Office of the Correctional Investigator (OCI)
Initial Assessment of the Correctional Service of Canada's (CSC) Response to the OCI's *Deaths in Custody Study*, *A Preventable Death* (Report into the Death of Ashley Smith) and the CSC National Board of Investigation into the Death of an Offender at Grand Valley Institution for Women

Preface

On August 17, 2009, the Correctional Service of Canada (CSC) released its public *Response* to the Office of the Correctional Investigator's *Deaths in Custody Study* (February 2007), *A Preventable Death - Report into the Death of Ashley Smith* (June 2008) and its own National Board of Investigation into Ashley Smith's death (February 2008). CSC's *Response* can be accessed at http://www.csc-scc.gc.ca/text/pblct/rocidcs/grid2-eng.shtml. The Office of the Correctional Investigator (OCI) remains committed to assessing the Service's actions and commitments as they relate to enhanced measures to preserve life and prevent deaths in custody. We are convinced that a full public accounting of the Service's *Response* is both a necessary and compelling matter of public interest.

The document that follows represents the OCI's Initial Assessment of CSC's *Response*; subsequent progress assessments will be issued on a quarterly basis beginning in December 2009. As a point of principle, we have purposefully avoided adopting a simple "checklist" approach because we believe that it is the quality and not quantity of commitments that ultimately will make a difference in reducing deaths in custody. There is no shortage of initiatives documented in the Service's *Response* – by our count, there are over fifty separate "key actions/commitments" detailed. In the past three years, policies have been revised and re-issued, instructions to the field clarified and circulated, new reporting and monitoring measures introduced, the "preservation of life" principle enunciated, strategies implemented, training provided, research commissioned, commitments undertaken and Action Plans distributed. We do not dispute this activity or the attention that has been given to these matters within the CSC, but we are concerned that the focus to date has largely been on process and not progress.

Indeed, we are principally concerned not with the stated commitment of the Service to prevent deaths in custody, but rather by the fact that its *Response* is not well integrated, communicated or adequately implemented across different sectors of correctional activity and intervention – security, health care, case management, programs and psychological treatment. Too often, and with sometimes tragic results, overly "security-focused" approaches have trumped clinical interventions. It is our opinion that unnecessarily punitive and potentially harmful practices, including segregation, isolation, use of restraints and the withholding or withdrawing treatment as a consequence of negative behaviour, continues to be too common of an occurrence when dealing with mentally disordered offenders.

Recommendations that go to the very core of accountability and governance within federal corrections – e.g. oversight of women's corrections at the national level, external monitoring of segregation, expert chairing by an independent mental health professional of national boards of investigations involving suicides and incidents of self-injury – continue to be rejected or supported only "in part" by the Correctional Service. We also note that the Service chose not to directly include in its *Response* the recommendations made by its own Board of Investigation into the death of Ashley Smith. The OCI is aware that the Service has turned its attention to these recommendations and looks forward to reviewing actions taken within the context of our quarterly assessments. It is for this reason that this Initial Assessment incorporates the recommendations of CSC's Board of Investigation into Ashley Smith's death at Grand Valley Institution for Women.

The events, decisions, individual and systemic failures that ultimately contributed to Ashley Smith's death need to be understood and situated in a broader context, one that goes beyond a communications exercise. In our view, it is extremely important to provide the five recommendations of the independent Psychologist (Dr. Margo Rivera) who reviewed

the treatment and management of Ashley Smith during her time in federal custody. As noted in our Assessment, Dr. Rivera makes some important observations and recommendations that directly speak to issues of governance and accountability of women's corrections, as well as providing insightful and expert direction on matters of professional, clinical and ethical judgement in corrections management.

We look forward to issuing a further review of the Service's progress in December 2009, hopeful that the three substantive points outlined above and documented below will be addressed in appropriate detail - the need for an integrated response to prevent deaths in custody across all sectors of correctional intervention; deeper and more significant consideration of accountability and governance deficiencies within federal corrections; and finally, a complete and transparent response to the findings and recommendations contained in CSC's internal Board of Investigation into the death of Ashley Smith.

Office of the Correctional Investigator Recommendations	**OCI Initial Assessment of CSC's *Response***
Recommendation 1	
I recommend that all recommendations emanating from the National Board of Investigation and the Independent Psychological Report produced by Dr. Margo Rivera as part of that investigation, be implemented and applied as widely as possible including within men's facilities. *National Board of Investigation Recommendations:* 1. That the Correctional Service of Canada immediately begin the process of identifying and putting in place appropriate alternatives to long-term administrative segregation for inmates with severe mental health issues who are not certifiable under provincial mental health legislation and do not consent to treatment. It is imperative in the design/development of such alternatives that there be no contact between high profile/high risk inmates (i.e. Management Protocol offenders) and inmates who have difficulty with behavioural and emotional disregulation and therefore require this specialized type of facility. 2. That the role of the Women Offender Sector, including authorities, reporting relationships, accountabilities and responsibilities, be reviewed, revised as necessary and communicated to all parts of the Correctional Service of Canada so they are working collaboratively to effectively manage women offender issues, particularly those impacting challenging inmates such as Smith. 3. That the Women Offender Sector, in collaboration with Mental Health and in conjunction with regional management, establish an inter-disciplinary mental health team approach, involving external experts as required, to assist institutional management effectively deal	**The Office of the Correctional Investigator (OCI) purposefully chose to issue this recommendation as the first of sixteen recommendations in our report into the death of Ashley Smith (*A Preventable Death*). The Correctional Service of Canada's (CSC) National Board of Investigation, convened shortly after Ashley Smith's death on October 19, 2007 at Grand Valley Institution for Women, makes ten recommendations. The internal Board of Investigation documented numerous compliance issues and deficiencies in Ashley's care and treatment over the course of her 11.5 months in federal incarceration. It is a particularly credible and commendable investigation and its findings and recommendations reach far beyond the immediacy of the events at Grand Valley Institution.** **The CSC Board of Investigation is complemented by the expertise of Dr. Margo Rivera who was asked to complete a Psychological Review of Ashley's time in federal custody for the Board. Importantly, Dr. Rivera had full access to CSC documents, personnel, case files and interview records. Dr. Rivera made five recommendations based on her findings and observations. The Board concurred with Dr. Rivera's recommendations and included them as part of its Final Report.** **The fifteen recommendations from CSC's Board of Investigation are** **reproduced here. The OCI believes strongly that release of the Board's recommendations is an issue of public interest. For the Service, it is ultimately a matter that goes to issues of accountability, credibility and transparency.**

with each female inmate with severe mental health needs. The role of the inter-disciplinary team would be to work with each site to identify the necessary resources, develop the management and reintegration plan, ensure appropriate staff are available and trained to implement the plan and provide direction and support to the institution to ensure the quality and effectiveness of implementation. The inter-disciplinary team should have final decision making authority on all aspects of managing the case. (Please refer to a similar recommendation, listed below, from the Psychological Report appended to the Board of Investigation's report).

4. That the Correctional Service of Canada policy be introduced and/or revised to clarify that any authorized item that is used, or altered to be used, by an inmate for self-injury be considered unauthorized and be required to be removed immediately regardless of the level of assessed risk.

5. That the role of health care at women's institutions be strengthened to ensure they are an integral part of the Secure Unit team and that the Chief Health Care is involved in all decisions relating to the management and care of inmates with severe mental health needs.

6. That a more efficient use of force review process be developed for cases that generate more than a specified number of uses of force and that this process involve a joint review by institutional, regional and national representatives so immediate concerns can be identified and appropriate action taken to rectify them.

7. That the resource indicators for all disciplines at women offender facilities be reviewed and adjusted as required to ensure adequate staff coverage on all shifts. This review should give specific consideration to issues impacting safety and security (i.e. the requirement for an additional 2 person patrol team).

8. That an immediate review of the recruitment and staffing practices at Grand Valley Institution be completed, with specific emphasis on the number of approved accommodations. This will address the instability that has been a constant for several years and ensure critical vacancies are filled, overtime utilization is decreased, ordering of staff is eliminated and operational adjustments are appropriately utilized.

9. That specialized training in the area of mental health be enhanced for all staff at women institutions. Specifically, the National Training Standards for Dialectical Behaviour Therapy should be reviewed to ensure management and all staff working in women's facilities are familiar with the concepts. All frontline staff who are expected to use Dialectical Behaviour Therapy in their interactions with inmates should receive more in-depth training and more frequent refresher training. General mental health training should

The OCI notes in the Service's *Response* that rather than respond specifically and directly to each of the recommendations issued by its Board of Investigation, they are instead summarized and grouped into seven discrete categories in the *Response* grid. While this exercise may provide a gist of how the Service is responding, it lacks sufficient detail. In many instances, the *Response* falls considerably short of addressing the specific and substantive issues raised by the Board's findings and recommendations.

Often, both the CSC's Board and Dr. Rivera come to similar conclusions, particularly in recommending a review of the reporting relationships, accountabilities and responsibilities of the Women Offender Sector within federal corrections. In a similar vein, the OCI report recommends structural changes in the governance, decision-making and accountability mechanisms of women's corrections as a response to documented systemic failures and deficiencies. Significantly, the Service's *Response* appears to reject the context, if not the very substance, in which these reports and recommendations are framed.

Dr. Rivera's recommendation that security, health care and psychological services need to be more integrated in a "continuum of care" model is especially instructive. As Rivera points out, the tension between security and clinical perspectives in managing Ashley Smith often led to decisions and actions that were clearly not in her best interest. In several instances, security practices trumped clinical opinion; treatment was often withdrawn or withheld as a result of "behavioural" issues that were typically met by a security response. In a very important respect, the interplay between security and clinical perspectives is largely missing in the Service's *Response*. We expected to see an engaged and informed discussion of this problem precisely because it goes to the crux of better managing the needs of mentally ill offenders in federal penitentiaries. The *Response* is disappointing in its lack of engagement on this point.

The Service cites the construction of secure interview rooms in the Secure Units of women's facilities as a positive development under the administrative segregation heading of its *Response*. The problem is that these "secure" rooms actually prohibit the kind of human – and humane – contact that mentally ill offenders so often desperately seek. As the Board of Investigation notes, Ashley Smith's behavioural disturbances were a response to her continued confinement in segregation; an

be developed and be mandatory training for all staff working in women's institutions.

10. That a review of the design of segregation units at the Women Institutions be undertaken with specific emphasis on the design of cells equipped with cameras and that physical changes be made to assist staff more effectively observe, manage and interact with high need offenders.

Dr. Margo Rivera Recommendations:

1. Difficult to serve women offenders with mental health problems should not be transferred from one institution to another in response to staff complaints or staffing constraints. The assumption should be that it is in the woman's interest to remain in her home institution. Any transfers of such inmates should only be undertaken when it is clearly in the woman's interest, and the request and rationale for such a transfer should be thoroughly scrutinized at the highest level of the Correctional Service of Canada, including the Deputy Commissioner for Women, the Manager of Health Programs for Women and Regional Headquarters.

2. Management of particularly difficult-to-serve women offenders with mental health problems should be supervised directly at the National Level.

3. A pre-treatment individualized Dialectical Behaviour Therapy program should be constructed for women offenders with problems in emotion and behaviour regulation who are not able for a variety of reasons to participate in group programming, with some resources that could be used in individual sessions with mental health professionals and others that could be used by the inmate with the help of the security staff.

4. Security, Health Care and Psychological Services should be more integrated in the Women's Institution to ensure best practices are carried out regarding the care of women offenders.

5. Structures should be put in place whereby all staff have an opportunity to address issues of concern to them regarding any of the practices they are asked to carry out in the workplace, particularly when they relate to the best interests of the women offenders in their care. At all levels, staff should be encouraged to put such concerns in writing.

environment that, in Dr. Rivera's reckoning, "was lacking in even the most basic sensation and stimulation."

While the Board of Investigation correctly acknowledges the need for the Service to put in place "appropriate alternatives" to long-term segregation of mentally ill offenders, the secure rooms actually provide for an even more restrictive and depriving environment. There is no mention anywhere in the *Response* of the need to limit or reduce the use of long-term segregation, no acknowledgement that isolation and deprivation might be potentially harmful to mental health status, nor are there any measures, in our estimation, that would qualify as an "alternative" to segregation. We do not find the Service's response to the recommendations calling for significant changes to how segregation is applied to offenders with mental health issues to be adequate.

On other points listed in the *Response*, the OCI welcomes the fact that the Service is putting more focus and attention on meeting the needs of offenders with mental health problems, has augmented resources for clinical assessments, and provided training for more front-line staff to better equip them to meet the needs of the mentally ill. These are generally positive developments, which the Office is committed to tracking and monitoring.

As we see it, the key in moving forward will be to bring cohesion, vision and clarity of purpose to what are now a long list of somewhat disjointed undertakings. Clearly, to make measurable and sustained progress, a more focused, integrative and collaborative "continuum of care" approach is required. Such an effort involves bringing together different sectors of correctional activity and intervention and working towards a common vision. This direction must continue to come from the highest levels within the Service.

Recommendation 2	
I recommend that the Correctional Service provide a full public accounting of its response to the OCI ***Deaths in Custody Study****. This should include a detailed Action Plan with clearly identified outcomes and time frames.*	**The Office shares the Service's point of view that the public posting of its *Response* is an important and necessary public accountability measure. We favourably note, in particular, the Service's intention to report to Parliament on its commitment to prevent deaths in custody via the *Report on Plans and Priorities* exercise.**
Recommendation 3	
I recommend that the Correctional Service group its women's facilities under a reporting structure independent of the Regions, with the wardens reporting directly to the Deputy Commissioner for Women.	**The Service's rejection of this recommendation, which goes to the issue of accountability in women's corrections, is both troublesome and disappointing. The Office is in good company in making this recommendation. In fact, nearly every single independent report or expert that has reviewed the state of women's corrections over the past two decades following a significant incident has come down pointedly on the need for a governance structure for federally sentenced women that contains the following features: i.) is independent of men's corrections; ii.) allows for a direct reporting relationship from the institutional to the national level and; iii.) empowers the Deputy Commissioner for Women with substantive and final decision-making authority.** **Such a model recognizes that matters which significantly affect the care, custody and retained rights of federally sentenced women (e.g. long-term segregation, involuntary transfers, use of force, management of chronic self-harming offenders) should be the remit and resolve of the Deputy Commissioner for Women. Answerability is a key aspect of effective accountability. The Deputy Commissioner for Women, second only to the Commissioner, is where the proverbial buck should stop when there is an issue within women's corrections.** **Perhaps as concerning is the following assessment: the governance model which failed Ashley Smith is essentially the same system that is operating today. There continue to be offenders presenting a similar mental health profile as Ashley's currently in federal custody and many more who will enter in the future. While the specific and immediate circumstances that contributed to her death were obviously unique, many of the documented failures were largely systemic in nature. In rejecting this key recommendation, it is not clear that the lessons from Ashley's untimely death are indeed being applied and the necessary corrective actions implemented. We strongly encourage the Service to review governance issues inside women's corrections on an urgent and priority basis.**

Recommendation 4	
I recommend that the Correctional Service issue immediate direction to all staff regarding the legislated requirement to take into consideration each offender's state of health and health care needs (including mental health) in ***all*** *decisions affecting offenders, including decisions relating to institutional placements, transfers, administrative segregation, and disciplinary matters. CSC decision-related documentation must provide evidence that the particular offender's physical and mental health care needs were considered by the decision-maker.*	**We are largely satisfied with the Service's response to this recommendation, and will continue to follow-up on compliance. The Office notes that segregation wards across the country are filled with offenders who suffer with mental health issues of one kind or another, despite the directive for CSC decision-makers to take into account the state of an offender's mental health. Long-term segregation of the mentally ill is not safe. The practice should not be considered an acceptable "alternative" in offender population management.**
Recommendation 5	
I recommend that the Correctional Service immediately review all cases of long-term segregation where mental health issues were a contributing factor to the segregation placement. Particular attention should be paid to inmates with histories of suicide attempts or self-injurious behaviour. The results of this review should be provided to the institutional heads and Regional Deputy Commissioners and, in the case of female offenders, to the Deputy Commissioner for Women.	**The OCI looks forward to the operational review that the Service will conduct on long-term administrative segregation. The Office will endeavour to ensure that the exercise is indeed the subject of an external review process.**
Recommendation 6	
I recommend that the Correctional Service seek independent expertise - with a strong women-centered component - to review its policies on managing self-injuring inmates, and inmates displaying challenging behavioural issues. This review should focus on the appropriateness of placing those inmates on administrative segregation status.	**The OCI would like to see more movement and action on the second part of this recommendation, namely the appropriateness of managing self-injurious offenders in segregation. Our Office views self-injury in prison as a mental health issue; the "solution" does not lie in a response that effectively blames, sanctions or punishes the mentally ill for their behaviours. Submission to and acceptance of correctional authority by means of punitive or disciplinary segregation are not especially effective interventions for offenders afflicted by mental illness. Clinical assessment, treatment and intervention offer far more promising and corrective approaches to challenging behaviours resulting from underlying mental health problems.**
Recommendation 7	
I recommend that all Correctional Service National Boards of Investigation into incidents of suicide and self-injury be chaired by an independent mental health professional.	**This is another significant accountability measure that is not supported by the Service. It is instructive to note that CSC's Board of Investigation into the death of Ashley Smith, which we earlier cited for the incisive and insightful quality of its deliberations, benefited from the observations of the Psychological Report conducted by an outside mental health expert (Dr. Rivera). As the Service's *Response* indicates, in August 2007 policy directions for conducting investigations were revised to the effect that national investigations would no longer be specifically required to include a health care professional on Boards of Investigation involving death or serious self-injury of offenders. Ashley's death occurred in October 2007; as such, it would have been one of the first Boards to be convened under the new**

	policy direction. Our Office intervened to recommend CSC ensure representation of an independent mental health expert on this Board of Investigation. Although Dr. Rivera was not a member of the Board (she was retained to provide clinical input), it is significant that the other members of the Board concurred with her findings and recommendations and chose to include them in the official report. **Our Office reviews all Boards of Investigation. It is our experience that Boards which are comprised of, or chaired by, an independent professional usually deliver a consistently high-quality product precisely because it is informed by expert opinion and independent judgement. Professional distance from the immediacy of the events and circumstances being reviewed is also generally a good practice. We strongly encourage the Service to revisit its response to this recommendation, if only to protect the integrity and credibility of its own investigative process.**
Recommendation 8	
I recommend that the Correctional Service review and revise its administrative segregation practices to ensure that all long-term segregation placements are reviewed by regional managers, inclusive of health care, after 60 days of segregation. I further recommend in those cases where segregation status is maintained, that the decision and supporting documentation be referred to the Senior Deputy Commissioner and, in the case of female offenders, to the Deputy Commissioner for Women.	**"Supported in part," the Service's *Response* in this matter is troubling. It is important to appreciate that this recommendation results from the fact that Ashley Smith never benefited from, nor received the protections of mandatory reviews afforded in law, despite her perpetual segregation status. This recommendation attempts to place some additional procedural restraint on the use of segregation, cognizant of the fact that it represents the most severe form of deprivation that can be imposed in Canada. In accordance with the principle that the more liberty is deprived greater are the protections afforded to protect against abuse, we see a need to institute additional review and bring a higher standard of accountability to the decision-making regarding administrative segregation. It is not entirely clear why the Service would not fully support what amounts to the operational expression of an important legal principle.**
Recommendation 9	
I recommend that the Correctional Service amend its segregation policy to require that a psychological review of the inmate's current mental health status, with a special emphasis on the evaluation of the risk for self-harm, be completed within 24 hours of the inmate's placement in segregation.	**Another recommendation supported only "in part," the Service is satisfied that an assessment by a registered nurse within 24 hours of placement in segregation is adequate and appropriate. It is important to understand that the risk of suicide and self-injury is considerably elevated in the first 24 hours of a segregation placement. A registered nurse may not have the same level of training and expertise as a psychologist to adequately assess the level of self-risk that an offender may present.**

Recommendation 10	
I recommend that the Correctional Service immediately implement independent adjudication of segregation placements of inmates with mental health concerns. This review should be completed within 30 days of the placement and the Adjudicator's decision should be forwarded to the Regional Deputy Commissioner. In the case of a female inmate, the Adjudicator's decision should be forwarded to the Deputy Commissioner for Women.	**There is a legal requirement for the Correctional Service to review all inmates placed on administrative segregation at the five, thirty and sixty days mark. The purpose of these reviews is to examine the impact of segregation on the inmate, to determine whether continued placement on this status is appropriate, and to carefully explore and document possible alternatives to continued segregation. In Ashley Smith's case, despite her perpetual segregation status, the internal checks and balances for ensuring legal compliance failed her at nearly every turn. In our opinion, independent adjudication of segregation placements of inmates with mental health concerns is a modest but necessary measure of modern and accountable corrections. It would effectively provide for a system of external review and restraint in the use of segregation to manage the mentally ill.**
Recommendation 11	
I recommend that the Situation Management Model be modified to require staff to give consideration to an offender's history of self-harm and his/her potential for future or cumulative self-harm when determining whether immediate intervention is required.	**On August 19, 2009, the Service issued a "Security Bulletin" to the field in response to recommendation #11 from our report into the death of Ashley Smith. For the record, we include our detailed reply, as sent to the Assistant Commissioners of Health Care Services and Correctional Operations and Programs, respectively, on August 20, 2009.** ***" … We understand that this Bulletin is issued as a response to a recommendation made in our Ashley Smith report (A Preventable Death). In that regard, we are curious as to why this Bulletin is issued as a Security Bulletin, and not, for instance, as a Health Care Services bulletin or a clarification to the Situation Management Model (SMM). Although we appreciate that the Service's response to the recommendation in question relates primarily to the SMM (which is an area under the purview of Security), our Office has been clear that we think the Service should be treating incidents of self-harm, especially chronic cases, first and foremost as a mental health concern/issue, not necessarily, and certainly not exclusively, as a security response to a 'behavioural' problem.*** ***In our view, how the issue of self-harm is communicated throughout the Service, particularly to the front-line correctional staff, is extremely important. The Service's recent review of this issue, "A Study of Reported Self-Harm Incidents in CSC" (February 2009), is especially instructive as it contains some***

	important observations about this growing phenomenon: • ***Self-harm does not necessarily equate to attempted suicide; most self-harmers are not trying to end their lives.*** • ***Most offenders are very open with their use of self-harming behaviours; in the majority of incidents, offenders had timed their self-harm acts so staff would discover them quickly.*** • ***Self-harm in a correctional environment deserves to be understood in its own right ... to help inform more effective management and treatment strategies.*** • ***Consistent with the risk principle, repetitive self-harmers deserve our most intense interventions.*** • ***We must continue to assess every individual who self-harms to determine their suicide intent and potential and develop clinical/management plans accordingly.*** ***Although the Bulletin ends with the statement that 'CSC is taking action on a number of fronts with respect to self-harm cases,' it is not clear how, or to what extent, the Bulletin might be informed by the above observations, nor the extent to which these actions are being integrated across CSC's care and custody mandate - treatment, prevention, intervention, case management and security.*** ***Self-harm in prisons is a perplexing and growing problem inside CSC institutions; it requires an equally comprehensive, cohesive and integrated response, which would include more oversight by NHQ of chronic self-harmers. How staff initially respond, especially the timeliness and appropriateness of that response, to incidents of self-harm is extremely critical. Security is a piece of the Service's overall response to self-harming, but it is only one part of a much larger and complex dynamic in more adequately addressing the mental health problems and needs of federal offenders.*** ***We would be grateful for a response to our concerns."*** **We are still awaiting a response from the Service.**

Recommendation 12	
I recommend that the Senior Deputy Commissioner review all of the complaints, and the Correctional Service's response to those complaints, that were submitted by Ms. Smith during her period of federal incarceration, inclusive of the complaint submitted by Ms. Smith in September 2007 at GVI. A written response to these complaints should be issued, and appropriate corrective action and policy clarification should be undertaken.	**As indicated in the Service's *Response*, "CSC has completed the review of all known complaints and grievances filed by Ms. Smith."** **The fact that some of Ashley's grievances were not even read, much less responded to, until after her death is a poignant reminder that the internal complaints and grievance system is often unresponsive and ineffective.** **We are encouraged that the Service is moving toward a fundamental review and reform of the entire complaints and grievances system. We urge the Service to seek independent and expert advice in this matter.**
Recommendation 13	
I recommend that all grievances related to the conditions of confinement or treatment in segregation be referred as a priority to the institutional head and be immediately addressed.	**As above.**
Recommendation 14	
I recommend, once again, that the Correctional Service immediately commission an external review of its operations and policies in the area of inmate grievances to ensure fair and expeditious resolution of offenders' complaints and grievances at all levels of the process.	**As above.**
Recommendation 15	
I recommend that the Minister of Public Safety, together with the Minister of Health, initiate discussions with their provincial/territorial counterparts and non-governmental stakeholders regarding how to best engage the Mental Health Commission of Canada on the development of a National Strategy for Corrections that would ensure a better coordination among federal/provincial/territorial correctional and mental health systems. The development of the National Strategy should focus on information sharing between jurisdictions, and promote a seamless delivery of mental health services to offenders.	**The consultations that have been held to date are a good first step in more broadly addressing the corrections and mental health nexus. We remain hopeful that federal, provincial and territorial collaboration will one day result in a much-needed *National Mental Health Strategy for Corrections*. We note that the Standing Committee on Public Safety and National Security is currently seized by the issue of mental health and addictions in corrections and its observations will serve as an important reference point for Government in this area.**
Recommendation 16	
I recommend that the CSC undertake a broad consultation with federal/provincial/territorial and non-governmental partners to review the provision of health care to federal offenders and to propose alternative models for the provision of these services. The development of alternative models should include public consultations.	**We appreciate that the Service is but one of many actors in a complex web of overlapping jurisdictional responsibility. We encourage the Service, and indeed the federal government, to look at promising models from other countries in terms of how they are organized to deliver mental health and physical health care services inside correctional facilities. We think there is much to learn, and an immediate need to engage the public and initiate the reform process.**