CCRA 5 YEAR REVIEW

HEALTH SERVICES

February 1998

Ce rapport est disponible en français

This report is part of a series of 24 research/evaluation reports (listed below) that were prepared as background to the Consolidated Report of the Working Group studying the provisions and operations of the Corrections and Conditional Release Act and related Consultation Paper.

The Working Group is composed of representatives from the following agencies:

Correctional Service Canada
National Parole Board
Correctional Investigator
Justice
Department of the Solicitor General

Research/Evaluation Reports:

Information about Offenders
Security Classification of Inmates
Judicial Determination
The Temporary Absence Program: A Descriptive Analysis
Personal Development Temporary Absences
Work Release Program: How it is used and for what purposes
Day Parole: effects of the CCRA (1992)
Case Management: Preparation for Release and Day Parole Outcome
Accelerated Parole Review
Statutory Release and Detention Provisions
Community Supervision Provisions
Provisions Relating to Victims
Observers at National Parole Board Hearings
The National Parole Board Registry of Decisions
CSC Human Resources
Administrative Segregation
Search, Seizure and Inmate Discipline
Offender Grievance System
Urinalysis Testing Program
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Aboriginal Offenders
Health Services
Women Offenders

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CCRA REFERENCE:

Sections 85 to 89

These Sections of the Act deal with definitions of health care. "Health Care", according to the Act means medical, dental and mental health care provided by registered health care professionals.

The CCRA defines "mental health care" as the means of care of a disorder of thought, mood, perception, orientation or memory that significantly impairs judgement, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life.

The CCRA requires that the Correctional Service of Canada (CSC) shall provide every inmate with essential health care and reasonable access to non essential mental health care that will contribute to the inmate's rehabilitation and successful integration into the community.

Sections 85 - 89 of the CCRA also indicate that:

- the provision of health care shall conform to professionally accepted standards;
- at key points or events in an offenders sentence (such as decisions relating to placement, transfer, administrative segregation, disciplinary matters, release preparation and supervision) the offenders' state of health and health care needs must be taken into consideration before decisions are made;
- inmates must give voluntary and informed consent to treatment and have the right to refuse treatment;
- inmates who choose to fast, and understand the consequences of fasting, shall not be force-fed by the Service; and,
- offenders may participate in research projects, but only if they agree and if an independent committee has reviewed the case and approved the project.

Section 36(1)

This section requires that a registered health care professional visit the inmates in the administrative segregation unit at least once a day.

PERCEIVED INTENT OF THE CCRA

The CCRA requirement to deliver "essential" health services provided CSC with a focus for changing its service delivery. This requirement to deliver essential services was previously included in regulations to the Penitentiary Act. In addition to meeting the intent of the CCRA to reduce the number of regulations, including it in the body of the CCRA also focussed attention on the need for the definition of essential services. The primary health care model of health services delivery was identified as having principles consistent with the intent of the CCRA.

Primary health care is considered to be essential health care made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford. It relies on an enhanced role for the nurse in first interventions where health care is being sought. By making the nurse the first point of contact and using their assessment capabilities to determine next steps, expensive physician time is reduced. The primary health care model also involves health promotion endeavours designed to instil responsible behaviours in clients in order to improve overall health and minimize preventable illnesses.

CSC has traditionally provided health services to inmates on demand, regardless of the level of actual need. To meet the CCRA requirement the provision of health services will now respond to the needs, not the demands, of inmates. Inmates will now be expected to take responsibility for their own wellness and to take steps to avoid and prevent illness.

The mandatory registration of the professionals providing health services (sec. 85) acknowledges the standard in communities across Canada.

Section 87 which requires that an offender's state of health and health care needs be taken into consideration in all decisions affecting the offender as well as in preparation for release and supervision is new in the CCRA. The addition of this requirement to the CCRA recognizes the integral role of health service provision in the correctional environment and enshrines in legislation the prevailing practice in the CSC case management process.

PROJECT METHODOLOGY

Review the Management, Administration, and Operations Review (MAOR) Health Services Committee work plans and achievements.

Review the Policy Review Task Force report.

Review the Case Management Manual.

Review the Health Services Standards and Health Services Manual.

Review of the Commissioner's Directives relating to Health Services.

DISCUSSION OF ISSUES

The Management, Administration and Operations Review (MAOR) process within CSC was established in June 1993, in response to a federal government wide requirement to identify areas of expenditure savings. A national MAOR committee of CSC health professionals (with representation from each of the five CSC regions and National Headquarters) was established to identify cost savings in Health Services.

This committee recognized that the introduction of a new paradigm of health services delivery would provide an overall policy and program framework for effecting changes aimed at producing long term cost savings. It was felt that the CCRA, by the stipulation in Section 86 (1) that essential health care shall be provided to every inmate, was consistent with the primary health care model which has as a central principle, the provision of essential health services (i.e., those without which a healthy life is not possible) to every citizen.

The community primary health care system was originally described at the World Health Assembly in Alma Ata, USSR in 1978. In this model the primary responsibility for health status rests with the individual. For CSC, inmates are primarily responsible for taking care of themselves and are expected to contribute to their own wellness by making informed health choices. CSC provides the health care that an inmate **needs** (essential health care), which may be quite different than what an inmate **wants**. The need is determined through a clinical assessment performed by a nurse. Nurses are also actively engaged in health promotion so that inmates have the information they need to make good choices.

The MAOR Health Services Committee initiated a number of activities that were primarily designed to achieve cost savings. The first task was to revise the existing policy documentation to reflect the primary health care paradigm and provide the policy support for subsequent operational changes. The national MAOR Health Services committee identified a number of change initiatives designed to make the delivery of CSC health services more consistent with community primary health care paradigm as well as achieve the cost savings targets. The initiatives included elimination of nurse staffing of midnight shifts, introduction of inmate screening by nurses before a visit to the physician, introduction of over-the-counter medications for purchase by inmates in the inmate canteen, rationalization of professional services (e.g., dentist and physician), clustering of service provision such as a regional pharmacy. It is estimated that savings of approximately $3 million (roughly 4% of the total Health Services budget) were realized through the introduction of the various MAOR initiatives.

The rationalization of professional services resulted in more effective use of highly skilled health professionals. Under review it became evident that a substantial amount of the work performed by dentists under contract to CSC was work that, in the outside environment (i.e., in the dentist's office in the community) is performed by a dental hygienist. Rationalization of these services ensured that the appropriate professional is hired to conduct the required work.

The introduction of over-the-counter medications into the inmate canteen has had a two-fold effect. A cost savings has been realized since these medications were previously prescribed by the physician, which entailed the physician's time for the consultation, pharmacy dispensing fees and, nurse's time to deliver the medications. Very modest prices for these products have been secured through negotiations with suppliers in order to alleviate potential financial burden on inmates. The availability of these products also highlights for inmates that they are expected to take a more active role in making choices to maintain their health status.

The introduction of regional pharmacies has resulted in cost savings associated with central dispensing of pharmaceuticals and negotiation of more favourable pricing through bulk purchasing. The establishment of regional pharmacies also provides more ready access to up-to-date management information for monitoring the usage of pharmaceutical products (e.g., prescribing patterns, usage of certain categories of drugs such as psychotropics) and in general provides better opportunity to monitor adherence to the drug formularies.

The elimination of the night nursing shift was implemented only in institutions where the response time to outside emergency services was similar to that for the external community. The night shift was retained in CSC institutions in remote locations. The elimination of this shift has resulted in substantial cost savings and there has been no indication of a degradation in care to the inmates.

The success of the MAOR Health Services committee in identifying, initiating and monitoring fundamental changes demonstrated the importance of strong leadership in the change process. The use of a group of staff and managers from the functional area (health services) to provide leadership was an innovative approach. It provided a sense of ownership since the changes were proposed and managed from within the health services community, not imposed from an external source. In October 1996 the Senior Deputy Commissioner approved the formation of a National Health Services Council to ensure that leadership for the delivery of health services within CSC would continue to be provided at a national level.

To address the three issues identified in the project plan the first steps were to review Health Services policy documents (Commissioner's Directives, Health Services Manual, Standards for Health Services) and the Case Management Manual (CMM). From this review, questions would be developed for a survey of Health Services staff and a review of files. A number of issues were identified in this review that had a direct bearing on the usefulness of conducting a survey of staff or file reviews. As a result the survey of staff was not conducted.

The first issue identified in the project plan is "How is essential health care determined and delivered to inmates?". The CCRA stipulates in Section 86 that CSC "shall provide every inmate with essential health care". Essential health care is defined in Commissioner's Directive (CD) 800 (Health Services). In terms of medical care the definition states that essential services shall include emergency care (i.e., delay of service will endanger the life of the inmate) and urgent care (i.e., the condition is likely to deteriorate to an emergency or affect the inmate's ability to carry on the activities of every day living).

This definition is reiterated in the Standards for Health Services and the Health Services Manual. There are no further criteria provided in these documents which would provide guidelines for front line Health Services staff to operationalize the delivery of the essential services as defined.

The examination of the second issue relating to the delivery of health services to inmates by qualified professionals was not addressed since information was to be gathered from the survey of staff.

The third issue identified in the project plan addressed the extent to which the offender's state of health and health care needs are taken into consideration in decisions affecting the offender and in the preparation for release and supervision of the offender (Section 87 of the CCRA). Once again, the CSC Health Services policy documents were reviewed. In addition the Case Management Manual (CMM) was also reviewed since it is the primary document providing procedures and guidance to the case management officers. It provides detailed guidelines on the information to be considered and the format for reports to be used for recording this information for the decision making process.

The Health Services Manual outlines the requirement of Section 87 that any person preparing documentation for a decision must include a discussion of the offender's state of health and health care needs. The CCRA provides examples, but not an exhaustive list of the decisions for which the offender's state of health and health needs shall be considered. A complete listing of the decisions to which this section of the CCRA applies is not provided in the Health Services Manual, the Standards for Health Services or the CMM.

There is no guideline provided in these documents as to what type of information describes the state of health or health care needs of an offender. Another issue which warrants examination is whether the type of decision has a bearing on the type or amount of health information that is relevant. In addition, the issue of confidentiality of medical information and the professional requirements relating to confidentiality of patient medical information (to which health professionals are, in many cases, legally bound) is not addressed in relationship to the CCRA Section 87 requirement in the policy or procedures documents. A clear definition of both state of health and health care needs would allow CSC's health professionals to provide a consistent set of health information for use in the case management process. Offenders may lodge a complaint or file a grievance if they are not satisfied with the way they have been treated or with the way their health information has been handled. The Inmate Affairs Training Manual stipulates that complaints and grievances relating to treatment and diagnosis decisions shall be referred to the institutional Chief, Health Services (CHS) or equivalent for coding and for prioritization.

The Section 36 (1) requirement that a registered health care professional visit each inmate in administrative segregation on a daily basis was examined by the Task Force Reviewing Administrative Segregation. The Task Force found no compliance problem with Section 36 (1) but made recommendations concerning mental health issues, specifically on ways to strengthen the role of the psychologist in the administrative review process. These were made in the context of the high prevalence of severe mental disorders among segregated inmates and the potentially harmful effects associated with the segregation experience. The recommendations deal with the roles and responsibilities of psychologists in assessing the mental health of inmates in administrative segregation rather than the requirement that a health professional make a daily visit to each inmate in administrative segregation. The Task Force did not make a recommendation concerning this essential requirement.

It was concluded that since the primary documents used by staff (both Health Services and Case Management) to provide guidance on the sharing of information on the offender's state of health and health care needs do not provide detailed guidelines on some of the essential elements, a survey of staff would not be fruitful. The Management, Administration and Operations Review (MAOR) process brought several important changes to the policy structure and the delivery of Health Services within CSC. Further changes are still required in the operational guidelines and delivery structure to ensure that CCRA requirements are appropriately and adequately reflected in critical policy and procedures documentation. These documents should provide sufficient detail to allow staff to clearly understand their obligations with respect to the rule of law in this area.

CURRENT STATUS

The Director General, Health Services has initiated a comprehensive examination of the delivery of CSC health services. This will include a review of the current policy and procedure documentation and the range of activities that are delivered. The purpose of the study is to ensure that these documents adequately and appropriately reflect the legislative mandate and to ensure that staff are provided with detailed criteria to assist them in providing daily delivery of health services that are consistent not only with the legislative mandate but from region to region. This study commenced in December 1997 and the anticipated completion will be early summer 1998.

This study will provide the basis for the development of national standard practices for the various areas of health services. This standardization will provide consistency in health services delivery across regions and allow the application of a funding formula. It will also provide the standardization required to implement an automated offender health information system.