.03 billion annually.[cxxxiii]
- HCV: The total annual cost of HCV in Canada amounted to $103 million in 2001.[cxxxiv]
- CSC is one of four federal departments[91] involved in the Federal Initiative to Address HIV/AIDS in Canada. Through this initiative, CSC provides HIV testing, pre- and post-test counselling, education on risk reduction, medical treatment and surveillance for HIV-infected offenders.[cxxxv]

[90] Direct and indirect costs represent medical costs, labor productivity costs, and loss of quality of life.
[91] Other federal government organizations include; the Public Health Agency of Canada, the Canadian Institute of Health Research, and Health Canada.

  - An evaluation of the Federal Initiative to Address HIV/AIDS over the period 2008-09 and 2012-13 found that the cost of HIV infection ($4.03 to 5.03 billion per year) was much higher than the cost to operate the initiative ($72.6 million per year) suggesting it is cost-effective.[cxxxvi]

- Research has shown that the cost-effectiveness of interventions vary depending on the prevalence of infection in the target population and the cost of the proposed intervention.[cxxxvii] For example, studies have shown that school-based programs for students (a population with a very low prevalence of HIV) are the least cost-effective, whereas displaying videos in sexually-transmitted disease (STD) clinics (a population with a higher prevalence of HIV infection) is most cost-effective.[cxxxviii]

Given that the CSC offender population has a higher rate of infectious and blood borne disease (e.g., HIV/AIDS, HCV) relative to the general population[92], delivery of programs within this population provides a significant public health opportunity to reach a high-risk population.

Evidence: Harm reduction measures and initiatives

In addition to health education programs and materials, harm reduction materials and initiatives are offered to offenders throughout incarceration to reduce the risk of transmitting infectious disease and other negative effects of harmful behaviours, including injection drug use and unsafe sex.[cxxxix] To reduce and eliminate the transmission of bloodborne and sexually transmitted infections among inmates while incarcerated, CSC Health Services offers numerous programs and services that range from screening and testing, treatment, vaccinations, health education and awareness, harm reduction materials, and staff education and training[93]. The following section focuses on specific harm reduction measures, including the distribution of harm reduction materials, such as bleach, condoms, dental dams, and lubricants, as well as Opiate Substitution Therapy (OST).

[92] CSC surveillance data indicate the majority of offenders with HIV/HCV infection acquired infection prior to federal incarceration.

[93] A more detailed list of these programs and services includes: staff education and training, screening and testing, HIV testing normalization, addictions screening, health education and awareness, anti HIV-stigma campaigns, peer support programs, risk assessment and counselling, vaccination, diagnosis and treatment of viral hepatitis (A&B), substance abuse counselling, opiate substitution therapy, overdose emergency response and counselling, bleach distribution, mental health referral/counselling, condom/dental dam distribution, post-exposure prophylaxis, HIV and HCV treatment, discharge planning, prevention, diagnosis and treatment of TB.

Harm reduction programs and materials can be effective in reducing offenders' risky behaviours. However, harm reduction materials, such as bleach kits, were not always available to offenders as required.

Opiate Substitution Therapy (OST):

CSC also offers Opiate Substitution Therapy (OST) to address the treatment needs of those with an opiate dependency. The OST program was first introduced to offenders in 2008. It was formerly the Methadone Maintenance Treatment Program (MMTP) and has been revised several times, most recently to add Suboxone and is now called OST.[cxl]

- According to a 2014 research study, offenders who participated in MMTP reported a significantly lower prevalence of heroin injection, injection drug use and syringe sharing. Also noted were reductions in the number of positive tests (26.7% vs. 16.9%) and test refusals (29.0% vs. 21.2%).[94]
- In addition to the harm reduction benefits related to the reduction in drug use and reduction in needle sharing, offenders participating in MMTP incurred fewer serious disciplinary offences (39.7% pre to 32.9% post), spending significantly more time in education programs[95] and having more positive post-release outcomes.[96]
- Many health services staff (55%, n=79) and general staff (58%, n=54) agreed that the administration of opiate drugs addresses the needs of offenders with an opiate dependency, but some suggestions to better address their needs were offered:
    - Improving the delivery (e.g., ensure sufficient number of staff; health services staff n=16; general staff n=3).
    - Improving the format/content of the program (e.g., provide addictions counseling or education health services staff n=9; general staff n=4).
    - Improve monitoring of the program (e.g., continue to monitor offenders for possible diversion of their opiate drugs; health services staff n=7; general staff n=4).

[94] These results are from a pre two year and post two years time period.
[95] In the two years following MMTP initiation, the proportion of successful program completions or attendance more than doubled for substance abuse programs, increasing from approximately 29% in the pre period to 63% in the post period.
[96] The risk of re-incarceration was 36% higher for male non-MMPT offenders compared to MMPT offenders who continued methadone treatments.

Harm reduction materials:

Harm reduction materials provided in institutions include: condoms, bleach, dental dams, and water-based lubricant.[97]

- Many health services staff and general staff surveyed agreed that harm reduction products have a positive impact on offenders' behaviour including reducing the likelihood of risky behaviours such as unsafe tattooing/drug use, and unprotected sex (72%, n=58 and 61%, n=41, respectively).
- Many (60%, n=54) offenders agreed that the health information and harm reduction products that they received enabled them to avoid engaging in risky behaviours. A few offenders (23%, n=21) disagreed:
    - Health information was insufficient to prevent/reduce risky behaviours (n=9)
    - That harm reduction measures were insufficiently supplied (n=5)

Accessibility and supply of harm reduction products such as bleach and condoms:

According to *Commissioner's Directive 800: Health Services*, the Institutional Head is responsible for ensuring that non-lubricated, non-spermicidal latex condoms, water-based lubricants, individually packaged dental dams and bleach are discreetly available to offenders at a minimum of three locations within each institution, as well as in all private family visiting units.[cxli] Furthermore, the *Bleach Distribution's Guidelines* state that upon reception, offenders should be issued bleach kits, informed on the bleach whereabouts, and instructed on the use of bleach as a harm reduction measure.[cxlii]

- Many health services staff (69%, n=51), general staff (78%, n=47), and offenders (69%, n=96) agreed that a sufficient supply of harm reduction products like condoms and bleach kits were available to meet the needs of offenders.
- Most health services staff (87%, n=76), general staff (87%, n=61), and offenders (91%, n=128) agreed that offenders know where to go to access harm reduction products like condoms and bleach kits if needed.

[97] Health services staff and general staff reported that condoms (99%, n=99; 91%, n=73), bleach kits (83%, n=83; 86%, n=69), dental dams (70%, n=70; 56%, n=45), and lubricants (74%, n=74; 63%, n=50) are available in their institutions, respectively.

- Many health services staff (79%, n=62), general staff (78%, n=51) also agreed that harm reduction products (such as bleach kits or condoms) were placed in an easily accessible location for offenders.
- The fall 2015 Compliance and Operational Risk Report found that all CSC sites had a bleach program and designated coordinator in place. However, problems were identified regarding the availability and documentation of bleach kits.[cxliii] 17% of sites were non-compliant in ensuring bleach kits were available and properly labeled. Specifically, it was noted that dispensers were not always available or that they were malfunctioning.[cxliv]

Health services staff, general staff and offenders provided several suggestions related to harm reduction products (e.g., bleach, condoms, dental dams, lubricants):

<u>Increasing the accessibility and range of harm reduction products and ensuring that offender confidentiality is maintained.</u>

- Although many staff and offenders reported that harm reduction products were accessible, some did not (health services staff 20%, n=15; offenders 20%, n=28), suggesting that not all have equal access. They suggested increasing the availability and accessibility of harm reduction products such as ensuring station refills, increasing the frequency of station refills and expanding accessibility (health services staff n=12; offenders n=21).
- Expand the range of harm reduction products offered (general staff n=4; offenders n=15).
- Make harm reduction products available in more locations (e.g., should be available in segregation, in maximums, and on the ranges; offenders n=7).
- Ensure the confidentiality of offenders using harm reduction products (e.g., place stations in more private areas, offenders afraid to ask for stations to be refilled; health services staff n=5).

<u>Providing more education opportunities or information regarding harm reduction products.</u>

- Provide more education on the use of harm reduction products (e.g., increased education on diseases and best practices, how to properly use products, information about effectiveness of bleach in eliminating HIV; offenders n=13).

- Improve the management of harm reduction products (e.g., inform staff on location of products, improve awareness of who is responsible for filling stations; offenders n=6; health services staff n=4).

RECOMMENDATION 5: HEALTH EDUCATION AND HARM REDUCTION

That CSC Health Services ensure that offenders have timely access to health education programs and harm reduction products by:

- Providing clear direction and accountability for delivery and tracking of health education programs; and
- Monitoring the distribution of harm reduction products (bleach, condoms, dental dams, and lubricants) and addressing any identified accessibility issues.

FIFE #5: INSTITUTIONAL MENTAL HEALTH SERVICES

The following section focuses on CSC institutional mental health services, which are provided in mainstream institutions and Regional Treatment Centres. The impacts of institutional mental health treatment on offender behaviour and integration into the institutional environment are examined. In addition, several aspects of treatment for those with high or complex mental health needs are assessed. This included offender admissions to RTCs, offender perceptions of this care, and the role of RCMHCs.

Overview: CSC's Mental Health Care Model

CSC provides a variety of institutional mental health services that are appropriate to offenders' level of need to ensure that offenders are receiving the right interventions at the right time in their sentence. Currently, CSC offers three different levels of institutional mental health care to offenders in mainstream CSC institutions or in a RTC, which include: primary, intermediate[98] and psychiatric hospital care.[cxlv]

Primary mental health care includes mental health promotion, prevention and early intervention, screening, assessment and individualized treatment planning, evidence-based treatment and support services, monitoring of offenders in segregation, and crisis intervention. Primary care also involves coordination of referrals to other levels of care (i.e., intermediate mental health care, psychiatric hospital care, or discharge planning where available). Primary care is provided in mainstream institutions by mental health professionals.

Intermediate mental health care provides mental health care to offenders who do not require admission to hospital, but require a higher level of mental health care than available at the primary care level. Services include: clinical case coordination, assessment, treatment, psychiatric symptom management, therapeutic recreation and leisure activities, provision of care associated with activities of daily living, and discharge planning (where available). There are two types of intermediate mental health care provided to offenders based on their level of need – moderate and high.

- Moderate intensity is intended for those offenders with chronic or sub-acute mental health conditions and with symptoms that are moderate but do not require 24-hour care or access to 24-

[98] Intermediate mental health services were not included in the scope of this evaluation because these services were not fully implemented in CSC institutions at the start of the evaluation.

hour care. These services are offered in mainstream institutions and include availability of clinical staff up to eight hours per day Monday to Friday and evenings and weekends as available.

- High intensity is intended for those offenders with chronic or sub-acute mental health conditions who do not require admission to hospital but whose needs exceed services available in moderate intensity, intermediate mental health care and primary care. These services are offered in close proximity to a hospital or within a RTC. Nursing staff is available up to 12 hours per day Monday to Friday and up to eight hours per day on weekends. Offenders may also have access to 24-hour nursing care if required.

Psychiatric hospital care is provided at RTCs located in each region for offenders with acute mental health concerns requiring a clinical environment that provides 24-hour care. RTCs are "hybrid facilities" in that they are considered to be both a "penitentiary" and a "hospital" subject to the provisions of the federal *Corrections and Conditional Release Act* (CCRA), and relevant provincial legislation respectively. [cxlvi] Services include intensive psychiatric treatment, comprehensive and specialized mental health assessments, intensive psychiatric and nursing services for stabilization, clinical case coordination, psychiatric symptom management, therapeutic recreation and leisure activities and provision of care associated with activities of daily living and discharge planning (where available). Once symptoms are explored and behaviours are stabilised offenders can be returned to mainstream institutions and receive lower levels of mental health care.

3.11 INSTITUTIONAL MENTAL HEALTH CARE OUTCOMES

FINDING 11: INSTITUTIONAL MENTAL HEALTH CARE OUTCOMES

Institutional mental health care provided in CSC mainstream institutions and RTCs was associated with positive impacts on offenders' behavioural stability following treatment, such as reduced likelihood of incidents, serious charges, and involuntary segregation.

Evidence: Institutional Mental Health Care Outcomes

Mental health treatment is essential to alleviate symptoms, improve well-being, facilitate participation in correctional programs and support safe reintegration into institutional and community environments.[cxlvii] Intended mental health care treatment objectives include: symptom reduction,

development of viable coping strategies, improved self-management, prevention of relapse and reduced risk for criminal behaviour.[cxlviii]

The following section focuses on the impact of institutional mental health care services on correctional outcomes among two groups of offenders: (1) those who received mental health care within a mainstream CSC institution only; and, (2) those who received mental health care within a RTC.[99] Correctional outcomes include institutional incidents, institutional charges,[100] admissions to involuntary segregation,[101] national correctional program completions, and education course/credit completions. Overall, institutional incidents were analyzed as well as select sub-categories of incidents recorded in OMS (i.e., assault, behaviour, self-harm)[102] that could be associated with mental health issues.

Correctional outcomes were assessed during two separate time periods: (1) during treatment; and (2) after treatment, and both were compared to before treatment levels. Offenders may receive mental health treatment services at various points in a mainstream institution. For the purposes of this analysis, a "treatment period" was defined as a block of continuous service, where treatment-oriented services[103] were delivered within four months of each other.

[99] Some offenders received treatment at both mainstream institutions and RTCs. These offenders were included in the "RTC group" for analysis. The focus was on the impacts of care received while at a RTC (i.e., "after treatment" outcomes were assessed following RTC treatment, whether or not other treatment may have continued following return to the institution).
[100] Institutional charges may differ from institutional incidents, as correctional staff members may resolve an institutional incident informally (CD 580; CCRA section 41 (1) & (2)). Institutional incidents were included for analysis if the offender was identified as an instigator or an associate in the incident.
[101] Statistical analysis of voluntary segregation could not be conducted due to low rates of the indicator.
[102] In addition to assault, behaviour, and self-harm, other incident sub-categories are recorded in OMS (i.e., possession of contraband, property offences, escapes, and deaths). Although all sub-categories were included in the analysis for "overall incidents," only the three categories with theoretical links to mental health needs were included for sub-incident analysis (i.e., assault, behavior, self-harm).
[103] Treatment-oriented services included: mental health counselling: group/individual; psychiatric clinic; skills training/self-care/activities of daily living (ADL); suicide or self-injury intervention; treatment planning; counselling: group/individual. Many offenders had more than one "treatment period," but the treatment period with the *most* treatment services was selected to be included in the analysis.

- **Legend:** Analysis of outcomes during treatment is shown in tables outlined in "blue" and analysis of outcomes after treatment is shown in tables outlined in "purple".

During Treatment	After Treatment

Outcomes: Treatment in Mainstream CSC Institutions[104]

After treatment, mental health services provided in mainstream institutions were associated with positive outcomes, including: reduced likelihood of incidents, charges, and involuntary segregation, and greater likelihood of completing a correctional program or an education course or credit. During treatment, mental health services provided in mainstream institutions were associated with: reduced likelihood of involuntary segregation, and an increased likelihood of national correctional program completions.

a) During Treatment (vs. Before Treatment):

- *All Offenders:* Offenders receiving mental health treatment in mainstream CSC institutions were less likely to be involuntarily segregated and more likely to complete a national correctional program during treatment, compared to before treatment (see Table 1).
- *Indigenous Offenders:* Indigenous offenders were more likely to complete a national correctional program during treatment in a mainstream institution, compared to before treatment (see Table 1).

[104] Separate statistical analyses were not conducted for women offenders due to the smaller number of women offenders receiving mainstream institutional mental health treatment. However, they are included in the overall sample of "all offenders".

Table 1: Mainstream Institutional Mental Health Treatment – During Treatment vs. Before Treatment

	All Offenders (n = 3,167)	Indigenous Offenders (n = 802)
Incidents - Overall	NS	NS
Assault	____	____
Behaviour	NS	NS
Self-Harm	____	____
Charges		
Minor	NS	NS
Serious	NS	NS
Involuntary Segregation	13% less likely	NS
National Correctional Program Completions	20% more likely	38% more likely
Education Course/ Credit Completions	NS	NS

*More likely and less likely refers to an increase or decrease in the overall likelihood of the outcome event occurring during treatment compared to before treatment.
**NS indicates non-significance.
*** ---- indicates that statistical analysis was not conducted on the outcome due to low rates of the indicator.
****See Appendix F: Table 1 and 2 for more detailed statistical results.

After Treatment (vs. Before Treatment):

- *All Offenders:* After mental health treatment in mainstream CSC institutions, offenders were less likely to be involved in incidents overall, less likely to be charged with a serious offence, and less likely to be involuntarily segregated, compared to before treatment. Offenders were also more likely to complete a national correctional program and education course or credit after receiving mental health treatment in CSC's mainstream institutions (see Table 2).
- *Indigenous Offenders:* Indigenous offenders were less likely to be involuntarily segregated, and more likely to complete a national correctional program and education course or credit after treatment, compared to before treatment (see Table 2).

Table 2: Mainstream Institutional Mental Health Treatment – After Treatment vs. Before Treatment

	All Offenders (n = 3, 167)	Indigenous Offenders (n = 802)
Incidents - Overall	9% less likely	NS
Assault	_____	_____
Behaviour	NS	NS
Self-Harm	_____	_____
Charges		
Minor	NS	NS
Serious	30% less likely	NS
Involuntary Segregation	32% less likely	30% less likely
National Correctional Program Completions	23% more likely	30% more likely
Education Course/ Credit Completions	34% more likely	23% more likely

*More likely and less likely refers to an increase or decrease in the overall likelihood of the outcome event occurring after treatment compared to before treatment.
**NS indicates non-significance.
*** ---- indicates that statistical analysis was not conducted on the outcome due to low rates of the indicator.
****See Appendix F: Table 1 and 2 for more detailed statistical results.

Outcomes: Treatment in RTCs[105]

Mental health services provided in RTCs were associated with positive outcomes following treatment, including a reduced likelihood of incidents, serious charges, and involuntary segregation. During treatment, the likelihood of institutional charges and involuntary segregation was reduced; however, the likelihood of incidents was observed to increase.

a) During Treatment vs. Before Treatment:

- *All Offenders:* During treatment, offenders in RTCs were more likely to be involved in incidents overall, including assault and behaviour[106] related incidents, compared to before treatment. However, they were also less likely to be charged with a serious offence, and less likely to be involuntarily segregated during treatment, compared to before treatment (see Table 3).

[105] Separate statistical analyses were not conducted for Indigenous and women offenders due to the smaller number of Indigenous and women offenders receiving treatment at a RTC. However, they are included in the overall sample of "all offenders".
[106] Behaviour related incidents include: minor/major disturbances, disruptive behaviour, substance use, disciplinary problems, threats towards staff/others and cell extraction.

Table 3: RTC Mental Health Treatment: During Treatment vs. Before Treatment

	Overall (n = 617)
Incidents - All	22% more likely
Assault	47% more likely
Behaviour	31% more likely
Self-Harm	NS
Charges	
Minor	NS
Serious	31% less likely
Involuntary Segregation	39% less likely
National Correctional Program Completions* **	NS
Education Course/ Credit Completions* **	NS

*More likely and less likely refers to an increase or decrease in the overall likelihood of the outcome event occurring during treatment compared to before treatment.
**NS indicates non-significance.
***See Appendix F: Table 3 for more detailed statistical results.

b) <u>After Treatment vs. Before Treatment:</u>

- *All Offenders:* After treatment in a RTC, offenders were less likely to be involved in incidents overall, including all incident sub-types examined (assault, behaviour, self-harm), and less likely to be charged with a serious offence, compared to before RTC treatment. Offenders were also less likely to be involuntarily segregated (see Table 4).

Table 4: RTC Mental Health Treatment: After Treatment vs. Before Treatment

	Overall (n = 617)
Incidents - All	19% less likely
Assault	29% less likely
Behaviour	21% less likely
Self-Harm	34% less likely
Charges	
Minor	NS
Serious	31% less likely
Involuntary Segregation	19% less likely
Nat. Correctional Program Completions	NS
Education Course/ Credit Completions	NS

*More likely and less likely refers to an increase or decrease in the overall likelihood of the outcome event occurring after treatment compared to before treatment.
**NS indicates non-significance.
***See Appendix F: Table 3for more detailed statistical results.

Summary:

Overall, mental health treatment had a positive impact on correctional outcomes for offenders. After receiving treatment, offenders were generally less likely to be: involved in institutional incidents, charged with a serious institutional offence, and involuntarily segregated. Further, they were more likely to complete national correctional programs (in mainstream institutions). Although some offenders demonstrated an increased likelihood of incidents during mental health treatment, it is possible that these increases may be associated with heightened emotional instability during this time of crisis or high need.

There was a possibility that some correctional outcomes were being impacted by time alone (i.e., some outcomes may be more or less likely to occur later in an offender's sentence). In order to determine which outcomes were impacted by time, a random sample of offenders was selected from CSC's database and correctional outcomes were measured near the end of an offender's sentence, compared to the beginning of their sentence. Results suggested that, over time, there was a decrease in the likelihood of segregation,[107] an increase in the likelihood of education course or credit completion,[108] and an increase in national correctional program completion.[109] Changes following mental health treatment were also observed for these outcomes (segregation, education, and correctional programs). In some cases, the impact of mental health treatment appeared to have an even greater impact than that observed due to time alone (e.g., 32% decrease in involuntary segregation following treatment for offenders in mainstream institutions, whereas, the overall change from time alone was only 16%). However, it is possible that some of these observed results may have been influenced by time as well.

Overall, institutional mental health treatment demonstrated a number of positive impacts. Given the prevalence of mental health needs in the offender population, management of these needs continue to be a priority to CSC. The next section explores mental health care for offenders with high or complex needs receiving treatment in RTCs or requiring oversight through RCMHCs.

[107] Offenders in the comparison group were 16.6% (HR = 0.834; 95% CI = 0.770-0.903) less likely to be involuntarily segregated closer to the end of their sentence, compared to the beginning of their sentence.
[108] Offenders in the comparison group were 15% (HR = 1.150; 95% CI = 1.028-1.288) more likely to complete an education course or credit closer to the end of their sentence, compared to the beginning of their sentence.
[109] Offenders in the comparison group were 21.8% (HR = 1.218; 95% CI = 1.148 – 1.293) more likely to complete a national correctional program in the middle of their sentence compared to the beginning of their sentence.

3.12 LEVEL OF CARE BASED ON NEED

FINDING 12: LEVEL OF CARE BASED ON NEED

The Health Services Sector developed a *Mental Health Need Scale* to assess the level of mental health need and determine the appropriate level of care required in accordance with the new refined model of mental health care (primary, intermediate, psychiatric hospital). The validity and reliability of this scale have not been assessed, and electronic data on offender scale results have not been consistently recorded.

Evidence: Implementation of Care for those with High or Complex Needs

More than half of admissions to RTCs occurred within seven days of referral and more than three-quarters within twenty-eight days. The majority of offenders interviewed at RTCs felt that it was the right setting for them to address their mental health needs and that their mental health needs were identified in treatment planning processes.

Services provided to offenders with mental health needs are prioritized based on urgency of the referral, level of need, and the complexity of the case. Offenders' level of need as well as risk and eligibility/release dates are considered as the primary criteria for prioritizing admissions.[cxlix]

- In 2014-15, a total of 633 referrals were made to a RTC, of which 587 offenders were admitted. Of the offenders admitted, 317 were new admissions and 270 were readmissions.[cl,110]
- Of the 587 admissions, 84 had missing referral dates. Of the 503 remaining admissions, 55% (n=277) occurred within seven days of referral and 24% (n=119) within seven to twenty-eight days of referral.[111]
- According to the *Integrated Mental Health Guidelines*, admissions to Psychiatric Hospital Care are intended for offenders with acute mental health concerns requiring a clinical environment that provides 24-hour offender care coverage.[cli]
- About half of health services staff respondents familiar with RTCs and the referral process (46%, n=30) agreed that admissions to RTCs during incarceration are appropriate for the offenders' level of need.

[110] Referrals are reviewed and offenders may not be admitted to a RTC due to their eligibility or lack of consent.
[111] This information was extracted from MHTS for this evaluation.

- Health services staff provided suggestions to improve the referral and admission process to RTCs during incarceration, including:
  - Increasing bed spaces (n=7).
  - Having a designated mental health professional or physician to make referrals (e.g., psychiatric nurse, clinical professional, psychiatrist, physician) (n=7).
  - Streamlining the referral process (n=5).
  - Clarifying and improving communication regarding offender admission criteria (n=4).

Offender perceptions of RTCs:

- Among RTC offenders interviewed for the evaluation:[112]
  - 84% (n=27) reported that the RTC was the right place to take care of their mental health needs.
  - 72% (n=23) perceived that all of their mental health needs were identified in their treatment plan.
  - 41% (n=13) recalled being involved in developing their treatment plan and objectives.[113]
  - 56% (n=18) reported being satisfied overall with the mental health services they were receiving. A few reported being dissatisfied (6%, n=2), and the remaining offenders reported having mixed experiences (e.g., satisfied with mental health services received, but wish it could be a faster process; 38%, n=12).

CSC recently refined its mental health care delivery model to provide more options for mental health services (primary, intermediate, psychiatric hospital care) and to better target the right service and intensity level at the right time for an offender.

- CSC recently refined its mental health care delivery model to provide more options for mental health services (primary, intermediate, psychiatric hospital care) and to be consistent with community and other correctional models of care.

[112] Offenders receiving treatment in RTCs in two regions were interviewed (N=32) about their experiences with receiving care. Due to the varied health conditions of this population and the small number of offenders interviewed, the questions were asked in a more open-ended fashion designed to elicit discussion around specific themes related to admission, treatment and services received.

[113] Some of the remaining RTC offenders did not report awareness or involvement in treatment planning (21%, n=6). Others reported awareness of the planning process (e.g., having meetings), but did not recall being involved in developing their treatment plan and objectives (32%, n=9).

- The goal of the new service delivery model is to better target the right service and intensity level at the right time for the right person. The intensity of mental health services provided to offenders is matched to the identified level of mental health need.
- Prior to 2015, intermediate mental health care services were not implemented in CSC institutions, and health services offered two levels of care: primary and psychiatric hospital care.
- In April 2015, CSC began the phased implementation of intermediate mental health care services in RTCs and select mainstream institutions.[114] Intermediate care was intended to fill the gap between primary care and psychiatric hospital care provided at RTCs.[clii]

The Health Services Sector has developed the Mental Health Need Scale to assist in determining appropriate level of care. Scale information has not been consistently recorded electronically.

- The *Mental Health Need Scale* (MHNS), developed in 2015, was recently revised by the Health Services Sector to better assist in determining the appropriate level of care (primary, intermediate, psychiatric hospital care) based on overall level of mental health need. The MHNS was modelled after various tools that assess mental health status and/or clinical domains.
- The MHNS is a seven-point scale; it is a revision of the previous four-point scale. The previous scale did not indicate eligible levels of care associated with assessed level of mental health need. It replaces the institutional mental health triage form. The current MHNS also provides a more flexible, universal scale capable of showing any changes in an offender's mental health needs over time.
- Under the refined new model of care and according to the new *Integrated Mental Health Guidelines*, referrals for mental health care are triaged using the MHNS to determine the most appropriate required level of care (primary, intermediate, psychiatric hospital care).
- The MHNS provides a series of need indicators ranging from no need, to low, medium or high need. Each level of need corresponds to one or more levels of care: primary care, intermediate moderate intensity care, intermediate high intensity care, and psychiatric hospital care.[cliii,115]
- Given the emphasis on the use of this scale in the new *Integrated Mental Health Guidelines* to determine offender level of need and subsequent assignment to level of care, it is important that

[114] Implementation of intermediate mental health care was completed in April 2016.
[115] If offenders are assessed as no need or low need on the MHNS, self-care may also be an option if necessary, for example psycho-educational sessions on a particular mental health topic or skill development.

this scale be reliably implemented to ensure appropriate placement. However, the reliability and accuracy of this scale have not yet been examined.

- Results of the MHNS are retained electronically on the Electronic Medical Record (EMR) and in hard copy in Mental Health/Psychology, Psychiatric Hospital and/or Health Care files, as appropriate.
- It remains important that accurate results from the scale be recorded electronically to assess implementation and impacts of the new model. Following completion of the MHNS, offender level of need was to be entered into electronic systems (i.e., MHTS and then the EMR once it was fully implemented). However, accurate current and historical data regarding the MHNS was not available electronically to determine level of mental health need of offenders.[116] In addition, historical data regarding the previous MHNS was being overwritten as the system did not allow for the retention of historical information.
- In December 2015, health services staff were instructed to ensure updates to the MHNS were recorded electronically, and in March 2016, a new feature was introduced into the MHTS to allow for historical data to be captured and maintained.

RECOMMENDATION 6: LEVEL OF CARE BASED ON NEED

That CSC Health Services ensure offenders are referred to the appropriate mental health services by:

- Implementing effective management practices to ensure that current information on offender level of need is recorded electronically and that previous records are retained; and,
- Assessing the validity and reliability of the Mental Health Need Scale.

[116] Health Services Sector reported that electronic data on MHNS was not always being entered as required.

3.13 REGIONAL COMPLEX MENTAL HEALTH COMMITTEES

FINDING 13: REGIONAL COMPLEX MENTAL HEALTH COMMITTEES

Regional Complex Mental Health Committees have been established to assist and support institutions in providing an effective continuum of care to offenders with complex mental health needs. The degree to which funds were expended relative to those allocated at the regional level could not be accurately determined because funding was not fully tracked in the financial system.

Regional Complex Mental Health Committees have been established to assist and support institutions in providing an effective continuum of care to offenders with complex mental health needs.

Regional Complex Mental Health Committees

In April 2010, EXCOM approved the establishment of Regional Suicide/Self-Injury Prevention Management Committees to assist institutions in the management of self-injurious and suicidal behaviour. The scope of the committees was later expanded in October 2013, to include offenders with complex mental health needs as well as offenders who persistently and chronically self-injure.[cliv]

The RCMHCs meet monthly to review complex cases, and are mandated to:[clv]

- Identify complex cases for the High Risk/High Needs consultation process;
- Monitor cases of complex mental health needs, as identified by the High Risk/High Need consultation process;
- Monitor incidents of suicidal and self-injurious behaviour, with a focus on repeat self-injurious behaviour;
- Flag items of concern;
- Consult/engage institutions to offer support and advice on management and treatment, as necessary; and,
- Update the National Complex Mental Health Committee (NCMHC) on regional committee activities.

RCMHCs are comprised of senior regional health services and operational staff. Members include: Regional Director of Health Services (Co-Chair), Assistant Deputy Commissioner of Institutional

Operations (Co-Chair), Senior Psychiatrist, Executive Director of the Treatment Centre, Institutional Mental Health Manager, and, as required, Community Mental Health Manager and District Director. Ad hoc members may be included as determined by the meeting chair.

RCMHCs are supported by the NCMHC which provides assistance to regions in providing an effective continuum of care to offenders experiencing significant mental health concerns. The NCMHC:

- Monitors a national list of offenders with complex mental health needs;
- Provides oversight of regional monitoring of suicidal and self-injurious behaviour;
- Supports regional networking and sharing of best practices; and,
- Provides support to RCMHCs to enhance their ability to implement an interdisciplinary team approach.

Through RCMHCs, Health Services released funds to the regions, of which 59% was confirmed in expenditures at the regional level for offenders with complex needs.

During the period of April 1, 2015 to March 31, 2016:[clvi]

- The cases of 229 individual offenders with complex mental health needs were reviewed and discussed at the various RCMHC and NCMHC meetings; this included thirty-eight (38) cases discussed at the NCMHC meetings.
- Specialized funds for additional resources for the treatment and management of twenty (20) offenders with complex mental health needs were provided.
    - Health Services released $764,170 to the regions; 59% of that amount ($447,244) was confirmed in expenditures at the regional level for offenders with complex needs. These funds were provided for:
        - Dedicated staff resources in order to provide additional support to offenders with complex mental health needs;
        - O&M costs associated with complex cases (outside hospitalization, ambulance costs, examinations/tests, physician costs, etc.); and
        - Specialized external assessments and provision of staff training.

- The reason for the discrepancy between funds released and expended is unknown; it is possible that there may have been errors in coding these expenditures in the Integrated Financial and Material Management System (IFMMS).

Health services staff provided some suggestions to enhance RCMHCs such as reviewing roles and functions, creating greater awareness and improving communication and information sharing.

- Some health services staff (42%, n=81) and a few general staff (18%, n=29) reported being familiar with the RCMHCs. Not all staff members would necessarily be expected to be aware of RCMHCs, depending on their role in the institution. Most staff members who reported being aware of the RCMHCs either worked in the health domain or could be included as RCMHC members. These included mental and clinical health professionals (i.e., psychologists, nurses) as well as those in senior operational management positions (i.e., wardens, managers).
- Of the health services staff and general staff [117] who were familiar, some agreed that RCMHCs:
  - Assist institutions in monitoring offender's complex mental health needs (health services staff 61%, n=45; general staff 70%, n=19).
  - Offer support to staff working with offenders with complex mental health needs (health services staff 40%, n=29; general staff 67%, n=16).
  - Provide a forum to share best practices in the provision of care for offenders with complex mental health needs (health services staff 40%, n=27; general staff 77%, n=17).
  - Assisted institutions to improve their capacity to provide effective care/interventions for offenders with complex mental health needs (health services staff 28%, n=19; general staff 58%, n=14).
- Health services staff suggested the following to enhance RCMHCs:
  - Review the role and function of RCMHCs to provide broader support (n=12).
  - Increase resources to better support institutional staff working with complex needs cases (e.g., more nurses, occupational therapists, psychologists, outside specialists; n=12).
  - Improve communication and sharing of information and best practices (n=7).
  - Review composition of RCMHCs (e.g., add front line staff or clinical personnel; n=5).
  - Increase the awareness of RCMHCs and their role (n=4).

[117] Use caution when interpreting the results from general staff members due to the small number of respondents.

Next Steps:

In August 2016, the Terms of Reference (TOR) of the RCMHC were revised and approved. Although the majority of RCMHC roles and activities remained the same, the mandate was expanded to include additional activities, such as psychiatric consultations, non-emergency transfers, and requests for specialized resources. In addition, the membership was expanded to include wardens of Treatment Centres.[clvii]

RECOMMENDATION 7: REGIONAL COMPLEX MENTAL HEALTH COMMITTEES

That CSC Health Services:

- Track nationally and report on activities and expenditures of funds released to regions through RCMHCs; and
- Provide information to institutional staff regarding the role of RCMHCs and identified best practices.

FIFE #6: PRE-RELEASE AND COMMUNITY HEALTH SERVICES

CSC provides a variety of mental health care services to the offender population throughout the continuum of care. The following section focuses on transitions to the community (i.e., discharge planning) and community mental health services. Transition of offenders to community health services is examined, including routine discharge planning, assisting offenders to obtain provincial health cards, and payment for community health services during the transition. The implementation and impacts of community mental health services and clinical discharge planning for those with significant mental health needs are also assessed.

Routine Discharge Planning

Discharge planning is a client-centred process that prepares offenders for transitions in care (e.g., release to the community). Routine discharge planning, offered to all offenders who have ongoing health care needs, consists of comprehensive planning (e.g., needs assessments, intervention planning, coordination of services) to ensure that offenders receive continuity of care when they are released to the community.[clviii] This is important as more offenders are being released with continuous and/or complex health needs and the goal is to prevent "increased physical and psychiatric symptoms, relapse, hospitalization, suicide, homelessness, family and social discord as well as continued involvement with the criminal justice system after release to the community."[clix]

Discharge planning requires coordination among several institutional staff members, including institutional nurses and parole officers.[clx]

The institutional nurse:

- Reviews and updates the offender's health care file;
- Finds out whether the offender is receiving health care that will likely continue after release, identifies any appointments required with community health care specialists, and any accommodation needs related to functional and/or cognitive impairment and arranges for follow-up medical, dental, and/or mental health appointments with health service providers as soon as possible after release;
- Completes required discharge forms (e.g., Health Status at Discharge: Gist Report, Health Services Discharge Summary Report, and Medication Reconciliation);

- Determines whether the offender has a health card or has started the process to obtain one with their institutional parole officer; and,
- Arranges with the regional or local pharmacy for the provision of two weeks supply of medication; additional medication and/or prescription supply may also be provided. Discharge medication is provided to the offender on the release date.

The institutional parole officer (IPO):

- Develops a comprehensive release plan that includes the offenders' health information if relevant to discharge;
- Assists the offender to obtain a provincial health card in the province of the offenders' releasing institution;[clxi] and,
- Informs health services of upcoming case preparation in advance of 6 months before hearing/release, and informs health services of upcoming release 3 weeks in advance (or as soon as possible for last minute releases).[clxii]

3.14 ROUTINE DISCHARGE PLANNING AND OFFENDER INDENTIFICATION

FINDING 14: ROUTINE DISCHARGE PLANNING AND OFFENDER IDENTIFICATION

Processes to assist offenders in obtaining provincial health cards vary across regions and are dependent on provincial/territorial health authority requirements. Procedural challenges associated with assisting offenders to obtain provincial/territorial health cards exist (e.g., prerequisite for a birth certificate, fee requirements, releases to different provinces).

Evidence: Routine Discharge Planning and Offender Identification

The most commonly reported challenges identified by CSC staff related to discharge planning were assisting offenders to obtain provincial/territorial health cards and other ID. It was difficult to determine exactly how many offenders have health cards at release, since information regarding the number of offenders with health cards was inconsistently documented in OMS.

CSC staff reported some challenges related to routine discharge planning:

- More than 50% of CSC staff respondents reported *always* or *frequently* experiencing challenges assisting offenders to obtain provincial health cards (51%, n=90) and other ID (56%, n=93).
- Between 41% and 45% of staff respondents reported *always* or *frequently* experiencing challenges with timely notification of requests for discharge planning (45%, n=81), coordinating medical services in the community (44%, n=77), housing/accommodations for those with special needs (43%, n=73), and coordinating access to medication in the community (41%, n=74).
- Other issues related to discharge planning reported by staff respondents included:
  - Issues related to communication and information sharing within CSC pertaining to discharge planning (n=54). Such as:
    - Insufficient notice of the offender's release (e.g., offender's notice of release is not always provided to health services, quick releases from parole hearings or last minute changes to residency conditions).
    - Need to clarify discharge planning roles and responsibilities (e.g., duplication of work may occur as a result of unclear understanding of responsibilities regarding follow-up).
  - Challenges with ensuring continuity of care (n=50). Such as:
    - Issues coordinating medication (e.g., coordination of methadone treatment in the community or when offenders are released without a two-week supply of medications).[118]
    - Offenders are being released without ID, primarily without their health cards.
  - Challenges with the discharge planning process (n=27). Such as:
    - Not enough planning for complex needs cases (e.g., offenders with high needs).
    - Issues with discharge planning could be improved in terms of consistency, timeliness and resource allocations for discharge planning.

Number of offenders in the community with a health card:

- OMS*:* Records showed that 28% (n=2,289) of CSC offenders in the community[119] had a health card. However, data was missing in OMS for an additional 62% (n=5,133) of CSC offenders in the community, suggesting that OMS is not a reliable source of information.

[118] The Audit of Release Process (2012) also found offenders were not always released with their medications.

- Audit of Offender Release Process*:* 42% (n=117) of offenders had three pieces of identification (ID) upon release (i.e., birth certificate, social insurance number, and health card) according to a file review conducted during an internal audit of the release process (2012).[120] However, information on ID was missing from 39% (n=109) of files reviewed.[clxiii]
- Staff Questionnaires*:* 52% (n=130) of CSC staff reported that more than half of the offenders they worked with had a health card at release.

The process to assist offenders in obtaining provincial/territorial health cards varies across regions and is dependent on provincial/territorial health authority requirements. In some provinces and territories, offenders must wait until after release to apply for a health card.

- According to *CD 712-4 Release Process*: The Institutional Head/District Director must ensure that procedures exist to assist the offender "in obtaining relevant documentation, including health care coverage, social insurance number, birth certificate and citizenship card/permanent resident card."[clxiv]
- According to *CD 566-12 Personal Property of Offenders*: "Important documents (not exceeding $1,000) will be recorded on the Inmate Personal Property Record and will be securely stored in a fireproof cabinet or safe. Items stored in this manner will be photographed and the inmate will sign the Inmate Personal Property Record to confirm its authenticity. These items will also be photographed and the photograph and Inmate Personal Property Record will be stored electronically in OMSR-OPP and will remain in the Admission and Discharge File."[clxv] The CD does not define "important documents" so it is unclear whether offender ID would be considered an important document.

Prior to release

- Regional personnel reported that the process to obtain a health card generally involves the IPO completing and submitting the health application to the provincial/territorial health service. However, the staff member responsible may vary by site, and others may also be involved (e.g., Admissions and Discharge Department, clinical discharge planners).[121] A birth certificate or

[119] Extracted from the data warehouse on 2016-02-28 for all offenders active on that date. Offenders were coded as having a health card if their *most recent record* from OMS indicated they had a health card in their possession, in their personal effects, of with a community support person.
[120] The Audit sampled release files from the period of April 2010 through March 2011.
[121] Based on consultation with Regional Directors of Health Services (RDHSs) in August, 2016.

proof of residency is required to apply for provincial/territorial coverage; if the offender does not have a birth certificate or proof of citizenship, it must be obtained first. The timeframe to complete applications for health cards varies by province and territory. In some provinces and territories the application can be submitted before offenders are released to the community and in others, the application cannot be submitted until after they are released.

- Many (72%, n=131) CSC staff respondents reported that that there are procedures in place at their institution for assisting offenders to obtain provincial/territorial health cards.
  - 55% (n=66) of CSC staff agreed that procedures at their institutions were *effective*;
  - 43% (n=50) of CSC staff agreed that procedures at their institutions were *efficient*.

Following release

- If an offender does not have his or her health card once released, the staff member responsible to assist them varies from region to region (e.g., community parole officers and community mental health staff). Community Residential Facility staff may also assist offenders to obtain their health cards.[122]

New province

- An *Inter-provincial Agreement on Eligibility and Portability* ensures offenders have health coverage for the first 3 months after release. Section 2 of the Agreement reads as follows: "In the case of members of CAF, RCMP, and penitentiary prisoners on discharge or release, the province where incarcerated or stationed at time of release or discharge or, in the case of those on leave prior to discharge, the province where residence has been established, as may be appropriate, will provide initial coverage for the customary waiting period of up to three months."[clxvi]
- The province that the offender was incarcerated in, and subsequently released from, is responsible to provide the coverage if the offender does not have a health card. However, CSC health staff reported that offenders in some provinces did not appear to receive coverage through this Agreement.
  - About half (52%, n=149) of CSC staff members indicated that they were aware of the Agreement.

[122] Based on consultation with RDHSs in August, 2016.

- Of those aware of the Agreement, 33% (n=48) reported that they had *frequently* or *always* initiated the process for offenders who did not have their health card at release; and, another 31% (n=45) reported that they had *occasionally* initiated this process.

According to CSC policy and guidelines, offenders are responsible to ensure the funds are available to obtain personal ID and institutional parole officers are responsible to assist offenders in obtaining a provincial/territorial health card. Other staff, such as community POs, community mental health staff, and institutional nurses, also report assisting offenders to obtain provincial/territorial health cards.

The *Discharge Planning and Transfer Guidelines* outline the roles and responsibilities of offenders and CSC staff to support the continuity of health care for offenders and to support post-release access to health care and community resources. This includes ensuring that offenders have the necessary identification documents (e.g., provincial/territorial health cards) at release.[clxvii]

According to policy and guidelines, offenders, IPOs, and nurses all have a role in relation to obtaining offender identification, including health cards.

- Offender: The offender is responsible for budgeting to ensure that they have the funds available for personal identification (e.g., birth certificate).[clxviii]
- Institutional Parole Officer: The IPO assists the offender in obtaining a provincial/territorial health card prior to release or assists the offender to make a plan to obtain a card as soon as possible after release.[clxix]
- Institutional Nurse:
  - "Within 6 months of being notified of an offender's projected or definite release date," the institutional nurse finds out whether the offender has a health card or has started the process to obtain one with their IPO. [clxx] This information is included in the Health Status at Discharge: Gist Report,[123] which is then sent to the IPO.
  - Within three weeks of discharge, the institutional nurse checks to ensure that the offender has a health card and updates the Health Status at Discharge: Gist Report accordingly.[clxxi]

[123] The Health Status at Discharge: Gist Report includes other health related information related to release, such as any appointments required with community health care specialists and any accommodation needs related to functional and/or cognitive impairment, etc.

- Are the Roles Clear?
  - The percentage of CSC staff who reported that the *Discharge Planning and Transfer Guidelines* clearly outline the roles related to offender health cards is reported below:
    - 54% (n=102) of CSC staff agreed that roles for *IPOs* were clear,
    - 46% (n=75) of CSC staff agreed that roles for *Institutional Nurses* were clear.
- Is it Part of Your Role?
  - The percentage of staff who reported that it was part of their role to assist offenders in obtaining provincial/territorial health cards:
    - IPOs (78%, n=28)
    - Institutional Nurses (24%, n=9)
    - Community POs (25%, n=21)
    - Selected Community Mental Health Personnel[124] (31%, n=15)
- Do you Assist Offenders to Obtain Health Card?
  - Whether they perceived it to be part of their role or not, various CSC staff respondents reported that they had *directly* assisted at least one offender to obtain their health card over the last year:[125]
    - IPOs (70%, n=23)
    - Institutional Nurses (24%, n=8)
    - Community POs (72%, n=59)
    - Selected Community Mental Health Personnel[126] (82%, n=41)
  - Additionally, many staff respondents (72%, n=182) indicated that they had *indirectly* assisted at least one offender to obtain their health card over the last year (e.g., providing notification that an offender did not have a health card).

Procedural challenges related to assisting offenders to obtain provincial/territorial health cards emerged (e.g., need for a birth certificate, fee requirements, releases to different provinces). Suggestions to address these challenges included: modifying existing practices, engaging with provincial/territorial partners, and providing additional support to offenders.

[124] Included: Clinical Discharge Planners, Community Mental Health Nurses, Clinical Social Workers
[125] Note that not all staff responded to this question. Percentages are reported out of the total number of staff responses to this question.
[126] Included: Clinical Discharge Planners, Community Mental Health Nurses, Clinical Social Workers

Challenges in Obtaining Provincial Health Cards

- CSC staff respondents agreed that the following circumstances create challenges to obtaining provincial/territorial health cards:
  - Offender does not have a birth certificate (86%, n=209).
  - Fee requirements to pay for ID (82%, n=182).
  - The province of incarceration was different from the province of release (80%, n=191).
  - Completion of forms (62%, n=146).
- Other challenges were raised by staff through various communications, including the staff questionnaire and other questions directed to Regional Directors of Health Services and Wardens:
  - Require additional supports/procedures to assist the offender in obtaining ID (e.g., through ETAs to get ID or staff follow-up on the process).
  - Issues around offenders' motivation to obtain a provincial/territorial health card.
  - In some provinces/territories offenders are unable to apply for provincial/territorial health coverage until after they have been released (application regulations differ among provincial/territorial health authorities).
  - ID is lost (offenders may leave ID with their family, friends, or at remand centres, where ID is eventually lost or destroyed).
  - In some provinces/territories, CSC provides health coverage until provincial/territorial health insurance is in effect. CSC must then obtain reimbursement within three months, which is time-consuming for community staff.

Good Practices

The following good practices were identified by staff in one or more regions:

- <u>Providing additional support to staff who assist offenders with ID</u>
  - Identifying one person at each institution to be a designated point of contact between the site and the provincial/territorial health authority (e.g., to send applications and receive identification cards).
  - Providing resource sheets for staff members outlining procedures and providing relevant contact information for obtaining health cards in each province/territory.

- Strengthen partnerships with provincial/territorial health authorities
    - Having an administrative agreement with provincial/territorial health authorities outlining the process for an offender to obtain a health card while incarcerated.
    - Identifying a dedicated contact/liaison from the health authority to answer questions.
- Provide additional support or assistance to offenders to obtain provincial/territorial health cards:
    - Providing offenders with a letter from a parole officer to confirm their identity and or address in order to get a health card.

Suggestions

Modifying Existing Processes:

- *Timing: Begin the process to obtain ID earlier:*
    - Complete the application procedures to obtain the provincial/territorial health card (including obtaining birth certificate/proof of citizenship) earlier in the offender's sentence.
    - Begin the process to obtain a birth certificate at intake.
- *Maintain and track existing ID:*
    - Electronically scanning existing ID and putting it in the offender's files so that both case management and health care staff can access as required.
    - Establishing a protocol to store ID.

Engaging Partners:

- *Strengthen partnerships with provincial/territorial health authorities:*
    - Work with provincial/territorial authorities to review the process to obtain identification.
    - Invite representatives from the health authority to the institution to assist inmates with the application process (e.g., through ID clinics).[127]

[127] Community-based ID clinics are offered in multiple regions, for example, through community housing resource centres, community health centres, legal clinics, and other community service organisations.

- *Engage community partners and/or volunteers:*
    - Liaise with community partner agencies that provide ID clinics in the community for at-risk populations.
    - Have community partners or volunteers come to the institution regularly to assist offenders to apply for ID (e.g., host regularly scheduled ID clinics).

Providing Additional Support to Offenders

- *Provide assistance with forms or alternate forms of ID:*
    - Provide assistance in completing applications forms (e.g., give examples of completed forms, offer assistance from staff members or community partners/volunteers).
    - Provide offenders with alternative form of ID from CSC that confirms offenders' identity and citizenship and can be used to help obtain health cards.
- *Facilitate offender payment for ID:*
    - Allocate funds from offender pay to obtain their birth certificates (prerequisite to obtain a provincial/territorial health card).
    - Explore other means of paying for ID (e.g., CSC assumes cost, support from ID clinics offered through community-based services).

RECOMMENDATION 8: RELEASE PLANNING & OFFENDER IDENTIFICATION

That CSC adopt measures to address challenges related to offenders accessing health care in the community by retaining or obtaining offender ID (including health cards); and to clarify the policy, guidelines and procedures pertaining to coordinating access to medication while transitioning to the community.

- Develop guidelines to support the retention of offenders' ID including health cards;
- Establish mechanisms to obtain key ID at intake; and,
- Clarify existing release policy related to the requirements for medication at release and provide consistent communications to staff.

3.15 PAYMENT FOR COMMUNITY HEALTH SERVICES

FINDING 15: PAYMENT FOR COMMUNITY HEALTH SERVICES

According to CSC policy, CSC may cover the cost of some medical expenses in the community if offenders are not covered by provincial/territorial health insurance or other provincial/territorial plans (e.g., disability benefits, drug plans) and have no personal means to pay. Medical expenses covered by CSC in the community vary across regions, which may be related in part to variations in provincial health coverage.

Evidence: Payment for Community Health Services

- According to the *National Essential Health Services Framework*, essential health services are funded by CSC for offenders residing in Community Correctional Centres (CCCs) in circumstances where provincial coverage is not available. CCCs are CSC facilities, therefore offenders residing in CCCs are under CSC's jurisdiction for health services; community residential facilities (CRFs) are not CSC facilities and therefore offenders residing in CRFs are under provincial jurisdiction for health services. Exceptions to the criteria specified in the *National Essential Health Services Framework* must be pre-authorized and approved in writing by the Regional Director Health Services or delegate.[clxxii]
- In some provinces/territories, offenders may apply for provincial/territorial health coverage during incarceration, while in other provinces/territories they may only apply for coverage after release.
- Provincial/territorial health services consist of:
    - General health care (e.g., physician services, hospital or emergency care, mental health services, emergency dental services).
    - Disability benefits (e.g., non-emergency dental care, prescription drugs, prosthetics, mobility aids). Disability benefits are not usually available to the general population, but rather for special needs populations who meet the criteria. Up to date income tax returns and supporting medical assessments may be criterion of applying for disability benefits.

- Prescription drug plans (e.g., for residents that do not have insurance coverage through an employment/group plan or other federal or provincial/territorial plan). Up to date income tax returns may be required to apply for this coverage.

Covering the Cost of Medical Expenses (General)

- In 2015-16, CSC spent $1,765,267 on "pharmacy administration" health related expenditures in the community.[128] The majority of these expenditures were for medications, representing approximately 81% of this total cost, with the remainder being spent on items such as medical devices, optometry, emergency health care, etc.[129]
- CSC provides coverage for essential physical health services. In some regions if the offender has not yet obtained coverage, CSC may pay for appointments, dental care, eyewear, or equipment/medical devices until covered by other provincial benefits. Coverage for medication varies by region, and may also depend on provincial/territorial health care disability benefits or drug plans. In some regions, between two weeks to three months, coverage may be offered pending issuance of provincial/territorial coverage. Some CSC regions support mental health services in the community beyond what is offered through CSC's community mental health services. This can include follow-up psychiatric services offered through contract psychiatrists (e.g., where access to community resources is limited), or visits to a family physician or other specialists. Emergency situations requiring hospitalization may also be covered by CSC.
- Most staff members (86%, n=122) reported that if an offender does not have provincial/territorial health coverage but requires essential health services in the community, there are circumstances in which CSC covers the cost. Services that could be covered included:

  Medication/pharmacy items (94%, n=113)

  - Some staff members reported that CSC provides medical/pharmacy services when:
    - Offenders reside in a CCC/CRF or if they are on conditional release (e.g., day parole, full parole, statutory release with residency condition; n=23);

[128] This is in addition to community health expenditures in other areas such as mental health and other general administrative, nursing or methadone costs.
[129] Source: Integrated Financial and Material Management System (IFMMS), extracted September, 2016.

- Offenders are not covered by health insurance (e.g., provincial health insurance, disability or other social assistance programs, employer's health insurance; n=21);
- Offenders are released without the required two weeks of medication (n=4).[clxxiii, 130]

- Staff respondents reported that CSC could cover the cost for medical services and certain specialized medication, such as:
  - Methadone (n=16)
  - Physical health medication (e.g., lupron, insulin, HIV medication; n=8)
  - Mental health medication (e.g., psychiatric; n=10).

Mental health services (other than those already supported through regular CSC mental health services; 38%, n=46)

- Some staff members reported that CSC covers mental health services in some circumstances:
  - Psychiatric/psychological services and programs (e.g., contract services for remote locations, crisis support, counselling; n=16).

Physical health services (52%, n=62)

- Staff members reported that CSC could cover the costs for services such as:
  - General physical health equipment, such as mobility devices (e.g., walkers, canes, wheelchairs; n=11);
  - Dental care (n=11);
  - Doctor/specialist/emergency care (n=11);
  - Optometry (n=9); and
  - Physiotherapy (n=6).

[130] The type of medication dictates the duration of the supply provided at discharge. According to the *CSC National Formulary*, non-narcotic and non-controlled mediations are generally provided for 14 days; whereas, narcotic and controlled medications (e.g., ADHD medications) are provided for 3-days and at the discretion of the physician. This distinction is not clarified in the Discharge *Planning and Transfer Guidelines* or CD *712-4 Release Process*.

RECOMMENDATION 9: ACCESS TO AND PAYMENT FOR COMMUNITY HEALTH SERVICES

That CSC improve access to community health services to ensure a continuum of health care for offenders during the transition to provincial/territorial health coverage, by:

- Improving partnerships with provincial and territorial health authorities to determine how offenders can better access health care services and disability benefits; and,
- Clarifying and communicating policies and procedures related to CSC's coverage (i.e., payment) for health services in the community and requirements for medication at release.

Overview: CSC's Community Mental Health Services Model

CSC's community mental health services model promotes the continuity of mental health services for offenders transitioning from institutions to the community. This model consists of clinical discharge planning, which is provided in institutions; and community mental health services, which are offered to offenders in select locations in the community. [clxxiv] Community mental health and clinical discharge planning services are provided to offenders on a priority basis, based on urgency of referral, level of need, risk, responsivity and policy requirements.[clxxv] Services are provided by clinical social workers, mental health nurses and psychologists.

- Community mental health services include mental health services for offenders being released from a CSC institution to the community and those under parole supervision in the community. Services include: mobile services, advocacy, clinical accompaniment support, community capacity building, client/family education and monitoring and addressing behaviour related to risk reoffending.[clxxvi]
- Clinical discharge planning services include transitional services to support offenders being released from an institution to the community. Services include: assisting in the development of comprehensive plans to address offender needs at discharge through coordination of services offered institutionally, ensuring consultation and coordination as applicable, and responding to referrals for consultation in complex cases.[clxxvii]
- Eligibility criteria, offenders with major mental disorders and/or moderate to severe impairment are eligible for community mental health and clinical discharge planning services. This includes

those with medium (considerable) or high level of mental health need on the Mental Health Needs Scale.[clxxviii]

3.16 COMMUNITY MENTAL HEALTH SERVICES & CLINICAL DISCHARGE PLANNING

FINDING 16: COMMUNITY MENTAL HEALTH SERVICES & CLINICAL DISCHARGE PLANNING

Community mental health specialists services provided to offenders were associated with lower rates of recidivism; whereas, clinical discharge planning services alone did not appear to have an impact. The number of offenders receiving clinical discharge planning services could not be determined due to inconsistencies in data recording; providing continuity of care is challenging when offenders who receive discharge planning services are released to locations with limited CSC community mental health staff.

Evidence: Community Mental Health Services & Clinical Discharge Planning

Community mental health specialist services were associated with lower rates of recidivism for men and women offenders; whereas, clinical discharge planning services alone did not appear to have an impact on recidivism rates.

- As part of CSC's National Mental Health Strategy, a Community Mental Health (CMH) services model was implemented to better prepare offenders with serious mental disorders for release into the community by strengthening the continuum of specialized mental health support, providing continuity of support and reducing the probability of offenders' criminal recidivism.[clxxix]
- In 2008, an evaluation found preliminary evidence for CMH's effectiveness in reducing recidivism; however, the follow-up period was brief.[clxxx] A more recent study was conducted in 2014 to examine results for this early group of CMH service recipients over a more extended period of time (i.e., 24 months post-release and 48 months post-release) following three treatment groups receiving community mental health services: those who received clinical discharge planning (CDP), those who received Community Mental Health Specialist (CMHS) services, and those who participated in both CDP and CMHS services. Results from the study indicated: [clxxxi]

- Fewer men in the CMHS services group recidivated within 24 months post-release or 48 months post-release compared to men who did not receive the CMHS services or those who received both CDP and CMHS or CDP alone (see Appendix G).
- Fewer women in the CMHS services group or in the combined CDP/CMHS services group, recidivated within 24 months post-release or 48 months post-release compared to women offenders who did not receive CMHS services (see Appendix G).[131]

Community Mental Health Services are provided to approximately 23% of the community offender population. The number of offenders receiving clinical discharge planning services could not be determined due to inconsistencies in data recording.

Offender Access to Community Mental Health Services and Clinical Discharge Planning

- In 2014-15, the community offender population flow-through (i.e., total offenders supervised in the community) totalled 14,178. Of these offenders, 23% (n=3,312) received a community mental health service.[132] The percentage of offenders in the community receiving community mental health services has remained relatively stable over time, ranging from 22% to 23% from 2010-2011 to 2014-2015.[clxxxii]
- In 2014-15, offenders most commonly received their first community mental health service within 14 days of referral (59%, n=1,643). The remaining offenders received their first community service within 15 to 28 days (21%, n=583) or 29 days or later (20%, n=583).[clxxxiii]
- The number of offenders receiving clinical discharge planning activities could not be assessed based on available electronic data due to inconsistencies in recording information in the Mental Health Tracking System (MHTS).
- Most staff members (76%, n=105) agreed that offenders who receive clinical discharge planning services meet eligibility criteria.
- Some staff members (43%, n=62) agreed that offenders receive clinical discharge planning in a timely manner.[133,134]

[131] This should be interpreted with caution because the risk profiles were not equivalent between groups and the group size for women offenders was too small to allow for survival analysis and only a fixed follow-up analysis was undertaken.
[132] Community mental health services provided to offenders may include mental health counselling (individual or group), accompaniment support, suicide or self-injury intervention, assessments, etc.
[133] CDP Timeframe: "The timing of referrals for CDP is guided by the offender's anticipated release date, the case management process and the anticipated level of need."

Offenders with a mental health need receiving mental health services in the community

- Community Mental Health Services were examined further to determine how many offenders with a mental health need received a community mental health service:
  - A sample of offenders released in 2014-15 who were supervised in the community for at least one month (N=5,912),[135] was examined to determine receipt of mental health services *based on mental health need*. Of this sample, 40% (n=2,369) had a mental health need 6 months prior to release.[136] Of those with a mental health need, 40% (n=941) received a mental health service in the community within 6 months following their institutional release.
  - Of those who did not have a mental health need within 6 months prior to release (n=3,543),[137] some (16%, n=552) also received mental health services in the community within 6 months following their release.

Clinical discharge planners' roles and responsibilities are broad. Staff reported that clinical discharge planners spend a significant proportion of their time providing support in areas that may not relate directly to their core responsibilities (e.g., brief interventions, assisting offenders to obtain provincial health cards, indirect support to offenders not on their caseload).

Clinical Discharge Planning Roles and Responsibilities:

- The Discharge Planning Matrix Tool,[138] the *Discharge Planning and Transfer Guidelines*, and the *Integrated Mental Health Guidelines* outline the roles and responsibilities for CSC staff in relation to CDP (see Appendix H for a complete description).[clxxxiv]
- There is an average of two clinical discharge planners per region. Discharge planners are located in CSC institutions or RHQ and provide services to offenders in their region according to need/priority.[clxxxv]

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[134] Remaining staff members either reported "neither agree nor disagree" (21%, n=30) or "disagree/strongly disagree" (36%, n=52).
[135] Our sample included offenders on their first conditional release of FY2014-15, but only if they remained in the community for 30 days or more (this was done to allow time to receive mental health services).
[136] Mental health need is defined as any offender who received a treatment-oriented mental health service 6 months prior to their release. Note that this provides an approximation of need. Reliable information from other data (such as the Mental Health Need Scale) was not available. Therefore, the receipt of a treatment-oriented mental health service in the institution 6 months prior to release was used as a proxy indicator of offender mental health need.
[137] Absence of mental health need was identified as offenders who did not receive a treatment oriented service 6 months prior to release.
[138] The Discharge Planning Matrix Tool was developed in April 2013 as a reference accompanying the *Discharge Planning and Transfer Guidelines.*

Staff Perceptions of Clarity of Clinical Discharge Planning Roles and Responsibilities:

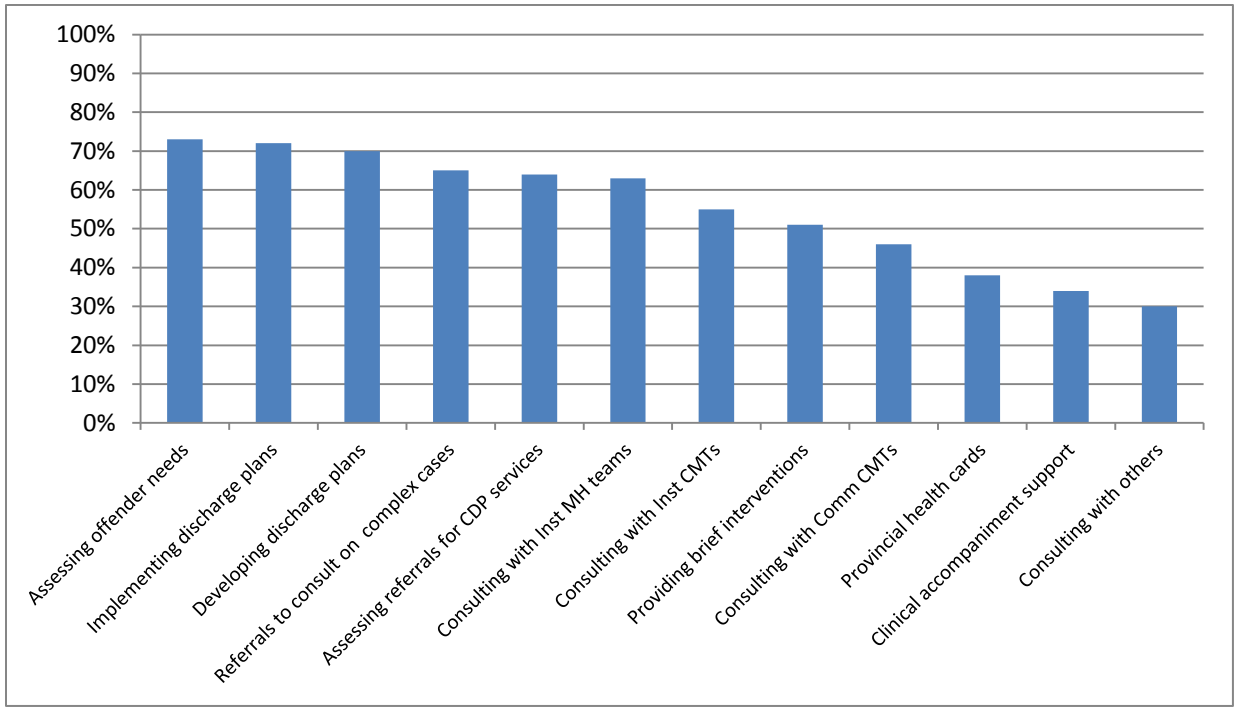
- Staff members agreed that the *Discharge Planning and Transfer Guidelines* and the *Community Mental Health Service Delivery Guidelines* clearly outline the roles and responsibilities related to clinical discharge planning for the following CSC staff:
  - Clinical discharge planners (73%, n=81)
  - Community mental health specialists (69%, n=77)
  - Institutional nurses (62%, n=71)
  - Community parole officers (57%, n=69)
  - Institutional parole officers (52%, n=58)

Clinical Discharge Planning Activities:

- CSC staff respondents reported that clinical discharge planners spent *quite a bit* or a *great deal* of time on the following activities: (see Figure 1).
  - Between 70% and 73% of staff respondents reported: assessing offender needs, implementing discharge plans, and developing discharge plans.
  - Between 55% and 65% of respondents reported: responding to referrals for consultation in complex cases, assessing referrals for clinical discharge planning services, and consulting and coordinating with institutional CMTs and mental health teams.
  - Many respondents (51%) reported that clinical discharge planners spend a great deal or quite a bit of time providing brief interventions, including:
    - Referrals, access and coordination of community services, such as providing information on availability of community resources, supporting application processes, scheduling social assistance appointments, conducting medication reviews (n=17);
    - Therapeutic services for offenders like counselling, crisis intervention, and education (n=9), and,
    - Assisting offenders with administrative tasks like completing forms (n=6).
  - Between 30% and 46% of respondents reported: consulting and coordinating with community CMTs or other staff, helping offenders obtain provincial health cards, and providing clinical accompaniment support.

- Indirect support to offenders not on their caseload:
  - About half of staff respondents (54%, n=28) reported that clinical discharge planners spend more than 20% of their time providing support to offenders not on their case load. Types of support included:
    - Providing assistance and information on an ad hoc basis, such as answering offenders questions and helping them find community services, making referrals for services, assisting parole officers, and attending CMT meetings (n=10).

Figure 1: % of Health Services staff who reported that Clinical Discharge Planners spend quite a bit or a great deal of time on the following activities:



There are no specific guidelines for follow-up on clinical discharge planning once an offender is in the community. Staff report that follow-ups may be done by community mental health staff, community POs, or community psychologists, but that providing continuity of care is challenging when offenders who receive discharge planning services are released to locations with limited CSC community mental health professionals.

Outcomes of Clinical Discharge Planning

- Referrals: Most staff respondents (76%, n=107) agreed that as a result of developing a clinical discharge plan, offenders are being referred to community-based services for mental health interventions.
- Attendance: Many staff respondents (64%, n=81) agreed that as a result of developing a clinical discharge plan, offenders are attending the community-based mental health services/interventions to which they were referred.
    - Of those that disagreed, the most common response was related to challenges accessing community-based mental health interventions/services for offenders (n=9).

Clinical Discharge Planning Follow-up

- Almost all staff respondents (93%, n=110) reported that there is a need to follow-up, at least occasionally, on the clinical discharge plan once an offender is released to the community:
    - 57% (n=67) reported there is *frequently* or *always* a need, and
    - 36% (n=43) reported there is *occasionally* a need to follow-up.
- When asked if follow-up on the clinical discharge plan is done, some respondents (40%, n=43) reported that it was *always* or *frequently* followed-up on and another 35% (n=37) said that it was *occasionally* followed-up on once offenders were released to the community.
- There are no specific guidelines outlining responsibility for follow-up for clinical discharge planning. However, respondents indicated follow-ups were most frequently[139] done by:
    - Community mental health specialists (67%, n=75);
    - Community parole officers (65%, n=73); and,
    - Community psychologists (59%, n=56).

[139] Numbers/percentages reflect the number of staff who reported that each of the following categories of staff "frequently" or "always" followed-up on clinical discharge plans.

Clinical Discharge Planning: Offenders Released to Areas with Limited CSC Community Mental Health Professionals

- According to CSC's *National Essential Health Services Framework*, limited Community Mental Health services (clinical social workers, mental health nurses and psychologists) are available in select locations for offenders with significant mental health needs.[clxxxvi]
- Many[140] staff respondents reported that 20% or more offenders who received clinical discharge planning services were released to an area with limited presence of CSC community mental health professionals.
    - Many staff respondents (96%, n=119) reported that there are challenges when this occurs. Ensuring continuity of care for offenders was the most common challenge identified (n=83), including:
        - Insufficient access to community resources (n=40);
        - Insufficient access to CSC resources (n=29);
        - Difficulty following-up with offenders (n=19); and,
        - Transportation-related issues for offenders and staff (n=16).
- Staff members provided the following suggestions to support offenders released to an area with limited CSC community mental health professional presence:
    - Improving access to community mental health services available to offenders (n=50) by:
        - Hiring more CSC community mental health staff or contractors (n=31);
        - Improving partnerships with community organisations and provincial health systems (e.g., increased number of agreements)(n=17); and,
        - By using alternative methods of service delivery such as increased use of telemedicine (e.g., videoconferencing), liaising with non-traditional community mental health partners (e.g., police services) (n=11).
    - Improving discharge planning processes through better communication with community agencies, timely referrals for services and establishing a connection between the service provider before release or early needs identification (n=26).

[140] 65% (n=50) of staff who responded to this question indicated that at least 20% of offenders were released to area with limited community mental health specialists.

- Providing transportation funds for CSC community mental health staff to travel to better support offenders in the community (n=8).

Staff Perceptions Relating to Challenges and Suggestions for Improving CSC's Community Mental Health Services Model

Challenges:

- Insufficient resources in CSC for community mental health services and clinical discharge planning (e.g., not enough staff to provide services, high workloads, limited services for offenders in remote locations or small centres, and many offenders are complex cases or have high needs; n=59).
- Accessibility of non-CSC community based programs and services (e.g., shortage of service providers that work with offenders, difficulties with timely access to provincial health services and other community-based service providers, particularly in relation to psychiatry services and accommodations for offenders with mental health needs; n=37).
- Other specific challenges including:
  - Information sharing and collaboration (e.g., communications between health services and other sectors or between the institution and the community; n=20).
  - Continuity of medication in the community (e.g., offender released without enough medication, clinics unwilling to fill prescriptions for narcotics; n=16).
  - Challenges related to timeliness of discharge planning (e.g., planning needs to happen earlier, not enough notice given before offenders release date to make referrals, residency location determined at the last minute; n=15).
  - Offenders are being released without provincial health insurance or ID (n=6).

Suggestions:

- Improving communication and collaboration between sites and community (e.g., using a team approach, meeting regularly to discuss referrals, complex cases and suspension, earlier information sharing between health staff and community PO; n=39).
- Increasing resources and/or modifying staff complement to enhance discharge planning services (e.g., increase the number of discharge planners and social workers; n=17).

- Clarifying roles and responsibilities related to the discharge planning process (e.g., establish guidelines to clearly outline caseworkers' roles, clarify Health Services and parole officers roles in the process; n=13).
- Providing offenders with support to ensure continuity of care (e.g., accompanying to appointments, providing supply of medications at discharge, following up on discharge plans in the community, establishing intervention plans that are health-focused; n=16).
- Offering specialized services at CCC/CRF, particularly for mental health (n=8).
- Enhancing community mental health staff ability to respond to offenders' specific needs, for example cultural competency, training or professional upgrading, attention to gender-specific needs (n=7).
- Active engagement between community mental health specialists and external resources (e.g., need to establish links with community resources, develop more partnerships; n=5).

Staff also identified the following good practices currently used in one or more regions:

- Using interdisciplinary teams comprised of health and case management staff.
- Having a mental health nurse working out of the CCC provides direct support to offenders and in-person communication with case management staff.
- Offering community mental health services and discharge planning services in group format.
- Offering individual and group services in the community that include elder services.
- Community mental health staff and clinical discharge planners meet quarterly through videoconferencing to discuss complex cases and resource sharing, etc.
- On-site psychiatric clinic at parole office.

RECOMMENDATION 10: CLINICAL DISCHARGE PLANNING AND COMMUNITY MENTAL HEALTH SERVICES

That CSC:

- Review the model of community mental health service delivery to ensure that community mental health services are being provided to offenders with the greatest mental health needs.
- Ensure that clinical discharge planning activities are tracked in electronic information systems.

FIFE #7: MANAGEMENT & COORDINATION OF HEALTH SERVICES

The following section focuses on overall management and coordination of health services. Health care expenditures and impacts are assessed, and changes to the governance of health services to promote standardization and integration of health services delivery are reviewed. Specific health care needs and initiatives for sub-populations of offenders, including women, Indigenous, and older offenders are examined to identify any potential gaps.

3.17 COORDINATION OF CSC'S HEALTH SERVICES

FINDING 17: COORDINATION OF CSC's HEALTH SERVICES

Following changes to the health services governance structure, there has been greater standardization and integration of health services.

Evidence: Management of CSC's Health Services

CSC has implemented gradual changes to the health services governance structure to promote streamlined and integrated service delivery across mental, clinical, and public health domains.

In 2007, CSC began implementing a new governance structure for Health Services, including the following major changes:

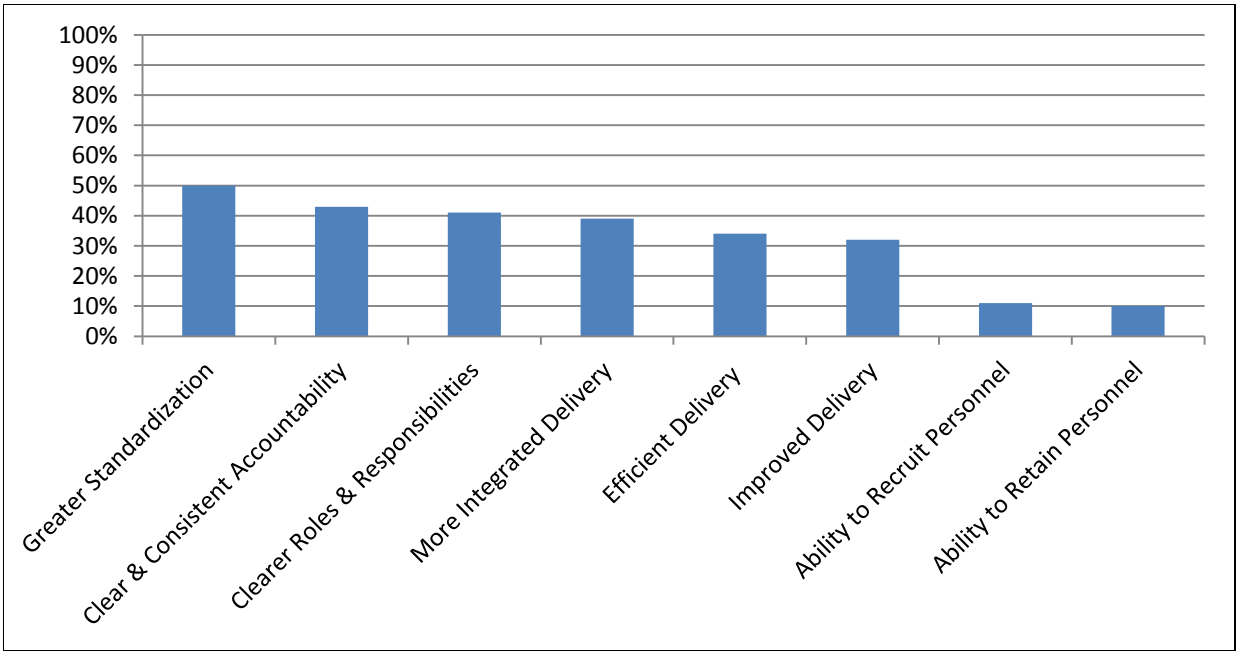
- Creation of the position of Assistant Commissioner Health Services, Director General positions at NHQ, as well as the Regional Director positions in each of CSC's regions (2007).
- Changes in reporting for mental health staff occurred more recently with:
  - Mental health staff in mainstream institutions and the community beginning to report to the Health Services Sector (2013).
  - Health functions in the Regional Treatment Centres beginning to report to the Health Services Sector and the operational function to report through the Warden (2014).

The governance changes were meant to promote clear and consistent accountability, standardization of health service practices, greater collaboration and integration, greater capacity to recruit and retain health services personnel, and efficient delivery of health services.[clxxxvii] Based on their experiences,

institutional health services staff members were asked about perceived impacts of the changes to the Health Services governance structure (see Figure 2).[141]

- Health staff respondents were most likely to agree that changes to the health services governance structure were working well to improve standardization of health care practices. There was also moderate agreement that the governance structure promoted clear and consistent lines of accountability, increased clarity of roles and responsibility, and integrated delivery of physical and mental health services.
- Health services staff were less likely to report that changes to the governance structure had an impact on increasing efficiency of health services delivery, improving delivery of health services, and increasing ability to recruit and retain health services professionals.

Figure 2: Percentage of Institutional Health Services Staff who agreed that the new health services governance structure has resulted in improvements in the following areas



[141] Figure 2 shows percentage of staff who agreed that the governance structure impacted specific issues. Remaining staff either disagreed that there had been an impact of the governance structure, or provided a neutral response "neither agree nor disagree".

- Some institutional and community staff[142] reported experiencing challenges under the new governance structure, including:
  - Not enough resources to support recruitment and retention of health services staff (n=42).
  - A need for greater clarification of roles and responsibilities between different groups (e.g., physical and mental health, community and institutional health services, health services and operations; n=41).
  - Impacts on institutional level decision making (e.g., need for greater involvement/consultation at the regional level and with front line staff; n=29).

CSC has integrated its management and staff reporting structures for mental, clinical and public health services.

- Over the past decade, Health Services has initiated gradual changes to integrate all health services staff in one sector. This includes the integration of mental health staff reporting into the Health Services Sector, (i.e., mental health staff in the institutions and community in 2013, and health services personnel in Regional Treatment Centres in 2014).
- Health Services has also merged clinical health and public health in the NHQ management structure as well as through the Program Alignment Architecture in 2015-2016.
- Health Services has developed guidelines and frameworks to promote standardization and integration of services, such as the *National Essential Health Services Framework* (2015)*;* the *CSC National Formulary* (2016)*;* and, the newly promulgated *Integrated Mental Health Guidelines* (2016).
- Accreditation Canada has identified efforts by Health Services to integrate and standardize services:[clxxxviii]
  - The leadership and staff in all Regions and all levels of the organization, from the national to the regional and institutional, showed efforts to integrate, streamline, standardize, and coordinate practices and processes.
  - Most policies and procedures are developed at a national level, which supports a coordinated and consistent approach to the delivery of quality health services.

[142] This included both health services and general staff in the institution and the community.

- Services for offenders with multiple health care needs:
  - About half of Health Services staff respondents (53%, n=68) agreed that the health services for offenders with multiple health care needs are delivered in an integrated manner in order to best address their needs.[143] They reported some remaining challenges to integration related to:
    - Collaboration, communication and information sharing practices between staff within health services, such as mental and physical health, and between sectors (e.g., Health and Operations) within CSC (n=22).
    - Shortages of specialized health care professionals (e.g., behavioural technicians, occupational therapists and mental health nurses; n=16).
  - Most offenders interviewed (77%, n=97) reported that the health care staff worked well together to provide them with the care they needed.

The Health Services Sector provides mental health and public health performance information and health services prevalence data through research and other special reports. Several recommendations for additional health-related data collection and reporting have been included in relevant sections of this evaluation report to address gaps identified during the evaluation.

- Within CSC, Health Services provides performance information through various reports, including:
  - Annual Mental Health Performance Measurement Reports[144] and Public Health Quarterly Reports.
- Accreditation Canada found the following in regards to collecting information for planning:[clxxxix]
  - Most regions collected and analyzed client flow information. However, several regions did not sufficiently use this information to develop a strategy for meeting demand and improving service.
- CSC research reports and health services prevalence studies (e.g., *Estimates of chronic disease prevalence among CSC inmates, 2015)* inform health services on various clinical, mental and public health related topics. Several recent research reports also identify prevalent clinical,

[143] Some (31%, n=40) health services staff disagreed or strongly disagreed that the health services for offenders with multiple health care needs are delivered in an integrated manner to best address their needs. A few (16%, n=20) neither agreed nor disagreed that the health services for offenders with multiple health care needs are delivered in an integrated manner.

[144] The Mental Health Branch also reports its information disaggregated by sex and Indigenous or non-Indigenous status.

public, and mental health disorders within CSC. These reports provide information about offender health needs, which can be used to inform Health Services planning.

Staff Suggestions:

- CSC's health services staff varied in their perceptions of the sufficiency of analysis of health information for health services planning and activities, with approximately one-third agreeing, one-third disagreeing and one-third being neutral.[145]
- Suggestions to improve health services planning across health domains by Health Services staff included:
  - Dedicating staffing and resources to collect information and conduct planning (n=22).
  - Reviewing health information to ensure relevancy of information collected (e.g., revising performance indicators, resource indicators; n=11).
  - Greater consultation and information sharing between institutions and NHQ regarding data collection and planning (n=14).

Recommendations regarding data collection and reporting:

- To ensure that reliable data will be available to direct future health services planning and analysis, several recommendations have been made throughout this evaluation to collect additional information or to strengthen data recording processes where gaps were identified, specifically:
  - FIFE 2, Recommendation 2: Ensuring health referrals are appropriately recorded and monitored;
  - FIFE 3, Recommendation 3: Collecting data on wait times to access selected specialists services for non-urgent care;
  - FIFE 4, Recommendation 5: Providing clear direction and accountability for delivery and tracking of health education programs;
  - FIFE 5, Recommendation 6: Implementing effective management practices to ensure that current and historical information on offender level of need data is recorded electronically;

[145] Public health planning: 26% (n=23) agreed; 38% (n=33) neither agreed nor disagreed; and 36% (n=31) disagreed. Clinical health planning: 33% (n=32) agreed; 34% (n=33) neither agreed nor disagreed; and 32% (n=31) disagreed. Mental health planning: 34% (n=37) agreed; 36% (n=39) neither agreed nor disagreed; and 31% (n=34) disagreed.

- FIFE 5, Recommendation 7: Tracking expenditures of funds released to regions through RCMHCs;
- FIFE 6, Recommendation 8: Recording identification in OMS; and,
- FIFE 6, Recommendation 10: Ensuring that clinical discharge planning activities are tracked in electronic information systems.

Health Services Expenditures

Health Services account for approximately 11% of CSC's total direct program spending. From 2012-2013 to 2015-2016, CSC total Health Services expenditures (institution and community) decreased by 11%.

- In 2014-2015, total CSC Health Services expenditures ($247.2 million) accounted for 11% of total CSC direct program spending.[146]
- Consistent with CSC's mandate for health services delivery, the majority of spending occurred during the incarceration period. In 2015-2016, institutional health care services accounted for approximately 94%, and community health services account for the remaining 6% of total health services expenditures (see Table 5).
- Total CSC Health Services expenditures decreased by 11% from 2012-2013 to 2015-2016.
- The largest decrease in Health Services expenditures was 7% from 2012-2013 to 2013-2014. This is consistent with an overall reduction in CSC spending that year, as part of the federal government's *Economic Action Plan, 2012,* through which CSC committed to reducing its operating budget by $295.4 million by April 1, 2014.[cxc] During this period, CSC made reductions in the following areas related to health services: dental care, methadone treatment, accreditation, training and NHQ/RHQ.

[146] Direct program spending includes strategic outcome spending (custody, correctional interventions and community supervision), but excludes spending on internal services.

Table 5: CSC Health Services Expenditures, 2012-2013 to 2015-2016

	2012-2013	2013-2014	2014-2015	2015-2016
Clinical and Public Health Services	160,474,397	154,656,758	149,137,433	150,609,703
Mental Health Services[1]	99,224,071	87,259,906	87,617,326	75,474,645
Total Institutional Health Services	**259,698,469**	**241,916,664**	**236,754,759**	**226,084,348**
Community Mental Health Services	8,575,448	8,361,468	8,083,791	11,788,085
Other Community Health Services	2,769,240	2,614,395	2,388,310	2,372,580
Total Community Health Services	**11,344,688**	**10,975,862**	**10,472,101**	**14,160,665**
Total Health Expenditures	**271,043,157**	**252,892,526**	**247,226,860**	**240,245,013**

[1]In 2012-2013, psychology and RTCs and in 2013-2014 RTCs were reported under other Sectors and were not generally reported under Health Services in the Program Alignment Architecture (PAA). However, expenditures related to psychology and RTCs are included in the HS totals reported in this table, since they were included in the Health Services examined as part of this evaluation.
Source: Integrated Financial and Material Management System (IFMMS), extracted September 22, 2016

3.18 INFECTIOUS DISEASE TREATMENT: HEPATITIS C VIRUS

FINDING 18: INFECTIOUS DISEASE TREATMENT: HEPATITIS C VIRUS

CSC expenditures for Hepatitis C Virus (HCV) medication more than tripled from 2013-2014 to 2015-2016 due to a new Canadian approved standard of care. New treatment is more costly, but has resulted in an increased cure rate for individuals with the disease, also reducing the risk of spread of HCV to others.

Evidence: Cost-Effectiveness of Infectious Disease Treatment: Hepatitis C Virus

Health Canada has recently approved several new drugs for HCV treatment, which have improved treatment outcomes.

HCV Treatment:

- Results of a research report in 2014 estimated that the number of cases of HCV within the Canadian population would diminish from 260,000 in 2003 to 188,190 by 2035. However using *first-generation treatments,* the total direct cost of HCV was projected to increase from $168.4 million in 2013 to $258.4 million by 2032. Increases in costs were attributed to complications, such as advanced liver diseases and liver transplantations, which can be further exacerbated as the infected population ages.[cxci]

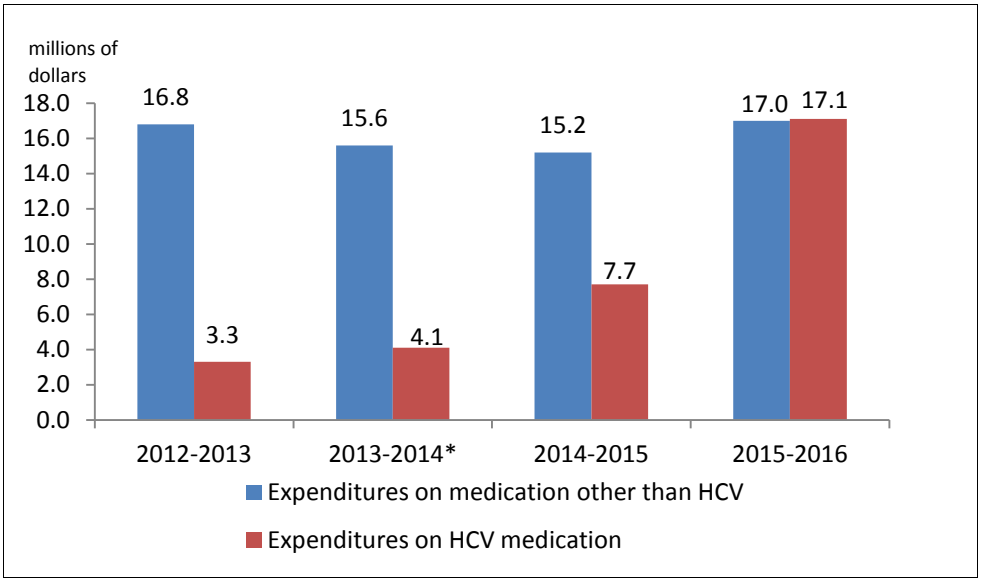
- In 2013 and 2014 Health Canada approved several new drugs for HCV treatment. Treatment outcomes in Canada for HCV have improved as a result of the introduction of highly effective medications including Sovaldi, Harvoni and Holkira Pak.[cxcii] These *new treatments* are now the approved standard of care in Canada and other countries.
- In comparison to the previously approved treatment standards (referred to as "first-generation treatments"), these new treatments:
  - Reduce treatment duration, from approximately 24-28 weeks to 12-24 weeks.[cxciii]
  - Increase drug tolerability by decreasing the number of side effects.[cxciv]
  - Increase the cure rate.
- A person is considered cured when, after completing treatment, the HCV viral load in the blood is undetectable for 12 consecutive weeks. This is called a sustained virological response (SVR).[cxcv] Once cured, the virus can no longer be transmitted to others.[cxcvi]

CSC medication expenditures have increased, related primarily to costs of new HCV treatments which have become the approved standard of care.

CSC Medication Expenditures:

- Increases in CSC medication expenditures in recent years are related primarily to costs of new HCV treatments. CSC is mandated under the CCRA section 86(1) to provide essential health care that conforms to the professionally accepted standards of practice.
- Overall, CSC expenditures for medication increased by 73% from 2013-2014 ($19.7 million) to 2015-2016 ($34.1 million).
- The increase during this time period (2013-2014 to 2015-2016) was mainly due to expenditures for HCV medication, which more than tripled in cost, from $4.1 million in 2013-2014 to $17.1 million in 2015-2016. The largest year-over-year increase occurred from 2014-2015 to 2015-2016 (see Figure 3).
- As a percentage of *total* medication expenditures, costs for HCV medication rose from 16% to 50% of *all* medication expenditures from 2012-2013 to 2015-2016.

Figure 3: Health Services Medication Expenditures, 2012-2013 to 2015-2016



Note. In 2013-2014 the new HCV treatment came into effect which is represented by (*).
Source: IFMMS, extracted September 19, 2016.

Implications:

Health of HCV-Infected Individuals

- The prevalence of HCV in the offender population was 17%[cxcvii] in 2013-2014, which is about 20 times higher than the Canadian population (1%).[cxcviii]
- The Health Services Sector conducted an analysis of treatment outcomes for chronic HCV infections[cxcix] and found that among 312 offenders in CSC treated between February 2015 and April 2016 with the new treatment drugs, HCV was cured in 90-95% of cases. This compares to previous treatments, in which research has demonstrated cure rates of between 40% and 80% in the Canadian population.[cc]
- Increased cure rates of new HCV treatments are associated with reduced cases of liver-related diseases and deaths.[cci]
- While new treatment regimes are more expensive, the introduction of these new treatments suggest cost-effectiveness can be achieved by:
    - Decreased treatment durations;

- Decreased side effects, thereby increasing likelihood of treatment continuity and completion; and,
- Decreased complications that arise from the disease (e.g., cirrhosis of the liver, liver cancer), resulting in reduced medical costs to treat these complications. [ccii]

HCV Prevention

- The Public Health Agency of Canada reported that in 2012 the majority of HCV infections in Canada occurred through the sharing of drug preparation and injection materials.[cciii]
- Once a HCV cure has been achieved through the administration of HCV drugs, HCV can no longer be transmitted to others.[147] This has positive impacts for public health both while offenders are incarcerated and following their release into the community.
- As such public health risks and costs can be reduced by:
  - Reducing ongoing HCV transmission,
  - Reducing public health expenditures for incidences of advanced liver diseases and liver-related deaths.[cciv]

3.19 HEALTH SERVICES FOR SPECIFIC POPULATIONS

FINDING 19: HEALTH SERVICES FOR SPECIFIC POPULATIONS

CSC has implemented policies, guidelines and strategies to address the special health care needs of women and Indigenous offenders. Additional support related to the chronic disease needs of older offenders is required.

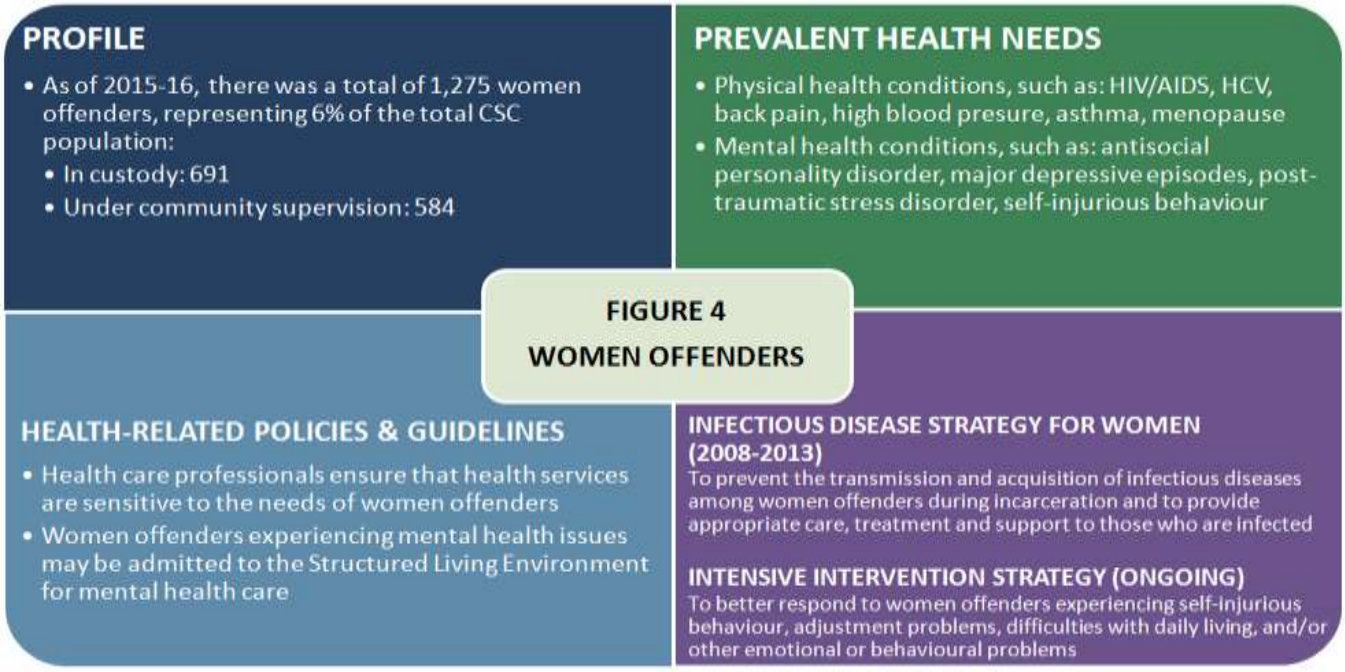
Evidence: Health Services for Specific Offender Populations

CSC is committed to delivering health services in a way that is respectful of gender, culture, religion, and linguistic differences. According to *Commissioner's Directive (CD) 800: Health Services*, Health care professionals must also ensure that health services "are sensitive to the needs of Indigenous and women offenders, and offenders with special needs."[ccv] The evaluation examined the specific health needs, initiatives and strategies for specific populations of offenders, including women, Indigenous and other visible minority groups, as well as older offenders (50 years or older).

[147] Research has shown the rate of late relapse occurs in less than 1% of patients.

Figures 4 to 6 provide a summary of prevalent health conditions and CSC's policies, programs and initiatives designed to address the health needs of women offenders, Indigenous offenders and older offenders (Appendix I provides more detailed information).

Figure 4: Women Offenders



CSC has developed several women-centered programs, initiatives, and strategies to meet the needs of women offenders. Staff reported some challenges accessing resources for women offenders in the community.

Intensive Intervention Strategy

- Under the Strategy, women offenders with mental health problems and/or cognitive limitations are provided with intensive intervention, treatment and programming opportunities and housed in one of two living units, depending on their security level: Structured Living Environments (SLEs) for women offenders classified as minimum and medium security; and, Secure Units for women classified as maximum security.
- Previous findings have indicated that both staff and women offenders agree that the SLE is meeting its intended objectives. Participants of the SLE program stated that the program was meeting their needs and helping to improve their behaviour and reduce institutional incidents.

Infectious Disease Strategy for Women

- Overall, 17% (n=33) of health services staff respondents reported being knowledgeable about the Strategy and about half (52%, n=17) agreed that it had a positive impact on CSC's capacity to address the health needs of women offenders.

Women-Specific Initiatives

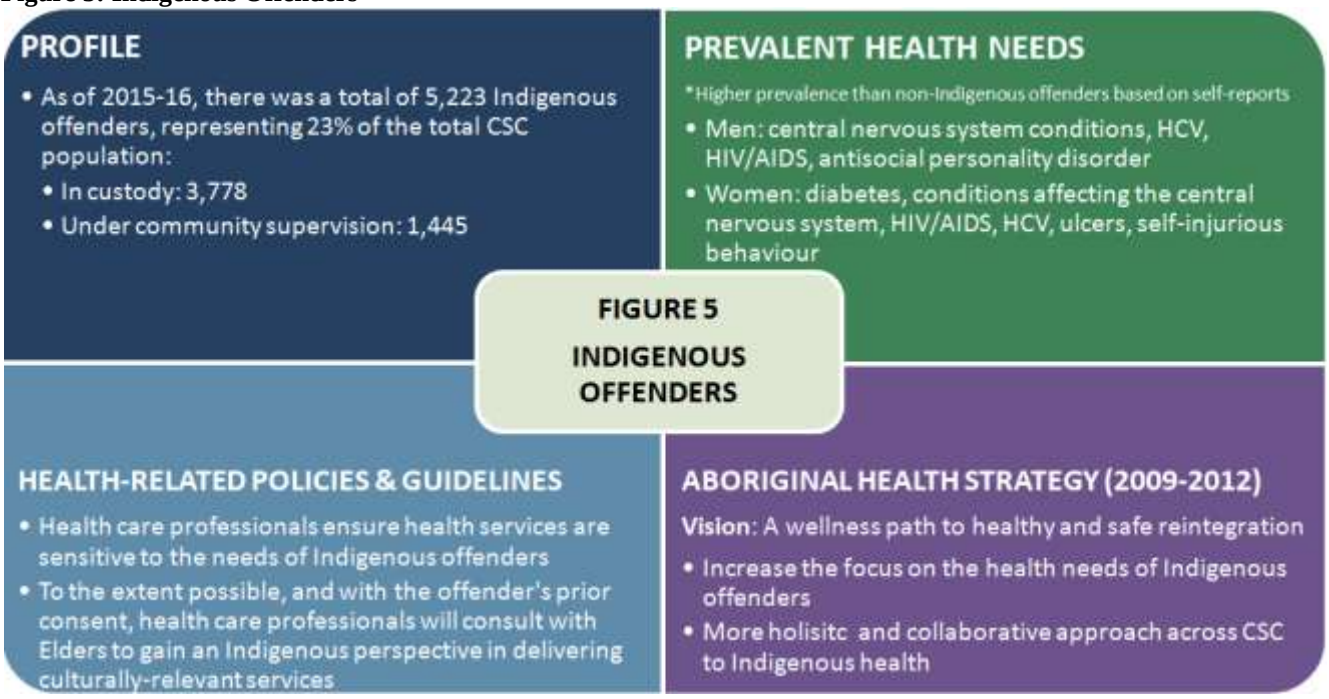
- Specific products have been developed and tailored to meet the health needs of women, including: the Reception Awareness Program for Women, national fact-sheets (e.g., diabetes and women, HIV and women), and the integration of the Peer Education Course and the Peer Support Program into a new program called the Peer Mentorship program.
- According to the *Integrated Mental Health Guidelines*, the Deputy Commissioner of the Women Offender Sector participates in the National Complex Mental Health Committee, and Wardens of women's institutions participate in the Regional Complex Mental Health Committee to provide input into appropriate care for women offenders with complex mental health needs.

Overall Perceptions of Health Services for Women Offenders

- Overall, the majority of staff respondents reported that CSC was meeting the health service needs of women offenders.
- Some staff respondents indicated there were insufficient resources for mental health in the community.

Note: The results presented are not comprehensive, but provide a brief overview of some main initiatives/results within the scope of the evaluation.

Figure 5: Indigenous Offenders



CSC has implemented several initiatives and guidelines to meet the needs of Indigenous offenders. Staff reported some challenges accessing resources for Indigenous offenders in the community.

Aboriginal Health Strategy

- Overall, 22% (n=42) of health services staff respondents reported being knowledgeable about the Aboriginal Health Strategy and some (36%, n=14) agreed that it had a positive impact on CSC's capacity to address the health needs of Indigenous offenders during incarceration.
- During the timeframe of the Aboriginal Health Strategy, 54 Health Services personnel took Aboriginal Perceptions Training from 2009-2010 to 2012-2013.

Indigenous-Specific Initiatives

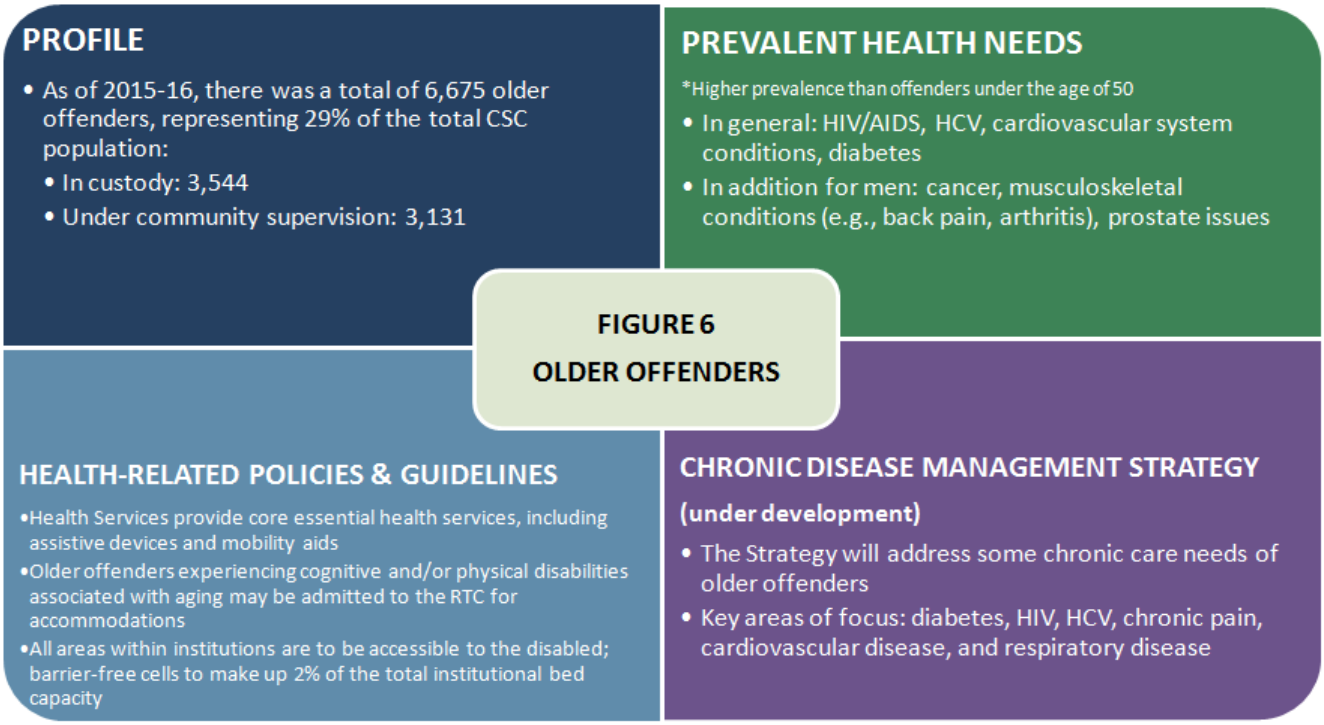
- An Indigenous culture component has been included within the Fundamentals of Mental Health training for staff, and the Aboriginal Peer Education Counsellor program trains Indigenous offenders as peer educators to provide support and education on infectious diseases.
- The Guidelines for Sharing Personal Health Information were updated to include culturally relevant information (e.g., regarding the sharing of health information with Elders).
- The Director General, Aboriginal Initiatives participates in the National Complex Mental Health Committee to provide input into appropriate care for Indigenous offenders with complex needs.
- Indigenous offenders have access to Elders, Spiritual Advisors, Aboriginal Liaison Officers, and other culturally-competent staff who are available to support offenders during intake/assessment (e.g., COMHISS, 24-hour nursing assessments) and throughout their sentence.
- The Elder is invited to be a member of the interdisciplinary health team for managing offender health needs.

Overall Perceptions of Health Services for Indigenous Offenders

- Some staff reported consulting with an Elder for incarcerated Indigenous offenders who want to follow a traditional healing path in regards to mental health needs (51%, n=66), clinical health needs (28%, n=35), and public health needs (9%, n=11).
- Overall, the majority of staff respondents reported CSC was meeting the health service needs of Indigenous Offenders
- The biggest challenge identified by staff was insufficient resources for community mental health services, especially in remote locations or on reserves (n=37).
- Of the Indigenous offenders interviewed (n=51), some (n=17) said that it would have been beneficial to have an Elder present while receiving health care services (e.g., help navigate the health system, provide information on traditional health alternatives).

Note: The results presented are not comprehensive, but provide a brief overview of some main initiatives/results within the scope of the evaluation

Figure 6: Older Offenders



CSC has developed some initiatives to meet the needs of older offenders. Staff suggested that there were opportunities to better meet the needs of older offenders related to services for chronic care and accommodating older offenders within existing infrastructure.

Older Offender-Specific Initiatives

- CSC Health Services conducts screening for "fall risk" as part of their intake assessment. Risk factors are managed through regular consultations with physicians as appropriate and interventions may occur to mitigate the identified risks.
- CSC has introduced an Aging Offenders Resource Kit via Infonet to inform staff on common mental and physical health issues associated with aging and best practices for working with older offenders with health needs.
- The Pacific Region created Echo - a psycho-geriatric unit at the RTC with a Peer Assisted Living (PAL) Caregiver program.
- CSC has a total of 428 barrier-free cells in its mainstream institutions and RTCs.

Overall Staff Perceptions of Health Services for Older Offenders

- Some staff agreed that health services were meeting the health-related needs of older offenders in the institution and in the community. Among those who disagreed, they reported challenges related to:
  - Insufficient resources in the institution (e.g., geriatric care, and services for high needs and/or multiple needs offenders; n=36) and the community (e.g., palliative care, mental health professionals; n=27).
  - Providing accommodations for older offenders within the existing institutional infrastructure (e.g., provide specialized unit or range for offenders with mobility or age related issues; n=34).
  - Finding accommodations in the community (e.g., community care facilities willing to accept them, CCCs/CRFs not equipped for their needs; n=20).

Offender Perceptions of Health Services for Older Offenders

- Of the 42 older offender respondents, more than half (57%, n=24) reported having age-related health care needs.
- Older offenders also reported challenges in the physical layout of the institution, accessing specialized health care equipment, and performing daily activities. Respondents made the following suggestions for improvement:
  - Offer specialized services (e.g., hearing specialist, pain clinics; n=12) and products (e.g., eyeglasses, cane; n=11)
  - Accommodate older offenders through infrastructure changes (e.g., improve wheelchair accessibility; n=10)

Note: The results presented are not comprehensive, but provide a brief overview of some main initiatives/results within the scope of the evaluation.

Summary:

Specific guidelines, programs, and strategies have been initiated for several offender populations, particularly for women and Indigenous offenders. Many of these initiatives have a component related to mental health (e.g., participation in complex mental health committees to represent the needs of women and Indigenous offenders, involvement of Elders on interdisciplinary mental health teams), or public health (e.g., Reception Awareness Program for Women). Positive impacts of mental health initiatives for women and Indigenous offenders have been demonstrated. For example, positive impacts of mental health treatment were reported for Indigenous offenders in the current evaluation (FIFE 5), and positive impacts related to Structured Living Environments,[ccvi] mental health services offered at Pinel,[ccvii] and the Community Mental Health Initiative (CMHI) [ccviii] have been reported in other evaluations or research studies.

The health-related needs of older offenders have become more of a focus for CSC, in part due to the increase in the older offender population in recent years. Chronic and infectious diseases are particularly important for the older offender population, as these are among the most prevalent health-related needs of older offenders. In addition, although few staff identified challenges in the provision of health care for women and older offenders, some staff and offender respondents suggested that there are opportunities to improve the capacity to accommodate individuals with mobility needs within CSC's institutions, and to address specific age-related health care needs for this population.

Next Steps:

- CSC Health Services is currently developing a comprehensive *Chronic Disease Management Strategy*.
    - The Strategy includes seven key health priorities, including diabetes, HIV, HCV, chronic pain, cardiovascular disease, respiratory disease, and the use of antibiotics.
    - Although the *Chronic Disease Management Strategy* is not specifically designated for older offenders, many of the health issues prioritized in the strategy include health issues prevalent among older offender populations.

RECOMMENDATION 11: SPECIFIC POPULATIONS OF OFFENDERS

That CSC Health Services continue to implement the Chronic Disease Management Strategy, with reference to any special needs/requirements for older, women, and Indigenous offenders, and methods for tracking impacts.

4.0 CONCLUSION

The concept of universality respecting health care is outlined in the Canada Health Act,[ccix] this means that all Canadians are entitled to access health care in accordance with the health insurance plan of their respective province; in the case of federally incarcerated persons, CSC provides access to health care.

The evaluation found that CSC Health Services are relevant and meet the needs of federal offenders. Positive impacts were found regarding institutional mental health care where offenders had a reduced likelihood of incidents, serious charges and involuntary segregation following treatment. Several key areas were identified for service improvements, such as:

- Access to institutional health services, for example limited access to some health education programs, bleach kits and community health care specialists;
- Effectiveness and efficiency of the health services intake assessment process, for example duplication of offender health information through intake processes and tools;
- Gaps in policy and procedures to support offenders in obtaining necessary ID required to transition from CSC health services to provincial and territorial health services upon release; and
- Missing or unreliable data among referrals to specialist services (in person or telemedicine), clinical health services information and the mental health needs scale.

This evaluation will assist CSC in improving the delivery of health services for all offenders across the continuum of care.

APPENDIX A: POLICY AND LEGISLATION

A list of Commissioner's Directives that involve a health related component includes:

- CD 705: Intake Assessment Process and Correctional Plan Framework
- CD 705-3: Immediate Needs Identification and Admission Interviews
- CD 702: Aboriginal Offenders
- CD 566-12: Personal Property of Offenders
- CD 860: Offender's Money

APPENDIX B: NEED FOR HEALTH SERVICES

Clinical Health Needs

Men Offenders[ccx]

- 34% of male offenders self-reported head injuries, whereas 19% suffer from back pain, and 15% have asthma. With respect to head-injuries, the prevalence pertains to any current or history of head injuries, and may therefore include a broad range of injuries. A review of health files found that 2% of offenders had evidence of recent brain injury.[ccxi]
- The rates of many chronic conditions (e.g. high blood pressure, high cholesterol, angina, arthritis, etc.) are significantly higher for men offenders over the age of 50 years compared to men offenders under 50 years of age.
- A significantly higher proportion of men offenders have asthma (15%) compared to men in the Canadian population (7%).
- Indigenous peoples in the Canadian population have an increased risk of developing cardiovascular disease,[ccxii] and they comprise a disproportionately high percentage of the incarcerated population (compared to the general population).
- Indigenous men offenders have significantly higher rates of head injuries (43%) than non-Indigenous men offenders (32%).

Women Offenders[ccxiii]

- According to self-reports, 26% of women offenders suffer from back pain followed by head injuries (23%), menopause (19%) and asthma (16%).
- A higher proportion of older women offenders have conditions affecting their cardiovascular system (47%) and they also have a higher prevalence of diabetes (17%) compared to younger women offenders (15%; 4%).
- Compared to the Canadian women population (10%), a higher proportion of women offenders (16%) have asthma.
- A higher proportion of Indigenous women offenders compared to non-Indigenous women offenders have health conditions affecting their central nervous systems (29%; 25%), diabetes (11%; 3%) and ulcers (11%; 6%).

Public Health Needs[148]

The most prevalent public health issues self-reported by men and women offenders are identified below.

Men Offenders[ccxiv]

According to self-reports:

- HCV (9%) and HIV (1%) are the most prevalent communicable diseases among an admission cohort of federal men offenders.
- Indigenous men offenders have a significantly higher prevalence of HCV (16%) and HIV (2%) than non-Indigenous men offenders (HCV 8%, HIV 1%).
- Men offenders over 50 years of age have a higher prevalence of HCV (13%) and HIV (2%) in comparison to men offenders under 50 years of age (HCV 9%; HIV 1%).

Women Offenders[ccxv]

According to self-reports:

- Among an admission cohort of women offenders, the most prevalent self-reported public health issues were HCV and HIV/AIDS (20%). [149]
- In addition, the prevalence of HCV and HIV/AIDS was higher among Indigenous women offenders (27%) than non-Indigenous women offender counterparts (17%).
- Older women offenders have a slightly higher prevalence of HCV and HIV/AIDS (22%) relative to younger women offenders (20%).

[148] The prevalence rates reported in this section were based on offender self-report upon admission and do not take into account test results completed as part of the intake period. Self-reported rates of infectious diseases may be lower than actual prevalence rates. Some information on prevalence rates for specific groups of offenders in CSC from 2000-2006 is available at http://www.csc-scc.gc.ca/publications/infdscfp-2005-06/tb-eng.shtml.

[149] Due to self-reported frequencies of less than five, the prevalence rates for HCV and HIV were reported together in the source research report.

Mental Health Needs

Men Offenders

- Common mental disorders among men offenders were: antisocial personality disorder (44%), anxiety disorders (30%), mood disorders (17%), and major mental illness (12%), which includes major depressive disorder, bi-polar I and II disorders, or any psychotic disorder.[150] [ccxvi]
- Indigenous men offenders had higher rates of personality disorders compared to non-Indigenous men offenders with the most pronounced differences being antisocial personality disorder (60% and 40% respectively) and borderline personality disorder (22% and 14% respectively).[151] [ccxvii]
- Men offenders did not engage in self-injurious behaviour (SIB) as frequently as women offenders; however, their SIB are more likely to result in minor and serious injury compared to women offenders whose incidents of SIB are more likely to result in no significant injury.[ccxviii]

Women Offenders

- The vast majority of women offenders had a psychiatric disorder at some point in their lives. Among the most common were: lifetime prevalence of antisocial personality disorder (83%); experience of a major depressive episode, a type of mood disorder, at some point in their lives (69%), and post-traumatic stress disorder, a type of anxiety disorder, in the past year (31%).[152] Borderline personality disorder was more common in women offenders than in men offenders.[ccxix]
- Twenty-two percent of women offenders had attempted suicide prior to being admitted to CSC.[ccxx]
- Indigenous women offenders experienced higher occurrences of conduct disorder than their non-Indigenous women counterparts (64% and 42% respectively).[ccxxi]
- Although women offenders accounted for 5% of CSC's incarcerated population, they comprised 12% of the offenders who had a SIB incident and accounted for 32% of all SIB

[150] These figures are for one-month current prevalence rates.
[151] Use caution when interpreting these results given the small number of offenders in the Indigenous group in some categories.
[152] Where possible current rates are provided; however, in some cases, only lifetime rates were available.

incidents. Furthermore, Indigenous women offenders engaged in twice as many incidents of SIB compared to non-Indigenous women.[ccxxii]

APPENDIX C: MENTAL HEALTH DIVERSION

Pre-contact with the criminal justice system – crime prevention:

Focus on preventing individuals with mental health needs from coming into contact with the criminal justice system through intervention on risk factors before crime happens.

Post-contact with the criminal justice system – Sequential Intercept Model[ccxxiii]

1 **First interactions with law enforcement and emergency services:** the goal at this stage of diversion is to divert individuals with mental health needs from arrest by providing alternative treatment options and to decrease risk of harm resulting from these interactions.

There are four models of police-based diversion in Canada:

- Crisis Intervention Teams (CIT) – interdisciplinary community liaison teams;
- Psychiatric Emergency Response Teams (PERT) – police officers are paired with licensed mental health professionals;
- Crisis Mobile Teams (CMT) – behavioural mental health specialists assist police officers in situations involving persons with mental disorders; and
- Informal police diversion – police may refer an individual to community mental health services in lieu of charges (generally for less serious acts or on first-arrest).

2 **Post-arrest (pre-trial):** this type of diversion interrupts the standard prosecution process, it occurs between the individual's arrest and their appearance in court. Offenders are diverted from the criminal justice system and referred for treatment or other specialized diversion programs.

There are four elements of the process:

- Appointment of counsel;
- Assessment of the offender;
- Consultation with the victim; and,
- Prosecutorial review of charges and possible diversion. This type of diversion can be requested on behalf of the individual with the mental health need by the defence counsel, crown counsel, police, mental health services, diversion programs, citizens, etc.

3 **Court-based diversion:** designed to divert individuals with mental health needs through mental health courts, mental health dockets, or traditional courts with alternative sentencing planning strategies to a judicially monitored diversion program. The focus is on community-based treatment and restorative remedial measures versus prosecution, and may involve a multidisciplinary team (e.g., judge, crown attorneys, mental health workers).

4 **Re-entry planning from jails, prisons, and forensic hospitalization:** does not specifically focus on diversion per se; rather, it focuses on continuity of care and successful reintegration (or re-entry) into the community. Preparation for reintegration should begin prior to release. Post release, interventions should support offenders' transition from the prison to the community and help maintain gains made in treatment while incarcerated.

5 **Community corrections and community support:** the goal is to divert individuals with mental health needs under community supervision from re-entering the criminal justice system.

Best practices include:

- Mental health screening;
- Managing treatment conditions and technical violations through the use of non-traditional methods that emphasize non-custodial alternatives;
- Use of intensive and specialized case management; and,
- Use of a specialized caseload model (e.g., Have a set of dedicated officers for offenders with mental disorders, reduce officers caseload (typically one third of a traditional caseload); provide officers with sustained training on mental health and other related issues; have officers intervene with offenders directly and coordinate community services)

Sequential Intercept Model Notes

Intercept 1: First interactions with law enforcement and emergency services

Evidence suggests that diversion at this intercept can increase referrals to mental health resources, increase the number of days spent in the community, and reduce the use of force in police interactions with mentally ill offenders.[ccxxiv] More generally, however, the research in this area is limited and further evaluation is needed before firm conclusion can be drawn about the effectiveness of mental health diversion at this intercept.

Intercept 2: Post-arrest (pre-trial)

Generally, diverted offenders at this intercept have more time in the community, greater treatment participation, fewer hospital days in the community, fewer arrests (1 year follow-up), less homelessness (1-year follow-up), and more emergency room contacts.[ccxxv] It is noted that this research needs to be interpreted with caution due to a small number of studies, differing methodology, and variability in what was considered to be a 'diversion' program.[ccxxvi]

Intercept 3: Court Based Diversion

The purpose of mental health courts is to target the root causes of crime committed by individuals with mental health needs (e.g., untreated mental illness) and to help prevent mentally disordered individuals from reoffending. Mental health courts have been associated with fewer arrests and jail days (e.g., an average of 3 days instead of 23 days), reduced recidivism, and lower costs over time (relative to traditional courts.[ccxxvii] Further, mental health courts better linked individuals to mental health services and those individuals were more like to stay in a higher level of treatment than individuals not participating in a mental health court program.[ccxxviii]

Mental health dockets refer to dedicating a period of time during traditional court (e.g., one afternoon per week) to individuals with mental health needs.

Intercept 4: Re-entry planning from jails, prisons, and forensic hospitalization

Preparation for reintegration (or re-entry) into the community should begin prior to release. Good practice suggests that post-release interventions should support offenders' transition from the prison to the community and help maintain gains made in treatment while incarcerated.[ccxxix] This recommendation is in line with CSC's Mental Health Strategy which suggests "dedicated services are required to support a seamless continuity of care from the community to the correctional system and upon return to the community" for offenders with mental health needs.[ccxxx]

Intercept 5: Community corrections and community support

Offenders with mental health issues can have trouble complying with their conditions, placing them at higher risk for technical violations, new offences, and new sentences. Revocation prevention strategies include: incentives for compliance with conditions (e.g., reduce frequency of reporting); graduated scheme of responses before employing the most serious response (i.e., revocation of probation/parole); consult with treatment providers before taking action on a violation related to treatment/mental health evaluation and consider treatment alternatives (e.g., refer to more intensive

treatment); respond to minor technical violations early to prevent more serious technical violations, establishing agreements and guidelines with service providers regarding the support that they will provide and the actions that will be taken for failure to participate in treatment; and, have mental health professionals help offenders better understand the consequences of their behaviour in terms of sanctions.[ccxxxi]

CSC Community Mental Health Specialist services follow an assertive community treatment model in that multidisciplinary teams of professionals provide mentally ill offenders with services tailored to their needs in the community and share responsibility for the offender.[ccxxxii] Generally assertive community treatment based programs (relative to 'treatment as usual') were found to be associated with "better criminal justice outcomes (e.g., any conviction, mean jail time), better improvement of substance abuse problems, and improvement in global functioning and economic self-sufficiency".[ccxxxiii]

APPENDIX D: EFFECTIVENESS OF INTAKE ASSESSMENT FOR SPECIFIC POPULATIONS

Indigenous Offenders

- Most health services staff members and Indigenous offenders did not report any barriers specific to this sub-population of offenders in completing health status intake assessments.[153]
    - Those health services staff members who did identify challenges reported that there were communication or cultural barriers in completing intake assessments for Indigenous offenders (n=10).
- Many health services staff members reported that Indigenous offenders interested in following a traditional healing path, "never" or "rarely" had an Elder involved in completing intake assessment tools.[154]
- Most (78%, n=18) Indigenous offenders interested in following a traditional health path reported that they did not have an Elder present during health intake assessments, but many (n = 11) reported it would have been helpful.[155]
- Indigenous offenders are equally as likely to receive intake assessments (i.e., 24-hour and 14-day) within the appropriate timeframe compared to the whole offender population (Indigenous and non-Indigenous offenders).[156] [ccxxxiv]

Visible Minority Offenders

- Most[157] health services staff members reported that they did not face any challenges completing intake assessments for visible minority offenders.

[153] Percentage of Health Services Staff Questionnaire participants reporting no barriers/challenges for Indigenous offenders: 24-hour (82%, n=44), 14-day (80%, n=41), infectious disease screening (86%, n=36) and CoMHISS (72%, n=13). No Indigenous offenders interviewed at intake reported any specific barriers to intake assessments (0%, n = 31).
[154] Percentage of Health Services Staff Questionnaire participants reporting that Elders were never or rarely involved in completing intake assessment tools: 24-hour Assessment (64%, n=38), 14-day Health Intake Assessment (61%, n=34), Infectious Disease Screening (73%, n=33); or CoMHISS (73%, n=16).
[155] Of those offenders who participated in the current evaluation, 33% (n=34) identified themselves as being Indigenous of First Nations (84%; n=27) or Métis (16%; n=5) descent, and of those 68% (n=23) expressed an interest in following a traditional healing path.
[156] 24-hour assessment - 97% (n=4192) of the whole offender population (Indigenous and non-Indigenous) were screened within the appropriate timeframe compared to 94% (904) of Indigenous offenders. 14-day assessment – 70% (n=3010) of the whole offender population (Indigenous and non-Indigenous) were screened within the appropriate timeframes compared to 70% (n=659) of Indigenous offenders.

- Among those who did report challenges, it was noted that there were communication or cultural barriers in completing intake assessments for visible minority offenders (n=15).

Older Offenders

- Most health services staff members and older offenders did not report any challenges specific to this sub-population of offenders in completing health status intake assessments.[158]
- Some (44%, n=7) older offenders reported having additional health care needs including physical health concerns (e.g., knee pain, osteoarthritis) and other health issues (e.g., heart difficulties, hearing problems, diabetes, and cancer).
  - Of those older offenders who indicated that they had additional health care needs, about half reported that the health services intake assessment screening tool did not identify their age-related health needs (n=4).[159]

Women Offenders

- Most health services staff members and women offenders did not report any challenges completing intake assessments for women offenders.[160]
- Women offenders are equally as likely (or more so) to receive the 24-hour assessment, 14-day assessment, and CoMHISS within the appropriate timeframe compared to the whole offender population (women and men offenders).[161] ccxxxv

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[157] Percentage of Health Services Staff Questionnaire participants reporting no barriers/challenges for visible minority offenders: 24-hour (83%, n=45), 14-day (77%, n=39), infectious disease screening (85%, n=34) and CoMHISS (67%, n=12).

[158] Percentage of Health Services Staff Questionnaire participants reporting no barriers/challenges for older offenders: 24-hour (80%, n=44), 14-day (86%, n=44), infectious disease screening (88%, n=35) and CoMHISS (75%, n=12). Almost all older offenders who responded to this interview question reported that they did not experience any specific barriers in completing intake assessments (93%, n=13).

[159] It is difficult to draw conclusions from this information, given the small number of offenders who identified as an older offender (i.e., over the age of fifty) who participated in the evaluation interviews during the intake assessment period (n=16). Older offender health requirements and services will be assessed in additional aspects of the evaluation where possible.

[160] Percentage of Health Services Staff Questionnaire participants reporting no barriers/challenges for women offenders: 24-hour (88%, n=28), 14-day (88%, n=30), infectious disease screening (90%, n=26) and CoMHISS (100%, n=11). Almost all women offenders interviewed at intake reported that they did not experience any specific barriers in completing intake assessments (95%, n=19). Of those offenders who participated in the current evaluation, 20% (n=21) were women.

[161] 24-hour assessment - 97% (n=4192) of the whole offender population (women and men) were screened within the appropriate timeframe compared to 98% (232) of women offenders. 14-day assessment – 70% (n=3010) of the whole offender population (women and men) were screened within the appropriate timeframes compared to 87% (n=204) of

APPENDIX E: DESCRIPTION OF HEALTH EDUCATION INITIATIVES

Reception Awareness Program (RAP):

- RAP is offered to all newly admitted offenders at reception; however, attendance is voluntary.[ccxxxvi] Separate versions of the program are developed and delivered for men and women to address their specific health care needs. RAP provides general information on infectious diseases, harm reduction measures, and related health services and programs offered by CSC.[162] [ccxxxvii]

Peer Education Course/Aboriginal Peer Education Course (PEC/APEC):

- CSC offers PEC and APEC, which are one week training programs[ccxxxviii] offered to offender volunteers who want to become PEC/APEC support workers to other offenders.[ccxxxix] PEC includes a series of modules dealing with infectious diseases and the provision of peer support to offenders infected and affected by these diseases.[ccxl] Similarly, APEC is a one week culturally sensitive training course offered to offender volunteers who want to provide peer support to offenders within the context of the Indigenous culture.[ccxli] The goal of APEC is to learn the basic facts of infectious diseases in order to support encourage and empower Indigenous peers to sustain behavioural and lifestyle changes.[ccxlii] After participating in the PEC/APEC training program, offenders can be selected to work as Peer Support workers within their institutions. Offenders in need of health service support can than request the services offered through a PEC/APEC support worker.

Inmate Suicide Awareness and Prevention Workshop (ISAPW):

- The ISAPW is a three-hour workshop that provides offenders information about suicide including: suicide facts and myths, possible stressors to suicide, signs and symptoms of suicide risk and what to do if someone is thinking about suicide.[ccxliii] The program is delivered by personnel from chaplaincy, nursing, programs, and/or volunteers.[ccxliv] *Commissioner's Directive 843: Management of Inmate Self-Injurious and Suicidal Behaviour* highlights the

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women offenders. CoMHISS – 84% (n=3538) of whole offender population (women and men) were screened within the appropriate timeframes compared to 80% (n=189) of women offenders.

[162] Health services staff members reported that RAP included information on the health services available at CSC (87%, n=33), how to access these services (92%, n=35), how to prevent infectious disease in prison (95%, n=36).

importance of having the Inmate Suicide Awareness and Prevention Workshop available on a regular basis and providing offenders access to the workshop.[ccxlv] CSC aims to deliver this workshop at reception centers in an effort to provide the training to all offenders.[ccxlvi]

Health Services factsheets:

- Health Services offers monthly health promotion and infectious disease prevention factsheets and PowerPoint presentations. The factsheets address specific areas of health concerns, including infectious diseases, chronic conditions, mental health, and general healthy living. Topics may inform on HIV/AIDS, diabetes, TB, heart disease, suicide prevention, and substance abuse.

APPENDIX F: INSTITUTIONAL MENTAL HEALTH SERVICES

Mainstream Institutional Mental Health Treatment

Table 1: Proportional Hazards Regression, Mainstream Institutional Mental Health Treatment & After Treatment Periods Onto Correctional Outcome Likelihood (N = 3, 167)

			95% Confidence Interval	
Variables	***B***	**HR**	**Lower**	**Upper**
Incidents: All				
During Treatment (vs. Before Treatment)	-0.04070	0.960	0.863	1.068
After Treatment (vs. Before Treatment)	-0.09101	0.913*	0.836	0.997
Incidents: Behaviour				
During Treatment (vs. Before Treatment)	0.04524	1.046	0.854	1.281
After Treatment (vs. Before Treatment)	-0.07826	0.925	0.794	1.077
Minor Charges				
During Treatment (vs. Before Treatment)	0.02530	1.026	0.897	1.173
After Treatment (vs. Before Treatment)	-0.06023	0.942	0.836	1.060
Serious Charges				
During Treatment (vs. Before Treatment)	-0.12578	0.882	0.727	1.070
After Treatment (vs. Before Treatment)	-0.35008	0.705***	0.602	0.825
Involuntary Segregation				
During Treatment (vs. Before Treatment)	-0.13634	0.873*	0.769	0.990
After Treatment (vs. Before Treatment)	-0.38467	0.681***	0.605	0.765
National Correctional Program Completions				
During Treatment (vs. Before Treatment)	0.17865	1.196***	1.078	1.327
After Treatment (vs. Before Treatment)	0.20870	1.232***	1.122	1.352
Education Course/Credit Completion				
During Treatment (vs. Before Treatment)	0.02233	1.023	0.901	1.160
After Treatment (vs. Before Treatment)	0.29131	1.338***	1.188	1.508

* p.<.05; **p < .01; ***p<.001. The log-likelihood test for all models were significant as a whole (i.e., p< .0001)

Each model controlled for risk, need, motivation, reintegration potential, age, gender, and Indigenous status. Time interactions were also implemented for variables that violated the proportional hazards assumption.

The significance values for the hazard ratios were corrected for dependence using the modified sandwich estimator (Allison, 2010).

Assault-related incidents, self-harm, and voluntary segregation are not included due to low number of offenders who experienced that event.

Mainstream Institutional Mental Health Treatment: Indigenous Offenders

Table 2: Proportional Hazards Regression, Mainstream Institutional Mental Treatment & Post-Treatment Periods Onto Correctional Outcome Likelihood for Indigenous Offenders (N = 802)

			95% Confidence Interval	
Variables	***B***	**HR**	**Lower**	**Upper**
Incidents: All				
During Treatment (vs. Before Treatment)	-0.02019	0.980	0.795	1.207
After Treatment (vs. Before Treatment)	-0.07465	0.928	0.784	1.098
Incidents: Behaviour				
During Treatment (vs. Before Treatment)	-0.00847	0.992	0.686	1.434
After Treatment (vs. Before Treatment)	-0.24882	0.780	0.580	1.048
Minor Charges				
During Treatment (vs. Before Treatment)	-0.00244	0.998	0.807	1.234
After Treatment (vs. Before Treatment)	-0.07810	0.925	0.751	1.139
Serious Charges				
During Treatment (vs. Before Treatment)	-0.06992	0.932	0.639	1.360
After Treatment (vs. Before Treatment)	-0.20298	0.816	0.639	1.043
Involuntary Segregation				
During Treatment (vs. Before Treatment)	-0.12117	0.886	0.700	1.122
After Treatment (vs. Before Treatment)	-0.35983	0.698**	0.555	0.877
National Correctional Program Completions				
During Treatment (vs. Before Treatment)	0.32006	1.377**	1.137	1.668
After Treatment (vs. Before Treatment)	0.26252	1.300**	1.090	1.551
Education Course/Credit Completion				
During Treatment (vs. Before Treatment)	-0.00478	0.995	0.804	1.233
After Treatment (vs. Before Treatment)	0.20521	1.228*	1.002	1.505

* p.<.05; **p < .01; ***p<.001. The log-likelihood test for all models were significant as a whole (i.e., p< .0001)

Each model controlled for risk, need, motivation, reintegration potential, age, gender, and Indigenous status. Time interactions were also implemented for variables that violated the proportional hazards assumption.

The significance values for the hazard ratios were corrected for dependence using the modified sandwich estimator (Allison, 2010).

Assault-related incidents, self-harm, and voluntary segregation are not included due to low number of offenders who experienced that event.

RTC Mental Health Treatment

Table 3: Proportional Hazards Regression, RTC Mental Health Treatment & Post-Treatment Periods Onto Correctional Outcome Likelihood (N = 617)				
			95% Confidence Interval	
Variables	***B***	**HR**	**Lower**	**Upper**
Incidents: All				
During Treatment (vs. Before Treatment)	0.19464	1.215***	1.087	1.358
After Treatment (vs. Before Treatment)	-0.21539	0.806***	0.714	0.911
Incidents: Assault				
During Treatment (vs. Before Treatment)	0.38367	1.468**	1.141	1.887
After Treatment (vs. Before Treatment)	-0.34242	0.710*	0.541	0.933
Incidents: Behaviour				
During Treatment (vs. Before Treatment)	0.27319	1.314**	1.099	1.571
After Treatment (vs. Before Treatment)	-0.23994	0.787*	0.654	0.947
Incidents: Self-Harm				
During Treatment (vs. Before Treatment)	0.04428	1.045	0.799	1.368
After Treatment (vs. Before Treatment)	-0.41555	0.660*	0.454	0.959
Minor Charges				
During Treatment (vs. Before Treatment)	-0.23779	0.788	0.605	1.027
After Treatment (vs. Before Treatment)	-0.05286	0.949	0.679	1.324
Serious Charges				
During Treatment (vs. Before Treatment)	-0.36885	0.692**	0.524	0.912
After Treatment (vs. Before Treatment)	-0.37151	0.690***	0.554	0.859
Involuntary Segregation				
During Treatment (vs. Before Treatment)	-0.49070	0.612***	0.513	0.731
After Treatment (vs. Before Treatment)	-0.20673	0.813**	0.695	0.951
National Correctional Program Completions				
During Treatment (vs. Before Treatment)	-0.22237	0.801	0.565	1.135
After Treatment (vs. Before Treatment)	0.05852	1.060	0.824	1.364
Education Course/Credit Completion				
During Treatment (vs. Before Treatment)	-0.28018	0.756	0.548	1.041
After Treatment (vs. Before Treatment)	0.05759	1.059	0.776	1.445

* p.<.05; **p < .01; ***p<.001. The log-likelihood test for all models were significant as a whole (i.e., p< .0001)

Each model controlled for risk, need, motivation, reintegration potential, age, gender, and Indigenous status. Time interactions were also implemented for variables that violated the proportional hazards assumption.

The significance values for the hazard ratios were corrected for dependence using the modified sandwich estimator (Allison, 2010).

Voluntary segregation is not included due to low number of offenders who experienced that event.

APPENDIX G: COMMUNITY MENTAL HEALTH SERVICES

Table 1: Recidivism Outcomes for Men and Women CMHI and non-CMHI Participants

Recidivism within 24 months after release				
	Men		**Women**	
	n (%)	N	n (%)	N
CMHS services	74 (30%)	249	9 (27%)	33
CDP services	34 (52%)	65	6 (43%)	14
CDP/CMHS	27 (43%)	63	3 (17%)	18
Non-CMHS	138 (51%)	269	19 (33%)	58
Recidivism within 48 months after release				
	Men		**Women**	
	n (%)	N	n (%)	N
CMHS services	90 (36%)	249	10 (30%)	33
CDP services	38 (59%)	65	7 (50%)	14
CDP/CMHS	32 (51%)	63	5 (28%)	18
Non-CMHS	165 (61%)	269	27 (47%)	58

Source: MacDonald, S. F., Stewart, L. A., & Feely, S. (2014). *The impact of the Community Mental Health Initiative (CMHI) (R-337)*. Ottawa, ON.

APPENDIX H: CLINICAL DISCHARGE PLANNING - ROLES & RESPONSIBILITIES

The clinical discharge planning process involves coordination among several key staff members whose level of involvement varies according to the offender's health needs.

Roles and responsibilities of clinical discharge planning

The Discharge Planning Matrix Tool,[163] the *Discharge Planning and Transfer Guidelines*, and the *Integrated Mental Health Guidelines* outline the roles and responsibilities for CSC staff in relation to CDP.[ccxlvii]

- The clinical discharge planner is responsible for the following in relation to CDP caseload offenders:[ccxlviii]
    - Developing discharge/integration plans (i.e., Mental Health Assessment for Clinical Discharge in accordance with the content guidelines for Mental Health Assessment and Treatment/Intervention Plans) that include referrals and follow-ups in the various areas such as Housing; Identification; Community Support; Spiritual/Religious/Cultural/Ethnic, etc.
    - Providing the IPO/Community Parole Officer with information for reference in the completion of the Correctional Plan Update, Community Strategy and to assist with other release decision making processes – in accordance with case management timelines.
    - Setting up necessary appointments and medication follow up appointments prior to release.
- The clinical discharge planner is also responsible for the following:
    - Providing brief interventions for offenders when referral for services are two months or less prior to release date or WED; or to address specific needs (e.g., referral to a psychiatrist).[ccxlix]
    - Responding to referrals for consultation in complex cases.[ccl]

[163] The Discharge Planning Matrix Tool was developed in April 2013 as a reference accompanying the *Discharge Planning and Transfer Guidelines.*

- The institutional parole officer, as part of offender case preparation is responsible for the following in relation to collaboration and communication with Health Services:
    - Submits referral request to Health Services for a consultation to clinical discharge planners.[ccli]
    - Informs Health Services of upcoming case preparation in advance of 6 months before hearing or release.[cclii]
    - Informs Health Services of upcoming release 3 weeks in advance (or as soon as possible for last minute releases).[ccliii]
    - Prompts pre-release case-conference prior to release if significant change is shared in the GIST report provided by Health Services prior to release.[ccliv]
- The institutional parole officer, is also responsible for the following in relation to managing offender health information:[cclv]
    - Includes the relevant Health Services information in the Correctional Plan.
    - Ensures the Health Status at Discharge: Gist Reports are placed in the offender Case Management file.
    - Assists offenders to obtain a provincial health card in the province of the offender's releasing institution, or when an offender is being released to a different province, assists the offender to apply for temporary provincial health coverage in the province of incarceration.[cclvi]
- The community parole officer, in preparation for an offender's release to the community, is responsible for the following:[cclvii]
    - Develops the community release strategy in collaboration with the IPO and the clinical discharge planner (where relevant).
    - Includes relevant health care needs in the development of the community supervision strategy.
    - Participates in pre-release conferences when the offender is subject to a condition (e.g., condition to take a medication).

- Institutional nurse, in preparation for offender discharge is responsible for the following:
    - Consults with the clinical discharge planner as required to arrange for follow-up appointments for community health care services.

APPENDIX I: REFERENCES AND SUPPLEMENTARY INFORMATION FOR SPECIFIC POPULATIONS OF OFFENDERS

Women Offenders

Profile[cclviii]

- As of 2015-16, there were a total of 1,275 women offenders in CSC, representing 6% of the total number of federal offenders (n=22,969),[164] including:
  - 691 women offenders in custody, representing 5% of the total in custody population (n=14,646).
  - 584 women offenders under community supervision, representing 7% of the total community population (n=8,323).

Prevalent Health Needs[cclix]

- According to several research reports that examined offender health needs,[165] the most prevalent health conditions for women included: some infectious diseases (e.g., HIV/AIDS, HCV), chronic health conditions (e.g., back pain), and various mental health disorders (e.g., antisocial personality disorder, major depressive episode).

Health-Related Policies and Guidelines

- *Commissioner's Directive (CD) 800 Health Services*: "are sensitive to the needs of Aboriginal and women offenders, and offenders with special needs."[cclx]
- *Commissioner's Directive (CD) 578 Intensive Intervention Strategy in Women Offender Institutions/Units.*[cclxi]

[164] The total offender population includes all active offenders, who were incarcerated in a CSC facility, offenders who were on temporary absence from a CSC facility, offenders who were temporarily detained, offenders who were actively supervised, and offenders who were unlawfully at large for less than 90 days.
[165] Results for physical health were based on a file review of offender self-reported health needs at intake, and results for mental health were obtained from clinical tools used with a sample of offenders.

Health-Related Strategies and Initiatives[cclxii]

- CSC developed the *Infectious Disease Strategy for Women Offenders (2008-2013)* as a framework for the prevention, care, and treatment of infectious diseases in order to support women offenders affected by infectious diseases.[cclxiii] The Strategy was intended "to prevent the transmission and acquisition of infectious diseases among women offenders during incarceration and to provide appropriate care, treatment and support to those who are infected."[cclxiv]
- The *Intensive Intervention Strategy for Women Offenders* was initiated in 1999[cclxv] and was developed to better respond to women offenders experiencing self-injurious behaviour, adjustment problems, difficulties with daily living, and/or other emotional or behavioural problems. As part of the Strategy, women offenders are offered Dialectical Behaviour Therapy (DBT), which is a systematic and comprehensive psychotherapeutic intervention approach that involves learning and developing strategies to help regulate problematic emotions and behaviours.[cclxvi]
- The Peer Mentorship program does not provide therapeutic counselling; rather, it is meant to provide confidential support, and connect offenders to resources and services within and outside the institution. The program provides an opportunity for increased problem solving for individuals and contributes to the personal development and employability of offenders who are trained as Peer Mentors. Implementation of Peer Mentorship is scheduled for 2016-17.[cclxvii]

Overall Perceptions of Health Services for Women Offenders[166]

- Many staff member respondents *agreed* that health services were meeting the needs of Women offenders:

  Institutional Health Services:

  - Health services staff: 71%, n=36
  - General staff: 83%, n=40

  Community Mental Health Services:

  - Health services staff: 72%, n=38
  - General staff: 57%, n=52
  - Staff reported challenges:

[166] Remaining staff either reported "neither agree nor disagree" or "disagree/strongly disagree".

- A few CSC staff members (n=17) indicated that there were insufficient resources for community mental health, including access to CSC mental health services or other mental health services in the community.

Indigenous Offenders

Profile[cclxviii]

- As of 2015-16, there were a total of 5,223 Indigenous offenders in CSC, representing 23% of the total number of federal offenders (n=22,969),[167] including:
  - 3,778 Indigenous offenders in custody, representing 26% of the total in custody population (n=14,646)
  - 1,445 Indigenous offenders under community supervision, representing 17% of the total community population (n=8,323)
- As of 2014-15, there were 3,600 Indigenous offenders in custody and 1,356 in the community, representing approximately 22% of CSC's population.[cclxix]

Prevalent Health Needs

- According to several research reports examining offender health needs,[168] Indigenous offenders were more likely than non-Indigenous offenders to have health needs in some areas of mental health (e.g., antisocial personality disorder) and chronic health conditions (e.g., central nervous system conditions, diabetes) and infectious diseases (e.g., HCV, HIV/AIDS).[cclxx]

Health-Related Policies and Guidelines

- According to *Commissioner's Directive (CD) 702: Aboriginal Offenders*, the Institutional Head is responsible for ensuring that offenders are provided with services from an Elder/Spiritual Advisor.[cclxxi]
- According to the *Integrated Mental Health Guidelines,* mental health care professionals must "document that Aboriginal Social history has been considered in arriving at a conclusion and

[167] The total offender population includes all active offenders, who were incarcerated in a CSC facility, offenders who were on temporary absence from a CSC facility, offenders who were temporarily detained, offenders who were actively supervised, and offenders who were unlawfully at large for less than 90 days.
[168] Results for physical health were based on a file review of offender self-reported health needs at intake, and results for mental health were obtained from structured clinical interviews used with a sample of offenders.

recommendations, and integrate a discussion of relevant aspects of this history into assessment reports." [cclxxii]

Health-Related Strategies and Initiatives[cclxxiii]

- The *Aboriginal Health Strategy (2009-2012)* offered a strategic framework for CSC to improve culturally-appropriate health services for Indigenous offenders, based on the continuum of care (i.e., through intake, incarceration, pre-release, and community corrections) and the Medicine Wheel. The Strategy had three primary goals:[cclxxiv]
    1. *Increase the focus on the health needs of Aboriginal offenders*
    2. *Building capacity for culturally-safe health services*[169]
    3. *Enhancing collaboration within and outside of CSC*[170]
- An Indigenous culture component was recently added to the Fundamentals of Mental Health Training. The training provides modules that educate on traditional values for Indigenous health, Indigenous social history, symptoms of mental disorder, and resources for working with Indigenous offenders. The modules also focus on applying Gladue principles through case studies.
- As of 2016, the Director General, Aboriginal Initiatives sits on the National Complex Mental Health Committee to provide input into appropriate care for Indigenous Offenders with complex mental health needs. [cclxxv]

Overall Perceptions of Health Services for Indigenous Offenders[171]

- Many staff member respondents *agreed* that health services were meeting the needs of Indigenous offenders in the institution, but fewer agreed that we were meeting their needs in the community:

  Institutional Health Services:

    - Health services staff: 65%, n=78
    - General staff: 72%, n=69

[169] Culturally-safe services are provided by professionals that are aware and understand Indigenous culture and are open and supportive an offender's choice regarding traditional Indigenous healing practices.
[170] Collaboration within and outside of CSC refers internally to collaboration between CSC NHQ, RHQs and each institution; between the Health Services Sector and Aboriginal Initiatives Directorate. Externally, collaboration should occur between internal partners and with the Indigenous Community, and at the federal and provincial/territorial level.
[171] Remaining staff either reported "neither agree nor disagree" or "disagree/strongly disagree".

- Staff reported challenges:
  - Need to address Indigenous health needs in culturally responsive ways (n=12)
  - Insufficient resources (n=6)

Community Mental Health Services:

- Health services staff: 49%, n=34
- General staff: 35%, n=44
- Staff reported challenges:
  - Insufficient resources, including difficulties accessing mental health services in remote locations or on reserve, or insufficient Indigenous staff members or Elders (n=37)
  - Communication or cultural barriers (n=9)

Elder Services:

- Some health services staff respondents reported consulting with Elders regarding Indigenous offenders for:
  - Mental health services (51%, n=66)
  - Clinical health services (28%, n=35)
  - Public health services (9%, n=11)
- Health services staff reported that they consulted an Elder to discuss:
  - Mental health treatment plans or interventions (n=22)
  - Understanding of offenders' cultural beliefs and languages (n=22)
  - Use of culturally sensitive approaches in clinical health care (n=15)
- Health services staff suggested that Elders should be more involved in:
  - Treatments, services, or interventions for offenders (n=18)
  - Communication and information sharing with health services (n=12)

Offender Perceptions:

- Among Indigenous offenders interviewed (n=51):
  - A few (n=3), reported having an Elder present while receiving health care services. Some (n=17) said that it would have been beneficial (e.g., to help navigate the health system, to provide information on traditional health alternatives).

Other Visible Minority Offenders

Profile[cclxxvi]

- The following table shows the ethnic groupings of all CSC offenders at the end 2015-16.[172] The most common other visible minorities (i.e., non-Indigenous offenders) were Black, Asian, and Other offenders.

Ethnic Grouping	Total (%)
Indigenous	5,223 (23%)
Asian	1,256 (5%)
Black	1,768 (8%)
Caucasian	13,521 (59%)
Hispanic	237 (1%)
Other	964 (4%)

Overall Perceptions of Health Services for Other Visible Minority Offenders[173]

- Many staff member respondents *agreed* that health services were meeting the needs of other visible minority offenders in the institution, but fewer agreed that we were meeting their needs in the community.

  Institutional Health Services:

  - Health services staff: 66%, n=74
  - General staff: 75%, n=71
  - Staff reported challenges:
    - Communication and cultural barriers (n=7).

  Community Mental Health Services:

  - Health services staff: 52%, n=34
  - General staff: 29%, n=30

[172] The total offender population includes all active offenders, who were incarcerated in a CSC facility, offenders who were on temporary absence from a CSC facility, offenders who were temporarily detained, offenders who were actively supervised, and offenders who were unlawfully at large for less than 90 days.
[173] Remaining staff either reported "neither agree nor disagree" or "disagree/strongly disagree".

- Staff reported challenges, primarily related to community mental health services:
  - Insufficient resources to meet the needs of visible minority populations (e.g., limited services, lack of information resources; n=18).
  - Language and/or cultural barriers (n=9).

Older Offenders

Profile[cclxxvii]

- As people age, the risk of ill health or disability increases, as does the demand for health care.[cclxxviii] Today, aging Canadians face chronic, mental health, and neurological conditions.[cclxxix]
- As of 2015-16, there were a total of 6,675 older offenders in CSC, representing 29% of the total number of federal offenders (n=22,969),[174] including:
  - 3,544 older offenders in custody, representing 24% of the total in custody population (n=14,646)
  - 3,131 older offenders under community supervision, representing 38% of the total community population (n=8,323).

Prevalent Health Needs

- According to several research reports that examined offender health needs,[175] older offenders had a higher prevalence than offenders under the age of 50 in some areas, such as chronic health conditions (e.g., cardiovascular system issues, diabetes) and infectious diseases (e.g., HIV/AIDS, HCV).[cclxxx]

Health-Related Policies and Guidelines[cclxxxi]

- According to the *National Essential Health Services Framework* core essential health services include physical health, mental health, public health, and dental services. Although there are some exceptions, many items relevant to older offenders and/or offenders with physical disabilities (e.g., mobility devices) are provided under special authorization.[cclxxxii]

[174] The total offender population includes all active offenders, who were incarcerated in a CSC facility, offenders who were on temporary absence from a CSC facility, offenders who were temporarily detained, offenders who were actively supervised, and offenders who were unlawfully at large for less than 90 days.
[175] Results for physical health were based on a file review of offender self-reported health needs at intake.

- According to the *Integrated Mental Health Guidelines*, offenders may be referred for admission to RTC if they experience cognitive and/or physical disabilities (e.g., dementia) that are associated with aging and require 24-hour nursing and other clinical care.[cclxxxiii]
- According to the *Federal Correctional Facilities Accommodation Guidelines*, "all areas within institutions must be accessible to the disabled, including staff, visitor and inmate activity areas". Although some spaces are not required to be accessible due to the nature of the activities (e.g., control posts, mechanical spaces), a portion of spaces are required to be accessible (i.e., a maximum of 2% of cells/bedrooms and support space within housing units).[cclxxxiv] Although these guidelines do not directly address challenges for older offenders, they provide options to address issues of accessibility and mobility, which commonly affect older offenders.
- There are a total of 15,364 regular population (rated-capacity) cells within CSC institutions. Of those, CSC provides 428 barrier-free cells, of which 37 are transitional (i.e., health care cells, segregation cells). As such, 391 permanent barrier-free cells represent 2.5% of all accessible spaces across CSC, which is above the 2% requirement in the *Federal Correctional Facilities Accommodation Guidelines* for CSC as a whole. However, some *individual* institutions were above the 2% level of accessible cells, whereas others were below.
- Barrier-free cells are provided in maximum, medium, and minimum security institutions, women's institutions, multi-level institutions, healing lodges[176] as well as in its RTCs. These cells are distributed in each of the five Regions as follows:
  - Atlantic: 43
  - Ontario: 111
  - Quebec: 75
  - Prairies: 115
  - Pacific: 84

Health-Related Strategies and Initiatives[cclxxxv]

- CSC Health Services is currently developing a comprehensive *Chronic Disease Management Strategy*.

[176] CSC operated healing lodges.

- The Chronic Disease Management Strategy includes seven key health priorities: HIV, HCV, chronic pain, cardiovascular disease, respiratory disease, and the use of antibiotics.
- Although the *Chronic Disease Management Strategy* is not specifically designated for older offenders, many of the health issues prioritized in the strategy include health issues prevalent among older offender populations.

- Health Services conducts screening for "fall risk" as part of the Intake Health Status Assessment for offenders aged 65 and older[177] and/or those with self-care needs (as of August 2015, the age requirement to conduct an assessment for incarcerated offenders has changed from 50 years or older to 65 years or older).[cclxxxvi] The assessment examines factors related to activities of daily living.[cclxxxvii,178]
- The Pacific Region has created a psycho-geriatric unit at the RTC, called Echo, with a Peer Assisted Living (PAL) Caregiver program.[cclxxxviii]
  - PAL Caregivers are offenders who work in cooperation with staff to assist a peer who has a physical or cognitive disability, in activities of daily living (e.g., help with eating, bathing, dressing, toileting, maintenance of the living environment and mobility).
  - Training is provided and offenders applying to the program should be actively engaged in their correctional plan and demonstrate positive working relationships with their case management team.

Overall Perceptions of Health Services for Older Offenders[179]

- Some staff *agreed* that health services were meeting the health-related needs of older offenders in the institution and in the community.

  Institutional Health Services:

  - Health services staff: 41%, n=52
  - General staff: 59%, n=61
  - Staff reported challenges:
    - Insufficient resources, services and specialized service providers (e.g., personal care, geriatric specialists, high needs/multiple needs offenders; n=36)

[177] As of August 2015, the age requirement to conduct
[178] Screening for "falls risk" is a Required Organizational Practice under Accreditation Canada.
[179] Remaining staff either reported "neither agree nor disagree" or "disagree/strongly disagree".

        - Challenges accommodating the needs of older offenders within the existing infrastructure (e.g., provide specialized unit or range for offenders with mobility or age related issues; n=34)

    Community Mental Health Services:

    - Health services staff: 46%, n=34
    - General staff: 34%, n=41
    - Staff reported challenges:
        - Insufficient resources, such as palliative care or mental health professionals (n=27)
        - Difficulties finding accommodations (e.g., community care facilities willing to accept them, CCCs/CRFs not equipped for their needs; n=20)

- Twenty-nine percent (29%, n=42) of offenders interviewed reported being over the age of fifty; of these, 57% (n=24) reported having age-related health care needs. They reported having age-related needs such as:
    - Joint or muscle problems (n=12),
    - Cardiovascular conditions (n=5), or
    - Other age-related chronic conditions (e.g., diabetes, menopause, etc; n=12).
- Older offenders also reported experiencing challenges with the physical layout of the institution (55%, n=12), accessing specialized health care equipment (47%, n=9), and performing daily activities (33%, n=7).
    - Offenders interviewed made the following suggestions to address age-related challenges: Offer specialized services (e.g., hearing specialist, pain clinics; n=12);
    - Provide access to specialized products and equipment (e.g., eyeglasses, cane; n=11); and,
    - Accommodate older offenders through infrastructure changes (e.g., improve wheelchair accessibility; n=10).

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This is **Exhibit "W"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

Correctional Service of Canada

2019–20

Departmental Plan

Minister of Public Safety and Emergency Preparedness

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Minister’s message

As Canada's Minister of Public Safety and Emergency Preparedness, it is my pleasure to present to Parliament the Departmental Plan (DP) for 2019–20 as prepared by the Correctional Service of Canada (CSC).

The DP explains to Parliament and Canadians what we are planning for the next three years and the results we are hoping to achieve, as we deliver on our departmental mandate commitments and continue supporting CSC’s corporate priorities.

I am encouraged to see the progress CSC has begun to make in response to the mandate letter I provided to the Commissioner this past September. As we work together to transform federal corrections, we will continue to seek out new approaches and innovative ideas to longstanding challenges. This important work will help ensure that Canada’s federal correctional system is progressive and responsive to the needs of a diverse offender population, while also maintaining CSC’s institutions as safe and secure environments for offender rehabilitation, staff safety, and the protection of Canadians.

I am likewise encouraged by the progress of Bill C-83 through Parliament, strengthened thus far by amendments proposed by parliamentarians in response to witness testimony, as part of a robust and productive examination by the House of Commons’ Standing Committee on Public Safety and National Security. Supported by major investments announced in the 2018 Fall Economic Statement, Bill C-83 eliminates administrative segregation, introduces a new correctional model, and establishes Structured Intervention Units. This will promote both institutional and public safety by ensuring that inmates who need to be separated from the mainstream offender population receive the mental healthcare and rehabilitative interventions they require.

Looking forward, we will continue to address the critical concern of the overrepresentation of Indigenous Peoples in Canada’s criminal justice system. CSC has implemented Aboriginal Intervention Centres (AICs) as a core strategy to improve reintegration results for Indigenous offenders. These centres are intended for Indigenous Peoples, particularly those with shorter sentences. During the coming year, we will monitor the impact of AICs on offender participation in rehabilitative programs, release planning, and access to parole.

We are also doing more to address the mental health needs of the most vulnerable inmates. In 2019–20, CSC will continue to implement intermediate mental health units at specific institutions in all regions. We will continue to improve our capacity in this area through the $150 million funding investment announced in the 2018 Fall Economic Statement, for enhancing mental health services including early diagnosis, improved mental health care, and creating a patient advocacy system for inmates.

Finally, CSC remains committed to ensuring its workplaces are safe, respectful and supportive environments for all employees, and that they are free from bullying, discrimination, harassment and violence. Through the Respectful Workplace Campaign, CSC will continue to promote programs, services, and recourse mechanisms for employees.

I look forward to continuing our work to deliver real change[i] for Canadians and ensure our federal correctional system remains progressive, accountable, and focused on protecting Canadian communities through effective rehabilitation and safe reintegration.

Sincerely,

The Honourable Ralph Goodale, P.C., M.P.

Minister of Public Safety and Emergency Preparedness

Plans at a glance and operating context

During fiscal year 2019–20, the Correctional Service of Canada (CSC) will support the Minister of Public Safety and Emergency Preparedness as he delivers on key components of his mandate. Aligned with CSC's corporate priorities, and supporting both the Minister's and the Commissioner's mandates, this plan focuses on four key areas: population management, Indigenous offenders, mental health, and staff wellbeing.

CSC administers court-imposed sentences of adult offenders sentenced to two years or more. The department is geographically dispersed across the country and is responsible for managing 43 institutions, 14 community correctional centres, and 92 parole and sub-parole offices.

As per the Corrections and Conditional Release Act, CSC is responsible for:

a) The care and custody of inmates
b) The provision of programs that contribute to the rehabilitation of offenders and to their successful reintegration into the community
c) The preparation of inmates for release
d) Parole, statutory release supervision and long-term supervision of offenders
e) Maintaining a program of public education about the operations of the Service

On a typical day in 2017–18, CSC managed 23,060 offenders (14,015 incarcerated and 9,045 supervised in the community), many of whom have extensive histories of violence and violent crimes, previous youth and adult convictions, and affiliations with security threat groups. As well, the offender population has a high rate of mental health disorders, addictions, and infections including Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV). This population also contains an increased number of women offenders, a disproportionate representation of Indigenous offenders (compared to their representation in the Canadian population), a growing number of offenders who identify as members of an ethnic minority, as well as an aging population. To safely manage and reintegrate

CSC's Corporate Priorities

- Safe management of eligible offenders during their transition from the institution to the community, and while on supervision
- Safety and security of the public, victims, staff and offenders in institutions and in the community
- Effective, culturally appropriate interventions and reintegration support for First Nations, Métis and Inuit offenders
- Effective and timely interventions in addressing mental health needs of offenders
- Efficient and effective management practices that reflect values-based leadership in a changing environment
- Productive relationships with diverse partners, stakeholders, victims' groups, and others involved in support of public safety

this population into the community as law-abiding citizens, CSC offers programs, health services, spiritual services, and education opportunities, while operating with a great degree of adaptability, flexibility, rigour, gender responsiveness and cultural competency.

Population Management

In order to meet the needs of all offenders, including the particular needs of women offenders, Indigenous Peoples and others, CSC develops, implements, monitors, and reviews correctional policies, programs, practices and interventions to ensure they respect gender, ethnicity, cultural and linguistic differences.

Offenders belonging to ethnocultural minority groups often have specific needs based on their origin, language, culture, and/or belief system. CSC works to address these needs while respecting cultural identity and practices. There are interventions and services in place to help ethnocultural offenders adjust to their sentences, guide them through the system, and successfully reintegrate into the community. Many of these social and cultural tools were developed with partners such as the various Ethnocultural Advisory Committees.

Indigenous Offenders

Despite efforts, Indigenous Peoples continue to be overrepresented within the federal correctional system, and the need to effectively address this issue is specifically noted in the mandate letters of both the Minister and the Commissioner. Providing effective and culturally appropriate correctional and reintegration support for Indigenous offenders has been a CSC corporate priority for more than a decade.

In that regard, progress can be seen in recent years in the gradual increase in the percentage of Indigenous offenders who successfully reach their sentence expiry date (SED) and the corresponding drop in the rate of serious community convictions for Indigenous offenders over the past five years. There is also a downward trend in the percentage of Indigenous offenders who return to federal custody within five years of sentence expiry.

CSC has plans to increase its capacity to provide a responsive environment for Indigenous offenders by expanding the existing culturally appropriate correctional environment within its facilities. CSC will work to enhance partnerships with Indigenous communities to facilitate and support the conditional release of Indigenous offenders and to strengthen those interventions, correctional policies, programs, and operations designed to support them.

Mental Health

CSC’s offender population is characterized by a high rate of mental health needs and substance misuse.

In 2017–18, CSC began implementation of additional intermediate mental health units to meet the needs of inmates identified as presenting moderate impairment or significant mental health symptoms, who require more than what can be offered through primary care but do not require 24-hour care. CSC plans to proceed with the implementation of the intermediate mental health care units at select sites across all regions this fiscal year.

Introduced in October 2018, Bill C-83 proposes a proactive and transformative approach that will eliminate administrative segregation, enhance mental health services for all inmates and strengthen clinical independence and patient advocacy for inmates. CSC has developed action plans to comply with the Bill, should it come into force.

Staff Wellbeing

CSC is committed to ensuring the workplace is a safe, respectful and supportive environment for all employees, which is free from bullying, discrimination, harassment and violence. In February 2018, CSC launched its Respectful Workplace Campaign in response to allegations of staff misconduct. CSC will maintain ongoing efforts to promote programs, services, and make available recourse mechanisms to employees regarding harassment, bullying, discrimination, and/or conflict in the workplace.

Recognizing that the nature of correctional work creates higher than average workplace stress, particularly for front-line workers, CSC established a Special Steering Committee for Workplace Mental Health Injuries that functions in partnership with the unions to support employees who may develop mental health injuries at work, as well as their families. CSC also provides mental resiliency training to help reduce the stigma of mental illnesses and increase awareness of mental health. Following the full implementation of the Road to Mental Readiness Training in 2018–19, CSC will introduce Advanced Mental Strength training for staff over a three-year period beginning in 2019–20.

For more information on CSC’s plans, priorities and planned results, see the “Planned Results” section of this report.

Planned results: what we want to achieve this year and beyond

Core Responsibilities

Core Responsibility 1: Care and Custody

Description

CSC provides for the safety, security and humane care of inmates, including day-to-day needs of inmates such as food, clothing, accommodation, mental health services, and physical health care. It also includes security measures within institutions such as drug interdiction, and appropriate control practices to prevent incidents.

Planning highlights

To heighten safety and security in institutions thereby protecting visitors, staff and offenders, CSC will continue to implement its population management approach, taking into account the full diversity of the offender population. CSC will also put into place relevant action plans stemming from findings related to audits, investigation reports, coroners' inquiries and evaluations, to address Corporate Risk #1.

Corporate Risk #1

There is a risk that CSC will not be able to maintain required levels of operational safety and security in institutions and in the community.

Should Bill C-83 come into force, CSC will implement Structured Intervention Units (SIUs) to provide protected accommodation for inmates who cannot be safely managed in the mainstream inmate population. The design will provide inmates in SIUs with access to structured interventions and programming to address their specific needs in a safe and secure environment, with the objective of being able to return successfully to the mainstream inmate population in preparation for release. It is expected that SIUs will improve correctional outcomes and will help reduce the rate of violent incidents in institutions.

CSC will continue to examine technology to enhance the safety of community staff members and the public, as well as maintain ongoing efforts to test and adapt emerging security-related technologies to the evolving correctional environment, including the command and control systems, thermal cameras, and interception capability for air intrusion.

To eliminate the entry of prohibited materials and the trafficking and supply of drugs in institutions, and to locate and confiscate contraband, CSC will review and improve operational policies, procedures, approaches and current technology. In support of this important work, CSC will reinforce and formalize key public safety partnerships at the national, regional and local levels.

To support health service delivery that conforms to professionally accepted standards as required by the Corrections and Conditional Release Act (CCRA), CSC will monitor and continue implementing measures that maintain CSC's health services accreditation status as per the Accreditation Canada Qmentum Program.

CSC will maintain its Essential Health Services Framework, chronic disease management strategy and mental health strategy. CSC will enhance prevention, early diagnosis, and treatment of acute and chronic medical and mental health conditions, including substance misuse disorder. CSC will also continue progress toward infectious-disease prevention, particularly HIV and HCV, using screening, diagnostics, treatment, health education and harm reduction measures.

CSC will provide targeted assessment and intervention for the mental health needs of offenders at all security levels, who may be at risk of engaging in self-injury and/or suicidal behaviour and will improve institutional staff training rates for the Suicide & Self-Injury Intervention training program. CSC will also support a continuum of health care for offenders during their transition from CSC's health services to provincial/territorial health coverage.

To support offender wellbeing, CSC provides nutrition that is sufficient in quality and quantity and is in accordance with the Canada Food Guide.[ii] The food service meets the needs of offenders requiring specific diets for their faith or for therapeutic reasons.

CSC will work in accordance with its Sustainable Development Strategy and has plans to carry out additional environmental initiatives in support of its Environmental Protection Program, such as the reduction of greenhouse gas (GHG) emissions, and the reduction of waste and water consumption to help preserve the quality of natural ecosystems.

CSC will strengthen the management of facilities through improved governance, processes and information systems. CSC will sustain ongoing implementation of its 2015–20 Accommodation Plan and will maintain and improve the condition of its physical infrastructure in accordance with the 2015–20 Investment Plan.

Planned results

Departmental Results	Departmental Result Indicators	Target[1]	Date to achieve target	2015–16 Actual results	2016–17 Actual results	2017–18 Actual results
Institutions are safe and secure	Rate of non-natural and undetermined offender deaths in	0.95 – 1.26	2020-03-31	1.56	0.71	1.14

[1] Targets are established through the statistical analysis of historical data and a review of factors within the operational context. The methodology ensures that what is anticipated as a performance range (target) is objective and reflective of changes within the operational context.

	custody per 1,000 offenders (Objective: Zero)[2]					
	Rate of escapes per 1,000 offenders (Objective: Zero)	1.03 – 1.18	2020-03-31	1.22	0.57	1.06
	Rate of serious security incidents per 1,000 offenders in federal custody	5.74 – 6.97	2020-03-31	8.02	6.22	6.81
Inmates are managed in a humane manner	Maintain Health Services Accreditation	Maintain Accreditation	2020-03-31	Accredited	Accredited	Accredited
	Of the inmates identified as having a significant mental health need, the percentage who received mental health treatment*	90%	2020-03-31	N/A	N/A	95.8%
	Percentage of newly admitted offenders receiving health assessments at intake	95% –100%	2020-03-31	98.5%	98.7%	95.7%
	Rate of upheld inmate grievances per 1,000 offenders in	70.7 – 94.7	2020-03-31	95.0	75.9	74.7

[2] When dealing with deaths in custody, escapes, or drugs in institutions, CSC's objective is zero. It is necessary, however, to put that objective in the context of reality, therefore, CSC's results will be compared to the anticipated range, as this range fully considers the reality of CSC's past and current operational context.

	federal custody					
	Median days in administrative segregation	13.0 – 13.9	2020-03-31	12	11	11

* All offenders identified as having a significant mental health need are meant to receive mental health treatment, however offenders must consent and have the right to refuse treatment. The 90% target may also account for those offenders for which a need was identified at the end of the reporting period and for which there was insufficient time to provide treatment. In the latter cases, this would be reported on in the following year.

Budgetary financial resources (dollars)

2019–20 Main Estimates	2019–20 Planned spending	2020–21 Planned spending	2021–22 Planned spending
1,571,624,384	1,571,624,384	1,567,823,805	1,566,711,961

Human resources (full-time equivalents)

2019–20 Planned full-time equivalents	2020–21 Planned full-time equivalents	2021–22 Planned full-time equivalents
10,458	10,458	10,458

Financial, human resources and performance information for CSC's Program Inventory is available in the GC InfoBase.[iii]

Core Responsibility 2: Correctional Interventions

Description

CSC conducts assessment activities and program interventions to support federal offenders' rehabilitation and facilitate their reintegration into the community as law-abiding citizens. CSC also engages Canadian citizens as partners in its correctional mandate, and provides outreach to victims of crime.

Planning highlights

CSC delivers a range of correctional interventions that support successful offender reintegration into the community by encouraging them to be accountable for their actions and to participate fully in their rehabilitation. CSC will provide ongoing training and support to staff who deliver correctional interventions to offenders, and strengthen case management to augment assessment and intervention activities.

One of CSC's key priorities, in support of the Minister's mandate, is to provide Indigenous offenders with access to effective, culturally-appropriate interventions and services developed in collaboration with Indigenous partners to prepare them for successful and timely conditional release. CSC works with Indigenous partners to increase the number of community-run healing lodges established under Section 81 of the CCRA and the number of community-supported releases under Section 84. CSC is also currently reviewing proposals from several Indigenous communities who have expressed interest in entering into a Section 81 Agreement to establish a healing lodge facility for the care and custody of Indigenous offenders.

In 2018–19, CSC monitored the implementation of Aboriginal Intervention Centres (AICs) for Indigenous offenders. The AIC model begins at intake, where Indigenous offenders committed to a healing path are placed at centralized reception sites to have earlier access to programming during the intake process. AICs have specialized case management teams who understand the needs and cultural interventions for Indigenous offenders and are trained in Aboriginal Social History (ASH), which is considered in all decisions that pertain to Indigenous offenders. On an ongoing basis, CSC will monitor the impact of AICs through the collection of data on admissions, participation in various interventions including correctional, employment and education programs, Section 81 transfers, Section 84 release planning, as well as access to parole at an offender's first eligibility date.

In addition, CSC contracts organizations or groups to provide reintegration support to Indigenous offenders upon release to urban centers, as well as remote and rural areas. There are many Indigenous organizations that have the expertise to address the trauma that Indigenous people have experienced as a result of their social history in a culturally responsive and appropriate manner. Providing services to address related needs, both in the institution and as part of a transition to the community, significantly contributes to an offender's success upon reintegration. In addition, funding for release specifically to remote and rural areas provides more Indigenous

offenders the opportunity to prepare a section 84 release plan to their home communities, where family support, as well as culturally responsive community support is available.

In consultation with Indigenous partners, CSC will re-examine its governance structure and the role of the National Aboriginal Advisory Committee in order to ensure greater integration of Indigenous needs and perspectives into CSC decisions at the senior level.

CSC will strengthen Elder participation in the provision of correctional interventions to Indigenous offenders including those at the Intake Assessment Units, and will increase the use of Elder assessments/reviews as one of the key considerations in the transfer and/or discretionary release of Indigenous offenders.

Corporate Risk #2

There is a risk that CSC will not be able to respond to the complex and diverse profile of the offender population.

In the interest of effective rehabilitation, CSC continuously reviews its services, interventions, assessment tools and correctional approaches, to ensure they are tailored to address the full diversity of CSC's population and to mitigate Corporate Risk #2. CSC offers a wide range of interventions to offenders, including programs and services that respond to their cultural, educational, employment, social, spiritual, mental health, and criminogenic needs.

To help reduce recidivism, CSC develops and implements initiatives that improve how it delivers correctional programs, targeting offenders' criminogenic needs at intensity levels that match their risk levels.

CSC provides offenders with education programs to help them develop literacy, academic, and personal development skills enhancing employability and improving their overall capacity to successfully reintegrate into the community. During 2019–20, CSC will prioritize completion of secondary education and make post-secondary education more available through partnerships with universities via the Walls to Bridges project. This provides potential to connect community partners with offenders preparing for release with education and employment opportunities. These efforts will involve exploring options in distance learning and the supervised use of information technology, including the support of other correctional interventions.

CSC promotes the development of these relationships by safely minimizing barriers to visits and communication, and by exploring options for supervised use of e-mail. Providing ways for offenders to maintain contact with the outside world enables offenders' friends and family to assist in their effective preparation for release.

CSC provides social programs and activities that prepare offenders for reintegration into the community. They provide offenders with basic life skills, encourage them to adopt pro-social lifestyles, and contribute to meaningful use of time.

As part of correctional interventions utilized to contribute to offender rehabilitation, CORCAN's Employment and Employability Program provides offenders with skills training related to employment and employability to develop technical and soft skills that are transferable to community employment. This is achieved through on-the-job training, apprenticeship hours and vocational certifications to improve their chances of sustainable employment as part of their safe and successful release into the community. These training programs are endorsed by various provincial/territorial authority partnerships that assist offenders to obtain and maintain employment in the community. In 2019–20, CSC will review the employment and employability interventions provided to women offenders to ensure the breadth of interventions and services provided are responsive to their needs.

CSC has commenced reopening the penitentiary farms at Joyceville and Collins Bay institutions in Kingston, Ontario. This initiative will support offenders in their reintegration by building meaningful employment and employability skills that are measurable, transferrable, and applicable in Canadian communities. As the farm programs develop, they will be used to inform future opportunities for other employment and employability options. This, in turn, will create opportunities for CSC to address the needs of offenders and support their reintegration into the community.

CSC provides access for offenders to spiritual services through engagement with contractors, faith communities, volunteers and other community partners to support successful reintegration. The Strategic Plan for Chaplaincy will continue to provide institutional services based on the standards set forth by the Interfaith Committee on Chaplaincy (IFC) and will strengthen the re-focused faith-based community reintegration projects to ensure that offenders have access to religious and spiritual services throughout the sentence continuum.

CSC fulfills its legal obligation to disclose certain information to victims. It meets the requirements of the Canadian Victims Bill of Rights, including raising awareness and sharing information about restorative justice and CSC's victim-offender mediation services by providing client-centred mediation services through CSC's Restorative Opportunities program. CSC engages victims of crime within the correctional process and includes their concerns in its decision-making processes.

Corporate Risk #5

There is a risk that CSC will lose support of partners delivering critical services and providing resources for offenders.

To address Corporate Risk #5, CSC will advance its Integrated Engagement Strategy to promote, develop and strengthen diverse partnerships and stakeholder relationships at local, regional and national levels to share information and provide support for offenders, thereby contributing to the safe reintegration of offenders into Canadian communities and positive public safety results. CSC continues to explore the use of communications technologies to enhance engagement with partners and

stakeholders, including volunteers, advisory groups, victims, and faith and non-faith community organizations.

Planned results

Departmental Results	Departmental Result Indicators	Target[3]	Date to achieve target	2015–16 Actual results	2016–17 Actual results	2017–18 Actual results
Offenders are prepared for their release from CSC's jurisdiction as law-abiding citizens	Percentage of successful transitions to lower security (successful if no reclassification to higher security within 120 days)	94.7% – 96.2%	2020-03-31	95.1%	96.2%	95.1%
	Median percentage of sentence served prior to first release, for offenders with moderate or high reintegration potential	50.2% – 52.9%	2020-03-31	54.5%	46.5%	44.1%
	Of the offenders with an identified need for a nationally recognized correctional program, the percentage who complete prior to first release	84.1% – 87.5%	2020-03-31	87.8%	83.1%	82.4%
	Of the offenders with an identified need for an upgrade to their	54.0% – 64.8%	2020-03-31	67.3%	65.5%	66.2%

[3] Targets are established through the statistical analysis of historical data and a review of factors within the operational context. The methodology ensures that what is anticipated as a performance range (target) is objective and reflective of changes within the operational context.

	education, the percentage who upgrade prior to first release					
	Of the offenders with an identified need for vocational training (labour market skills), the percentage who complete prior to first release	58.2% – 60.5%	2020-03-31	60.3%	58.3%	58.5%
	Of the offenders with an identified need for employment in the community, the percentage who secure such employment prior to sentence expiry date	73.5% – 74.7%	2020-03-31	74.6%	75.2%	74.3%
	Of the offenders with an identified need for a nationally recognized correctional program, the percentage who complete prior to sentence expiry date	90.5% – 92.0%	2020-03-31	91.8%	88.9%	83.2%
	Of the Indigenous offenders who identify an interest in following a traditional healing path,	90.2% – 95.5%	2020-03-31	96.9%	96.4%	96.5%

	the percentage who receive an Elder Review (Elder reviews are required as part of a traditional healing path)					
	Percentage of offenders not readmitted to federal custody within 5 years following sentence expiry date	81.4% – 83.1%	2020-03-31	84.1%	84.7%	85.7%

Budgetary financial resources (dollars)

2019–20 Main Estimates	2019–20 Planned spending	2020–21 Planned spending	2021–22 Planned spending
449,192,653	449,192,653	448,106,395	447,788,613

Human resources (full-time equivalents)

2019–20 Planned full-time equivalents	2020–21 Planned full-time equivalents	2021–22 Planned full-time equivalents
4,202	4,202	4,202

Financial, human resources and performance information for CSC's Program Inventory is available in the GC InfoBase.[iv]

Core Responsibility 3: Community Supervision

Description

CSC supervises offenders in the community and provides structure and services to support their safe and successful reintegration into the community. Services include accommodation options, community health services, and the establishment of community partnerships. CSC manages offenders on parole, statutory release, and long-term supervision orders.

Planning highlights

CSC strengthens management and supervision of offenders in the community to reduce offender recidivism and increase their reintegration potential to address Corporate Risk #6.

Corporate Risk #6
There is a risk that CSC will not be able to sustain results related to violent reoffending.

In 2019–20, CSC will maintain electronic monitoring services to support CSC's ability to supervise offenders. To help plan for offender releases, CSC will finalize development of housing capacity, using OMS data to visually represent the community offender information, including Community Residential Facility (CRF) capacity, offender population, and the number of releases to each community. CSC regularly reviews community performance measures for data quality and how well those results reflect actual performance.

CSC works closely with partners, including operators of Community Residential Facilities (CRF), to create conditions for success for offenders on parole and statutory release, as well as those subject to long-term supervision orders with residency conditions. CSC will ensure CRF contracts are in place on time to meet the needs of the community offender population, and that Statements of Work are maintained to outline requirements of the operations of various types of accommodation options. As a result of a review of CRF needs, CSC will fund infrastructure projects such as wheelchair accessibility, fire safety systems, modernizing ventilation and updating security, in support of accommodations of offenders in the community. CSC continually assesses national and regional needs for expanded community capacity, to support increased demand and offender population needs.

Nationally, there has been a continuous increase in the number of offenders managed in the community from an average of 7,706 in 2012–13 to 9,045 in 2017–18 and a steady decline in the incarcerated offender population. In 2017–18, the highest number of day parole was reported within the last 10 years, including for Indigenous offenders and women offenders. This is a success story that brings challenges, as it places pressure on already limited community resources to meet the needs of conditionally-released offenders, particularly those who need specialized support in areas of accommodation, programming and/or mental health.

CSC collaborates with provincial and territorial medical services to ensure continuity of care upon release. CSC provides discharge planning matched to the offender's level of health needs to

support continuity of health care in transition from the institution to the community. This supports offenders' engagement with medical care on release, including primary care, medical specialists, pharmacists, and dental care.

Planned results

Departmental Results	Departmental Result Indicators	Target[4]	Date to achieve target	2015–16 Actual results	2016–17 Actual results	2017–18 Actual results
Offenders are reintegrated into the community as law-abiding citizens while under supervision	Percentage of offenders on conditional release successfully reaching sentence expiry date without re-admission (no revocation, charge or conviction)	54.9% – 58.5%	2020-03-31	56.6%	58.8%	61.0%
	Rate of convictions on supervision for serious or violent offences, per 1,000 offenders	28.2 – 35.8	2020-03-31	28.6	39.5	20.7
	Rate of convictions on supervision for offences resulting in death, per 1,000 offenders (Objective: Zero)	0.50 – 0.64	2020-03-31	0.48	1.01	0.55
	Of the offenders identified as having a significant	90%	2020-03-31	N/A	73.0%	86.6%

[4] Targets are established through the statistical analysis of historical data and a review of factors within the operational context. The methodology ensures that what is anticipated as a performance range (target) is objective and reflective of changes within the operational context.

	mental health need, the percentage who received mental health treatment from CSC in the community					
	Percentage of employable time spent employed, for offenders under community supervision	62.5% – 64.7%	2020-03-31	63.4%	64.9%	67.9%

Budgetary financial resources (dollars)

2019–20 Main Estimates	2019–20 Planned spending	2020–21 Planned spending	2021–22 Planned spending
162,388,951	162,388,951	161,996,255	161,881,372

Human resources (full-time equivalents)

2019–20 Planned full-time equivalents	2020–21 Planned full-time equivalents	2021–22 Planned full-time equivalents
229	229	229

Financial, human resources and performance information for CSC's Program Inventory is available in the GC InfoBase.[v]

Internal Services

Description

Internal Services are those groups of related activities and resources that the federal government considers to be services in support of Programs and/or required to meet corporate obligations of an organization. Internal Services refers to the activities and resources of the 10 distinct services that support Program delivery in the organization, regardless of the Internal Services delivery model in a department. These services are:

- Management and Oversight Services
- Communications Services
- Legal Services
- Human Resources Management Services
- Financial Management Services
- Information Management Services
- Information Technology Services
- Real Property Management Services
- Materiel Management Services
- Acquisition Management Services

Budgetary financial resources (dollars)

2019–20 Main Estimates	2019–20 Planned spending	2020–21 Planned spending	2021–22 Planned spending
301,888,481	301,888,481	301,158,439	300,944,868

Human resources (full-time equivalents)

2019–20 Planned full-time equivalents	2020–21 Planned full-time equivalents	2021–22 Planned full-time equivalents
2,577	2,577	2,577

Planning highlights

CSC recognizes the criticality of a safe, respectful, and supportive workplace to its success in achieving its mandate and priorities. As such, CSC continues to implement its Respectful Workplace Campaign in conjunction with strategies that improve the wellbeing of all staff. These strategies include training and increased promotion of services available to employees that include, but are not limited to, the Office of Conflict Management and the Office of Internal

Corporate Risk #3

There is a risk that CSC will not be able to maintain a safe, secure and healthy working environment as established by its legal and policy obligations, mission, and values statement.

Disclosure. Communication strategies for these services and employees' options regarding the elimination of workplace harassment also continue to be implemented. CSC is implementing and will monitor its Organizational Mental Health Strategy for staff, and is also progressing in its three-year plan to complete ethical risk assessments at operational sites and undertaking an internal audit on its culture to mitigate Corporate Risk #3.

CSC will action its 2019–22 Strategic Plan for Human Resource Management. The Plan will support the organization in meeting both new and existing human resource (HR) needs and challenges, as they relate to people management and HR service delivery. CSC will identify strategies to address these needs moving forward, including its Recruitment and Retention Action Plan for health professionals, as well as focus on hiring individuals with the needed diverse cultural competence. CSC also expanded ongoing mentoring for all wardens and deputy wardens and parole officer supervisors, in both women's and men's institutions.

CSC continues to work toward the formal implementation of the New Direction in Staffing. As well, CSC is engaged with the Office of the Chief Human Resources Officer to modernize the Public Service's classification approach, particularly the Program and Administrative Services (PA) Classification Conversion Exercise, which includes updating existing work descriptions and adopting standardized work descriptions. The PA Conversion is expected to be completed by 2022. CSC is maximizing its learning and development resources through changes to the organizational structure to create increased efficiencies, and is pursuing the acquisition of a Learning Management System and simulation equipment to enhance training.

With the creation of the Business Intelligence Tool, combined with decades of HR data, CSC is better able to support decision making across the organization through an enhanced ability to determine potential trends and risks.

CSC ensures it has empirical and fact-based information for decision makers to draft policies and guidelines through regular reviews of performance results and reports from internal evaluations, audits and investigations. Additionally, CSC's research group informs strategies around correctional approaches, interventions, policies, procedures and programs by providing relevant research and consultations. Finally, CSC reviews and considers reports from external sources including the Office of the Auditor General, the Office of the Correctional Investigator, and the Canadian Human Rights Commission mediation agreements, court/tribunal decisions. During the reporting period, CSC will strengthen monitoring and reporting related to commitments in its Departmental Security Plan.

To address Corporate Risk #4, CSC is employing financial strategies in response to budgetary constraints, working with central agencies to address the organization's financial challenges on a permanent basis, and continuing to refine the resource allocation model. This will include implementing the Treasury Board Policy on Financial Management and improving the efficiency of its budget allocation process, streamlining payments to suppliers and increasing the number of employees with Chartered Professional Accountant designations through both recruitment and support to current staff for ongoing education.

Corporate Risk #4

There is a risk that CSC will not be able to implement its mandate and ensure the financial sustainability of the organization.

When in effect, CSC will implement the Treasury Board's directive on the management of procurement to strengthen procurement planning across the organization, improve the efficiency of its procurement and materiel management activities, support financial management and enhance governance.

CSC continues to experience ongoing issues related to the Phoenix Pay System. Given the complexity of CSC's workforce coupled with the operational nature of the organization, CSC has experienced a significantly high number of pay related issues. CSC is continuously working internally and with external stakeholders to resolve these issues.

On an ongoing basis, CSC will engage in regular and open consultations with its federal/provincial/territorial and international partners to ensure that information and best practices are shared among the various jurisdictions. Internally, CSC will use a more integrated approach in the management of intergovernmental and international collaboration projects to maximize results across the organization.

CSC is implementing the CSC/Parole Board Canada Information Management (IM)/Information Technology (IT) 2017–20 Business Plan. CSC will continue the implementation of GCdocs as an information and work management solution across the organization. In conjunction with Shared Services Canada, CSC will continue to advance Government of Canada's modernization priorities, including the application migration and a new data centre and network consolidation. CSC will continue to advance a number of the IM/IT Plan's major IM initiatives including the eDiscovery project and the Enterprise Information Management (EIM) Strategy. A focus on evolving data and information governance will enable the EIM program to better meet the future business needs of CSC. In addition, CSC will work to ensure continued alignment with the GC's IT Strategic Plan through work such as the launch of the CSC Cloud Strategy.

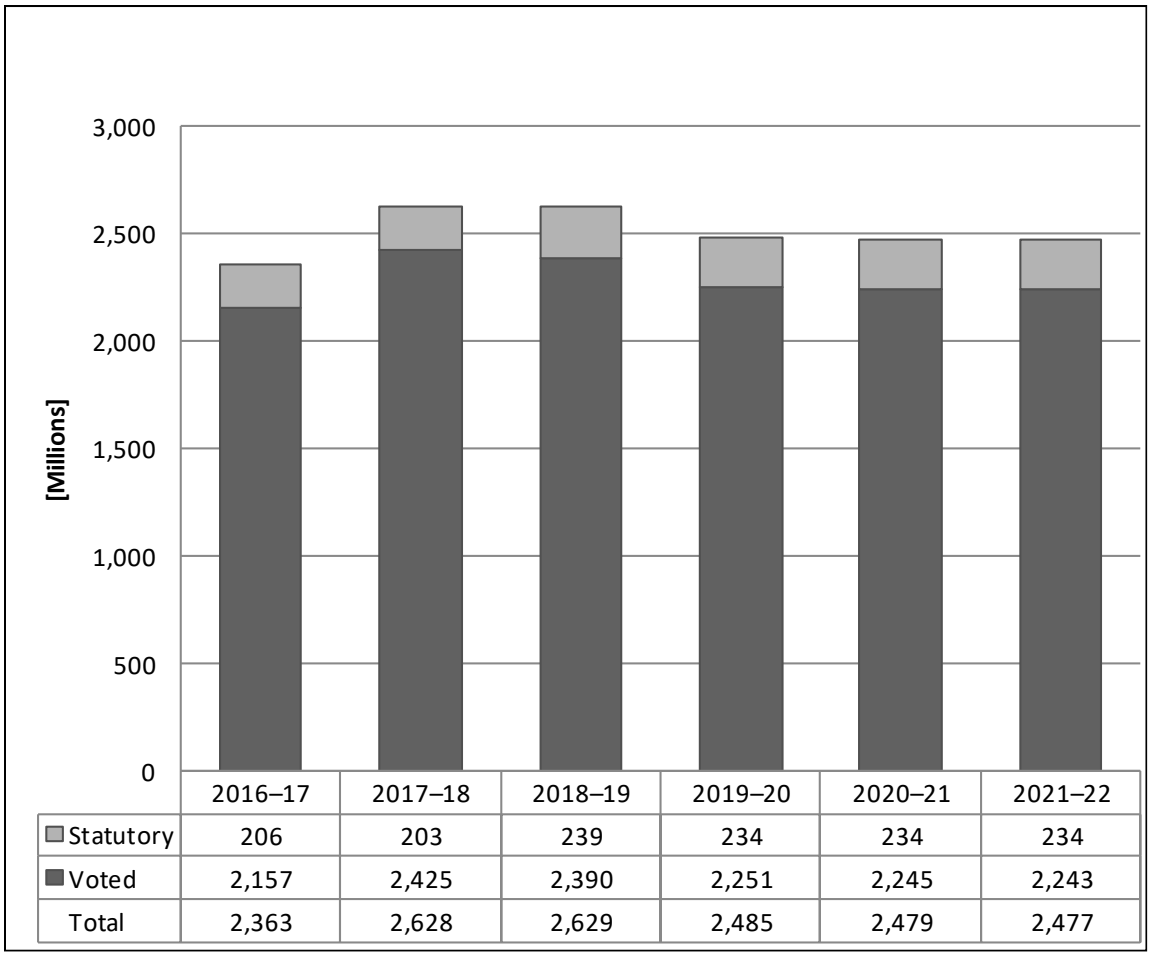
CSC will continue to advance the Offender Management System (OMS) foundation and modernization projects to ensure the continuity of this mission critical system, building a common framework that will allow for the long-term evolution of OMS in a modular way that is responsive to changes in legislation and business requirements. OMS initiatives include better

integration of information management services, policy, program and service delivery, embracing innovative and responsible use of new technologies, managing security and privacy, and being data-driven. CSC will be digitally enabled through strategic training plans to assimilate digital technology enhancements with improved methods of assessing and intervening with offenders. The outcomes are specifically focused on public safety effectiveness, offender reintegration efficiency, humane custody, and the safety and security of staff and offenders.

Spending and human resources

Planned spending

Departmental spending trend graph



	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22
Statutory	206	203	239	234	234	234
Voted	2,157	2,425	2,390	2,251	2,245	2,243
Total	2,363	2,628	2,629	2,485	2,479	2,477

Budgetary planning summary for Core Responsibilities and Internal Services (dollars)

Core Responsibilities and Internal Services	2016–17 Expenditures	2017–18 Expenditures	2018–19 Forecast spending	2019–20 Main Estimates	2019–20 Planned spending	2020–21 Planned spending	2021–22 Planned spending
Care and Custody	1,510,190,155	1,695,534,841	1,674,018,978	1,571,624,384	1,571,624,384	1,567,823,805	1,566,711,961
Correctional Interventions	398,249,136	438,244,603	458,104,750	449,192,653	449,192,653	448,106,395	447,788,613
Community Supervision	154,796,731	160,381,208	163,637,378	162,388,951	162,388,951	161,996,255	161,881,372
Subtotal	2,063,236,022	2,294,160,652	2,295,761,106	2,183,205,988	2,183,205,988	2,177,926,455	2,176,381,946
Internal Services	299,568,379	333,951,327	333,248,502	301,888,481	301,888,481	301,158,439	300,944,868
Total	2,362,804,401	2,628,111,979	2,629,009,608	2,485,094,469	2,485,094,469	2,479,084,894	2,477,326,814

The 2018–19 forecast spending of $2,629M and 2017–18 expenditures of $2,628M demonstrate that CSC is pursuing its activities in a similar fashion from year to year. For both years, CSC received additional funding to support its operations for amounts that were not initially included in its Main Estimates, respectively $74.7M in 2018–19 and $83.7M in 2017–18. CSC continues to require additional funding to support its operations in 2019–20, which will be addressed during the fiscal year.

The $143.9M variance between the 2018–19 forecast spending of $2,629M and the 2019–20 Main Estimates of $2,485.1M is mainly due to funding received during the 2018–19 financial year, and therefore not included in the 2018–19 Main Estimates.

There is a variance of $185M between the 2018–19 Main Estimates of $2,444M and the 2018–19 Forecast spending of $2,629M. This variance represents: additional funding to support operations $74.7M; Capital Budget Carry Forward $49.4M; Collective Agreement increases $31.7M; pay funding requirements under Vote 30 $19.3M; funding for Bill C-83 to enhance CSC recruitment processes, increase training resources and expand on existing health care services $7.5M; Budget 2018 programs to support Mental Health and Penitentiary Farms $5M; funding to address issues with pay administration $2.3M; and a contribution for enabling digital services to Canadians ($4.7M).

The variance between the 2019–20 Main Estimates of $2,485.1M and the 2018–19 Main Estimates of $2,444M is $41.1M. This increase is mainly due to: funding for collective agreements $27.6M; funding for incremental changes in offender population volumes and price fluctuations $7.9M; Budget 2017 programs addressing the needs of Vulnerable Offenders $6.2M; an increase in the employee benefit plan $6.1M; Budget 2018 programs to support the mental health needs of inmates and to support the reopening of the penitentiary farms $4.3M;

and contributions for enabling digital services to Canadians ($9.5M) and back office transformation ($1.3M).

The 2019–20 Main Estimates does not include funding for Bill C-83. This program will be further developed in 2019–20.

Considering the ongoing assessment of funding required to continue to support CSC's operations in 2019–20 and the impact of Bill C-83 to expand on existing health care services and implement structured intervention units, it is anticipated that additional funding will be received in 2019–20, which will increase CSC's expenditures to a level similar to, if not greater than, previous years.

Planned human resources

Human resources planning summary for Core Responsibilities and Internal Services (full-time equivalents)

Core Responsibilities and Internal Services	2016–17 Actual full-time equivalents	2017–18 Actual full-time equivalents	2018–19 Forecast full-time equivalents	2019–20 Planned full-time equivalents	2020–21 Planned full-time equivalents	2021–22 Planned full-time equivalents
Care and Custody	10,432	10,366	10,489	10,458	10,458	10,458
Correctional Interventions	4,057	4,112	4,093	4,202	4,202	4,202
Community Supervision	226	212	207	229	229	229
Subtotal	14,715	14,690	14,789	14,889	14,889	14,889
Internal Services	2,506	2,536	2,526	2,577	2,577	2,577
Total	17,221	17,226	17,315	17,466	17,466	17,466

The variance of 89 full-time equivalents (FTEs) between 2018–19 and 2017–18 is mostly due to 'Addressing the Needs of Vulnerable Offenders' (Budget 2017). The 151 FTE increase between 2019–20 and 2018–19 is largely due to increased planned staffing for correctional officers in order to bring the workforce to its optimal level. Staffing requirements for 'Addressing the Needs of Vulnerable Offenders' (Budget 2017) and 'Mental Health / Penitentiary Farms' (Budget 2018) also contribute to this increase. Future year FTEs are expected to increase should Bill C-83 come into force and related measures are implemented.

Estimates by vote

Information on CSC's organizational appropriations is available in the 2019–20 Main Estimates.[vi]

Consolidated Future-Oriented Condensed Statement of Operations

The Consolidated Future-Oriented Condensed Statement of Operations provides a general overview of CSC's operations. The forecast of financial information on expenses and revenues is prepared on an accrual accounting basis to strengthen accountability and to improve transparency and financial management. The forecast and planned spending amounts presented in other sections of the Departmental Plan are prepared on an expenditure basis; as a result, amounts may differ.

A more detailed Consolidated Future-Oriented Statement of Operations and associated notes, including a reconciliation of the net cost of operations to the requested authorities, are available on CSC's website.[vii]

Consolidated Future-Oriented Condensed Statement of Operations for the year ending March 31, 2020 (dollars)

Financial information	2018–19 Forecast results	2019–20 Planned results	Difference (2019–20 Planned results minus 2018–19 Forecast results)
Total expenses	2,738,956,499	2,648,269,988	(90,686,511)
Total revenues	62,110,640	65,793,519	3,682,879
Net cost of operations before government funding and transfers	2,676,845,859	2,582,476,469	(94,369,390)

CSC's 2019–20 planned expenses are projected to be $2,648,269,988. These expenses include planned spending presented in this Departmental Plan and also include expenses such as amortization and services provided without charge. CSC's planned revenues are projected to be $65,793,519 in 2019–20. Revenues are primarily generated by the CORCAN revolving fund.

Variances between the planned results for 2019–20 and the 2018–19 forecast results are largely attributable to the timing of key elements in the government expenditure cycle. For instance, funding and initiatives that were not approved in time to be included in the Main Estimates have not been included in the 2019–20 planned results. Additionally, the 2018–19 forecast results include one time funding for retroactive payments following the signing of various collective agreements and new initiatives announced in Budget 2018. These initiatives include:

- Reopening of Penitentiary Farms at Joyceville and Collins Bay Institutions to provide federal inmates training opportunities to acquire new skills, while preparing them for employment and successful reintegration and rehabilitation into the community. The farms will be operated by CORCAN, a key rehabilitation program and special operating agency of CSC.
- Additional funding to CSC to further support the mental health needs of federal inmates. Funds would largely be targeted towards providing enhanced mental health support for women in federal correctional facilities across Canada.
- One-time funding of $74.7 million was provided in 2018–19 to enable CSC to continue existing operations in support of its mandate. This funding is non-recurring and thus the funds are not included in the planned results for 2019–20.

The increase in fiscal year 2019–20 revenues is primarily attributable to the expansion of CORCAN business activities including construction, expansion of the Indigenous Offender Employment Initiative, and the expanded implementation of penitentiary farms.

Additional information

Corporate information

Organizational profile

Appropriate minister[s]: The Honourable Ralph Goodale, P.C., M.P.

Institutional head: Anne Kelly, Commissioner

Ministerial portfolio: Public Safety and Emergency Preparedness

Enabling instrument[s]: *Corrections and Conditional Release Act*, S.C. 1992, c. 20

Year of incorporation / commencement: 1979 (March 31)

Raison d'être, mandate and role: who we are and what we do

"Raison d'être, mandate and role: who we are and what we do" is available on CSC's website.[viii]

Reporting framework

CSC's Departmental Results Framework and Program Inventory of record for 2019–20 are shown below.

Program Code	Program(s) Name
Core Responsibility 1: Care and Custody	
P1	Institutional Management and Support
P2	Intelligence and Supervision
P3	Drug Interdiction
P4	Clinical and Public Health Services
P5	Mental Health Services
P6	Food Services
P7	Accommodation Services
Core Responsibility 2: Correctional Interventions	
P8	Offender Case Management
P9	Community Engagement
P10	Chaplaincy
P11	Elder Services
P12	Correctional Program Readiness
P13	Correctional Programs
P14	Correctional Program Maintenance
P15	Offender Education
P16	CORCAN Employment and Employability
P17	Social Program
Core Responsibility 3: Community Supervision	
P18	Community Management and Security
P19	Community Residential Facilities
P20	Community Correctional Centres
P21	Community Health Services
Internal Services	

Supporting information on the Program Inventory

Supporting information on planned expenditures, human resources, and results related to CSC's Program Inventory is available on CSC's website[ix] and in the GC InfoBase.[x]

Supplementary information tables

The following supplementary information tables are available on CSC's website[xi]:

- Departmental Sustainable Development Strategy[xii]
- Disclosure of transfer payment programs under $5 million[xiii]
- Gender-based analysis plus[xiv]

Federal tax expenditures

The tax system can be used to achieve public policy objectives through the application of special measures such as low tax rates, exemptions, deductions, deferrals and credits. The Department of Finance Canada publishes cost estimates and projections for these measures each year in the Report on Federal Tax Expenditures.[xv] This report also provides detailed background information on tax expenditures, including descriptions, objectives, historical information and references to related federal spending programs, as well as evaluations, research papers and gender-based analysis. The tax measures presented in this report are the responsibility of the Minister of Finance.

Organizational contact information

Correctional Service of Canada website[xvi]
340 Laurier Avenue West
Ottawa, Ontario
K1A 0P9

Feedback Form[xvii]

Appendix: definitions

appropriation (crédit)

Any authority of Parliament to pay money out of the Consolidated Revenue Fund.

budgetary expenditures (dépenses budgétaires)

Operating and capital expenditures; transfer payments to other levels of government, organizations or individuals; and payments to Crown corporations.

Core Responsibility (responsabilité essentielle)

An enduring function or role performed by a department. The intentions of the department with respect to a Core Responsibility are reflected in one or more related Departmental Results that the department seeks to contribute to or influence.

Departmental Plan (plan ministériel)

A report on the plans and expected performance of an appropriated department over a three-year period. Departmental Plans are tabled in Parliament each spring.

Departmental Result (résultat ministériel)

Any change that the department seeks to influence. A Departmental Result is often outside departments' immediate control, but it should be influenced by Program-level outcomes.

Departmental Result Indicator (indicateur de résultat ministériel)

A factor or variable that provides a valid and reliable means to measure or describe progress on a Departmental Result.

Departmental Results Framework (cadre ministériel des résultats)

The department's Core Responsibilities, Departmental Results and Departmental Result Indicators.

Departmental Results Report (rapport sur les résultats ministériels)

A report on the actual accomplishments against the plans, priorities and expected results set out in the corresponding Departmental Plan.

evaluation (évaluation)

In the Government of Canada, the systematic and neutral collection and analysis of evidence to judge merit, worth or value. Evaluation informs decision making, improvements, innovation and accountability. Evaluations typically focus on programs, policies and priorities and examine questions related to relevance, effectiveness and efficiency. Depending on user needs, however, evaluations can also examine other units, themes and issues, including alternatives to existing interventions. Evaluations generally employ social science research methods.

experimentation (expérimentation)

Activities that seek to explore, test and compare the effects and impacts of policies, interventions and approaches, to inform evidence-based decision-making, by learning what works and what does not.

full-time equivalent (équivalent temps plein)

A measure of the extent to which an employee represents a full person-year charge against a departmental budget. Full-time equivalents are calculated as a ratio of assigned hours of work to scheduled hours of work. Scheduled hours of work are set out in collective agreements.

gender-based analysis plus (GBA+) (analyse comparative entre les sexes plus [ACS+])

An analytical process used to help identify the potential impacts of policies, Programs and services on diverse groups of women, men and gender-diverse people. The “plus” acknowledges that GBA goes beyond sex and gender differences. We all have multiple identity factors that intersect to make us who we are; GBA+ considers many other identity factors, such as race, ethnicity, religion, age, and mental or physical disability.

government-wide priorities (priorités pangouvernementales)

For the purpose of the 2019–20 Departmental Plan, government-wide priorities refers to those high-level themes outlining the government’s agenda in the 2015 Speech from the Throne, namely: Growth for the Middle Class; Open and Transparent Government; A Clean Environment and a Strong Economy; Diversity is Canada's Strength; and Security and Opportunity.

horizontal initiative (initiative horizontale)

An initiative where two or more departments are given funding to pursue a shared outcome, often linked to a government priority.

non-budgetary expenditures (dépenses non budgétaires)

Net outlays and receipts related to loans, investments and advances, which change the composition of the financial assets of the Government of Canada.

performance (rendement)

What an organization did with its resources to achieve its results, how well those results compare to what the organization intended to achieve, and how well lessons learned have been identified.

performance indicator (indicateur de rendement)

A qualitative or quantitative means of measuring an output or outcome, with the intention of gauging the performance of an organization, Program, policy or initiative respecting expected results.

Performance Information Profile (profil de l'information sur le rendement)
The document that identifies the performance information for each Program from the Program Inventory.

performance reporting (production de rapports sur le rendement)
The process of communicating evidence-based performance information. Performance reporting supports decision making, accountability and transparency.

plan (plan)
The articulation of strategic choices, which provides information on how an organization intends to achieve its priorities and associated results. Generally a plan will explain the logic behind the strategies chosen and tend to focus on actions that lead up to the expected result.

planned spending (dépenses prévues)
For Departmental Plans and Departmental Results Reports, planned spending refers to those amounts presented in the Main Estimates.

A department is expected to be aware of the authorities that it has sought and received. The determination of planned spending is a departmental responsibility, and departments must be able to defend the expenditure and accrual numbers presented in their Departmental Plans and Departmental Results Reports.

priority (priorité)
A plan or project that an organization has chosen to focus and report on during the planning period. Priorities represent the things that are most important or what must be done first to support the achievement of the desired Departmental Results.

Program (programme)
Individual or groups of services, activities or combinations thereof that are managed together within the department and focus on a specific set of outputs, outcomes or service levels.

Program Inventory (répertoire des programmes)
Identifies all of the department's programs and describes how resources are organized to contribute to the department's Core Responsibilities and Results.

result (résultat)
An external consequence attributed, in part, to an organization, policy, Program or initiative. Results are not within the control of a single organization, policy, Program or initiative; instead they are within the area of the organization's influence.

statutory expenditures (dépenses législatives)

Expenditures that Parliament has approved through legislation other than appropriation acts. The legislation sets out the purpose of the expenditures and the terms and conditions under which they may be made.

sunset program (programme temporisé)

A time-limited program that does not have an ongoing funding and policy authority. When the program is set to expire, a decision must be made whether to continue the program. In the case of a renewal, the decision specifies the scope, funding level and duration.

target (cible)

A measurable performance or success level that an organization, Program or initiative plans to achieve within a specified time period. Targets can be either quantitative or qualitative.

voted expenditures (dépenses votées)

Expenditures that Parliament approves annually through an Appropriation Act. The Vote wording becomes the governing conditions under which these expenditures may be made.

Endnotes

[i] Minister of Public Safety and Emergency Preparedness Mandate Letter, https://pm.gc.ca/eng/minister-public-safety-and-emergency-preparedness-mandate-letter

[ii] Canada's Food Guide, https://food-guide.canada.ca/en/

[iii] GC InfoBase, https://www.tbs-sct.gc.ca/ems-sgd/edb-bdd/index-eng.html#start

[iv] GC InfoBase, https://www.tbs-sct.gc.ca/ems-sgd/edb-bdd/index-eng.html#start

[v] GC InfoBase, https://www.tbs-sct.gc.ca/ems-sgd/edb-bdd/index-eng.html#start

[vi] 2019–20 Main Estimates, https://www.canada.ca/en/treasury-board-secretariat/services/planned-government-spending/government-expenditure-plan-main-estimates.html

[vii] Future-Oriented Statement of Operations (FOSO) https://www.csc-scc.gc.ca/reporting/007005-2500-2019-2020-en.shtml

[viii] "Raison d'être, mandate and role: who we are and what we do", https://www.csc-scc.gc.ca/publications/005007-2607-05-en.shtml

[ix] Program Inventory, https://www.csc-scc.gc.ca/publications/005007-2607-07-en.shtml

[x] GC InfoBase, https://www.tbs-sct.gc.ca/ems-sgd/edb-bdd/index-eng.html#start

[xi] Supporting information tables, http://www.csc-scc.gc.ca/reporting/index-eng.shtml

[xii] Departmental Sustainable Development Strategy for 2018–20, https://www.csc-scc.gc.ca/publications/005007-8614-en.shtml

[xiii] Disclosure of transfer payment programs under $5 million, https://www.csc-scc.gc.ca/publications/005007-2607-01-en.shtml

[xiv] Gender-Based Analysis, https://www.csc-scc.gc.ca/publications/005007-2607-02-en.shtml

[xv] Report on Federal Tax Expenditures, http://www.fin.gc.ca/purl/taxexp-eng.asp

[xvi] CSC's website, http://www.csc-scc.gc.ca/reporting/index-eng.shtml

[xvii] Correctional Service Canada Feedback Form, http://www.csc-scc.gc.ca/contact-us/008-0001-eng.shtml

This is **Exhibit "X"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

_____

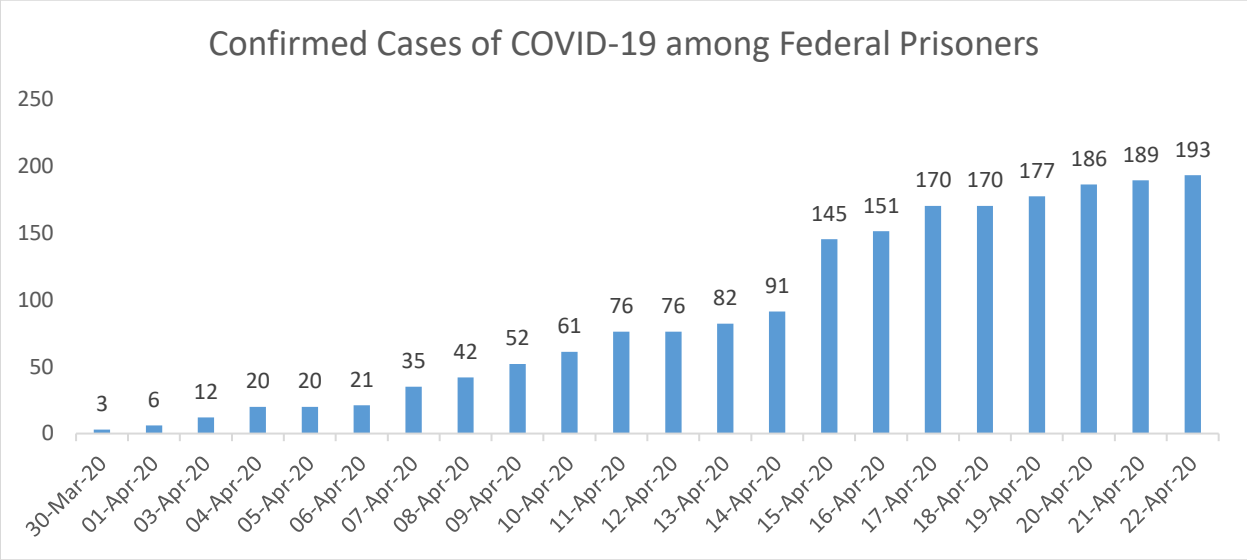
A Commissioner, etc

Office of the Correctional Investigator **April 23, 2020**

COVID-19 Status Update

Current Situation

As of April 23, 2020, there are 193 confirmed cases of COVID-19 in federal penitentiaries, representing 1.4% of the total inmate population (n = 13,869). Five of 43 penitentiaries have experienced or are currently managing an active outbreak. Infection rates reflect transmission trends found in the general community, with outbreaks in penitentiaries located in Quebec, Ontario and British Columbia. There are currently no active COVID-19 cases in federal prisons in the Prairie and Atlantic regions of Canada.



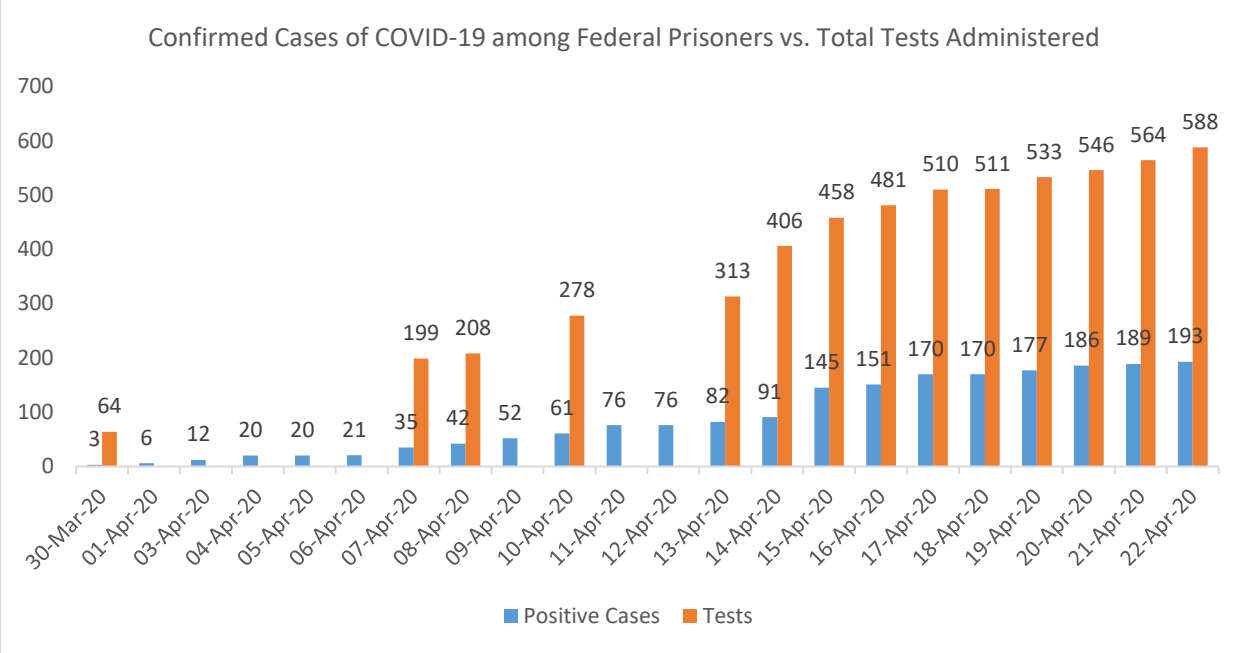
Affected Institutions

Institution	COVID-19
Mission Institution (British Columbia)	65
Federal Training Centre (Quebec)	54
Joliette Institution for Women (Quebec)	51
Port-Cartier Institution (Quebec)	15
Grand Valley Institution for Women (Ontario)	8

According to data maintained but not publicly released by the Correctional Service of Canada (CSC), even though there are 193 confirmed cases of COVID-19 contraction, there are close to 400 inmates flagged as being under some form of medical isolation, a term which expansively incorporates five categories:

1. New Warrant of Committals/Returns to Federal Custody Inmates.
2. Inmates with symptoms of influenza or COVID-19.
3. Inmates with diagnosed COVID-19 (laboratory or clinical diagnosis).
4. Inmates diagnosed with other viral illness such as influenza.
5. Inmates who are close contacts of other inmates (for example, on the same range).

CSC data further confirms that 588 federal inmates have been tested for COVID-19, representing roughly 4% of the total inmate population. The congruence between number of inmates tested and positive results is high, approximately 33%. Testing continues across the country as do medical isolation placements (not limited to facilities experiencing an outbreak) where early or presumptive indicators of infection appear to be present or in instances where other precautionary or separation measures dictate. It is still too early to say whether infection numbers and rates have peaked, but the cumulative and rising number of recovered cases to date (n = 45) and the overall lengthening of the period between doubling of cases are encouraging developments in flattening the transmission curve of this disease behind bars. To date, only one inmate has succumbed to COVID-19, though a number of cases have required hospitalization.



As we have seen in COVID-19 outbreaks in long-term care facilities, stopping the introduction of this virus once it is introduced from the outside in places where people live in shared but confined spaces has proved immensely challenging. On March 31, CSC issued national instruction (*Principles: COVID-19*), which included suspension of all visits. All transfers, except emergency, were discontinued. Prison gyms, libraries and other communal spaces were closed as preventative measures. Programs were suspended. Communal serving and eating were stopped, where feasible. Modified routines were implemented across the country, with a set of restrictions on out of cell time generally ranging from 2 to 4 hours. These routines remain largely in place at 38 non-affected institutions across the country.

At institutions experiencing an outbreak, the daily regime is much more restrictive and onerous. Daily access to the yard and fresh air exercise have been extremely curtailed, offered only every second day, half hour twice per week or sometimes simply suspended outright. For those under medical isolation, time out of cell is limited to just 20 minutes per day.

Additional and separate COVID-19 guidance was issued to all CSC staff members. All non-essential staff are working from home. Staff movement on and between units is restricted. Community contact is to be minimized. Elders and Chaplains are not on site

providing their services. National direction for staff indicates that soap and hand sanitizer were to be made available to everyone, though the Office has subsequently confirmed that inmate access to the latter has been denied on the basis of its high alcohol content, even though bittering agents can be added to the mixture. But even with all these measures in place and despite some contradictions and inconsistencies in their application (protective masks initially issued only to staff and inmates being an obvious example), practicing safe physical distancing in a prison context is to expect the impossible. It is remarkable that the virus has been contained to five penitentiaries.

Update on Office Activities and Emergent Findings

As an independent oversight and ombudsman body, my Office continues to provide an essential public service and critical activities through this pandemic. We remain vigilant, engaged and accessible. At a time when prisons are closed to the wider public, my Office is committed more than ever to shine a light on Canada's prisons. Though visits by staff to institutions remain suspended, Investigators are in contact with their assigned institutions on a weekly, and, in some instances, daily basis. Collaboration at the site level has been generally very good. The Office continues to take calls from inmates, engage directly with members of Inmate Welfare Committees and follow up on complaints. Investigators have reached out and have managed to speak with a few infected inmates only in Quebec Region so far in an attempt to hear first-hand accounts of how they are being treated. Investigators are collecting data, tracking cases and monitoring incidents.

Since mid-March, the Office has received nearly 500 complaints from inmates. To be expected, more than 25% of the issues brought forward to the Office over this time period are COVID-related. Complaints and allegations range from staff not wearing proper protective gear or not practicing safe physical distancing to loss of yard time, lack of access to programs, chaplaincy and overall restrictive routines and conditions of confinement.

The Office continues to closely monitor incident trends (e.g. self-harming, attempted suicides, and overdoses) that are often indicative of how imprisoned people adapt or cope with prolonged and uncertain periods of idleness, extended cellular confinement or lockdown. Conditions approaching or even surpassing solitary confinement (23 hours

in cell) are hard on mental health. I would encourage the Service to closely monitor the overall health and resiliency of the inmate population, including quickly responding to what appear to be clusters of self-injury at some non-affected sites. While I appreciate that the Service's over-riding priority is containing and controlling this virus, there appears to be an overall spike in incidents involving unusual or non-compliant inmate behavior at a number of sites, including disciplinary problems, protests, threats against staff, assaults on inmates, hunger strikes and other disturbances. The fact that all hearings by Independent Chairpersons in serious disciplinary cases have been suspended through COVID-19 remains a source of concern.

On the issues of testing and providing masks/facial coverings to inmates, I have recommended that all inmates and staff at institutions experiencing outbreaks be tested (Letter from the Correctional Investigator of Canada to the President of the Public Health Agency of Canada) and that masks be provided to inmates as an additional protective measure. These recommendations, which have been accepted by the Government, are consistent with public health measures in the rest of Canada. At the same time, mandatory testing and provision of masks to inmates (not just staff) recognizes that the spread and severity of COVID-19 infection in settings such as prisons and long-term care facilities is far more likely to be serious and widespread. Even still, the equivalency of care principle demands that the same measures and protections recommended by national public health authorities should be provided to the inmate population. For an outbreak to end, a facility must remain free of any COVID-19 cases for a period of 28 days (the sum of two incubation periods of the virus) after the onset of the first symptoms (or date of diagnosis) in the last confirmed case. As good prison health is also good public health, we cannot afford to leave anybody behind in the fight against this pandemic.

With respect to institutions experiencing COVID-19 outbreaks, conditions of confinement are extremely difficult. For affected or suspected cases, medical isolation is akin to a public health quarantine order. For infected inmates it means as little as 20 minutes out of cell time each day, and, on instruction of local public health authorities, even denial of access to the yard or opportunity for fresh air exercise. These conditions obviously violate universal human rights standards and though perhaps justifiable in context of a public health emergency, the stark choice for many infected inmates comes

down to taking a shower, or making a call to a lawyer, my Office or a family member. Even still, fundamental human rights and dignity adopted through a public health emergency must be respected.

It is very troubling that some infected inmates at Mission Institution have been subjected to periods of 24-hour lock-up with no access to phones, fresh air, lawyers or family members. Holding detained people incommunicado with the outside world in conditions of solitary confinement is a violation of universal human rights safeguards, and can never be considered justifiable, tolerable or necessary in any circumstance. To date, none of the 65 inmates infected with COVID-19 at Mission Institution have made or been able to contact my Office.

The practice of placing or housing infected with presumptive cases in medical isolation ranges, living units or so-called "COVID houses" (for women inmates) remains deeply concerning and perhaps speaks to prevailing limitations in resources, staffing and infrastructure. Though restrictions are gradually being eased at some affected institutions, including opening up of the yard and more time on the living units for the general population, daily routines and conditions in institutions where COVID-19 is present remain extremely depriving.

I continue to engage regularly with the Commissioner, Minister, media and senior levels of the federal public service. On April 16, I visited Port Cartier institution, which is the site of a major COVID-19 outbreak. I did not take the decision to drive to or visit this remote facility lightly. I chose to inspect this facility because it was the first institution to experience an outbreak, and simultaneously report a major incident related to COVID-19 that included deployment of the Emergency Response Team. In truth, it took a number of weeks for my Office to secure proper Personal Protective Equipment and thus be in a position to safely visit an affected institution. Donning protective gear and my temperature duly taken before entry, I personally witnessed the challenges of how one maximum-security institution was managing after the first presumptive inmate infection there was detected on March 26. I was well-received by staff and was impressed by the Warden's leadership. The resolve and dedication of front-line essential staff who literally put their lives on the line to serve is deeply commendable. At this facility, 150 of 200 of front-line Correctional Officers were sent home for 14 days by local public health authorities in an effort to contain the spread of the contagion.

More than 30 staff have been infected. Eight Correctional Officers from three different Quebec institutions were called in to assist as an emergency measure. Though still severely under-resourced, remaining staff have stepped up to provide essential services; some have volunteered to help out in the kitchen. The local community has also responded by donating much-needed sanitizing equipment. The solidarity and coming together of a tight-knit community in a time of need were genuinely heartening to witness.

Through these extraordinary circumstances, some general best practices have emerged, first and foremost among them include daily and frequent checks by registered health care staff. To CSC's credit, mitigating measures have been introduced at all prisons, including extension of phone and video-visitation privileges, increased access to canteen and snacks, and, in some institutions, provision of televisions and/or radios for inmates that lack them in their cells. Inmate pay has also been restored to pre-COVID levels, in line with interventions I have made to the Commissioner and Minister of Public Safety. It is a sign of the times that some prison industries are retooling to fabricate protective facial coverings. These measures recognize the extraordinary circumstances, but also the resiliency and adaptability of staff and inmates alike living or working under the constant threat of contracting a potentially deadly disease.

Concluding Observations and Recommendations

I would offer three concluding observations and two recommendations based on my recent institutional visit, which are confirmed by findings across a number of sites. First, it is not clear that CSC was resourced or fully prepared to deal with this pandemic when it eventually and predictability was introduced from the outside. Though CSC prepares for seasonal influenza each year, with all respect COVID-19 does not behave like a normal virus. At Port Cartier, prior to March 26th, there was just one registered nurse, one part-time physician and one psychologist on staff to care for 175 inmates, many of whom have underlying mental and/or chronic physical health conditions. Following the outbreak, two nurses were subsequently deployed to fill existing vacancies, but the capacity and contingencies to manage what had become a full blown health crisis were, by this time, quickly overwhelmed. This is also the experience at other penitentiaries that are dealing with outbreaks. There is much that we do not know about this virus, but speed and preparedness appear to be essential ingredients in containing its spread.

We knew from outbreaks in other countries that COVID-19 hits vulnerable people and closed settings hard, fast and indiscriminately.

Secondly, linked to my first observation, CSC's infection prevention and control (IPC) protocols and procedures need to be independently verified, audited, inspected and tested by outside expert bodies as a matter of emergent priority. There is an urgent requirement for an external audit of IPC procedures to be conducted, including cleaning, hygiene, staff awareness, education and training. Local and/or national public authorities need to visit, inspect and confirm that federal institutions have the capacity, resources, staffing and equipment to deal with an outbreak, when or if it occurs. Though it is encouraging that these inspections are occurring at some institutions experiencing an outbreak, it is important that IPC verification by an independent expert body is completed at all sites to provide assurance that CSC is prepared and that policy and procedure is consistent with appropriate public health guidance.

I recommend that local, provincial or national public health authorities immediately visit, inspect and verify that proper infection prevention and control procedures are in place in all federal penitentiaries in Canada.

Thirdly, it is clear that a pandemic of this nature, which has affected multiple sites at different times, cannot be managed or controlled centrally. Even through multiple outbreaks, there has been a general lack of proactive and regular information-sharing from CSC. The Service has not been as transparent or responsive through this crisis as it should be. A centralized (and often sanitized) approach to crisis communications does not serve the public interest well; indeed, top down command-and-control hierarchies can easily contradict or conflict with the direction of local public health authorities. In most cases, Wardens or their Deputies are best positioned to provide timely information and give accurate updates to concerned local communities, staff, families and other stakeholders. More than ever, this is a time to decentralize rather than control communications.

I recommend that CSC enhance its public communications during this crisis, including allowing Wardens (or their Deputies) to address the media on a regular basis to provide real-time information, updates and situation reports through the course of this pandemic.

Finally, going forward, my Office will continue to do what we do best. In a time like this it is important that the substance of our work is known and communicated widely, especially considering the lack of information released by CSC to the public so far. My office will consider conducting exceptional visits, as required and consistent with directives of local public health authorities. In due course, I expect restrictions to be gradually lifted at non-affected sites. The imposition of any new restrictions related to COVID-19 will be vigilantly monitored to ensure they have a legal basis, are necessary, proportionate, respectful of human dignity, and restricted in duration. Finally, my Office will continue to seek the advice and expertise of national public health authorities and bring forward concerns and issues as they arise.

Dr. Ivan Zinger
Correctional Investigator

April 23, 2020

This is **Exhibit "Y"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

‘Hundreds’ of inmates quietly released from federal prisons over COVID-19 fears: Blair

Lindsay Richardson (https://www.aptnnews.ca/author/lrichardson/)

Apr 20, 2020

Public Safety Minister Bill Blair says “hundreds” of federal inmates were quietly released amidst a COVID-19 outbreak in several government-run institution.

Speaking at a news briefing in Ottawa, Blair wanted to assure Canadians the government, Correctional Services Canada (CSC), and the Parole Board took “a number of very significant steps” to ensure the health and safety of the inmate populations.

"[Corrections officials] have been working hard to make sure those individuals are considered for early release, and literally hundreds of people have, in fact, been placed back into the community," he explained.

"But it's done in a very careful and supervised way because public safety is our first priority," Blair added.

For weeks, advocates called for exceptional measures – even early release for low-risk offenders – to stave off potential outbreaks in Federal institutions.

Blair said more than 600 federal inmates applied for early or exceptional release because of COVID-19.

When pressed for more information, Blair told reporters he didn't know the exact number of inmates who had applied, or had been released to date.

Nearly a quarter of the 14,000 inmates in federal custody are serving life sentences and are not eligible for parole, he said.

Blair dealt assurances that the CSC and Public Health Canada are working to take all "necessary measures" inside prisons – including provision of personal protective equipment (PPE) for Corrections officers and inmates and enforcing proper social distancing in all institutions where the virus is present.

Inmates in contact with *APTN News,* however, are reporting issues accessing regular showers, PPE, medication, and even medical attention. One inmate reported retaliation by prison guards for speaking out to media about his concerns.

Groups urged prisons to step up COVID-19 testing and sanitary measures to help prevent mass outbreaks among incarcerated populations as case loads grew at several institutions.

Once COVID-19 enters a prison, “it spreads rapidly and then it can have really dire consequences,” said Emilie Coyle, executive director of the Canadian Association of Elizabeth Fry Societies.

Since April 7, the number of confirmed cases at Joliette Institution for Women in Joliette, Quebec, grew from 10 to 50, the association said in a statement released Saturday.

That means about 60 per cent of prisoners at the facility, about 75 kilometres north east of Montreal, are infected, the group said, as only 80 people are incarcerated there currently. The group, which advocates for federally incarcerated women, notes the number of cases could be higher due to test result delays.

Prisons are a place that can’t contain the pandemic, said Coyle, as prisoners can’t physically distance themselves from others, they receive poor health care and the facilities are not clean.

“There have essentially been lockdowns put in place to allow people to be isolated and distanced from those who are affected,” Blair told reporters Monday.

But Corrections lawyers have also expressed concern about the negative impact of forced lockdown – in some cases, solitary confinement – on an inmate’s mental health.

Blair says officials are also looking at exceptional consideration for release for inmates with extenuating medical issues like a complex pregnancy, for example.

“We are trying to strike a balance between the importance of keeping that inmate population that can’t be released safe and healthy within the institutions, and ensuring those people who would benefit from an earlier release are given full consideration in that determination,” he added.

The Grand Valley Institution for Women in Kitchener, Ontario, has nine confirmed cases now, the group said, while the Fraser Valley Institution for Women in Abbostford, B.C., reported its first confirmed case Friday. Coyle said the Fraser Valley case is a staff member, not an inmate.

The outbreak isn't limited to women's facilities.

As of Friday, 170 inmates tested positive for COVID-19 at federal correctional institutions, according to Correctional Service Canada, out of 510 people tested. One person died and 14 have recovered.

The largest outbreak appears to be at B.C.'s Mission Medium Institution where the CSC website notes 60 positive tests. On Saturday, the province's health officer Dr. Bonnie Henry said up to 70 people, including 60 inmates, were impacted.

There are 66 correctional officers with COVID-19, according to a statement from the Union of Canadian Correctional Officers issued Saturday.

That includes 15 at Port-Cartier Institution, 34 at Joliette, four at Federal Training Center and two at Drummond Institution all in Quebec, as well as two at Ontario's Grand Valley Institution and nine at Mission Institution in B.C.

CAEFS is concerned Joliette is an example of what will happen at other institutions without immediate action.

Before the pandemic, the CAEFS offices received roughly 10 phone calls a week from inmates seeking support, said Coyle. Now, they receive dozens daily.

At Joliette, what were once called segregation units are being used to isolate ill prisoners, the group said it has been told – a measure the group calls cruel, punishing, lacking humanity and ineffective at containing the spread.

Prisoners have also told the association that in most cases only symptomatic people are tested.

It also hears concerns from the inmates' families.

"Their children are worried about them. They're worried about their children that they can't see. Their families are worried … and feel like they can't do anything about this," said Coyle.

The group called for immediate action, including the safe release of as many people as possible. That group ought to include people more vulnerable to COVID-19, including those over 50 years old, pregnant, with compromised immune systems or other factors, she said.

The group's call was echoed by the Congress of Aboriginal Peoples, saying in a statement Friday that it has been appealing for action for over a month.

It has heard inmates describe prison conditions that include failing to follow social distancing protocols and lacking sanitary products, among other troubles.

The congress reiterated its "call for immediate steps to address overcrowding and unsanitary conditions in federal prisons, and to immediately release low-risk and non-violent offenders, those close to the end of sentences and those with serious chronic health conditions."

Also Friday, a coalition of rights groups in B.C. called for immediate release of as many inmates as possible following the death of a Mission Institution prisoner this week.

Coyle remains hopeful about a possible release of prisoners.

'"We can't give up hope that there will be a response to our call," she said.

“I’m hopeful that people will see the people who are in prison as human beings.”

Correction: The article originally said there were 40,000 people incarcerated in Canada’s penitentiaries. That number represents the total number of people locked up in federal and provincial jails. The correct number is 14,000.

With files from The Canadian Press.

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Tags: British Columbia (https://www.aptnnews.ca/tag/british-columbia/), Correctional Service of Canada (https://www.aptnnews.ca/tag/correctional-service-of-canada/), covid-19 (https://www.aptnnews.ca/tag/covid-19/), Featured (https://www.aptnnews.ca/tag/featured/), National (https://www.aptnnews.ca/tag/national/), Ontario (https://www.aptnnews.ca/tag/ontario/), pandemic (https://www.aptnnews.ca/tag/pandemic/), penitentiaries (https://www.aptnnews.ca/tag/penitentiaries/), Prison (https://www.aptnnews.ca/tag/prison/), Public Safety Minister Bill Blair (https://www.aptnnews.ca/tag/public-safety-minister-bill-blair/)

Honour song for the dead: Mi’kma’ki mourns as death toll rises in shooting spree...

(https://www.aptnnews.ca/national-news/honour-song-for-the-dead-mikmaki-mourns-as-death-toll-rises-in-shooting-sprees-aftermath/)

Men’s healing group in Saskatchewan finds a

(https://www.aptnnews.ca/national-news/mens-healing-group-in-saskatchewan-finds-a-different-way-to-help-during-pandemic/)

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This is **Exhibit "Z"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

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A Commissioner, etc

Weekly Population Trends
2020-01-05 to 2020-04-26

The purpose of this report is to examine whether the Covid-19 pandemic is having an influence on CSC's federal offender populations. The offender counts are examined in light of the admissions and releases that have occurred during the same time periods. This report examines the following population groups --- all offenders, FSW, Indigenous, Caucasian and black.

The following population tables were derived from the CRS-M Offender Profile --- In Custody and Community data cubes. The inmate and supervised counts were taken for each week from January 5, 2020 to April 26, 2020, a total of 17 weeks. The admission and release data were extracted from the data warehouse directly. All admission and release information has been aggregated by week for the seven days prior to the snapshot dates. For instance, admissions and releases have been aggregated from December 29 to January 5 for the January 5th snapshot date.

Summary

- The inmate population of federal offenders has declined by 338 (2.4%) since its peak 2020-03-01
- The community population has increased by 61 (0.7%) offenders since 2020-03-01
- This appears to have resulted from a significant drop in warrant of committal admissions and a smaller drop in revocations
- There has been no increase in overall releases although day paroles have increased in the last two weeks

- The FSW inmate population has declined by 30 (4.5%) from its peak of 696 on 2020-03-29
- The supervised FSW population has increased by 25 (3.5%) since 2020-02-16
- This appears to have resulted from a drop in warrant of committal and revocation admissions and an increase in day parole releases

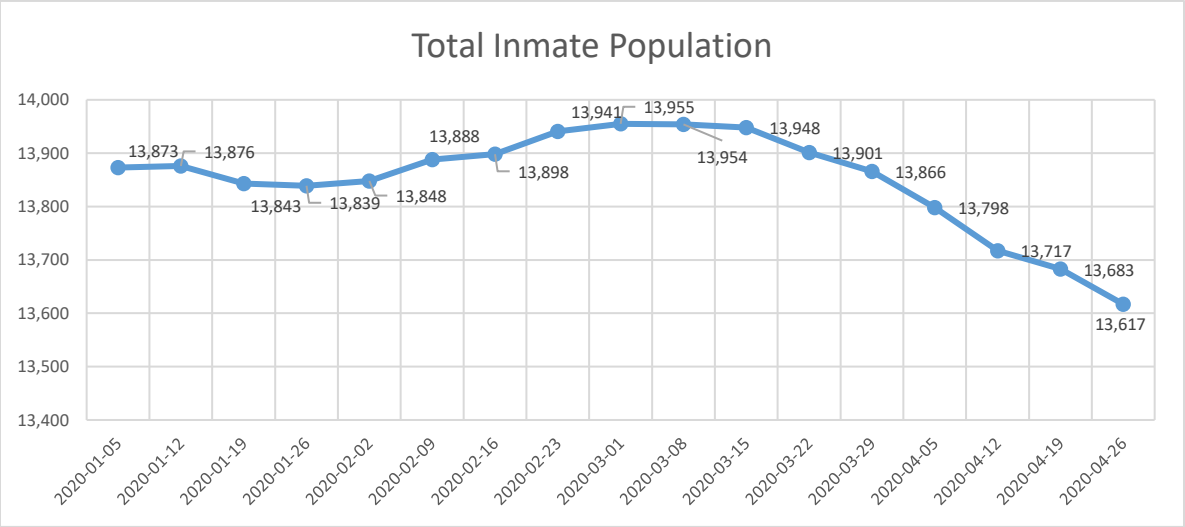
- The Indigenous inmate population has declined by 94 (2.2%) since 2020-03-08
- The Indigenous supervised population has increased by 54 (3.0%) since 2020-03-01
- This appears to have resulted from a drop in warrant of committal and revocation admissions

- The population of Caucasian inmates has declined by 206 (3.0%) since 2020-03-08
- The supervised population of Caucasian offenders has increased by 10 (0.2%) since 2020-03-29
- The decrease in population has resulted from a significant drop in warrant of committal and revocation admissions

- The population of black inmates has declined by 39 (2.9%) since 2020-03-15
- The supervised population of black offenders has increased by 37 (5.2%) since 2020-02-02
- The decrease in population has resulted from a significant drop in warrant of committal admissions

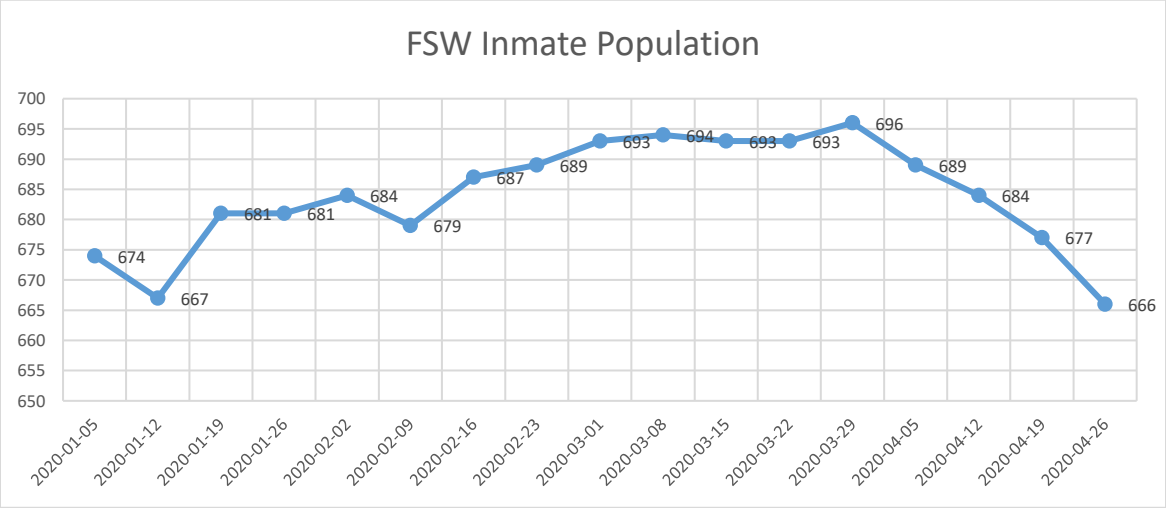
Section 1 – Inmate Population Trends

Graph 1: Total Inmate Population by Week



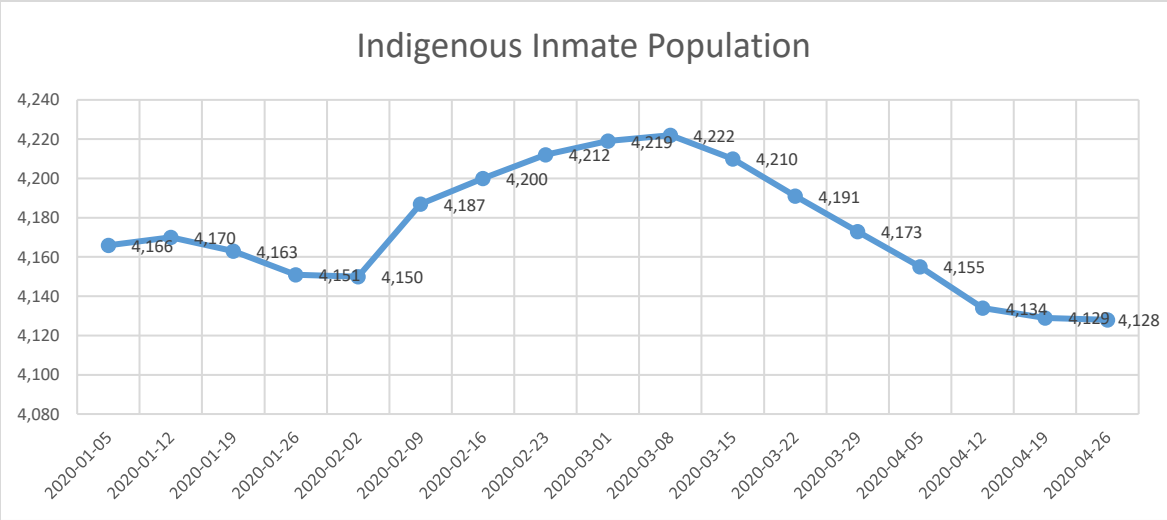
- The inmate population began to decline on 2020-03-01
- The inmate population has declined by 338 (2.4%) from its peak on 2020-03-08.

Graph 2: FSW Inmate Population by Week



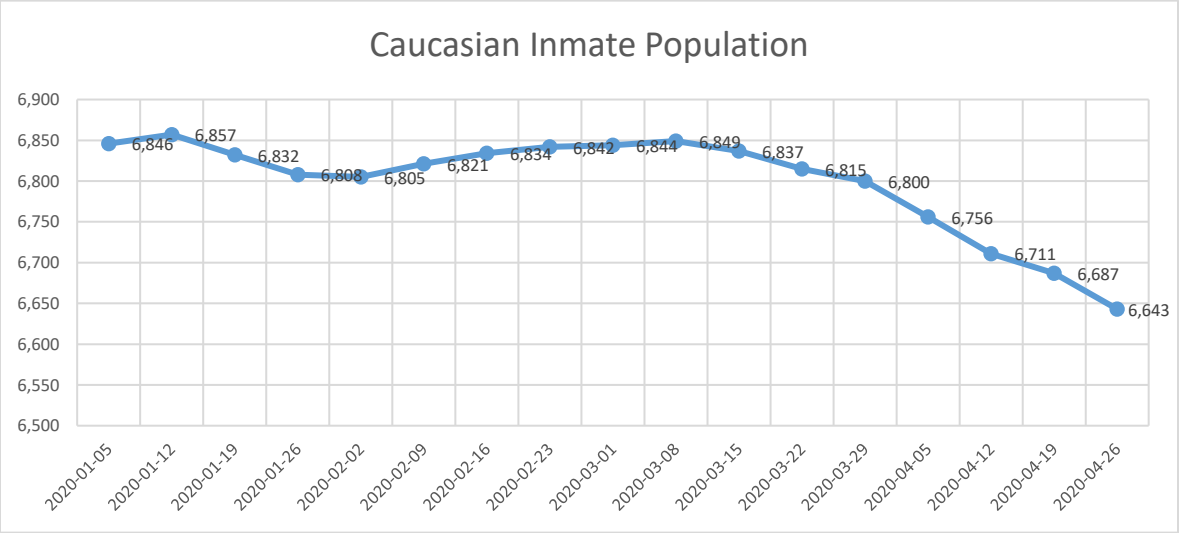
- The FSW inmate population has declined by 30 (4.5%) from its peak of 696 on 2020-03-29

Graph 3: Indigenous Inmate Population by Week



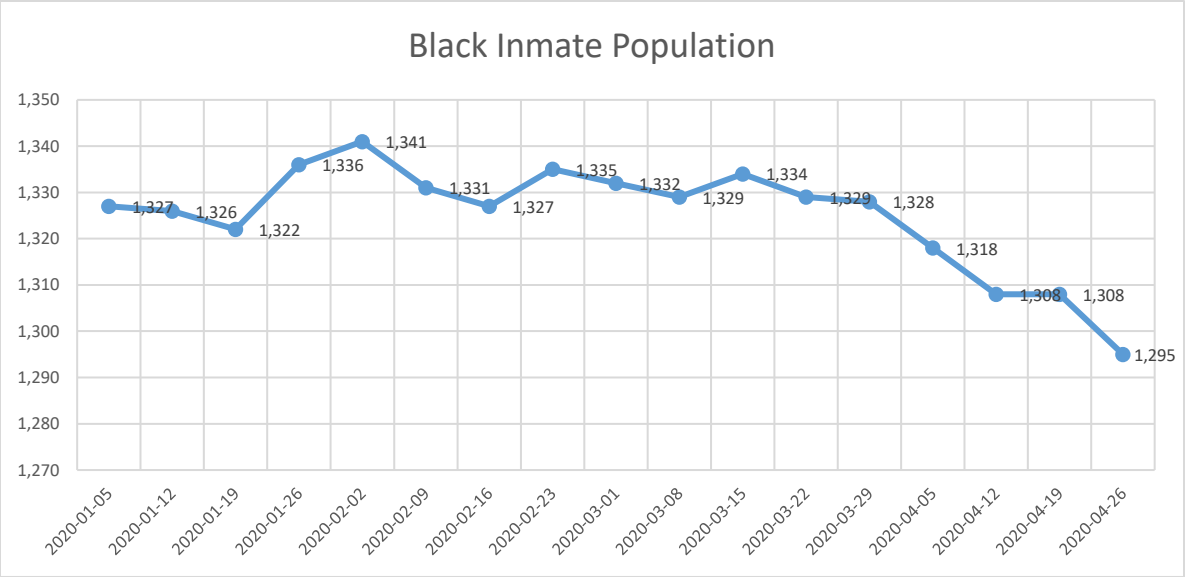
- The Indigenous inmate population has declined by 94 (2.2%) since 2020-03-08

Graph 4: Caucasian Inmate Population by Week



- The population of Caucasian inmates has declined by 206 (3.0%) since 2020-03-08

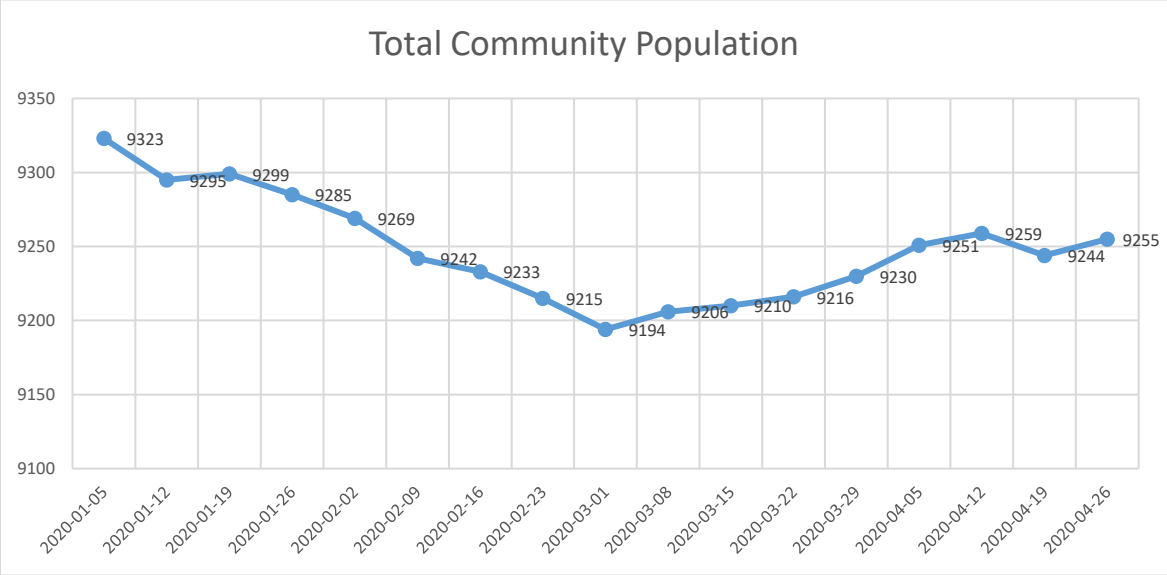
Graph 5: Black Inmate Population by Week



- The population of black inmates has declined by 39 (2.9%) since 2020-03-15

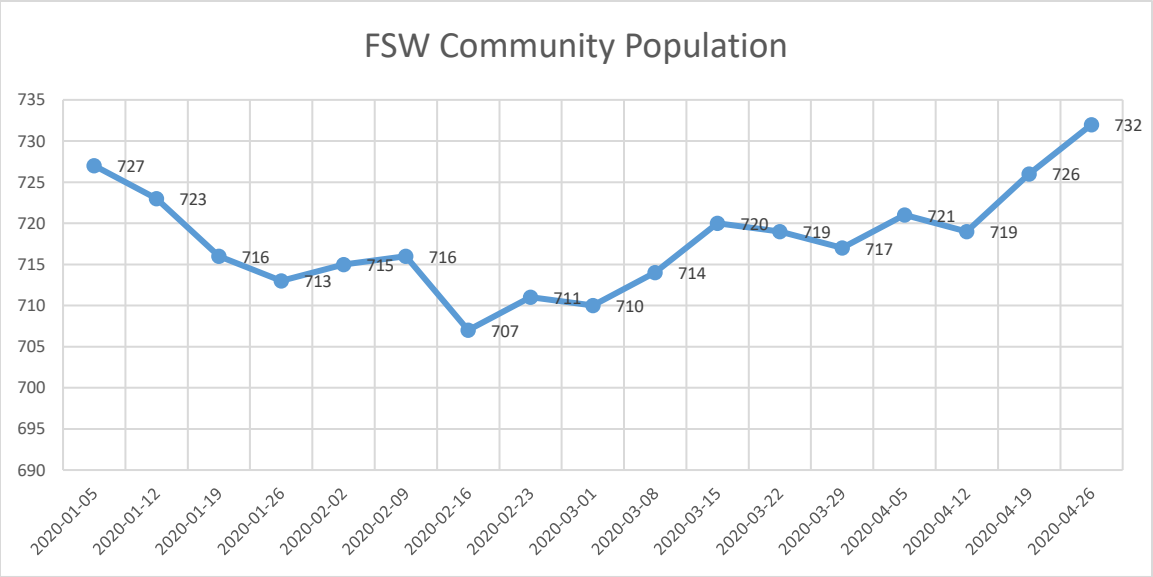
Section 2 – Community Population Trends

Graph 6: Total Supervised Federal Population by Week



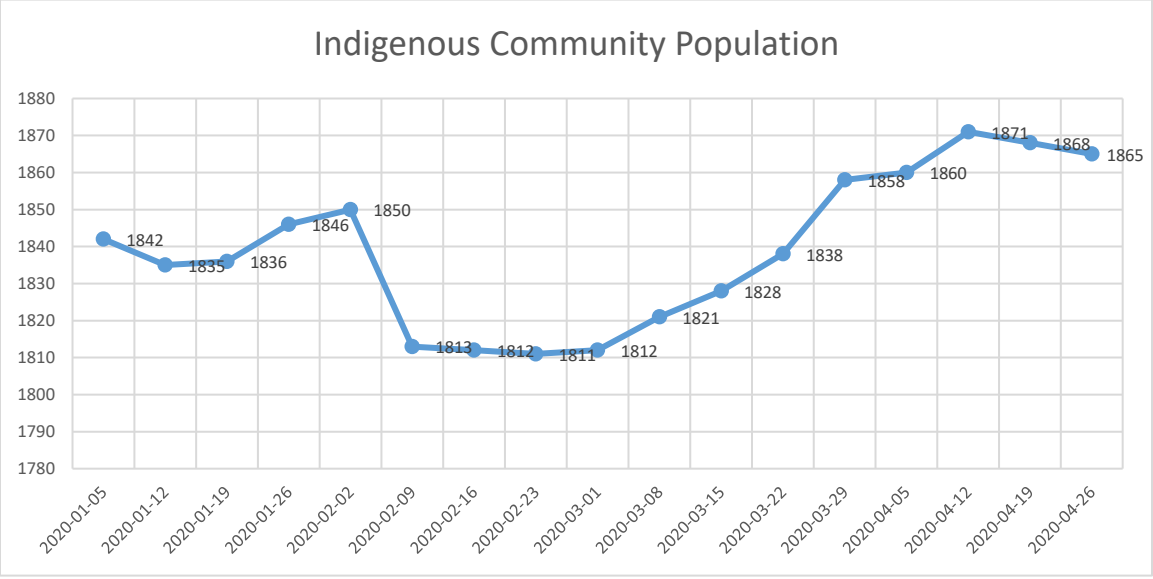
- The supervised population of federal offenders has increased by 61 (0.7%) since 2020-03-01

Graph 7: Total FSW Population by Week



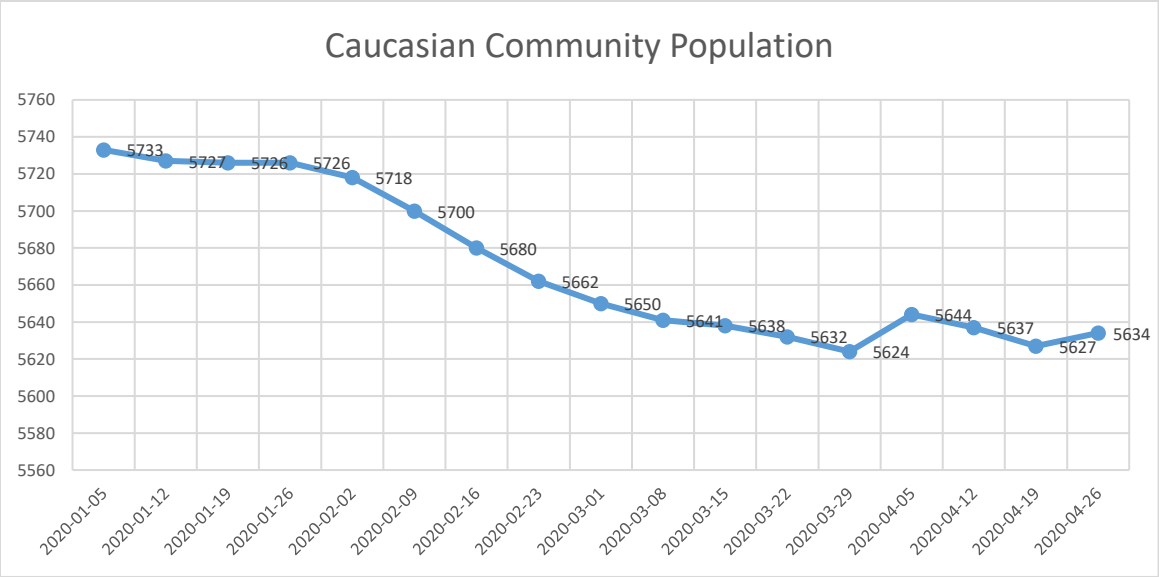
- The supervised FSW population has increased by 25 (3.5%) since 2020-02-16

Graph 8: Indigenous Supervised Federal Population by Week



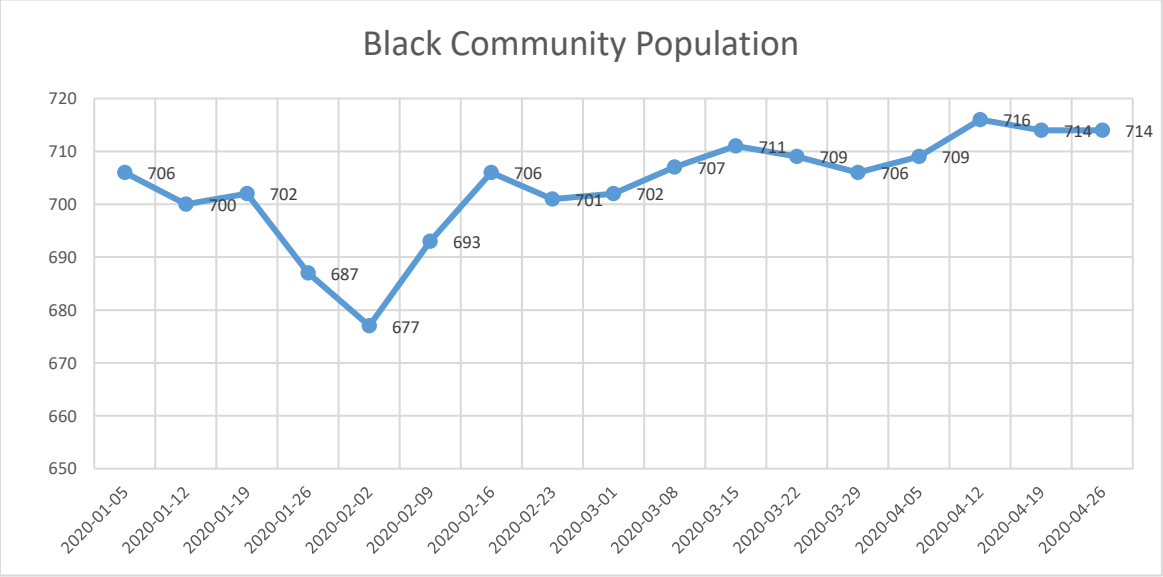
- The Indigenous supervised population has increased by 54 (3.0%) since 2020-03-01

Graph 9: Caucasian Supervised Federal Population by Week



- The supervised population of Caucasian offenders has increased by 10 (0.2%) since 2020-03-29

Graph 10: Black Supervised Federal Population by Week

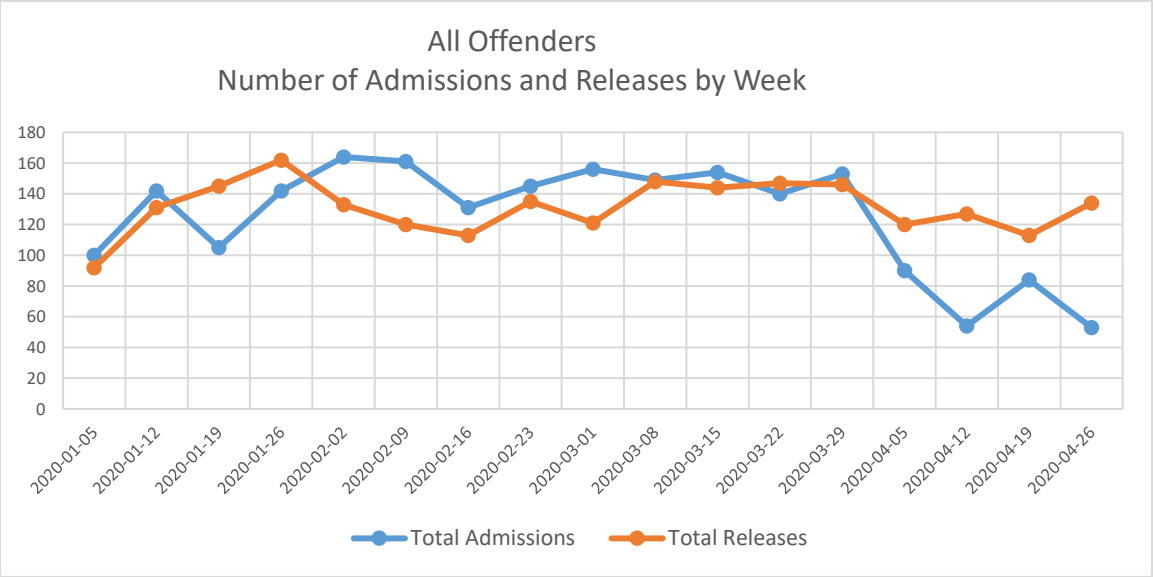


- The supervised population of black offenders has increased by 37 (5.2%) since 2020-02-02

Section 3 – Admission and Release Trends

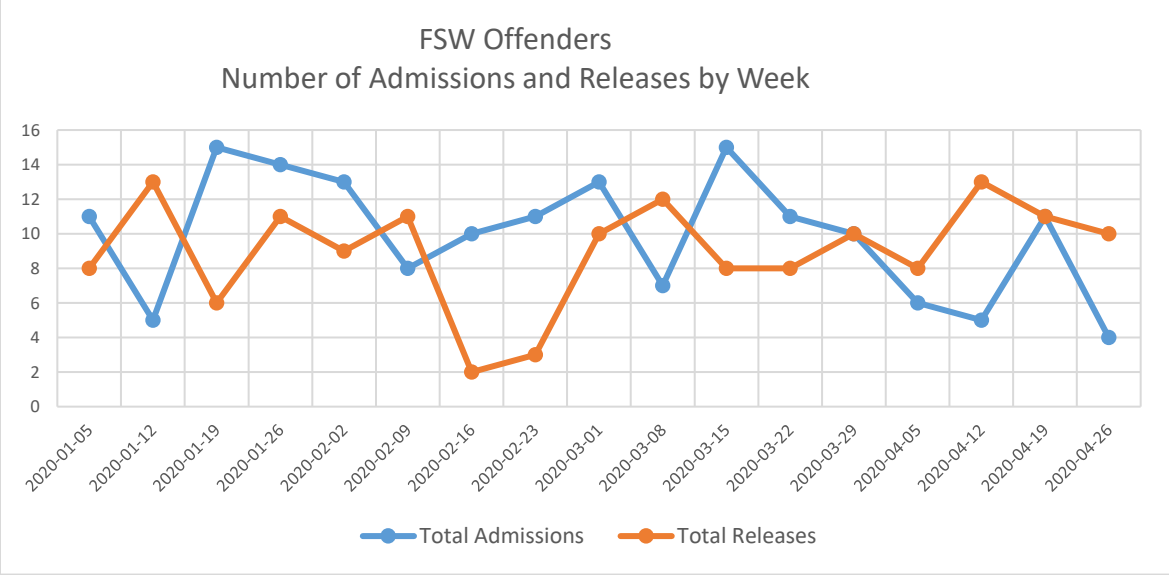
This section compares all admissions and releases for federal offenders by week.

Graph 11: Admissions and Releases by Week – All Offenders



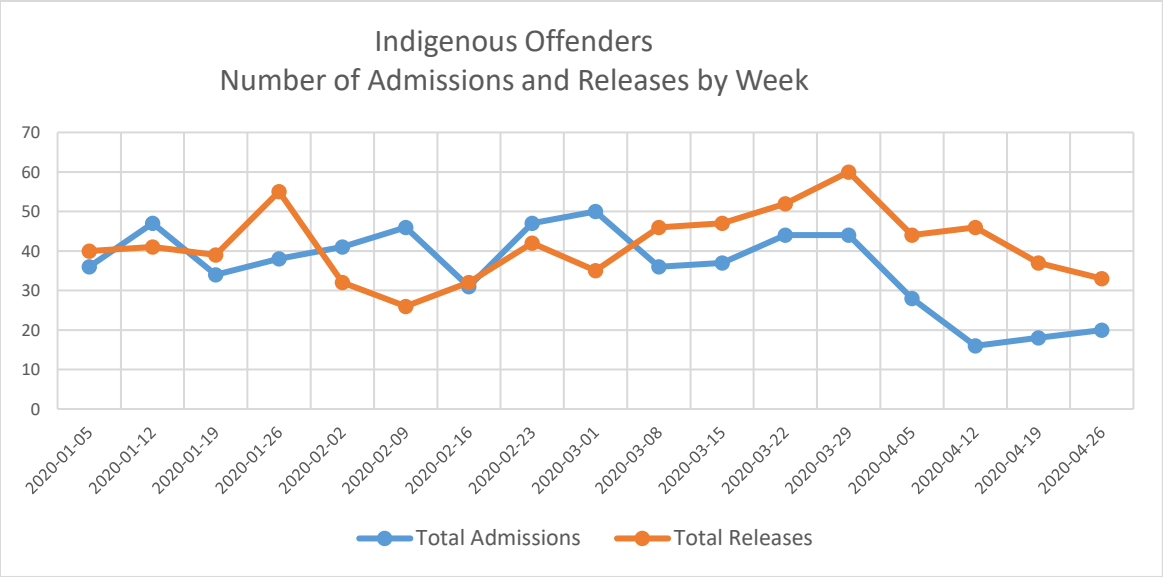
- Since 2020-03-29 the number of admissions per week has declined by 50% or more.

Graph 12: Admissions and Releases by Week – FSW



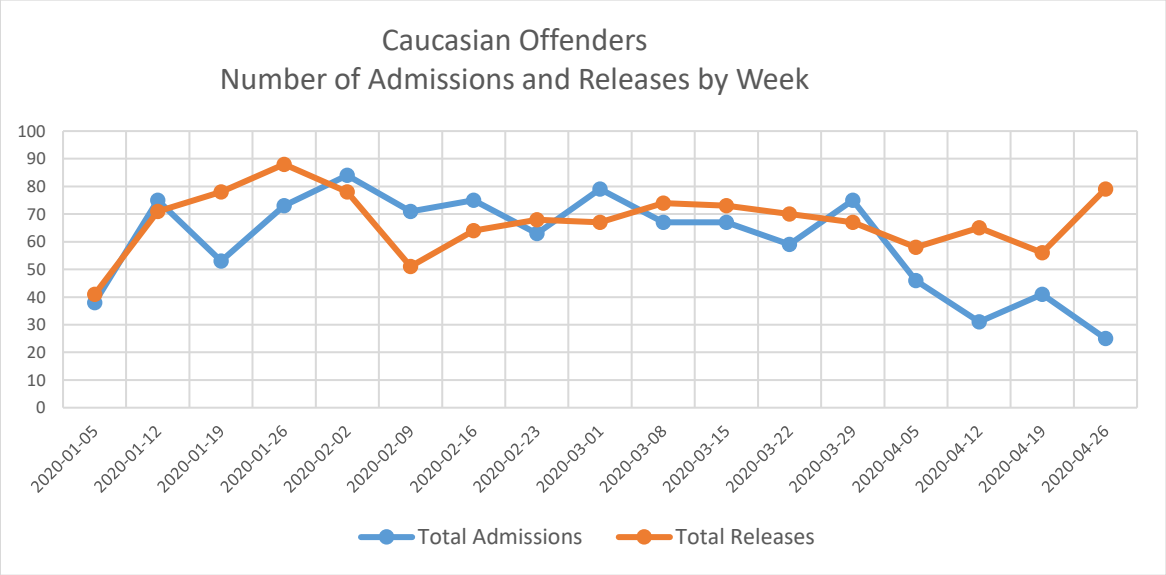
- The trends for this group fluctuate due to the small population.

Graph 13: Admissions and Releases by Week – Indigenous Offenders



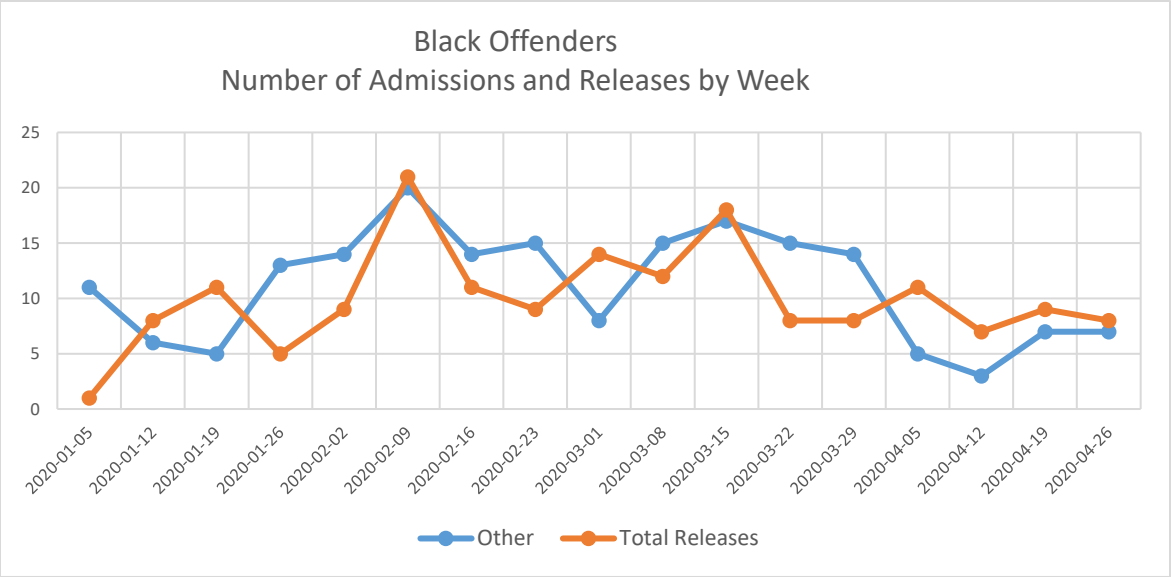
- The number of admissions for this group has declined since 2020-03-29

Graph 14: Admissions and Releases by Week – Caucasian Offenders



- The admissions for this group declined from a high of 75 a week on 2020-03-29 to a low of 25 a week 2020-04-26

Graph 15: Admissions and Releases by Week – Black Offenders



- Admissions for this group began to decline after 2020-03-15

Section 4 – Detailed Admission and Release Trend Tables

This section provides the detailed admission and release types.

Table 1: All Offenders

Week Ending	Warrant of Commit	Revoked	Other	Total Admits
2020-01-05	67	32	1	**100**
2020-01-12	94	45	3	**142**
2020-01-19	76	29		**105**
2020-01-26	83	58	1	**142**
2020-02-02	117	42	5	**164**
2020-02-09	114	45	2	**161**
2020-02-16	101	29	1	**131**
2020-02-23	108	36	1	**145**
2020-03-01	104	52		**156**
2020-03-08	112	36	1	**149**
2020-03-15	106	48		**154**
2020-03-22	81	58	1	**140**
2020-03-29	73	80		**153**
2020-04-05	34	54	2	**90**
2020-04-12	24	29	1	**54**
2020-04-19	51	33		**84**
2020-04-26	29	24		**53**
Total	**1374**	**730**	**19**	**2123**

Week Ending	Day Parole	Full Parole	Stat Release	LTSO	Other	Total Release
2020-01-05	11	3	74	2	2	**92**
2020-01-12	50	1	78		2	**131**
2020-01-19	47	6	83	5	4	**145**
2020-01-26	59	6	86	1	10	**162**
2020-02-02	49	9	67	3	5	**133**
2020-02-09	51	3	60	1	5	**120**
2020-02-16	42	4	66	1		**113**
2020-02-23	43	4	85	1	2	**135**
2020-03-01	32	4	80	2	3	**121**
2020-03-08	67	1	76		4	**148**
2020-03-15	49	4	85		6	**144**
2020-03-22	46	5	89	1	6	**147**
2020-03-29	30	1	108	2	5	**146**
2020-04-05	34	4	75	2	5	**120**
2020-04-12	28	3	90	1	5	**127**
2020-04-19	42	3	63		5	**113**
2020-04-26	67	4	60		3	**134**
Total	**747**	**65**	**1325**	**22**	**72**	**2231**

- Warrant of committal admissions have declined significantly since 2020-03-15
- Releases have not shown a definite upward trend although day paroles did increase in the last two weeks

Table 2: FSW Offenders

Week Ending	Warrant of Commit	Revoked	Other	Total Admits
2020-01-05	7	4		**11**
2020-01-12	1	4		**5**
2020-01-19	13	2		**15**
2020-01-26	9	5		**14**
2020-02-02	12	1		**13**
2020-02-09	3	4	1	**8**
2020-02-16	9	1		**10**
2020-02-23	7	4		**11**
2020-03-01	7	6		**13**
2020-03-08	6	1		**7**
2020-03-15	9	6		**15**
2020-03-22	6	5		**11**
2020-03-29	7	3		**10**
2020-04-05		5	1	**6**
2020-04-12	4	1		**5**
2020-04-19	9	2		**11**
2020-04-26	3	1		**4**
Total	**112**	**55**	**2**	**169**

Week Ending	Day Parole	Full Parole	Stat Release	LTSO	Other	Total Release
2020-01-05	3		5			**8**
2020-01-12	9		4			**13**
2020-01-19	3		2	1		**6**
2020-01-26	5		5		1	**11**
2020-02-02	5	1	3			**9**
2020-02-09	8		3			**11**
2020-02-16	2					**2**
2020-02-23	1		2			**3**
2020-03-01	6		4			**10**
2020-03-08	8		3		1	**12**
2020-03-15	2		6			**8**
2020-03-22	5		3			**8**
2020-03-29	4		6			**10**
2020-04-05	3		5			**8**
2020-04-12	6	1	6			**13**
2020-04-19	9		2			**11**
2020-04-26	9		1			**10**
Total	**88**	**2**	**60**	**1**	**2**	**153**

- No clear trends have emerged for this group to this point in time

Table 3: Indigenous Offenders

Week Ending	Warrant of Commit	Revoked	Other	Total Admits
2020-01-05	21	15		36
2020-01-12	27	20		47
2020-01-19	21	13		34
2020-01-26	15	23		38
2020-02-02	27	12	2	41
2020-02-09	27	19		46
2020-02-16	21	10		31
2020-02-23	34	13		47
2020-03-01	31	19		50
2020-03-08	27	9		36
2020-03-15	16	21		37
2020-03-22	21	23		44
2020-03-29	15	29		44
2020-04-05	7	21		28
2020-04-12	9	7		16
2020-04-19	8	10		18
2020-04-26	9	11		20
Total	336	275	2	613

Week Ending	Day Parole	Full Parole	Stat Release	LTSO	Other	Total Release
2020-01-05	7		31	1	1	40
2020-01-12	11		30			41
2020-01-19	9	1	24	3	2	39
2020-01-26	13	1	36	1	4	55
2020-02-02	12		19	1		32
2020-02-09	4	1	18		3	26
2020-02-16	6		25	1		32
2020-02-23	8	1	32		1	42
2020-03-01	5		29		1	35
2020-03-08	19		26		1	46
2020-03-15	8	3	35		1	47
2020-03-22	7	1	41		3	52
2020-03-29	10		47	1	2	60
2020-04-05	4	2	33	2	3	44
2020-04-12	7		38		1	46
2020-04-19	8	1	26		2	37
2020-04-26	14		18		1	33
Total	152	11	508	10	26	707

- Warrant of committal admissions have declined significantly since 2020-03-22

Table 4: Caucasian Offenders

Week Ending	Warrant of Commit	Revoked	Other	Total Admits
2020-01-05	22	15	1	38
2020-01-12	49	24	2	75
2020-01-19	40	13		53
2020-01-26	46	26	1	73
2020-02-02	61	21	2	84
2020-02-09	52	18	1	71
2020-02-16	58	16	1	75
2020-02-23	44	18	1	63
2020-03-01	46	33		79
2020-03-08	47	19	1	67
2020-03-15	43	24		67
2020-03-22	32	26	1	59
2020-03-29	34	41		75
2020-04-05	18	26	2	46
2020-04-12	11	19	1	31
2020-04-19	24	17		41
2020-04-26	17	8		25
Total	644	364	14	1022

Week Ending	Day Parole	Full Parole	Stat Release	LTSO	Other	Total Release
2020-01-05	3	3	34	1		41
2020-01-12	30		39		2	71
2020-01-19	28	5	44		1	78
2020-01-26	39	3	42		4	88
2020-02-02	28	7	37	2	4	78
2020-02-09	23	2	24		2	51
2020-02-16	29	3	32			64
2020-02-23	23	3	40	1	1	68
2020-03-01	21	2	42	1	1	67
2020-03-08	31	1	39		3	74
2020-03-15	29		39		5	73
2020-03-22	25	2	40	1	2	70
2020-03-29	14	1	49		3	67
2020-04-05	24	1	32		1	58
2020-04-12	17	2	42	1	3	65
2020-04-19	29	1	24		2	56
2020-04-26	35	4	38		2	79
Total	428	40	637	7	36	1148

- Warrant of committal admissions have declined significantly since 2020-03-29
- Revocations have declined since 2020-04-05
- Day parole releases have increased in the last two weeks

Table 4: Black Offenders

Week Ending	Warrant of Commit	Revoked	Other	Total Admits
2020-01-05	10	1	11	**22**
2020-01-12	5	1	6	**12**
2020-01-19	4	1	5	**10**
2020-01-26	7	6	13	**26**
2020-02-02	9	5	14	**28**
2020-02-09	16	4	20	**40**
2020-02-16	12	2	14	**28**
2020-02-23	13	2	15	**30**
2020-03-01	8		8	**16**
2020-03-08	12	3	15	**30**
2020-03-15	16	1	17	**34**
2020-03-22	10	5	15	**30**
2020-03-29	10	4	14	**28**
2020-04-05		5	5	**10**
2020-04-12	1	2	3	**6**
2020-04-19	7		7	**14**
2020-04-26	2	5	7	**14**
Total	**142**	**47**	**189**	**378**

Week Ending	Day Parole	Full Parole	Stat Release	LTSO	Other	Total Release
2020-01-05					1	**1**
2020-01-12	4		4			**8**
2020-01-19	2		8	1		**11**
2020-01-26			5			**5**
2020-02-02	1	1	7			**9**
2020-02-09	9		11	1		**21**
2020-02-16	3		8			**11**
2020-02-23	3		6			**9**
2020-03-01	4	1	8		1	**14**
2020-03-08	6		6			**12**
2020-03-15	9	1	8			**18**
2020-03-22	3	1	4			**8**
2020-03-29	1		7			**8**
2020-04-05	4		7			**11**
2020-04-12	2		5			**7**
2020-04-19	2		6		1	**9**
2020-04-26	7		1			**8**
Total	**60**	**4**	**101**	**2**	**3**	**170**

- No clear trends have emerged for this group to this point in time

This is **Exhibit "AA"** referred to in the
Affidavit of Howard Sapers
affirmed before me this 19th day of June, 2020

_____

A Commissioner, etc

CORRECTIONAL SERVICE CANADA

CHANGING LIVES. PROTECTING CANADIANS.

QUICK FACTS

CSC statistics – key facts and figures

Expenditures

In 2017-18, Correctional Service Canada's (CSC) expenditures totaled approximately $3.4 billion.

Staff

CSC has approximately 18,000 employees, including:

- 6,149 Correctional Officers
- 464 Correctional Program Officers
- 1,268 Parole Officers
- 465 Primary Workers
- 155 Aboriginal Liaison Officers
- 230 Social Program Officers
- 865 Nurses
- 252 Psychology Staff

Facilities

CSC manages and maintains:

- 43 institutions
- 11 Clustered Institutions
  - 2 maximum/medium/minimum security level
  - 9 medium/minimum security level
- 6 maximum security institutions
- 9 medium security institutions
- 5 minimum security institutions (including 2 healing lodges)
- 12 multi-level security institutions (including 2 healing lodges and six women's institutions)
- 91 parole offices
- 14 Community Correctional Centres
- 200+ Community Residential Facilities

Canadian average annual cost of an offender

It costs an average of $115,000 to maintain an offender in a CSC institution and almost $35,000 to maintain an offender in the community.

Offender profile

On a typical day in 2017-18, CSC was responsible for an average of 23,060 offenders – 14,015 in federal custody (including temporary detainees) and 9,045 supervised in the community.

Of these offenders, approximately:

- 20% were serving sentences for homicide
- 49% were serving sentences for sexual offences and other violent crimes
- 18% were serving sentences for drug-related offences

At the end of the fiscal year 2017-18:

- 24% of offenders were serving life sentences
- Approximately 40% of offenders were serving a sentence of less than four years
- 810 offenders were classified as Dangerous Offenders

Measuring performance

There has been a steady decline in the incarcerated offender population, from over 15,000 in 2012-13 to just over 14,000 in 2017-18, and a continuous increase in the number of offenders managed in the community, from approximately 7,700 in 2012-13 to over 9,000 in 2017-18.

In 2017-18, we saw the highest number of day paroles reported since 2012-13, including for Indigenous offenders and women offenders.

Offenders are being released earlier in their sentences. Women offenders especially have seen a significant decrease in terms of median percentage of sentence served before release, from about 50 percent in 2012-13 to almost 33 percent in 2017-18.

For more information

More information about CSC is available at www.csc-scc.gc.ca.

Updated October 2018

Court File No. T-539-20

FEDERAL COURT

BETWEEN:

**CANADIAN CIVIL LIBERTIES ASSOCIATION,
CANADIAN PRISON LAW ASSOCIATION
HIV & AIDS LEGAL CLINIC ONTARIO,
HIV LEGAL NETWORK,
& SEAN JOHNSTON**

Applicants

– and –

THE ATTORNEY GENERAL OF CANADA

Respondent

CERTIFICATE CONCERNING CODE OF CONDUCT FOR EXPERT WITNESSES

I, **Howard Sapers**, having been named as an expert witness by the Applicants, certify that I have read the Code of Conduct for Expert Witneses set out in the schedule to the *Federal Courts Rules* and agree to be bound by it.

July 10, 2020

Howard Sapers
323 Summit Avenue
Ottawa, Ontario K1H 5Z7
6130731-5652
Howard.Sapers@gmail.com

Court File No. T-539-20

FEDERAL COURT

BETWEEN:

**CANADIAN CIVIL LIBERTIES ASSOCIATION,
CANADIAN PRISON LAW ASSOCIATION,
HIV & AIDS LEGAL CLINIC ONTARIO,
HIV LEGAL NETWORK,
& SEAN JOHNSTON**

Applicants

– and –

THE ATTORNEY GENERAL OF CANADA

Respondent

**APPLICATION RECORD
VOLUME 4 OF 5**

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