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A SURVEY OF HEALTH-RELATED SERVICES IN ONTARIO'S YOUTH CUSTODY FACILITIES

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A SURVEY OF HEALTH-RELATED SERVICES IN ONTARIO'S YOUTH CUSTODY FACILITIES

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Abstract

This survey collected information on the nature and extent of health-related services in Ontario's youth custody facilities and examined how the services provided compare with standards recommended by the Canadian Paediatric Society and the World Health Organization for the health care of youth in custodial facilities. The results reveal that the facilities appear to be observing most of the recommendations from the Canadian Paediatric Society and the World Health Organization. There is considerable variation in the services provided across the facilities, and secure custody facilities have a greater variety of services available. Service provision appears to be related to a number of factors, including facility size, location, ownership, community resources and funding.

Keywords

Health-related services, health care, youth custody

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A Survey of Health-Related Services in Ontario's Youth Custody Facilities

Chapter 1: Introduction

Over the past decade, rising health care costs, fuelled by a rise in chronic and terminal illnesses and an aging population, have resulted in a significant amount of research being focused on health care issues. New drugs, new therapies, and health promotion interventions are some of the most common areas of research. In relation to child health care, current research tends to focus on physical health concerns, such as cancer, obesity, and diabetes, with an emphasis on possible cures, prevention, health promotion techniques and quality of life. Although such research is valuable and important, it typically focuses on the needs of children and youth within the context of family and everyday life. However, research suggests that there is a population of children and youth for whom appropriate health care and assessment seems to be lacking; they are referred to as youth in conflict with the law (American Academy of Pediatrics, 2001; Canadian Paediatric Society, 2005).

Described in the literature as a "vulnerable and underserved group of adolescents, who are often disenfranchised from traditional health care services" (American Academy of Pediatrics, p. 799), youth in conflict with the law are known to have higher rates of physical and psychological health problems than the general population of youth (American Academy of Pediatrics, 1973; 2001; Dolan, Holloway, Bailey, & Smith 1999; Frappier & Steinmetz 1977; Pauze, 2002; Rutter & Giller, 1984). Past surveys within the United States (US) and Canada have indicated that 23% to 50% of youth entering youth custodial facilities are in need of health care (American

Academy of Pediatrics; 1980; 1989; McCreary Centre Society, 2001; Pauze, 2002). Their principal health problems tend to include, skin lesions, upper respiratory tract infections, substance abuse disorders, dental problems, urological problems, depression, attention deficit hyperactivity disorder, emotional disorders and conduct disorder. Many of these youth also acquire a range of injuries and health care problems while in custody, due to fights, use of physical restraints, self inflicted injuries and other miscellaneous causes (American Academy of Pediatrics, 2001; Dolan et al., 1999; Her Majesty's Inspectorate of Prisons, 2007; 2008; 2009).

Young people involved in the juvenile justice system also tend to become involved in various risky sexual behaviours; they are known to engage in sexual activity in larger numbers than teens in the general population and also to initiate sex at earlier ages. Compared to 50% of high school youth (Kann et al., 2000), studies show that up to 80% of detained juveniles report engaging in sexual activity (Forst, 1994; Lanier, DiClimente, & Horan 1991; Weber, Gearing, Davis & Conlon, 1992) and other studies have even placed the figure at 90% (Harwell, Trino, Rudy, Yorkman, & Hollub, 1999; Kelly, Blair, Baillargeon, & German, 2000; Morris et al., 1998). The average age of initiation of sexual activity was found to be between 12 and 13 for youth involved in the justice system (Forst, 1994; Gillmore, Morrison, Lowery, & Baker, 1994; Harwell et al., 1999); however two studies of ethnic minority males within this population, reported sexual experiences by or before the age of 11 (Pack, DiClemente, Hook, & Oh, 2000; Weber et al., 1992).

Multiple sex partners and inconsistent condom use are also common behaviours within the population of youth in conflict with the law; consequently, they have been

found to have greater rates of sexually transmitted infections (STI) than other youth. Two studies of adolescent males in US detention centers revealed a median of eight sexual partners; 63% of the respondents reported inconsistent condom usage, 15% reported having an STI at the time of the study, and 34% reported being diagnosed with at least one STI prior to custody (Oh et al, 1994).

A 2004 British Columbia survey of 137 youth in custody revealed similar results. The results were compared to a 2003 study of mainstream youth; it revealed that 66% of the youth in custody had sexual intercourse before the age of 14, compared to 20% of youth in school. Additionally, 26% of youth in custody reported that they had sex with three to five people in the three months before being detained; whereas among youth in school, only 6% had sex with three or more people in the three months before the survey. Fewer youth in custody (59%) indicated that they used a condom the last time they had sex, in comparison to 68% of youth in school. Further, 13% of those in custody indicated that they had been told by a health professional that they had a STI (McCreary Centre Society, 2005). It should be noted that information on adolescent sexual behaviours is usually obtained through self-reports and should therefore be interpreted with care. Researchers advise that the data should be viewed as "indicative of trends, rather than as precise and accurate measures of current behaviour" (Besahrov & Gardiner, 1997, p.3).

The health care of female adolescents entering the juvenile justice system has become a topic of much interest over the past 20 years. Statistics indicate that girls are now entering the system in increasing numbers and with increasing problems

(Staples-Horne, 2007). Girls have been found to be three times more likely than boys to have been sexually abused and also have higher rates of physical abuse (Elemagno, Shaffer-King, & Hammel, 2006; Staples-Horne, 2007). Girls also present with higher rates of low self-esteem, lack of confidence, severe depression, post traumatic stress disorder and suicide attempts (Douglas & Plugge, 2006). Their sexual risk behaviours are similar to those of boys. In a 2005 national British study of female young offenders, 26% of the girls reported having three or more sexual partners in the year preceding custody, only 15% always used condoms, and 26% had been diagnosed with a STI (Douglas & Plugge, 2006). A 1998 survey of girls in US detention facilities also documented high rates of cervicitis, vaginitis, and complaints of vaginal discharge, and 33% of the girls tested positive for either gonorrhoea or chlamydia or both infections (Oh et al, 1998).

Research shows that within a traditionally male-dominated environment, girls have gender-specific health needs that are not always adequately addressed (Douds, Gallagher, & Dobrin, 2006; Staples-Horne, 2007). A 1990 US national survey found that while two thirds of facilities were housing between one and five pregnant females on any given day, only about one third (31%) of facilities provided prenatal services, and only 30% provided parenting classes (Widom & Hammet, 1996). The most recent census (2004) of juveniles in custody in the US also revealed that less than half of the facilities provide gynaecological exams (The Office of Juvenile Justice and Delinquency Prevention, 2006), and a British survey documented variable access to general practitioners, mental health professionals, sexual health experts and other health care

services across female custodial facilities (Douglas & Plugge, 2006). There are no comparable Canadian data available.

The health care issue that has been of most concern for youth in conflict with the law over the past 10 years is that of mental health assessment and treatment. The Canadian Psychological Association reports that, of the estimated 20% of youth in the general population with a diagnosable mental health condition, more than half are likely to commit serious crimes and become involved with the juvenile justice system (Canadian Psychological Association, 2008). A Toronto study found that 31% of youth in custody had a conduct disorder and 25% had Post Traumatic Stress Disorder (PTSD). In comparison, 4% of youth in a community sample had a conduct disorder and none had PTSD (Ulzen & Hamilton, 1998). In British Columbia, 6% of youth in custody reported that they were diagnosed with schizophrenia, 21% thought about killing themselves in the year prior to the survey, and 13% reported attempting suicide. Other studies have concluded that as many as 65% of youth in custody have a diagnosable psychiatric or substance abuse disorder and up to 10% have a serious mental illness, such as bipolar disorder or severe depression (Desai et al, 2006). Up to 75% of youth in custody have also been found to have more than one disorder occurring at the same time; usually substance abuse disorder and one other (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002).

The sad reality is that the youth in the justice system often do not receive the required mental health treatment. In one US study of 303 youth in custody who required mental health treatment, only 15.4% received treatment in their facility (Teplin, Abram, McClelland, Washburn, & Pikus, 2005). Although no comparable data are available for

Canada, it is estimated that up to 10% of the cost of crime in Ontario can be attributed to inadequate mental health care for children and youth (Steinhauer, 1998). Low treatment rates in Canada have principally been attributed to lack of personnel and inadequate funding. A 2006 Senate Committee Review of Mental Health, Mental Illness and Addiction Services in Canada, revealed that there are less than 500 child and adolescent psychiatrists in the country (The Standing Senate Committee on Social Affairs, Science and Technology, 2006). With respect to school psychologists, a 2007 review revealed that the average ratio of psychologists to students was 1 to 5,161, in the nine jurisdictions that responded to the survey (Saklofske et al, 2007).

The Ontario provincial government has made efforts to improve the children's mental health system with investments of $13 million in 2005 for community based programmes and $24.5 million in 2007 to address inequalities in local services and reduce wait times. Planned investments of $508.2 million were announced for 2009 to 2010, to assist with early identification and intervention, intake and assessment, counselling, family treatment, parent education and provision of support to various government run children's facilities (Ministry of Children and Youth Services, 2009). In spite of these investments, gaps in services are still reported to be a significant concern (Borgida & Semple, 2005; Ministry of Children and Youth Services, 2009). The results of a province wide mapping exercise undertaken by The Ministry of Children and Youth Services (MCYS) between 2007 and 2009 revealed that the average wait time for emergency mental health services across the province is 3 days. Hamilton and Niagara had the longest average wait time of 19 days; this region also had the highest wait time of 68 days for early intervention programmes, compared with the provincial average of

17 days. For highly specialized intensive treatment, the average provincial wait time is 52 days. Toronto has the highest average wait time of 79 days. Other findings in the report showed that 50% of children across the province are receiving general services within 29 days, but 36% are still waiting for services after 12 months (Davy, 2010).

In addition to mental health and physical health care issues, the population of youth in conflict with the law is unfortunately often "characterized by multiple forms of familial, socioeconomic and academic disadvantages" (Cesaroni & Peterson-Badali, p. 253). They are likely to have experienced physical abuse, family breakup and violence between parents and to have come into contact with the welfare system or social services system prior to custody (Doob, Marinos, & Varma, 1995). Additionally, research has suggested that approximately 75% of youth in custody may have a learning disability (Henteleff, 1999). In a survey of youth in all of Ontario's open youth custody facilities, 67% of those who responded to questions about involvement with social services indicated that they had been placed "in-care" at some point in their lives. The survey also revealed that there were youth who were unable to read or write in some of the facilities, but no specific figures were provided (Cook & Finlay, 2005).

The combination of these factors places youth in conflict with the law at risk for various poor developmental outcomes later in life, including unplanned pregnancy, school drop-out, depression, suicide and increased risk of medical and mental health problems (Bardone, Moffitt, Caspi, Dickson, & Silva, 1998; Cowan, Cowan & Schultz, 1996). Additionally, there is no research that reveals improved health status or less risky health behaviour tendencies when youth exit juvenile justice facilities (Forrest, Tambor, Riley, Ensminger, & Starfield, 2000). The few studies conducted on adolescents

released from custody show that they continue to engage in risky health behaviours (Teplin et al., 2007), experience ongoing mental health problems and have disrupted social lives after they return to their communities (Kosky, Sawyer, & Fotheringham, 1996).

It is therefore important that facilities that detain adolescents be able to provide adequate health care services. Numerous reports have shown that, although there are youth custody facilities that provide excellent health care, health care services within many facilities are often insufficient. In England there have been continued calls for additional health care staff to improve health care service delivery at many young offender institutions (Her Majesty's Inspectorate of Prisons, 2007; 2008; 2009). A review of youth custody in Brazil found that facilities failed to meet basic standards of health and hygiene, and mental health care was listed as a problem in all facilities (Bochenek & Delgado, 2006). In 2002 state quality control inspectors labelled health care in Miami-Dade juvenile facilities as minimal, while in California, several teams of outside experts concluded in 2003 that health care in juvenile facilities was not commensurate with community standards of care (Shirk, 2004).

Policy Recommendations and Data Accessibility

The documentation of high rates of poor physical and psychological health among youth in conflict with the law and minimal health care services within some of the facilities in which they are placed led several health care and correctional care organisations to develop and publish standards for health services for youth in custody. Recommendations for established standards of care have been published by the United Nations (1990), the World Health Organization (2003), the American Pediatric Society

(1973, 2004), the Canadian Paediatric Society (2005), the National Commission of Correctional Health Care (2004, revised) and other organisations. However, facilities (neither in Canada or any other country) are not obligated to adopt the recommended standards. The recommendations from each organisation are similar in nature (though some are more detailed than others) and address issues such as record keeping, the establishment of health committees, intake assessment procedures and timelines, provision of mental, dental, vision and substance abuse services, emergency care plans, continuous health assessment, staff qualifications, and site inspections.

The calls for improved health services for this population of youth have not been ignored at the governmental level. England, the US, and Canada have taken steps in recent years to address health care service policy and health service provision for youth in conflict with the law. Information regarding the policies, range of services, level of service provision, and adoption of recommended practices within England and the US is available online via the websites of the departments responsible for juvenile justice services and can also be purchased in hardcopy. Information on Canada's and Ontario's practices and services is, however, very limited and although it was reported that data have been collected (type of data unknown), the data are not available to the public. Attempts to obtain information from the Office of the Provincial Advocate for Children and Youth (Ontario) were met with the response that open custody reports could be accessed, but secure custody reports were "not intended for public release" (personal communication, June 10, 2008). In addition, the Ministry of Children and Youth Services (MCYS) informed that the Youth Justice Services policy manual could not be released for security reasons (personal communication, July 28, 2008).

The remaining sections of this literature review will therefore provide an overview of the current state of health-related services provision within the US and England, followed by information on Canada's and Ontario's youth justice system and associated health care policies.

The United States

To obtain information on health services provision, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) of the US Department of Justice sponsors a census of all public and private juvenile residential facilities in the United States. The Juvenile Residential Facilities Census (JRFC) was introduced in 2000 and was designed "in part, to answer questions about the conditions under which basic and specialized health care services are provided to young people" (Gallagher & Dobrin, 2007, p. 993).

Data from the last JRFC report (2004) revealed that 68% of facilities reported providing physical health examinations to all youth; this accounted for 69% of all youth admitted to custody or detention. Another 24% of facilities reported providing physical health examinations to some youth, including youth who were in the facility for a certain period of time, youth who displayed symptoms of illness or injury, youth with an existing health problem, youth with no available health care record and youth who came directly from home. Most facilities used a doctor or nurse to conduct physical exams; however, 33% used nurse practitioners and 29% used physician's assistants to perform some or all physical exams. Only 2% of facilities reported that some other individual performed physical exams. Figures for the provision of specialist services were however significantly lower. Less than half of the facilities reported that all youth in their care

receive a dental exam and even fewer reported that all youth receive a vision or a gynaecological exam.

The 2004 JRFC report recorded low figures for full population testing for communicable diseases and pregnancy. Figures ranged from 5% for pregnancy tests to 16% for testing all youth for the range of communicable diseases, with the exception of tuberculosis for which 43% of facilities tested all youth. Physical activity standards also vary. Information from detention facilities indicated that only 70% of facilities require one hour of vigorous exercise every day and 10% (housing 1,903 youth at the time of the census) do not provide opportunities for recreational exercise.

In relation to mental health care, figures from the 2002 JRFC report (most current statistics available) indicate that 68% of facilities evaluated all youth for suicide risk; those facilities held 81% of the juvenile offenders who were in residential placement. An additional 17% of facilities evaluated some youth, whereas 15% of facilities reported that they did not evaluate any youth for suicide risk. More than half (56%) of the facilities reported that the screenings were conducted by mental health professionals with at least a master's degree in psychology or social work. Some facilities also used counsellors to conduct screenings and a small percentage used neither mental health professionals nor counsellors to conduct suicide screenings.

Two-thirds of the facilities reported that screening for suicide risk was conducted on the youth's first day at the facility. Other facilities noted that they conducted their suicide screenings during the youth's first week at the facility, and a small proportion of facilities, conducted screenings only after the youth had been in the facility for a week. There were 10 deaths by suicide in juvenile justice facilities in 2002 and during the

month prior to the census there were 114 suicide attempts that were serious enough to require hospitalization. There were 16 deaths by suicide during 2003 and 2004.

With respect to overall mental health evaluations, 53% of facilities reported that in-house mental health professionals evaluated all youth to determine their mental health needs. An additional 34% reported that in-house mental health professionals evaluated some youth. The most common approach was to evaluate youth by the end of their first week at the facility. Thirteen percent of facilities did not provide a mental health evaluation.

Prior to introducing the JRFC in 2000, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) created a performance based standards system to improve health care and other conditions of confinement. The performance based system was in launched in 1995, however, by the end of 2000 only 60 of the 3500 facilities were implementing the system. Additionally, even though they are not obligated to do so, 56 facilities have received accreditation from the National Commission for Correctional Health Care for adopting their standards for health services in juvenile facilities (personal communication, March 31, 2009).

England

During January 2010, England's youth custody population totalled 2,348 (Youth Justice Board, 2010). It is estimated that the average cost of maintaining one young person per year in custody is £55, 674 (Byford & Barret, 2004). There are three types of custody accommodations, secure children's homes and secure training centres that are run by private operators, but, supervised by the Departments of Health and Education, and young offender institutions (secure custody) supervised by the Prison Service.

Revised criteria for the standards of care to be applied in facilities were published in 2004 by Her Majesty's Inspectorate of Prisons. To ensure that standards are being implemented, announced and unannounced inspections are conducted yearly in secure homes and centres. They are conducted biannually in young offender institutions, but in cases where numerous issues have previously been identified, annual follow up inspections occur. Inspections conducted in young offender institutions have identified significant improvements over time. Progress in areas such as in child protection from abuse, better coordination of safeguarding (which includes measures to prevent suicide and self-cutting), improvements in health care services provision, and improvements in sexual health promotion programming have been recorded. The 2006 to 2008 annual reports of the Chief Inspectorate of Prisons, however, noted many recurring problems, such as long waits for dental services, failure to appoint health professionals such as occupational therapists and opticians at many facilities, late night arrivals, placements far distances from youths' homes, which create problems for family contact and resettlement planning, insufficient fresh air and exercise, and poor access to showers.

In the 2007 to 2008 inspection surveys, insufficient access to exercise in the fresh air was listed as one of the major concerns, just under half of the girls and a quarter of the boys who were interviewed said they were able to exercise every day, and in one facility, none of those who were interviewed said they were able to exercise every day. In the 2008 to 2009 surveys, improvements were recorded with the female population as all of the girls reported having significant amounts of time outside; however only 15% of the boys in 7 of the 14 facilities surveyed said that they could

exercise daily, and the figure was as low as 3% at one facility. At 4 of the other 7 facilities, over 70% of the boys reported that they were able to engage in daily exercise.

Another major concern was that children with serious mental health problems continue to reside in these facilities. It was noted that " in-house mental health services had improved, but that it was insufficient to meet the present needs and therefore made these institutions inappropriate for the care of mentally ill children" (Her Majesty's Inspectorate of Prisons, 2007, p. 41). It was further found that criminal background checks were not always being carried out on staff, and at one facility criminal record checks were not conducted on half of the staff working with children. Inspections also continue to record concerns about fights and bullying, staff to youth ratios, and high levels of the use of force. It was indicated that "injuries sustained during restraint (including small numbers of wrist fractures) are often the highest single category of child protection referrals in a facility" (Her Majesty's Inspectorate of Prisons, 2007, p. 41).

Inspections conducted at the four secure training centers during the years 2006 to 2009 reveal more consistency and better overall conditions. Secure training centers differ from young offender institutions as they have a higher staff to youth ratio and are smaller in size, allowing for individual needs to be met more easily (Youth Justice Board, 2010). One of the centres was a recipient of Britain's healthy schools awards in 2004 for the nutritional content of its food menu and also received a Healthy Heart Award in that same year for encouraging healthy lifestyles (Commission for Social Care Inspections, 2006).

In relation to health care services, arrangements for young people to receive a range of health services on-site were reported to be well organised across the four

facilities (Commission for Social Care Inspections, 2006; 2007; Ofsted, 2008 & 2009). Well established processes for assessing young people's health needs on admission have also been observed. The assessments are reported to be carried out in a timely manner by nursing staff immediately upon a youth's arrival and the information gained from the assessment and accompanying documents is used to develop individual health plans for the youth. Each facility has onsite healthcare teams comprised of male and female providers. One facility has a 24 hour nursing team and another has care available from 7:30am to 10:00pm, with an on-call service for after hours. Visiting health professionals include an optician and dentist who visit on a weekly basis, a psychologist, a psychiatrist and a midwife who provides support for mothers and babies. Hepatitis B vaccines were also reported to be provided to all youth. Additionally, where mental health professionals are not employed onsite, there are links with mental health professionals at local health care trusts.

Canada

In Canada young people in custody usually range in age from 12 to 17 years. Under the Youth Criminal Justice Act (2003) a young person is defined as "a person who is or, in the absence of evidence to the contrary, appears to be twelve years old or older, but less than eighteen years old" (Youth Criminal Justice Act, 2003, p. 4). The average time spent in custody is 30 days and the maximum is 3 years (longer for murder) (Statistics Canada, 2007). There are two types of custody in which a youth can be placed: open custody or secure custody. Secure custody is typically intended for youth who have been found guilty of serious offences or who pose escape risks. This type of custody relies on close supervision by staff and is supplemented by locked

bedroom doors at night and electronic surveillance. Alternatively, most open custody facilities, have fewer restrictions on the youths' movements within the custody centres, and allow access to activities such as escorted community outings. Open custody facilities usually house youth in unlocked rooms at night (McCreary Society, 2005). Under the Youth Criminal Justice Act open custody facilities may consist of "a community residential centre, a child care institution, a group home and a forest or wilderness camp" (Youth Criminal Justice Act, 2003, p. 5).

It is estimated that it costs between $90, 000 to $120,000 (CDN) per year (average of $250.00 per diem, per youth) for each adolescent detained in custody (Canadian Association for Adolescent Health, 2000; Steinhauer, 1998). All youth custody facilities across Canada are provincially funded, federal custody facilities are for adults only. Not all youth custody facilities are, however, managed by the provincial government. There are also numerous privately run facilities (also referred to as transfer payment facilities). In these privately run facilities the Ministry responsible for youth justice does not deliver services itself. Instead, that Ministry contracts non-profit agencies to provide services on its behalf and provides strategic direction and annual funding for service planning and delivery (Office of the Provincial Auditor, 1997).

Prior to 2003 Canada was deemed to have one of the highest juvenile incarceration rates among Western countries and about 25,000 sentences to custody were dispensed per year under the Young Offenders Act (Canadian Center for Justice Statistics, 1996). In an effort to reform youth justice policy, The Youth Criminal Justice Act (YCJA) was developed in 1999 and enacted on April 1, 2003. The introduction of the YCJA resulted in a significant drop in incarceration rates. In 2008 to 2009, 15,832

youth (7,932 in Ontario) were admitted to remand (custody while awaiting trial or sentencing); however, only 3,799 received custody sentences (Statistics Canada, 2010).

The 2003 Youth Criminal Justice Act is said to provide a more inclusive framework that focuses on public awareness, crime prevention, education, child welfare, health, rehabilitation, family and the community (Tusten & Lutes, 2004). It does not, however, specifically address health care standards or procedures, other than to state that, those in custody are to be afforded the same health care as youth in the community. Canada therefore currently "has no national standards, procedural guidelines, or protocols for best practices for the care of youth in custody" (Cesaroni, 2001, p. 107). Each province determines its own health care policy for these youth. One attempt to introduce national standards has come from the Adolescent Health Committee of the Canadian Paediatric Society, which in 2005 released a position statement entitled "Health Care Standards For Youth in Custodial Facilities" and recommended that their medical protocol be adopted as guidelines for the health care of young people in custodial facilities. The Canadian Paediatric Society (CPS) does not have the authority to enforce recommendations on facilities, but revealed that there is a database of recommendations in place at each facility (personal communication, March 10, 2008).

Ontario

Within Ontario 1,250 young people were admitted to sentenced custody during the year 2008 to 2009 (Statistics Canada, 2010), this figure represents approximately 33% of the total number of youth sentenced to custody across Canada during that

period. Statistics for youth custody costs in Ontario reveal average per diem rates of $331.00 per youth, additionally; per diem rates calculated for four government-operated facilities were reported to range from $294.00 to $424.00 (Ministry of Community Safety and Correctional Services, 2001).

Provisions to protect children in custody in the province are contained within The Child and Family Services Act. This Act was amended on February 18, 2009 to separate the youth justice correctional system from the adult correctional system. It was expected that by April 1, 2009, all juveniles located in adult correctional institutions would be removed and placed in dedicated youth justice facilities (MCYS, 2009). In relation to health-related services, the Act lists several rights of children in care, including the right to the development and participation of a plan of care within 30 days of admission to custody; the right to receive meals that are well-balanced and of good quality; the right to be provided with clothing that is of good quality and appropriate for the child; and the right to receive regular medical and dental care and to participate in recreational and athletic activities that are appropriate for the child's aptitude and interests.

Programs and services for youth in conflict with the law are provided through youth custody facilities under the authority of the Ministry of Children and Youth Services (MCYS). The Ministry's website informs that youth in custody have access to programs in education, counselling, addiction counselling, anger management, life skills and recreational and cultural programs. The Ministry's Youth Justice Services policy manual also has additional standards and policies.

Whether the existing legislation and policies are being met, whether they are meeting the health care needs of those they were developed to serve, or whether they are meeting the best care standards recommended by national and international health bodies to increase the quality of health and health care services for youth in custodial facilities are questions of importance. Lack of access to information, however makes determining answers to these questions very difficult. Database searches recovered one qualitative study, conducted in 2005 by the Office of Child and Family Service Advocacy (OCFSA). The study entitled "Review: Open Detention and Open Custody in Ontario" examined issues such as access to family, safety, education, rights, health care, programmes, and the use of physical restraints within open custody facilities throughout Ontario. In relation to health care, youth were asked to identify concerns about basic care services. In 4 facilities there were no complaints about basic care. The concerns identified by youth at the other 57 facilities included unavailability of cough syrup, lozenges, and aspirin on nights and weekends, the distribution of medication in public, dry air quality that caused nose bleeds, fatty, greasy food, unchanging menus, and temperatures that are too cold while not being given a blanket or heater at night. In addition, agency managers raised concerns about not being able to access specialized services for youth with mental health needs or other special needs.

Summary

There is a body of literature that indicates that youth in conflict with the law have higher rates of physical and psychological health problems than the general population of youth. Attempts to improve this situation have been undertaken in Western countries, such as England and the United States. The data from these countries are somewhat positive in nature, but highlight the need for improvements especially in the areas of psychological care, vision, dental, gynaecological services, and physical activity levels. Canada has also undertaken efforts to improve services to this population. The extent and quality of Canada's and specifically Ontario's improvements is however unknown. The purpose of this study was to gather information regarding the current health-related services provided to young people detained in youth custody facilities within Ontario and to determine how the current services compare with the standards of care recommended for youth in custody by the Canadian Paediatric Society and the World Health Organization.

It was expected that there would be considerable variation in the services provided across facilities, but that a greater range of services would be provided in secure custody facilities. Additionally it was expected that current services would likely not meet the Canadian Paediatric Society and the World Health Organization standards.

Chapter 2: Method

Participants

At the time of the survey there were 70 youth custody facilities in Ontario, 49 were identified by the Ministry of Children and Youth Services (MCYS) as open custody facilities and 21 as secure custody facilities. All 70 facilities were invited to participate in the survey. The total response rate was 70%; this included 71% (35 of 49) of open custody facilities and 67% (14 of 21) of secure custody facilities. These rates compare favourably to the average response rates of 50% to 60% for electronic surveys, supplemented by follow up reminder notices (Kittleson, 1997) and also that of surveys of executives, which usually generate response rates of 20% to 30% (Cycota & Harrison, 2006). Of those facilities that responded, 69% were privately run and 31% were government run.

Measure Development

The majority of the items for the survey were devised using the Canadian Paediatric Society's (CPS) position statement on Health Care Standards for Youth in Custodial Facilities (2005). The World Health Organization's (WHO) consensus statement on Promoting the Health of Young People in Custody (2003) was also utilised, though to a lesser extent. The Canadian Paediatric Society's (CPS) recommendations focus primarily on physical health issues, such as health policies, service provision, intake assessment, individual health assessment, continuing health assessment and emergency care plans. The World Health Organization's statement reflects its broader concept of health as a state of complete physical, social and mental

well being and not merely the absence of disease (WHO, 2007). It therefore addresses issues such as staff qualifications and training, the provision of a caring, nurturing, stimulating environment, reintegration plans and the assignment of personal officers who develop plans of care and work with youth throughout their stay in the facility. Both sets of recommendations, however, share areas of similarities, including, privacy protection and health education, but neither organisation addresses physical activity or mental health; it was therefore decided that because physical activity and good mental health have been continually linked to the maintenance of good health, the survey would include items relating to these aspects of health. It should be noted that the WHO's statement is from its Regional Office for Europe and is based on experiences from its Health in Prisons Project. That project received much international recognition and award nominations and it was felt it that, because one of its strategic goals was to assist in improving prison health internationally, the recommendations could be used to gather information in Canada. Additional items were also generated from the United Nations Rules for Juveniles Deprived of Their Liberty (1990) and from reports on health service provision in youth custody in Britain and the US.

The survey items were reviewed several times to ensure that the research objectives were addressed and that all relevant aspects of the CPS's recommendations and the WHO's statement were included. The final review consisted of word editing to ensure clarity and redesigning the structure and layout of the questionnaire to improve readability and appeal. After obtaining approval from University's Office of Research Ethics, the survey was then forwarded to The Ministries of Community Safety and Correctional Services/Children and Youth Services Research Committee for further

review and approval. The survey was returned with a request for a change in terminology to one of the staff categories. The requested change was submitted in January of 2009. In July of 2009 there was a request for the removal of one question and the addition of a definition to one of the response options, the changes were made and approved and there were no further requests for changes.

The final survey instrument was an 81 item questionnaire consisting of 79 close ended and 2 open ended questions. Fourteen of the close ended questions had an option of 'other', which allowed respondents to provide a written response in the event that the response options did not capture the characteristics of the facility; space was also provided at the end of the questionnaire for additional comments. The survey was divided into 13 sections that requested information on facility demographic information, health care programming, intake assessments, health care services provision, privacy and consent issues, staffing information, emergency care, nutrition, health education, physical activity, mental health care and long term care. A copy of the survey can be found in Appendix A.

Procedure

Ethics approval from the University of Western Ontario was obtained in September of 2008. Notification of research approval was received from the Ministry of Children and Youth Services in March (MCYS) of 2009, they however informed that distribution could not occur, until notification about the research and a copy of the survey was sent to the regional directors (the province is divided into four regions, Central, Eastern, Northern, Western, for the delivery of youth justice services).The original method of distribution cited in the research proposal, was that the survey would

be mailed via regular post, with stamped return envelopes to facilitate easy returns; the MCYS however opted to distribute the survey. The revised version of the questionnaire was distributed to the regional offices in July of 2009. After perusal a query was made about a French version of the survey, but with so many previous delays, it was not possible to facilitate such a request at that stage of the research process. This resulted in an unexplained change by the MCYS in the distribution method; the new plan was that the survey would be distributed electronically by the researchers, who would be required to contact each facility to obtain e-mail addresses. This necessitated a revision to the Ethics approval from The University of Western Ontario.

Final approval to distribute the survey was granted in September of 2009. Two weeks were allowed for the regional directors to disseminate notification memorandums from the MCYS to the facilities. Using the list of contact information provided by the MCYS, calls were made to each facility to ascertain whether they had received the memorandum and to obtain e-mail addresses. After confirmation of knowledge of the research, an introductory statement, a copy of the survey, the letter of information and a statement clarifying the change in the dissemination process were forwarded via e-mail to the facility director, manager or the appointed respondent. Instructions relating to who should complete the questionnaire were outlined in the letter of information; the director or primary contact for the facility were listed as the intended respondents, however it was noted that should they prefer to entrust the task to another individual, a senior staff member with detailed knowledge of the facility could complete the survey.

Up to November of 2009, some facilities continued to report that they had not received the notification to allow them to participate in the study, it was later discovered

that some facilities were run by charitable organisations or mental health centers and that the notifications were sent to the executive directors of these organisations and not the facilities. All facilities were eventually contacted and provided with a copy of the survey by mid December of 2009. Reminder notices were sent to any facility who had not returned the survey after 3 weeks. Seven facilities opted to return the survey via the post. The final completed survey was returned on January 15 of 2010.

Data Analysis

The data were analysed using version 17 of the Statistical Package for Social Sciences (SPSS). Data analysis consisted mainly of simple descriptive statistics which were used to summarize the presence, prevalence and provision of health services and programmes and to allow evaluation of compliance with the CPS's and the WHO's recommendations. To determine if there were any differences between the two types of facilities, analyses were conducted separately for open custody facilities and secure custody facilities. The data were screened for entry errors before any analyses were conducted.

Chapter 3: Results

Part 1 - Facility Information

Approximately 57% (*n* = 28) of facilities reported having an all male population, 27% (*n* = 13) have both males and females and 16% (*n* = 8) have females only. Short term care and long term care, is provided by all facilities, while 89% (*n* = 44) provide transient care, which was defined in this survey as stays of less than 30 days. The average length of stay at open custody facilities ranged from 5 days to 120 days; 61% (*n* = 20) of open custody facilities reported average stays of 30 days or less, compared to 45% (*n* = 5) of secure custody facilities. The capacity rates at open custody facilities ranged from a minimum of 6 to a maximum of 24. Secure facility rates appear to be more varied, ranging from a minimum of 6 to a maximum of 77; 57% (*n* = 8) however reported capacity rates of 20 and under. At the time of the survey, approximately half of the open custody facilities had occupancy rates of 50% or less, whereas only 21% (*n* = 3) of secure custody facilities had similar rates. The survey did not request information that would assist in determining whether these were typical rates; however 29% (10 open and 4 secure) of all facilities, indicated that overcrowding sometimes occurs.

Part 2- Health Care Guidelines

As one of the purposes of the survey was to consider how the current services offered at youth custody facilities compare with the CPS's recommendations, the survey included questions about knowledge and implementation of the recommendations. Only 21% (7 open custody and 3 secure custody) of the facilities were aware of the CPS's

health care standards for youth in custodial facilities. This figure was surprising, given that the CPS had reported that a database of the recommendations was in place at each facility. Of the 10 facilities that indicated knowledge of the recommendations, 3 reported that they had all of the recommendations implemented at their facility and 4 indicated that they had most. The other 3 facilities, along with the other 39 that indicated they were not aware of the recommendations, reported that they were not guided by the CPS, but were instead guided by the standards set by the Ministry of Children of Youth Services (MCYS), the Youth Justice Services Manual and the Child and Family Services Act.

The Canadian Paediatric Society recommends that each facility have a health programme designed by a multi-disciplinary advisory committee and reviewed periodically to respond to changes within the facility or the population. They further recommend that the programme be overseen by a health care professional, but suggest that someone other than a health care professional can oversee the programme in settings where there are no nurses. Most facilities (n = 42; 86%) indicated that they have their own guidelines or programme of health in place, 4 facilities (8%) indicated that they did not and 3 (6%) facilities did not provide a response. The number of facilities with their own guidelines and programme of health is higher than expected. It may be that respondents interpreted this question in relation to having guidelines from the MCYS and the Child and Family Services Act. This question actually refers to the facilities devising their own operating procedures and health programme according to their size, location, population type, population needs, staffing numbers and available resources. The need for some facilities to have separate guidelines, or at least a

variation to some of the MCYS guidelines, based on the aforementioned characteristics, becomes apparent in other areas of the results section of this study and is further described in the discussion.

Overall, 49% (*n* = 21) (*n* =13; 42% open custody, *n* = 8; 57% secure custody) of the facilities indicated that their health programme was overseen by a health professional, 5% (*n* = 1) reported that it was overseen by a nurse practitioner, 14% (*n* = 3) by a nurse, 29% (*n* = 6) reported that either a nurse or a doctor oversees the programme and 52% (*n* = 11) reported that it was overseen by a doctor. Only 8 (19%) facilities indicated that their programme was designed by a committee of individuals; 1 reported that the individuals on the committee were trained in medical care; another facility reported members trained in medical and psychiatric care; 2 indicated that their committee members were trained in all of the areas listed in the survey (medical care, dental care, education, psychiatric and psychological care); 4 facilities chose 'other' but did not provide information. Only 10 facilities (27%) (6 open and 4 secure) reported that a committee meets to determine whether the objectives of the health care programme are being met; 1 facility reported that the committee met biweekly; 4 reported monthly meetings, 2 reported quarterly meetings and 3 reported yearly meetings.

Part 3 – Health Care Programme

This section of the survey gathered information about where facilities access health care services and about health care budgets. Of the 39 facilities that responded to the question about health care budgets 82% (*n* = 32) allotted less than 10% of their budgets to health care; 3% (*n* = 1) allotted 10%; 10% (*n* = 4) allotted 11-19%; and 5%

(*n* = 2) allotted 20-29%. Seventeen facilities reported having onsite medical facilities, but only 2 facilities indicated that there was a medical professional assigned to every shift (one has a medical professional from 7am to 10pm). More secure custody facilities (*n* = 9; 75%) have onsite medical facilities, compared to open custody facilities (*n* = 8; 24%). However, only 1 facility indicated that all of its health care services were provided onsite and this was an open custody facility. Health care services for all other facilities were provided or supplemented by walk in clinics, emergency rooms, facility contracted doctors or any available doctor's office. Additionally, 1 facility reported utilising a community medical clinic, 1 facility reported using an emergency medical clinic, and 3 facilities indicated utilising the youth's own doctor. Table 1 provides a more detailed look at each facility's usage of various service providers.

Table 1

Usage of Medical Service Providers

Service Provider	Open Custody	Secure Custody	All Facilities
Contracted Doctors	58%	42%	55%
Emergency Room	55%	92%	64%
Walk In Clinic	61%	50%	58%
Any available Doctor	21%	33%	24%
Other Medical Office	36%	17%	31%

The table shows that open custody facilities use facility contracted doctors, other medical offices, and walk in clinics at higher percentages; whereas 92% (*n* = 11) of secure custody facilities utilise emergency rooms, compared to 55% (*n* = 18) of open custody facilities. It is not clear whether this is an access issue, but many international studies show that youth in secure custody generally acquire more injuries that require emergency care. Secure custody facilities generally tend to house youth convicted of more serious crimes, sometimes violent crimes; these youth tend to display more behavioural problems and anger management issues, leading to higher rates of peer abuse, youth on youth altercations and staff and youth altercations. It is, however, not possible to say whether this is the case in the Ontario facilities.

Part 4 - Intake assessment

This section examined medical evaluation processes during the intake period. The majority of facilities (*n* = 43; 88%) undertake medical histories after the youth arrive; only 6 facilities (12%) indicated that medical histories are not routinely performed. Facilities were asked about who performs medical histories; 35% (*n* = 17) reported that they are performed by a nurse; 24% (*n* = 12) noted that they are performed by a doctor; 4% (*n* = 2) indicated that they are performed by youth counsellors; and 2% (*n* = 1) use an 'untrained other', but did not specify who this was. The full results are presented in Table 2.

Table 2

Who Records Medical Histories at Admission

Person Who Records	Open Custody	Secure Custody	All Facilities
Doctor	26%	21%	25%
Nurse Practitioner	3%	7%	4%
Nurse	29%	50%	35%
Doctor or Nurse Practitioner	3%		2%
Doctor or Nurse	11%	14%	12%
Doctor or Untrained Other	6%		4%
Trained Other	3%		2%
Untrained Other	6%		4%
Medical Histories Not Taken	14%	7%	12%

All facilities provide medical evaluations; 94% (*n* = 45) perform evaluations on each youth; 1 facility performs evaluations by youth or staff request; 1 performs evaluations on those with no health record available (it was indicated that youth usually undergo medical exams before coming to their facility); and another facility that chose the 'other' option did not provide any information. Doctors perform the evaluations at 51% (*n* = 25) of the facilities; 31% (*n* = 15) of the facilities report that evaluations are performed by either a doctor or a nurse; 10% (*n* = 5) report evaluation by a doctor or a nurse practitioner; 4% (*n* = 2) report evaluation by a nurse and 4% (*n* = 2) report evaluations by a nurse practitioner. The Ministry of Children and Youth Services

(MCYS) requires that intake medical exams be performed by a doctor within 72 hours, but notes that facilities may use a nurse, only in cases where they are able to demonstrate that they are unable to find a doctor. The CPS also recommends a 72 hour time frame, but suggests that an initial assessment may be performed by a doctor or suitably trained nurse or nurse practitioner and that a complete medical be performed at a later date. Not all facilities meet this 72 hour requirement. Only 8% (n = 4) of facilities indicated that medical evaluations are performed within 48 hours, 49% (n = 24) report that they are performed within 72 hours, another 4% (n = 2) report that evaluations are performed within 72 hours or at the next available doctor's appointment, 2% (n = 1) reported 'other' but provided no additional information, 23% (n = 11) report that evaluations are performed within 3 to 7 days and 14% (n = 7) report that evaluations are performed after 7 days. However, 5 of those 7 facilities that reported performing evaluations after 7 days indicated that an initial evaluation is performed by a nurse within 48 hours.

As expected, a higher proportion of secure facilities (n = 12; 86%) were able to meet the 72 hour requirement, whereas only 46% (n = 16) of open facilities were able to do so. Many of the facilities that were not able to have medical exams performed within the recommended time period reported that this was often due to doctor shortages and not negligence and that appointments were always made within 24 hours of admission. One facility reported that unless serious issues were identified, medical evaluations with a doctor were performed after 2 weeks (they have an initial evaluation with a nurse) and another noted that sometimes remanded youth leave the facility without being seen by a doctor, but that arrangements are made for such youth to be seen by a doctor when

they return to their community. Some facilities also identified themselves as being located in rural areas or small towns where doctor shortages are severe. One facility cited that in the past they attempted to use walk-in clinics in an effort to meet the 72 hour requirement, but were often not accepted.

Facilities were asked about the provision of various types of medical tests and exams during intake evaluations, including, dental, vision and gynaecological exams. The majority of exams were conducted either 'as necessary' or at the request of youth. More detailed information is provided in Table 3.

Table 3

Provision of Various Medical Tests and Exams for Intake Medicals at All Facilities

Type Of Test	Never	As Needed	Youth Request	Always	Court & Staff Request	As Needed & youth req.	As Needed & Court Req	Sexually Active	As Needed & Sex. Active
Drug	41%	45%	4%	2%	2%	4%	2%		
Dental		54%	6%	25%		15%			
Hearing		53%	18%	16%	2%	10%			
Vision		41%	8%	41%	2%	8%			
Hepatitis	6%	42%	33%	2%		17%			
HIV	2%	25%	50%			17%	2%	2%	
Other Comm. Disease	2%	47%	22%	2%			27%		
STIs	2%	25%	43%			14%		8%	8%
*Gynaecol.	5%	38%	29%	4%		9%			14%
*Pregnancy	5%	38%	29%	4%		14%		5%	5%

*Gynaecological exams and Pregnancy tests (n = 21) as there are only 21 facilities with female residents

Part 5 – Health Services Provision

This section examined post intake day-to-day medical services provision. Facilities were queried about the most common method of receiving medical attention. At 12% (*n* = 6) of facilities the youth complete a form, at 25% (*n* = 12) staff members request medical attention for youth, and at 27% (*n* = 14) the most common method is for the youth to ask staff. The other 35% (*n* = 17) of facilities reported that various combinations of those options were utilised to request medical attention.

In response to how soon health care concerns are addressed by a medical professional, 50% (*n* = 24) of facilities reported that they are addressed within 24 hours, 10% (*n* = 5) of facilities address concerns within 48 hours, 8% (*n* = 4) within 72 hours, 4% (*n* = 2) within 3 to 7 days, and 23% (*n* = 11) at the doctor's availability. It was consistently made clear that all emergencies are addressed immediately. The issue surrounding medical care and doctor shortages was again raised in response to this question. One facility located in a rural area noted that they were often placed on waiting lists at community medical centres; therefore "trips to the emergency room are the norm" for this facility.

The question about the time period for care was similarly asked in relation to addressing dental concerns. Results show that 12% (*n* = 6) of facilities indicated that dental concerns were addressed within 24 hours, 8% (*n* = 4) reported that they were addressed within 48 hours, 8% (*n* = 4) reported within 72 hours, 20% (*n* = 10) reported within 3 to 7 days and 49% (*n* = 24) reported that they were addressed at the dentist's availability. It was again consistently noted that pain and emergencies are addressed within 24 hours.

Facilities were also asked about the availability of non-prescription drugs; this was a concern raised by youth in open custody in a previous survey. In response, 76% (*n* = 37) of facilities indicated that non-prescription drugs were always available, 4% (*n* = 2) indicated they were frequently available, 10% (*n* = 5) of facilities reported they are sometimes available, and at 10% (*n* = 5) of facilities non-prescription drugs are never available. Three of the facilities that reported that non-prescription drugs are never available clarified that they do not provide non-prescription drugs unless directed by a doctor. Although this may appear to be a rigid policy, it may relate to the fact that some of the youth in these facilities may be taking prescription medications for physical or psychiatric reasons; such a policy may be directed at preventing possible dangerous drug interactions. One facility noted that they provide non-prescription medication with caution and always closely monitor requests to track possible addictions or substitution for previous substance abuse habits.

Part 6 – Privacy and Consent Issues

Both the Canadian Paediatric Society and the World Health Organization advocate that confined youth have a right to privacy, that they should be involved in and consulted on health care decisions, and that their health record should be protected. This section of the survey attempted to examine these issues. Approximately 53% (*n* = 26) of facilities reported that their onsite medical evaluations were always performed without the presence of staff; 25% (*n* = 12) reported that evaluations are never performed without staff being present and 14% (*n* = 7) of facilities indicated that they do not have onsite evaluations. For offsite evaluations, 49% (*n* = 24) of facilities reported that they were always performed without the presence of staff and at 14%

(*n* = 7) of facilities evaluations are never performed without staff. Open custody facilities were twice as likely to have staff present for onsite evaluations, whereas secure facilities were 6 times more likely to have staff present for offsite evaluations. The full results are presented in Table 4.

Table 4

Levels of Privacy at Onsite and Offsite Medical Evaluations

Exam Performed in Private	Open Custody	Secure custody	All Facilities
Onsite Evaluations			
Always	46%	72%	53%
Frequently	3%		2%
Sometimes	6%	7%	6%
Never	28%	14%	25%
No onsite evaluation	17%	7%	14%
Offsite evaluations			
Always	54%	35%	49%
Frequently	17%		12%
Sometimes	23%	29%	25%
Never	6%	36%	14%

To obtain a fuller understanding of this issue, facilities were asked to indicate the circumstances under which staff would be present during medical exams. In response 35% of facilities (*n* = 17) stated that staff would be present at the request of youth, 16%

(*n* = 8) indicated they would be present with high risk youth (those that may pose an escape risk or have a tendency toward violent behaviour), 6% (*n* = 3) reported that staff would be present at a doctor's request. One facility (2%) also noted that staff members are present for gynaecological exams. Twelve facilities (25%) indicated that staff presence at evaluations was not limited to one reason and they therefore chose a combination of at youth's request, high risk youth or a doctor's request, as reasons for staff being present during medical exams. Some facilities pointed out that staff members were often behind the curtain or just outside the door during exams; some also noted, that if exams were particularly sensitive, the doctor would ask the staff member to leave the room.

Almost all facilities indicated that youth were always actively involved in their health care decisions. Only one facility indicated that youth were frequently involved. Nineteen facilities (42%) noted that there were circumstances where medical decisions were made without the youth's consent. Of those 19 facilities, 8 stated this occurred in the event of medical emergencies and 6 reported that this occurred when a youth's refusal of medical care after an injury was overridden by professional or staff opinion. A court order, a guardian decision, an episode of psychosis, diminished capacity, being underage and doctor ordered medication dosage changes were each cited by a facility as other reasons when medical decisions are made without a youth's consent.

In response to the question about private dispensing of drugs, 53% (*n* = 26) of facilities reported that drugs are always dispensed in private, 33% (*n* = 16) reported that they are frequently dispensed in private, 12% (*n* = 6) reported drugs are sometimes dispensed in private and 1 (2%) open custody facility indicated that they were never

dispensed in private. Most facilities (n = 44; 92%) indicated that they never received complaints from youth about their medical issues being exposed within the facility, whereas 4 (8%) facilities (2 open and 2 secure) reported that they sometimes received complaints.

Part 7 – Staff Information

The majority of the questions adapted from the WHO's consensus statement relate to staffing issues. In the statement's introduction it is noted that "the importance of recruiting suitably qualified and trained staff and the importance of initial and continuing professional development for staff so that they continue to meet the needs of young people appropriately, are seen as two of three over-riding factors and cross cutting issues which need to be emphasised" (WHO, p.8). The questions in this section of the survey therefore relate to those issues.

The majority of the facilities do not have a multi-disciplinary health care staff as recommended by the WHO; only two of the facilities have a full health care staff complement. There was as expected a greater number of clinical and professional staff in secure custody facilities; the numbers are however not evenly distributed among secure custody facilities, even when comparisons are made based on facility size. Among the open custody facilities that provided information (n = 29), one has a part-time doctor, 9 have part-time nurses, and 8 have social workers; whereas for secure custody facilities (n = 12), 2 have part-time doctors on staff, 1 has 4 full-time and 4 part-time nurses, 5 others have part-time nurses, 1 has 2 part-time sexual health specialists, 2 have nurse practitioners, 1 has 2 part-time psychologists, 2 have full-time psychologists, 1 has 1 full-time psychometrist, another has 2 part-time psychometrists,

and 2 have part-time dentists. Almost all facilities reported that they never utilize opticians, audiologists, physiotherapists or occupational therapists. More information on staff complement is presented in Table 5 and Table 6 and it can be seen from these tables that there are variable numbers of youth service workers and youth counsellors (in open custody facilities these titles are interchangeable) among the facilities.

In relation to other non-clinical staff, 9 (20%) facilities reported having programme officers (individuals responsible for programme choice and implementation) and 48% (n = 21) of facilities reported having clerical staff. Within the literature, it is noted that the absence of clerical staff in prisons can lead to management and efficiency problems, as administrators spend time completing clerical duties, thereby reducing their ability to complete many other required tasks (Campaign for Responsible Priorities, 2006). It is not clear from the information gathered in this survey whether this is an issue for youth custody facilities in Ontario. Issues relating to staff numbers, ability to hire more staff and problems caused by insufficient staff were raised by some respondents and are further discussed in other sections of this report.

Table 5

Clinical Staff and Youth Service Staff Numbers at Secure Custody Facilities

Capacity	Average Stay (Days)	Doctor	Nurse	Nurse Practitioner	Social Worker	Psychologist	Psychometrist	Dentist	Sex Health Specialists	Youth Service Workers FT/PT*
10										8/10
12	40				1					15/0
12	30		1p							10/12
12	90		1p		2p	1	1			8/0
16	60									20/10
20	11		1p							29/13
26	28				1					16/0
30	24		1p		1p	1				24/22
32			2p		1p				2p	
40	46									35/0
48	13mts	3p	4/4		4	2	2p	1p		69/0
77	14	2p			6	2p		1p		86/0

*p indicates part time

*FT/PT- indicates full time versus part time

Table 6

Clinical Staff and Youth Service Staff Numbers at Open Custody Facilities

Capacity	Average Stay (Days)	Doctor	Nurse	Social Worker	Youth Service Workers FT/PT*	Counsellors FT/PT
6	15				6/7	2
6	5				6/8	
8	50				8/8	
8	50				8/12	
8					7/13	
8				0.5	8/15	
8	30					10/10
9	60				7/10	
9			1p	1p	8/8	
9			1p	1p	9/15	
10						10/2
10			1p		8/0	1/10
10	70	1	1p	2	18/0	
10	30		1p		8/8	
10	90		1p			

Clinical Staff and Youth Service Staff Numbers at Open Custody Facilities Table 6 Continued

Capacity	Average Stay (Days)	Doctor	Nurse	Social Worker	Youth Service Workers FT/PT*	Counsellors
10	14			1	10/5	
10						10/21
10				0.5	10/15	
10	21				10/18	
10	30				1/0	8/6
10	7				8/9	
10	45		1			12/0
10	30				10/2	
12	10		1		14/10	
12	8			1	12/7	
12	90				8/0	
15	30				12/10	
16	120	1p	1/1	2		19/12
24	54				5/5	

*p indicates part time
*FT/PT indicates part time versus full time

All facilities reported that they screened staff prior to hiring them; however different categories of staff are screened at different levels. Youth service workers were screened by 98% (*n* = 48) of facilities; 59% (*n* = 29) screen teachers; 47% (*n* = 23) screen other professional staff; and 31% (*n* = 15) of facilities screen medical and clerical staff. Facilities reported employing a variety of screening methods; 98% (*n* = 48) use police background checks; 92% (*n* = 45) use reference letters; 78% (*n* = 38) use single interviews; 70% (*n* = 34) use past employment reviews; and 55% (*n* = 27) use repeated interviews. Other screening methods not listed on the survey are also employed by 22% (*n* = 11) of the facilities. These additional methods include internships (*n* = 7), pre-employment job shadowing (*n* = 1), reference check interviews (*n* = 4) immunization records and medical exams (*n* = 5), panel interviews (*n* = 3), Google search (*n* = 1), drivers license checks (*n* = 1), problem management skills testing (*n* = 1), and aggression management skills testing (*n* = 1).

All facilities, excluding one, reported that continuous training was required of staff in their specific areas of work. The majority of respondents (*n* = 43; 90%) indicated that staff members are required to upgrade their skills yearly. Additionally, 40% (*n* = 19) of facilities indicated that they also provide training in response to incidents. More open custody facilities indicated providing training when incidents arose, with 43% (*n* = 15) of open custody facilities, compared to only 31% (*n* = 4) of secure custody facilities reporting training following incidents.

Facilities were also asked about providing training in a specific set of areas; all facilities provide training in behaviour management; 60% (*n* = 29) provide training in adolescent health care and adolescent psychological functioning, and 64% (*n* = 31)

provide training in adolescent motivation. Most facilities (*n* = 43; 90%) indicated that training in these areas was most often provided on a yearly basis. Information was also solicited about areas of training not listed on the survey; the responses are listed in Table 7. More open custody facilities (*n* = 14; 40%) reported providing additional training than was reported by secure custody facilities (n = 2; 15%).

Table 7

Additional Types of Staff Training Provided by Facilities

Type of Training	Open Custody	Secure Custody
Anti oppression training		1
Cognitive behavioural counselling		1
Crisis intervention	2	1
CPR training	13	
Facilitation skills	1	
*FASD	1	
Gender responsive training	1	
Managing peer aggression	3	2
Motivational interviewing	1	
*PMAB recertification	1	
Risk management	1	
Self injurious behaviours	1	
Substance abuse/addictions	2	
Suicide intervention	5	

Additional Types of Staff Training Provided by Facilities Table 7 Continued

Type of Training	Open Custody	Secure Custody
STI information	8	
Use of fire extinguishers	1	
Wilderness expedition skills	1	

*Fetal Alcohol Spectrum Disorder

*Prevention and Management of Aggressive Behaviour

Although the issue of staff training is more extensively covered by the WHO, the CPS recommends that the physicians who treat youth in custody should have expertise in youth health issues and that if a physician does not have expertise in this area, he or she should have access to or support from other physicians in the field of youth health care. This recommendation is supported in the literature on adolescent health care, where it is purported that the pivotal biological, psychological, social, and cognitive changes that occur during adolescence make practicing medicine with this population different from caring for young infants, young children, and adults (Geidd, 2004; Katzman, Frappier, & Goldberg, 2008; Palmert & Boepple, 2001). The facilities were therefore asked about training in this area; 24 facilities (65%) indicated that their medical and other professional staff members were trained in youth health care.

Part 8 - Emergency Care

In addressing emergency care plans, the CPS proposes a number of recommendations relating to first aid training, violent behaviour management, safety procedures, and staff training. This section of the survey consisted of questions that

gathered information relating to these recommendations. At the majority of the facilities (n = 42; 86%), all staff are reported to be trained in basic first aid; the remaining facilities (n = 7; 14%) indicated that most of their staff are trained in this area. The numbers of those trained beyond basic first aid are, however, significantly lower. Only 18% (n = 9) of facilities reported that all staff members were trained beyond basic first aid; 2% (n = 1) of facilities indicated that most staff are trained beyond basic first aid; at 39% (n = 19) some staff are trained beyond basic first aid and 41% (n = 20) of facilities reported that no staff were trained beyond basic first aid.

In Canada, the next level of training after basic first aid is referred to as standard first aid and it covers all of the areas addressed in basic first aid, but also includes training on burns, bites, stings, poisons, head and neck injuries, eye injuries, wound care, emergency childbirth, and multiple casualty management (St. John's Ambulance Brigade, 2010). Of the facilities that reported that members of their staff had training beyond basic first aid, only 18% (n = 8) reported that staff members with this training are present at all times.

All staff members at all facilities are trained in the management of violent and confrontational behaviour. Additionally, all facilities have 24 hour emergency care plans for medical and behavioural emergencies and 96% (n = 47) have plans for psychiatric emergencies. It was reported that 78% (n = 36) of facilities have all staff trained in the implementation of these plans; whereas the other 22% (n = 10) report that most staff are trained in the implementation of these plans. In response to how often training updates are provided for these plans, 54% (n = 26) of facilities indicated that they have training updates on a yearly basis, another 23% (n = 11) indicated that training occurs

both yearly and in response to incidents, 8% (*n* = 4) have training updates biannually and in response to incidents, 4% (*n* = 2) have training updates monthly, 4% (*n* = 2) quarterly, 2% (*n* = 1) biannually, and 2% (*n* = 1) reported that training updates are never provided.

Most facilities (*n* = 35; 76%) have a list of emergency resources posted on the wall and a manual that lists all available onsite and offsite resources (*n* = 35; 75%). All facilities reported having first aid kits and 7 facilities (*n* = 5, secure custody, *n* = 2, open custody), indicated that they have oxygen tanks; only 1 facility has most staff trained in the use of the oxygen tanks, whereas the other 6 have some staff trained. All facilities have fire drills for both staff and youth; the majority of facilities (*n* = 46; 94% for staff, *n* = 44; 92% for youth) conducted fire drills on a monthly basis.

The survey also inquired about professional site inspections. Professional in the context of this survey referred to "qualified inspectors, not belonging to administration of the facility" (United Nations, p.10). Inspections check on aspects of a building that are important in the event of an emergency, including checks on firefighting equipment and alarms, lighting and ventilation, storage of hazardous materials, and the general integrity of the building. The majority of facilities (*n* = 43; 88%) reported that they undergo professional inspections, whereas 12% (*n* = 6) indicated that they did not. Inspections were reported to be conducted yearly by 26% (*n* = 12) of facilities, monthly by 41% (*n* = 19), and quarterly by 17% (*n* = 8); 1 facility reported carrying out weekly inspections. It was surprising that some facilities reported that they do not undergo inspections; inspections are required as part of the yearly relicensing process. However one facility clarified that they do not undergo professional inspections, but that a local

committee conducts monthly inspections; it is not clear whether the other facilities that indicated they do not undergo professional inspections also employ a similar process. Greater clarity on facility inspections was sought from the MCYS; their personnel responded only in relation to yearly relicensing inspections and informed that those inspections are a shared process between the Ministry and the facilities, as some of the required work is conducted by both parties (personal communication, February 22, 2010).

Part 9 - Nutrition

This section of the survey consisted of 3 questions on food choices. All facilities indicated that they provide meals in accordance with Canada's Food Guide for Teens. Those guidelines require vegetables and fruit (fresh, frozen and canned) at 7 to 8 servings per day for females and 7 to 10 servings for males, grain products at 6 to 7 servings per day for females and 7 to 8 servings for males, milk at 3 to 4 servings per day or milk alternatives at 2 servings per day for both sexes and meat or meat alternatives at 2 servings per day for females and 3 servings for males (Health Canada, 2007). In addition to following the food guide, 52% (n = 25) of all facilities reported that a dietician or comparable medical professional have input into the food choices, and 33% (n = 16) reported that youth always have input regarding the types of food served. These results are presented in Table 8.

Table 8

Levels of Input into the Menu from Youth Residents, Dietician or Comparable Professionals

Youth Input	Open Custody	Secure Custody	All Facilities
Always	37%	21%	33%
Frequently	46%	36%	43%
Sometimes	17%	36%	22%
Never	8%	2%	2%
Dietician Input			**All Facilities**
Yes	51%	62%	48%
No	49%	39%	42%

Part 10 - Health Education

This section of the survey examined health education programming, the type of information taught, and the frequency of sessions. Most facilities (84%) reported having an ongoing health education programme, with only 8 facilities indicating that they did not have an ongoing programme. Four of the facilities that reported having ongoing programmes however indicated that, health education was provided 'as needed' (n = 2), and 'at admission' (n = 2). Such programmes do not meet the definition of ongoing; therefore a total of 37 facilities (76%) were considered as having an ongoing health education programme while 12 facilities (24%) were considered to not have an ongoing health education programme. For 1 of the facilities, it is understandable that they do not

have an ongoing programme as they are a transient care only facility, with average stays of less than 7 days. The other 11 facilities without ongoing programmes all indicated having average custody stays of 30 days or more.

For those who have programmes, 5% (*n* = 2) reported that health education sessions were conducted daily; 41% (*n* = 15) reported that they are conducted weekly; 11% (*n* = 4) have them biweekly; 24% (*n* = 9) have them monthly; 14% (*n* = 5) have their sessions quarterly; 5% (*n* = 2) reported that they conduct health education sessions 3 to 4 times a week and another 5% (*n* = 2) selected the option of 'other' but did not provide any specific information. Over 80% of all facilities provide education sessions in food and nutrition, sexual health, hygiene, drug education, and sports and exercise. Seven open custody facilities used the 'other' option on this question to report providing health education in areas not listed on the questionnaire. One facility reported providing first aid and CPR certification, 1 listed healthy relationships, 1 indicated self esteem, 1 listed cognitive skills, 1 listed cultural awareness and 2 facilities noted that their youth were enrolled in a school programme where they receive additional health information. The full results are reported in Table 9.

Table 9

Types of Health Education *Provided at Facilities*

Type of information	Open Custody	Secure Custody	All facilities
Dermatology	20%	25%	22%
Exercise and sports	88%	83%	86%
Food and nutrition	80%	100%	86%
Hygiene	100%	92%	97%
Mental health	64%	67%	65%
Parenting classes	52%	41%	40%
Prenatal classes	24%	16%	16%
Sexual health	100%	100%	100%
Other	16%	25%	19%

Facilities were asked about whether health education sessions were administered by experts. Of those facilities that provide ongoing health education programmes, 16% (n = 6) reported that this was always done, 38% (n = 14) indicated this was frequently the case, 41% (n = 15) of facilities indicated that this was sometimes the case and 5% (n = 2) reported that they never have experts administering health sessions. Four facilities volunteered further information on this question; 1 open custody facility reported that a social worker provides mental health sessions, 2 facilities (1 open custody, 1 secure custody) have speakers from their local hospital come in to conduct sessions, and another open custody facility indicated that a dentist comes to speak on dental hygiene. Approximately 40% (n = 15) of facilities indicated that the schedules for

these programmes are always maintained, 38% (n = 14) reported they were frequently maintained, and 22% (n = 8) reported that schedules are sometimes maintained. In addition to health education sessions, 87% (n = 41) of facilities indicated youth had regular access to books and pamphlets, and 84% (n = 38) reported that other health information in the form of posters and information sheets are on display in the facilities. These results can be seen in Tables 10 and 11.

Table 10

Levels of Expert Administration for Health Education Programmes

Frequency	Open Custody	Secure Custody	All Facilities
Always	8%	33%	16%
Frequently	28%	50%	38%
Sometimes	40%	17%	41%
Never	24%		5%

Table 11

Maintenance of Programme Schedule for Health Education Programmes

Frequency	Open Custody	Secure Custody	All Facilities
Always	48%	50%	40%
Frequently	40%	33%	38%
Sometimes	12%	17%	22%

Part 11 - Physical Activity

In 72% (*n* = 33) of facilities, physical activity was reported to be compulsory, whereas 28% (*n* = 13) indicated that it was not mandatory. Two of the facilities for whom it was not compulsory noted that it was strongly encouraged. Approximately 78% (*n* = 38) of facilities reported that they sometimes experienced problems getting youth to participate in physical activity, 10% (*n* = 5) reported that they frequently experienced problems, 6% (*n* = 3) reported always experiencing problems, and 6% (*n* = 3) reported that they never experience problems. Most facilities (*n* = 36; 80%) allow 60 minutes or more per day for physical activity, 11% (*n* = 5) allot 31-59 minutes and 9% (*n* = 4) allot 15-30 minutes. Only 20% (*n* = 10) of facilities have a sports or fitness coordinator.

Facilities were also asked about conducting physical activity assessments. In response, 23% (*n* = 10) reported that they are always conducted, 7% (*n* = 3) reported that they are frequently conducted, 19% (*n* = 8) reported that they are sometimes conducted, and 51% (*n* = 22) of facilities reported that they do not conduct physical activity assessments. Reported by 44% (*n* = 19) of facilities, indoor activity was listed as the most common type of physical activity; 16% (*n* = 7) listed outdoor activity as being the most common type of physical activity at their facilities, while 40% (*n* = 17) of facilities indicated that a combination of outdoor and indoor activity was most common. It was reasonable for indoor activity to be more common because of the climate in Ontario. Additional information from some facilities suggested that their predominance of indoor activity may not be a consequence of the weather. One facility noted that transportation was a factor in determining the type of activity. They are able to walk to the YMCA in the warmer months, but "walking to the YMCA with a set of kids in the

snow is not ideal". Another two facilities indicated that they do have not enough staff to accompany youth on outdoor activities and noted that it had been a few years since they were awarded a funding increase which would allow them to hire sufficient staff for such activities. These two facilities further noted that as small facilities, they have insufficient indoor space for team activities.

Organised sports are available at 78% (*n* = 38) of all facilities, and team sports are available at 63% (*n* = 31) of facilities. Secure custody facilities are more likely to have organised sports and team sports than are open custody facilities. To obtain a more comprehensive view of physical activity programming, respondents were asked to provide specific information about the availability of various sporting activities and equipment at their facilities. Having a basketball court and equipment (*n* = 45; 92% of facilities), volleyball court and equipment (*n* = 30; 61%), and weight room or weight training classes (*n* = 27; 55% of facilities) were most commonly reported, whereas dance classes were reported at only 4% (*n* = 2) of facilities and are the least common activity. The results are listed in Table 12.

Table 12

Types of Physical Activities Available at the Facilities

Activity/Equipment	Open Custody	Secure Custody	All Facilities
Aerobics	17%	50%	27%
Athletic competitions	23%		29%
Basketball	89%	100%	92%
Dance classes	6%		4%
Football	31%	79%	45%
Organised sports	71%	93%	78%
Swimming classes	26%	7%	20%
Swimming pool	23%	7%	18%
Team sports	49%	100%	37%
Tennis court	14%	21%	16%
Treadmills	40%	36%	39%
Volleyball court	49%	93%	61%
Weight training	49%		55%
Other activities	34%	36%	35%

Two open custody facilities have quite varied programmes; one reported that they were able to achieve this through links with various community organisations, whereas the other incorporates various forms of physical activity (for example kayaking, nature trails) as part of the rehabilitation process. Ten facilities indicated that they have YMCA memberships. This information regarding YMCA memberships was not

requested on the survey but rather was provided voluntarily. It is therefore possible that more facilities have YMCA memberships. Just over one third of facilities (*n* = 17; 35%) indicated that they provide other sporting activities that were not listed on the survey. These results are presented in Table 13.

Table 13

Additional Physical Activities Available at Facilities

Activity	Open Custody	Secure Custody
Balance boards	1	
Baseball	4	1
Boat rowing	1	
Bocci ball	1	
Bubble hockey	1	
Canoeing	1	
Cardio	1	
Cycling	1	
Elliptical trainer	1	
Exercise bikes		1
Floor hockey	2	6
Foozeball	2	
Hiking	2	
Kayaking	1	
Medicine balls	1	

Other Types of Sporting Activities Provided by Facilities Table 13 continued

Activity	Open custody	Secure custody
Ping pong	3	
Road hockey	1	
Rock climbing	1	
Ropes	1	
Running		2
Skiing	3	
Snow shoeing	4	
Soccer	2	
Wall climbing	1	
Walks	1	
Wii fit	1	2
Yoga	1	1

Questions about the types of recreational activities available were also included in this section of the survey. With the exception of computer classes, which were available at 49% (n = 24) of facilities and drama classes at 14% (n = 7) of facilities, all other recreational activities were reported to be available at more than 60% of all facilities. Table 14 reflects that secure custody facilities are likely to have computer classes and art classes while open custody facilities are more likely to have drama

classes, cooking classes, video games and other activities. Eleven facilities (22%) also reported providing additional recreational activities; these include sewing classes (*n* = 3), guitar playing (*n* = 1), cosmetology classes (*n* = 1), baking classes (*n* = 1), bingo (*n* = 1), card games (*n* = 1), pool table (*n* = 1), cultural programming (*n* = 1), library (*n* = 1), walkman use for youth with higher privileges (*n* = 1), participation in snack and meal preparation (*n* = 1), and animal visits (*n* = 1) (two dogs visit the facility).

Table 14

Types of Recreational Activities Available at Facilities

Activity type	Open Custody	Secure Custody	All Facilities
Art classes	69%	93%	76%
Board games	94%	100%	94%
Books and magazines	94%	93%	94%
Computer facilities	43%	64%	49%
Cooking classes	71%	64%	69%
Drama classes	17%	7%	14%
Music area or resources	60%	71%	63%
Television	97%	100%	98%
Quiet lounge area	80%	93%	84%
Video games	89%	71%	84%
Other activities	26%	14%	22%

Part 12 - Mental Health

This section of the survey focussed on psychological evaluations, suicide prevention, counselling resources, time allotted for counselling, and substance use screening. Only 4 facilities reported that all youth who enter their facility undergo psychological assessments, some secure custody facilities however noted that they provide psychological screenings. Screenings are usually brief in nature, whereas assessments provide a comprehensive analysis of the individual (Grisso, Vincent, & Seagrave, 2005). Facilities indicated that when youth undergo psychological assessments, they are performed for a variety of reasons. The majority of assessments (n = 22; 92%) were reported to occur due to court orders. All other options, such as having previous mental health issues, staff requests, in follow up to an incident and lack of a mental health record, were chosen at rates between 8% and 50%. One facility reported that they perform assessments for research purposes and another indicated that they are sometimes performed at a physician's request. Assessments are always performed by a licensed psychologist; 2 facilities indicated using psychiatrists and 49% (n = 24) of facilities reported that they always used psychologists trained in adolescent mental health.

One open custody facility noted that they experience extreme difficulty accessing a psychologist when reports are required and revealed that it was extremely difficult to find a child psychologist in their area. Another open custody facility reported that accessing mental health services in the region in which they are located is extremely difficult due to lack of availability and that wait times for assessments could be as much as 3 months or more depending on the nature of the assessment.

A substantial proportion of facilities (*n* = 26; 65%) state that youth always have access to counselling from trained counsellors; 12% (*n* = 5) of facilities reported that youth frequently have access to counselling and 23% (*n* = 9) reported that the youth sometimes have access to a trained counsellor. The survey also asked about the circumstances under which counselling is provided. The results are presented in Table 15 and show that counselling is most often provided at the request of youth (*n* = 38; 90%) and in response to incidents (*n* = 27; 64%). Only 33% (*n* = 14) of facilities indicated that they provide counselling for youth with a history of mental illness.

Table 15

Reasons Why Counselling Is Provided

Circumstance	Open custody	Secure custody	All Facilities
As necessary	43%	33%	40%
Court ordered	63%	42%	57%
Each youth	30%	42%	33%
History of mental illness	37%	27%	33%
Having a difficult time	27%	25%	26%
In response to incidents	63%	67%	64%
Youth request	90%	83%	90%
Short term sentences	13%	42%	21%
Long term sentences	17%	42%	24%
Long disposition times	10%	17%	12%
Other	23%	8%	19%

Facilities were also asked to indicate if there were reasons other than those listed on the survey under which counselling is provided; parental requests, staff concerns, and providing ongoing counselling as part of therapeutic relationship building with staff were reported. In response to the question regarding the time allotted for counselling, 47% (n = 20) of facilities stated that counselling was provided as needed, 23% (n = 10) reported that 60 minutes were allotted per session, 23% (n = 10) reported that more than 60 minutes were allotted per session, 5%, (n = 2) reported that counselling was provided based on need or availability and 2% (n = 1) reported that 30 minutes were allotted per session. Open custody facilities provide more counselling on an as needed basis, whereas secure custody facilities provide most counselling on a time structured basis. Three open custody facilities provided additional information on their counselling resources. One of these facilities noted that clinical staff come in once a week for 6 hours and uses the time as they see appropriate. Another reported that counselling sessions usually consist of group work, as their ratio is 1 therapist to 10 youth, but that individual counselling is arranged based on need and availability. The third facility noted that they have biweekly visits from a psychiatrist who assists in developing and supervising the implementation of plans of care.

Screening each youth for recent and past substance use was reported by 90% (n = 44) of facilities, 4 (8%) facilities reported screening youth 'as deemed necessary'. One (2%) facility reported that admission to their residence is based on history of drug use, hence they do not screen youth when they arrive. It was surprising that 4 facilities reported screening each youth 'as necessary' for recent or past substance use, considering that, the MCYS informed that their standardized intake self-reporting form

asks about substance use history. Only 25%, (*n* = 12) of facilities noted that those experiencing withdrawal symptoms are always seen in medically supervised settings; 8%, (*n* = 4) reported that this was frequently done, 47% (*n* = 23) reported that this was sometimes done and 20% (*n* = 10) of facilities reported that this was never done.

The survey also asked about suicide prevention and assessment. In response, 98% (*n* = 40) of facilities reported that they have a suicide prevention plan, 69% (*n* = 29) reported that all staff members are trained in suicide prevention measures, 21% (*n* = 9) reported that most staff members are trained and 10% (*n* = 4) reported that some staff members are trained in this area. Most facilities (*n* = 38; 78%) indicated that they perform suicide assessments on all youth and they all perform them routinely at intake. Only 2 (4%) facilities indicated that suicide assessments are performed by licensed psychologists or psychometrists. All other facilities (*n* = 46) reported that they use nurses, youth service workers, social workers or frontline staff.

Part 13 – Long Term Sentences

This section focussed on pre-release processes that would assist with reintegration into the community. The majority of facilities (*n* = 43, 88%) reported that plans of care are always completed in 30 days, in accordance with the Child and Family Services Act regulation. The other 6 (12%) facilities reported that they were frequently completed within 30 days. Approximately 51%, (*n* = 25) of facilities reported that all recommendations from the plan of care are implemented, 47%, (*n* = 23) reported that most recommendations are implemented, and 2%, (*n* = 1) reported that only some of the recommendations are implemented. At most facilities (*n* = 31, 63%) a social worker

or personal officer, (prime worker) is assigned within 24 hours, at 12% (n = 6) of facilities a social worker or personal officer is assigned within 48 hours, at 10% (*n* = 5) within 72 hours, at 4%, (*n* = 2) within 3 to 7 days, and at 8%, (*n* = 4) a social worker or personal officer is only assigned in certain situations.

Facilities were also asked if a medical professional is involved in pre-release plans. While 10% (*n* = 5) of facilities noted this is always done, 51% (*n* = 25) indicated that this only occurs if there is a serious health problem, 4% (*n* = 2) reported that this is frequently done, at 25% (*n* = 12) of facilities this sometimes occurs and at 10% (*n* = 5) of facilities medical professionals are never involved in pre-release plans. In response to whether medical evaluations are conducted on youth prior to discharge, 29% (*n* = 14) of facilities reported that they evaluate no youth, 20% (*n* = 10) evaluate those with known health problems and 14% (n = 7) evaluate those youth who request evaluation. Relative to secure custody facilities, open custody facilities are twice as likely not to evaluate any youth prior to discharge.

The final two questions queried whether medical and mental health plans were prepared and sent off to community care officers. At 43% of facilities (*n* = 21) medical health plans are always sent to community care (probation) officers, 6% (*n* = 3) of facilities frequently send medical health plans, 41% (*n* = 20) sometimes send off these plans and 10% (*n* = 5) never send these plans. For mental health plans, 45 % (*n* = 22) always forward these plans to community care officers, 22% (*n* = 11) frequently send off these plans, 25% (*n* = 12) sometimes send off these plans and 8% (*n* = 4) never send mental health plans to community care officers. One facility noted that such plans were only sent off if they obtained consent from the youth.

Chapter 4: Discussion

The purpose of this study was twofold; the first objective was to gather information on the current health-related services provided to youth in custodial facilities in Ontario and the second was to consider how those services compare with recommendations from the Canadian Paediatric Society and the World Health Organization for the health care of youth in custodial facilities. This discussion is therefore divided into two sections. The first section examines the facilities' observance of the CPS and the WHO recommendations and the second section examines other areas of service that were not directly or extensively addressed by those organisations. Recommendations for service improvement, study limitations, and future research are also considered.

Adherence to Recommendations

(A) Are Facilities Observing the Canadian Paediatric Society's Recommendations?

Although only 21% of the facilities indicated that they are aware of the CPS's recommendations, the majority appear to be meeting most of the guidelines that the CPS proposes. All facilities reported that youth are actively involved in their health care decisions and the majority reported that they take psychological, physical health, drug use, and behavioural histories when youth arrive; further, they transfer information to community care (probation) officers when youth leave the facility. Emergency plans are in place for medical and behavioural emergencies at all of the facilities. Psychiatric emergency plans are in place at 96% of facilities; 78% of facilities have trained all of their staff members in how to undertake these plans and the other 22% have trained

most of their staff. The CPS, however, recommends that all staff should be trained in emergency plans, this would reduce delays and ensure more efficiency and competency should an emergency occur. Fire drills for both staff and youth are conducted at all facilities. Every facility has first aid kits and 7 facilities indicated that they have oxygen tanks. The facilities appear to be protecting the privacy of their youth residents, and even though it was reported by some respondents that staff members are present during medical exams, this is justifiable given the tendency among this population towards problematic behaviours while in custody.

According to the responses, all facilities provide "nutritional services that promote healthy eating habits" (CPS, p. 288) as each facility indicated that meals are provided in accordance with Canada's Food Guide for Teens. In addition, approximately 76% of the facilities reported having ongoing health education programmes. These results, although encouraging, are viewed with caution as two previous surveys have shown that many open custody facilities have programmes that are listed on the daily schedules, but are not always delivered (Cooke & Finlay, 2007; Wormith & Mazaheri, 2002, as cited in Borgida & Semple, 2008). Additionally, a recent review of one of Ontario's newly built secure custody facilities showed that much of the promised programming was not actually delivered (Zlomislic, 2009). All of the facilities reported that they provide sexual health education. This is not surprising given the high percentages of this population who reportedly engage in high risk sexual behaviours. Education in food and nutrition, hygiene, and exercise and sports was also prevalent at most of the facilities.

It was particularly concerning that almost a quarter of the facilities (n = 12; 24%) reported not having ongoing health education programmes and that 11 of these 12 facilities reported average stays of 30 days or more. Even if the residents at some of these facilities attend schools in the community where they would access health education, youth custody personnel obtain intimate knowledge of these adolescents' problems and behavioural habits through intake forms and are therefore in a unique position to provide programming based on these identified problems and habits. Researchers in the field of adolescent health also propose that those designing health education programmes should consider the recent research, which suggests that the part of the brain that helps with decision-making and determining consequences is not fully developed in adolescents (Dahl, 2004; Geidd, 2004) and, thus, what adults see as problems, adolescents may see as higher priority needs, such as, engaging in tobacco smoking as a method of weight control or as a socialization requirement. It is advocated that "interventions therefore need to be based on understanding what it is adolescents are trying to resolve when they engage in risky behaviour" (Tonkin, 2001 p. 425).

It is also hoped that the focus of health education within the facilities is not just on the biomedical approach to health. The biomedical approach focuses on measuring and reducing physical risk factors for disease, such as cholesterol level, blood pressure, fat intake, sodium intake and exercise habits. In this approach, clients often remain passive recipients of directives from experts or professionals (Naidoo & Wills, 2000). In contrast, a health promotion approach would result in more emphasis being placed on other factors that influence health such as psychological, social, and spiritual issues

(Robison, 2004). Additionally, health education provided to youth in custody under a health promotion approach would provide reflective information and knowledge to recipients and would influence them to make their own rational decisions through the empowerment process (Tannahill, 1985).

The preceding discussion revealed that the facilities appear to be observing most of CPS's recommendations. There are however some aspects of the CPS's recommendations that are not widely implemented by the facilities. For example, the CPS proposes that all youth have complete dental exams as a part of their intake medical; however, only 40% of facilities report that they always provide dental exams. Additionally, only 20% of facilities reported having a committee that meets to determine if the objectives of the health programme are being met. Just under a quarter of the facilities reported that youth experiencing withdrawal symptoms from substance use are always seen in medically supervised settings; whereas 20% reported that this is never done.

Only 49% of facilities reported that a medical professional oversees their health programme. This figure is not surprising as the Ontario Medical Association estimates that the province is short in excess of 2,000 physicians (Ontario Medical Association, 2007). The problem is even more serious in rural Ontario, which is occupied by 15% of the population, but only served by 5% of the province's physicians. Many of the respondents indicated that the doctor shortage affects the facility's ability to meet the recommendation of having intake medicals performed within 72 hours. This challenge was most apparent among open custody facilities, with 40% more open custody facilities experiencing difficulty achieving this goal than secure custody facilities.

In order to assist all facilities in meeting this standard for medical oversight of their health care programme, perhaps in communities where facilities continuously experience problems finding a doctor within a reasonable time, the MCYS could consider relaxing the requirement to allow experienced nurses or nurse practitioners to conduct intake medicals on the condition that youth be seen by a doctor at a later date. Based on the data provided, this situation already is the practice in the MCYS direct-operated facilities where youth are seen by a nurse within 24 hours of admission and also at some private facilities that have nurses on staff, but are unable to have youth seen by a doctor within 72 hours. In some cases, this may require providing additional funding for a part-time nurse, especially in rural or remote areas. An increased role for nurses would not only assist with intake medicals, but would enhance general day to day medical service provision and would greatly reduce the need for reliance on emergency room visits for non-emergency issues. In addition to being stressful, emergency room visits reduce the staff numbers at the facility and could have effects on security and programme delivery. Further, ensuring that each facility has a nurse, or at least ready access to a nurse, would minimise a seeming disparity among facilities in terms of available medical staff services and would ensure that all youth entering youth custody facilities have the same opportunity to receive timely appropriate health care.

The other CPS recommendation that was generally not implemented at the facilities was the recommendation that each facility have its own health care programme and operating procedures designed by a multi-disciplinary advisory committee, which periodically reviews the standards to respond to changes within the facility or the population. All of the facilities noted that they are guided by the Child and Family

Services Act and the Youth Justice Services Manual and certainly in this case the law would supersede individuality. This CPS recommendation is observed in the United States where many facilities report that, although they are guided by the recommendations of the American Correctional Association and the National Commission on Correctional Health Care, they design their own operating policies and procedures based on their size, location and purpose. Small rural facilities in particular have indicated that even some of the recommendations in the American Correctional Association's manual for small facilities (less than 25 beds) are unreasonable for them and that they therefore had to make modifications that made more sense for their states (North Dakota Department of Corrections and Rehabilitation, 1998; State of Nebraska Jail Standards Board Standards for Juvenile Detention Facilities, 1993; Wyoming State Advisory Council on Juvenile Justice, 1999).

It is clear from the results, that service provision is not homogenous across the system. Although consistency across facilities is desirable, flexibility may be needed to address the challenges related to facility characteristics such as size, location, and availability of community resources. The recommendation for each facility to have a multi-disciplinary advisory committee is an important recommendation as such a committee could help to generate ideas and linkages to foster better service provision.

(B) Are Facilities Observing the World Health Organization's Recommendations?

The facilities appear to be following most of the WHO's recommendations for staff requirements. Staff members are screened prior to being hired by all facilities, but different categories of staff are screened at different levels. Youth service workers were screened by 98% of facilities, whereas, all other categories of staff are screened by

30% to 60% of facilities. As a precautionary measure, it is desirable for background checks to be performed on all categories of staff, as all staff members are likely to have some form of contact with youth residents at some time. Only one facility reported that staff members were not required to undergo continuous training in their specific areas of work. Training in behaviour management was the most frequently reported training. This was anticipated as it is well documented that there are fights, peer abuse and verbal altercations within youth custody facilities.

The majority of the facilities do not have a multi-disciplinary health care staff as recommended by the WHO. Only two of the facilities reported having a full health care staff complement. This was however expected, as not only would it be expensive for each facility to maintain a full staff complement, but there are different types of facilities within the youth justice system. The different types of facilities perform different functions and have different lengths of stays and it may be more practical for some facilities to utilise community and other resources as needed. Unequal staff numbers are also apparent in the youth service staff complement and, although it should be made clear that all facilities meet the MCYS requirement of 1 staff member to 5 youth, a few facilities did note that they have staff shortages that are directly caused by insufficient funding. It is not certain from the information collected in this survey that this is a significant issue for all facilities. In addition, Youth Justice Ontario, the organisation that represents agencies that provide youth justice services in Ontario, reported in 2007 that 634 staff positions, comprising 43% of the total staff complement, had been replaced over the previous two years. This represents an annual turnover rate of approximately 21%. They further noted that excellent staff training programs are

available through government support, but that these training programmes cannot move beyond basic training because of high staff turnover (Youth Justice Ontario, 2007).

Employees who leave the system are said to often cite low salaries as their principal reason (Youth Justice Ontario, 2007) and it should be noted that the MCYS has made attempts to redress this issue through increases in salaries and benefits. However the Borgida and Semple (2005) survey, entitled "Making a Case for Change in Open Custody and Detention", concluded that those adjustments did not eliminate the historic contract funding inequities within the system. This raises the issue of equity versus equality and because the MCYS reports that budget reviews are conducted every 3 months for privately operated facilities, it is hoped that a way can be found to equitably allocate funding according to size, resources, location, and need, so that all facilities are able to have the staff they need to provide quality services to the youth in their care.

The necessity of adequate staff numbers, careful staff selection and relevant staff training was reinforced in the latter part of 2009 when Ontario's advocate for children and youth investigated a 192 bed secure custody facility that opened in May of 2009. The youth at the facility complained that they were being deprived of food and programming and being subjected to excessive force, cold sleeping conditions and questionable body searches. More than 160 teens filed 250 formal complaints about the facility with Ontario's Children and Youth Advocate. At the time of the review there were 102 youth in residence and 166 full time youth service workers (Russel & Tustin, 2010; Zlosminc, 2009). To redress the concerns, the MCYS increased management presence to support the supervision of youth and staff, and hired and trained 34 new youth

officers. Further the MCYS ensured that new staff would be trained to work specifically with youth, reviewed the staffing model to ensure that there is a sufficient level of staff to meet the comprehensive needs of youth at the facility, addressed specific concerns raised by the youth, such as the need for lower lighting at night and adequate heating, and conducted unit by unit assessments to ensure that there would be greater consistency in how the various individual units within the facility are managed (MCYS, 2009).

The World Health Organization also promotes that the quality of care and the relationships established while in custody can affect general well-being and community reintegration. Most facilities reported that a plan of care is developed within 30 days and 98% of facilities reported that all or most of the recommendations are implemented; 92% of facilities also reported that a prime worker is always assigned to each youth. Medical professional involvement at release is, however, not consistent; half of the facilities report that medical professionals are only consulted if there is a serious health problem or if youth request a medical evaluation.

In discussing the issue of exit medical evaluations and medical professional involvement in post-release plans, it is taken into consideration that the majority of youth sentenced to custody serve a period of 6 months or less, and that in the year 2008 to 2009, 47% served 30 days or less (Statistics Canada, 2010). Being in custody can, however, be a period of significant stress for youth and may result in devastating psychological consequences, particularly for those who enter custody with multiple pre-existing risk factors (Cesaroni & Peterson-Badali, 2005). Furthermore, the literature indicates that there is no work that suggests that youth in custody are in a better state of

health, particularly mental health, when they are released from custody than when they entered. It may, therefore, be appropriate for all youth who are in custody for longer than 3 months to have a mental health screening and a brief medical evaluation by at least a nurse prior to being discharged. The evaluation can include checking weight, height, blood pressure, heart rhythm and lung function, a general body check for bruises and ensuring that any issues identified at entry have been resolved. Such a session can also be used to have a final discussion with the youth about health care. Research has shown that many youth view health care providers as credible sources of information and are likely to discuss both physical and non-physical problems with them if they find them to be non-judgemental and compassionate (MacDonald, 2006).

Other Service Provision

Physical Activity

Only 23% of all facilities reported that they always conduct physical activity assessments at intake. Physical activity assessments can be conducted using a survey instrument that asks questions about exercise habits, physical activity types and total minutes of physical activity per week. Individuals can then be rated as sedentary, moderately active, active, or very active. Physical activity assessments can also be conducted by asking participants to engage in various activities, such as a 12 minute run, a flexibility appraisal that includes a sit and reach, a vertical jump and a test of muscular strength (Temertzoglou & Challen, 2003). These assessments can ensure that the youth are not pushed beyond what they can handle and can also be used to generate critical thinking, self-awareness, and discussion about healthy lifestyles (Card, 2005).

Physical activity was reported to be compulsory at 72% of facilities. The health benefits of physical activity are well documented and research has listed benefits that are specific to youth in custody. These include constructive relief of boredom (Roberts, 1992, Rosenthal, 1982), increased self-esteem brought about by sporting achievement (Trujillo, 1983), the influence of sports leaders as positive role models (Nichols & Taylor, 1996; Sports Council North West, 1990), teaching fair play and team work, and the development of new skills and interest (Robertson & Dunway, 2005). The literature also notes that in order to achieve the mixture of physical benefits, as well as the development of personal and social skills, a high quality of staff must be present to deliver the activities, to engender mutual respect, and to maintain a clear behavioural code and discipline (Taylor, Crow, Irvine & Nicholls, 1999). The importance of trained physical education staff or staff with expertise or experience in physical education is highlighted, yet only 20% of facilities in this survey reported having physical education teachers. To address the need for experienced staff, facilities could consider utilising personnel and resources from high schools, universities, and members of various sports teams in their communities. These options should also be considered for those facilities that identified having challenges related to transportation, staff shortages, or facility size. However if community links are not available, other options need to be explored and the MCYS would need to review facilities on an individual basis to determine if funding increases are necessary.

It was encouraging that 80% of all facilities allot at least 60 minutes a day for physical activity. From this survey it is however not clear how much of this activity is organised, nor how often those with YMCA memberships visit the gym. Various types of

activities were reported to be available. This corresponds well with the literature that suggests that sporting programmes must be varied to keep the interest of youth in conflict with the law, as many youth do not have the self-discipline to engage in the same activity every day unless it is an activity in which they have a particular interest (Taylor, Crow, Irvine, & Nicholls, 1999). Open facilities tended to have a wider variety of activities not listed on the survey and to have fewer organised sports and team sports. This is possibly due to the fact that they have less structure, less resources, and shorter stays. Higher proportions of secure facilities provide more organised and traditional types of activities. This was expected not only because of their size, but because they tend to have youth in residence for longer periods and the focus of their physical activity may be more about skill building and positive development.

It is concerning that almost 30% of respondents reported that physical activity was not compulsory. Although it is also taken into consideration that some facilities only have short stays and that some facilities have youth who attend community schools where they may access physical activity, it is of note that a Canadian Community Health Survey reported that 79% of Canadian teenagers were not accumulating the minimum activity to meet international guidelines for optimal growth and development, (Statistics Canada, 2003). Youth custody facilities should endeavour, where possible, to help the youth in their care to achieve the recommended daily energy expenditure, while encouraging them to continue to engage in physical activity after their release.

Mental Health

It was not surprising that psychological assessments are not consistently performed at entry; as expected they are usually performed at the court's request. A substantial portion of facilities indicated that youth always have access to trained counsellors, however, close to a quarter of the facilities reported that youth only have access to trained counsellors some of the time. Counselling was generally provided at the request of youth. It was surprising that only 33% of facilities reported providing counselling to youth with a history of mental illness. It may be the case that more youth with a history of mental illness tend to reside in youth custody mental health treatment centres and those facilities are few in number. The majority of counselling provided appears to be group counselling. Individualised therapy seems to be more difficult to access, but the MCYS informed that there are funds set aside for specialised services and that these funds are provided on a case by case basis. As anticipated, some facilities expressed difficulty in accessing mental health services.

The difficulty in accessing children's mental health services in Ontario is well documented in the literature. To assist youth custody facilities in coping with mental health issues, the literature suggests that training staff to be better able to identify and deal with mental health issues would be very helpful and would lessen stress and improve manageability (Cocozza, 1992; Cocozza & Skowyra, 2001). It is suggested that they be trained in areas such as child development, psychological and psychiatric issues, behavioural and stress management, parenting skills, substance abuse, and gang affiliation (Levitt, 1999). Staff training cannot, however, substitute for professional intervention and until the gaps in care and access are resolved, youth custody facilities

will need to form better links with community services and other youth custody facilities where services are available. In her article on providing mental health services for youth in conflict with the law, Levitt (1999) recommends that facilities "should network with each other as this can generate new ideas, programs and resources and assist in limiting the time spent 'reinventing the wheel' to solve a particular problem" (p.79). She further recommends that facilities affiliate with volunteer programs and local training programs, such as medical schools, residency training programs, and master's programs, that can assist by providing needed manpower at low or no cost.

Only 78% of facilities reported providing suicide assessments to all youth. This figure is concerning and considered to be low as the MCYS reported that they have policies and standards for all residential service providers regarding screening for suicide at intake and throughout a youth's placement. It was not ascertained from this survey whether suicide assessments were conducted at a later date as is the case in one third of US facilities.

Conclusion

This survey provides an overview of the scope and range of health-related services provided in youth custody facilities in Ontario and the difficulties encountered by facilities in the provision of those services. There are however limitations to be acknowledged. This research project is descriptive in nature. The results, therefore, cannot be used to infer any direct link between the services provided and general findings from other research regarding the health status of youth in custody, or general outcomes for youth who have been in custody. Second, although a 70% response rate

is considered to be very favourable, participation by all of the facilities would have provided a more comprehensive view of the system.

The decision of the MCYS to have the questionnaires distributed and returned via e-mail eliminated the anonymity that would have been afforded to the responding facilities had the questionnaires been returned via the post. It is therefore possible that this could have resulted in a tendency toward socially desirable responding. Socially desirable responding is the tendency for participants to present a favourable image of themselves (Johnson & Fendrich, 2005) to avoid criticism or to gain social approval (King & Brunner, 2000; Huang, Liao & Chang, 1998). Socially desirable responding is most likely to occur in responses to socially sensitive questions (King &Brunner, 2000) and health-related research often covers socially sensitive topics. Socially desirable responding can obscure relationships among variables or produce artificial trends and patterns in the data and in the relationships between variables (King &Brunner, 2000).

It is also of interest that concerns about one of Ontario's newest secure custody facilities and a subsequent investigation by the Provincial Advocate for Children and Youth (see page 72) occurred during the data collection period for this survey. Reports of the complaints made by the youth at that facility and responses from the Provincial Advocate were highly publicised in local and out of town newspapers; in addition online blogs were created, and responses to the situation were posted on the websites of Youth Justice Ontario and the MCYS. Although it can only be speculated, it is possible that such highly publicised concerns about services and conditions within a youth custody facility may have had an indirect impact on some of the responses and may also have influenced some of the facilities' decision to participate in the survey.

In spite of these limitations it is believed that the survey captures a relatively accurate picture of the current range, nature, and extent of health-related services within the system. As expected, secure custody facilities provide a greater range of services, but it was also discovered that service provision is impacted by a number of factors. All of the facilities that participated appeared very motivated to provide the best possible care for the youth in their custody, yet there are some areas of concern in relation to staffing, use of community resources, and funding that need to be addressed. Perhaps some of these issues may prove easier and less expensive to resolve than others. There are some facilities that appear to manage and run very efficient programmes. Such facilities have a nurse, social worker (one has a clinical counsellor), and clerical staff; they have made links with their community resources for the provision of additional health care or physical activities; and they each obtain supplementary funding from their executive organisations. These facilities vary in size, type, and ownership and can be used by the MCYS as models to demonstrate to other facilities how to achieve similar results. A strategy of modelling based on the existing effective facilities would certainly be less expensive than bringing in expert consultants and would dually serve as a teaching and information sharing process between institutions that serve the same population and deal with similar issues. This could make for a stronger more networked youth justice system that works together collaboratively, and ensures that all youth have equitable and effective health-related programmes and services.

It is again necessary to note that even with a process such as modelling best practices, there can be no one-size-fits-all recommendations or application of ideas.

There is significant variation among the facilities and there will be some facilities that will require unique government assistance and support. This is made very clear from the data obtained from facilities located in remote areas, rural areas, or small towns. One very interesting situation was relayed by a respondent who indicated that there are high poverty levels in certain areas of their community and that the youth who come into custody from those areas often do not have any psychological or psychiatric issues. The youth often express that they became involved in illegal activity or obtained injuries due to boredom. A health education programme, recreational programme, or post-release programme for youth in this type of situation would certainly be different from those designed for youth from an area with more resources. In fact, there is a little that even the best trained facility staff can do for youth in such a situation; the issues extend to the broader community and area.

It is hoped that this information can be used by the MCYS, the Ministry of Community Safety and Correctional Services and the Youth Justice Services Division of the Ministry of Children and Youth Services, as well as other parties involved and interested in the health of youth in custody, to facilitate further dialogue on the issue of standards of care within youth custody facilities. It is further hoped that it may assist in identifying the strengths and weaknesses within the current system, informing budgetary planning and policy making and identifying staff training priorities in areas such as physical activity programming and health education, thereby ensuring that this at-risk population, receives appropriate health-related services in an effort to minimize the risk of poor health outcomes later in life.

Future research in this area may consider investigating the health-related service needs of youth at individual facilities to determine best fit programmes. As previously reported, youth in different areas of the province may have different needs. An open custody report also noted that based on the current structure within the system, youth are likely to be placed in existing programmes when they enter custody as opposed to having their individual needs addressed (Borgida & Semple, 2005). Additionally, although this research did not directly address the issue of youth in custody between the ages of 18 and 21, correctional literature and facility inspection reports have noted that the health-related needs of this older population of youth are particularly concerning, especially considering that they are usually incarcerated in adult facilities. The 2005 to 2006 annual report of the Canadian Office of the Correctional Investigator pointed out in its list of on-going concerns, that, "correctional services do not meet the special services and program needs of inmates aged 20 and younger. These younger offenders, numbering up to 400 at any given time, very often find themselves in disadvantaged situations, segregation, abuse by other inmates, limited access to and success in programming, gang affiliations, and delayed conditional release" (The Correctional Investigator Canada, p.19). Investigating the specific health-related needs and current services offered to this population of youth should also be considered.

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Appendix A

Letter of Information, Addendum to Letter of Information & Survey

Western
Health Sciences

Letter of Information

Title of Study: A Survey of Health-Related Services in Ontario's Youth Custody Facilities

Researchers: Lisa Cossy, MSc Candidate, Health and Rehabilitation Sciences Graduate Program
Linda Miller, PhD, Associate Professor, Faculty of Health Sciences

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The Youth Custody Facility for which you are the Director or primary contact is invited to participate in a research study looking at health-related services, resources, and activities within Youth Custody Facilities throughout Ontario.

Study Background

Previous research has revealed that youth admitted to custodial facilities tend to have higher rates of physical and psychological health problems than the general population of youth. Youth in conflict with the law are often characterized by multiple forms of familial, socio-economic and academic disadvantages. They are also often disenfranchised from traditional health care services. The health problems faced by these youth have led to calls from many organizations, such as The United Nations, the World Health Organization, the American Paediatric Society, England and Wales Youth Justice Board, and more recently the Canadian Paediatric Society, for established standards of care within youth custodial/custody facilities. In recent years England, Wales, and the United States have taken steps to address health care service policy and provision for young offenders. Over the years Canada and the provincial ministries responsible for youth in custody have also developed policies and legislation relating to the rights and care of youth in custodial facilities. The purpose of this study is to obtain an accurate description of the range and types of health-related services and resources currently provided in Ontario's youth custody facilities.

Participation in the Study

Participation in the study includes the completion of the survey included in this package. The survey contains questions describing a range of services and resources related to physical, mental, and social aspects of health. In particular, the survey questions inquire about the nature and extent of health-related services provided within your facility. The survey is not part of

any audit or review and the results will not be used to evaluate the individual facilities. You will not be asked to provide your names or the name of your institution on the survey.

The survey will require approximately 30 to 45 minutes to complete. As the Director or primary contact for the facility, we invite you to complete the survey on behalf of your facility. Should you prefer, you may choose to have a senior staff member with detailed knowledge of your facility complete the survey. The survey is anonymous. Please do not put any identifying information on the survey. When the survey has been completed, please use the stamped return envelope enclosed in this package to return the survey to the researchers.

Approximately one week after receiving the survey package, you will be contacted by one of the researchers to ensure that the package was received and to address any questions that you may have regarding the items included on the survey.

Facilities will not be identified by name and participating facilities will be anonymous. To ensure that confidentiality is not compromised, the identity of facilities will not be recorded in the data and will not be used in the final report. All research materials will be stored in a locked cabinet in a secure office and they will be destroyed after a period of one year.

Consent and Questions

You indicate your consent to participate in the study by completing and returning the questionnaire. If you have any questions about this study please contact Dr. Linda Miller at xxx xxx xxxx or by e-mail at xxxxxxxxxxxx. If you have any questions about your rights as a research participant or the conduct of this study, you may contact the Office of Research ethics at 519-661-3036 or by email at ethics@uwo.ca.

This letter is for you to keep.

Addendum - Letter of Information

At the end of paragraph two entitled 'Participation in the Study' it states that "when the survey has been completed please use the stamped return envelope enclosed in the package to return the survey to the researchers".

Please note that during the initial stages of research preparation the intention was to have the questionnaires sent and returned via the post, the Ministry of Child and Youth Services has however indicated a preference for electronic completion and return.

We hope this method is suitable for all, however if you prefer to return the questionnaire via the post please send to:

Lisa Cossy
Elborn College
University of Western Ontario
1201 Western Road
London, ON, N6G 1H1

Lisa S Cossy Msc Candidate Health and Rehabilitation Sciences Graduate Program

Linda Miller, PhD Vice-Provost (Graduate and Postdoctoral Studies)

Electronic Mail – Survey Notification

Dear Sir/Madam

By now you have received the memorandum from the Ministry of Children and Youth Services regarding the research entitled- A Survey of Health-Related Services in Ontario's Youth Custody Facilities.

As indicated in the memo the researcher would contact your facility with further information. I have spoken either directly with you or to another staff member who provided your e-mail address to allow electronic forwarding, completion and return of survey.

Please find attached (1) a copy of the survey instrument, (2) a letter of information which explains the background to the study, study participation and confidentiality issues. Also below is a clarification to the letter of information.

Please feel free to contact me if you have any questions concerning this survey and I once again thank you for your assistance.

Lisa S Cossy Msc Candidate Health and Rehabilitation Sciences Graduate Program

Linda Miller, PhD Vice-Provost (Graduate and Postdoctoral Studies)

Reminder Notice

Hello Again

This is a friendly reminder to please take a moment to complete the **Survey of Health- Related Services in Ontario's Youth Custody Facilities**.

The purpose of this study is to obtain a descriptive overview of the types of services and resources that are currently offered in Youth Custody Facilities throughout Ontario. The survey is not part of any audit or review and the results will not be used to evaluate individual facilities. Your participation is important to us; as it hoped that the results will provide The Ministry of Children and Youth Services and all Youth Custody Facilities with information which can assist with any needed enhancements in the area of health related services.

Please feel free to return the completed survey via email or if you prefer regular mail use the address below

Lisa Cossy
Elborn College
University of Western Ontario
1201 Western Road
London, ON, N6G 1H1

Thank You for your time and participation and please do not hesitate to contact us if you have any questions concerning this survey.

Lisa S Cossy Msc Candidate Health and Rehabilitation Sciences Graduate Program

Linda Miller, Phd, Vice Provost, Graduate Studies and Post Doctoral Studies

A Survey of Health-Related Services in Ontario's Youth Custody Facilities

The following questionnaire contains items relating to physical, mental, and social health services that may be offered within Youth Custody Facilities in Ontario. This questionnaire is being distributed to all Youth Custody Facilities in Ontario. The purpose of the questionnaire is to obtain a descriptive overview of the types of services and resources that are currently offered in Youth Custody Facilities in Ontario. Thank you in advance for your assistance.

Please place a tick in the box that most accurately reflects the situation at your facility.

Part 1: Facility Information

1. Please indicate the facility type:
   - ☐ Open custody facility
   - ☐ Secure custody facility

2. What type of care is provided by this facility? (Tick all that apply.)
   - ☐ Transient care (stays of less than 30 days)
   - ☐ Short term care
   - ☐ Long care term

3. Is this facility:
   - ☐ Government operated
   - ☐ Privately operated

4. What is the average length of stay for youth at this facility? _____

5. Please identify the population type:
   - ☐ All male
   - ☐ All Female
   - ☐ Male and Female

6. What is the stated capacity for this facility? _____

7. What is the current occupancy at this facility? _____

8. Is overcrowding an issue for this facility?
   - ☐ Always
   - ☐ Frequently
   - ☐ Sometimes
   - ☐ Never

9. Does this facility undergo professional site inspections for health and safety purposes?
   - ☐ No
   - ☐ Yes

   If yes, how often are they undertaken?
   - ☐ Weekly
   - ☐ Bi-Weekly
   - ☐ Monthly
   - ☐ Quarterly
   - ☐ Yearly
   - ☐ Bi-annually

Part 2: Health Care Guidelines

10. Are you aware of the medical protocol recommended by the Canadian Paediatric Society for Youth in Custody Facilities?
    - ☐ No, If no please go to Question 12
    - ☐ Yes

11. Are the guidelines recommended in the Canadian Paediatric Society's (CPS) medical protocol implemented at your facility?
    - ☐ Some of the guidelines
    - ☐ Most of the guidelines
    - ☐ All of the guidelines
    - ☐ This institution is not guided by the CPS medical protocol

12. If your institution is not guided by the CPS medical protocol does it have its own written set of guidelines or a program for health services in place?
    - ☐ No If no, please go to Question 13
    - ☐ Yes If yes, please complete parts *i* through *iii* below

    i. If yes, is the program overseen by a medical professional?
    - ☐ No If no please go to Question 13
    - ☐ Yes

    If yes, is it overseen by a:
    - ☐ Physician
    - ☐ Nurse-Practitioner
    - ☐ Nurse
    - ☐ Other: _____

ii. Was this program designed by a committee of individuals?

- ☐ No
- ☐ Yes

If yes, in which of the following areas were individuals on the committee trained: (Tick all that apply.)

- ☐ Medical care
- ☐ Dental care
- ☐ Education
- ☐ Psychiatric care
- ☐ Psychological care
- ☐ Other: _____

iii. Does a committee meet to review whether the objectives of the program are being met?

- ☐ Never
- ☐ Weekly
- ☐ Bi-Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Bi- annually
- ☐ Yearly

Part 3: Health Care Program

13. What percentage of the institution's budget is allotted to health care?
    - ☐ Less than 10%
    - ☐ 10 %
    - ☐ 11 – 19%
    - ☐ 20 - 29%
    - ☐ 30 – 39 %
    - ☐ 40 – 49 %
    - ☐ 50 – 60%
    - ☐ More than 60%

14. Does this institution have an onsite medical facility?
    - ☐ Yes
    - ☐ No

If yes, are medical services for this facility provided only through this facility?

- ☐ Yes
- ☐ No

If no, where are medical services usually provided?

- ☐ Walk in clinic
- ☐ Facility contracted doctors
- ☐ Emergency room
- ☐ Any available doctor's office
- ☐ Other: _____

Part 4: Intake Assessment – Medical Evaluations

For the purpose of the following set of questions, "medical evaluation" refers to routine examinations, such as temperature, blood pressure checks, heart and lung checks via stethoscopes, full body examination for pain and bruises.

15. Are medical histories undertaken after youth arrive at this facility? (Please tick all that apply)
    - ☐ No, not routinely performed
    - ☐ Yes, each youth is evaluated upon entry
    - ☐ Only those who appear to be ill at entry are evaluated
    - ☐ Only those known to have preexisting conditions at entry are evaluated
    - ☐ Only those with no medical record available at entry are evaluated
    - ☐ Only those who came from home rather than another facility are evaluated

ii If medical histories are recorded, by whom are they usually undertaken?

- ☐ Doctor
- ☐ Nurse
- ☐ Nurse Practitioner
- ☐ Trained other Please describe: _____
- ☐ Untrained other Please describe: _____

16. After arrival at this facility do the youth undergo a medical evaluation?
    - ☐ No, not routinely performed If no please go to question 20
    - ☐ Yes

If yes, which of the following best describes the medical evaluation practices of this facility at intake?

- ☐ Each youth is evaluated upon entry
- ☐ Only those who appear to be ill at entry are evaluated
- ☐ Only those known be ill at entry are evaluated
- ☐ Only those with no medical record available at entry are evaluated
- ☐ Only those who came from home rather than another facility are evaluated
- ☐ Evaluation at entry is performed at a youth's request
- ☐ Evaluation at entry is performed at staff member's request
- ☐ Evaluation at entry at is performed at the court's request
- ☐ Other: _____

17. If yes, within what time period after admission are medical evaluations generally performed?

- ☐ 24 hours
- ☐ 48 hours
- ☐ 72 hours
- ☐ 3 to 7 days
- ☐ Beyond 7 days
- ☐ Not routinely performed at entry
- ☐ Other: _____

18. By whom are medical evaluations usually performed?

- ☐ Doctor
- ☐ Nurse
- ☐ Nurse Practitioner
- ☐ Trained other Please describe: _____
- ☐ Untrained other Please describe: _____

19. Which of the following aspects are included in the medical evaluation?

a) Vision Tests
☐ Never ☐ As Necessary ☐ At youth's request ☐ At court/staff request ☐ Always

b) Hearing Tests
☐ Never ☐ As Necessary ☐ At youth's request ☐ At court/staff request ☐ Always

c) Dental Examination
☐ Never ☐ As Necessary ☐ At youth's request ☐ At court/staff request ☐ Always

d) Tests for illegal drug use
☐ Never ☐ As Necessary ☐ At youth's request ☐ At court/staff request ☐ Always

e) Tests for Hepatitis
☐ Never ☐ As Necessary ☐ At youth's request ☐ At court/staff request ☐ Always

f) Tests for other communicable diseases
☐ Never ☐ As Necessary ☐ At youth's request ☐ At court/staff request ☐ Always

g) Tests for HIV
☐ Never ☐ As Necessary ☐ At youth's request ☐ At court/staff request ☐ Always
☐ Those known to be sexually active

h) Tests for STDs
☐ Never ☐ As Necessary ☐ At youth's request ☐ At court/staff request ☐ Always
☐ Those known to be sexually active

i) Gynecological examinations
☐ Never ☐ As Necessary ☐ At youth's request ☐ At court/staff request ☐ Always
☐ Those known to be sexually active ☐Those thought or known to be pregnant

j) Pregnancy Tests
☐ Never ☐ As Necessary ☐ At youth's request ☐ At court/staff request ☐ Always
☐ Those known to be sexually active

Part 5: Health Services Provision – These questions relate to general day to day facility procedures

20. What is the most popular method for receiving medical attention at this facility?
    - ☐ Youth completes a request for medical attention form
    - ☐ Youth asks a staff member for medical attention
    - ☐ Staff member requests medical attention for the youth
    - ☐ Other: _____

21. How soon after health care concerns are reported are they usually addressed by a medical professional?
    - ☐ Within 24 hours
    - ☐ Within 48 hours
    - ☐ Within 72 hours
    - ☐ Within 3 to 7 days
    - ☐ Beyond 7 days
    - ☐ At the doctor's availability

22. How soon after dental concerns are reported are they addressed by a dentist?
    - ☐ Within 24 hours
    - ☐ Within 48 hours
    - ☐ Within 72 hours
    - ☐ Within 3 to 7 days
    - ☐ Beyond 7 days
    - ☐ At the dentist's availability

23. Is there a medical professional assigned to every shift?
    - ☐ Always
    - ☐ Frequently
    - ☐ Sometimes
    - ☐ Never

24. Are nonprescription medications available to the youth at all times?
    - ☐ Always
    - ☐ Frequently
    - ☐ Sometimes
    - ☐ Never

Part 6: Privacy and Consent Issues

25. Are onsite evaluations performed in a private room without the presence of other staff?
    - ☐ Always
    - ☐ Frequently
    - ☐ Sometimes
    - ☐ Never

26. Are offsite evaluations performed in a private room without the presence of other staff?
    - ☐ Always
    - ☐ Frequently
    - ☐ Sometimes
    - ☐ Never

27. Under what conditions, if any, are staff present during a medical examination?

    _____
    _____
    _____

28. Are the youth actively involved in decisions made about their health care?
    - ☐ Always
    - ☐ Frequently
    - ☐ Sometimes
    - ☐ Never

29. Are there ever circumstances where medical decisions are made without a youth's consent?
    - ☐ No
    - ☐ Yes

    If yes, what are those circumstances?

    _____
    _____
    _____

30. Are prescription and non prescription drugs usually dispensed to the youth in private?
    - ☐ Always
    - ☐ Frequently
    - ☐ Sometimes
    - ☐ Never

31. Are complaints ever received from youth regarding exposure of their medical problems within the facility?
    - ☐ Always
    - ☐ Frequently
    - ☐ Sometimes
    - ☐ Never

Part 7: Staffing Information

32. Please indicate the number of full-time and part-time staff members directly employed by the facility. Tick the appropriate box if these services are never utilized or are contracted outside of the facility as needed.

	Full Time	Part Time	Never Utilized	Contracted As Needed
Program Officer	_____	_____	☐	☐
Social Worker	_____	_____	☐	☐
Personal Officer	_____	_____	☐	☐
Doctor	_____	_____	☐	☐
Nurse Practitioner	_____	_____	☐	☐
Nurse	_____	_____	☐	☐
Dentist	_____	_____	☐	☐
Optician	_____	_____	☐	☐
Psychologist	_____	_____	☐	☐
Psychometrist	_____	_____	☐	☐
Counselors	_____	_____	☐	☐
Sexual Health Specialist	_____	_____	☐	☐
Physiotherapist	_____	_____	☐	☐
Occupational Therapist	_____	_____	☐	☐
Dietitian	_____	_____	☐	☐
Audiologist	_____	_____	☐	☐
Teacher	_____	_____	☐	☐
Vocational Teacher	_____	_____	☐	☐
Special Education staff	_____	_____	☐	☐
Physical Education Staff	_____	_____	☐	☐
Youth Service Worker	_____	_____	☐	☐
Clerical Staff	_____	_____	☐	☐

33. Are the medical and other professional staff employed by this facility usually trained in youth health care?
    - ☐ No
    - ☐ Yes

34. Are the youth service workers employed by this facility usually trained in youth care?
    - ☐ No
    - ☐ Yes

35. Are staff members screened to determine their suitability for working with youth?
    - ☐ No If no, please go to Question 32.
    - ☐ Yes

    If yes, which category of staff undergoes screening for suitability to work with youth?
    - ☐ Medical Staff
    - ☐ Other Professional Staff
    - ☐ Clerical Staff
    - ☐ Teaching Staff
    - ☐ Youth Service Workers

    Are any of these methods involved in the screening process?
    - ☐ Single Interviews
    - ☐ Repeated Interviews
    - ☐ Police Background Checks
    - ☐ Reference Letters
    - ☐ Past Employment Reviews
    - ☐ Other: _____

36. Are staff members required to undergo continuous training in their areas of work?
    - ☐ No If no, please go to Question 37.
    - ☐ Yes

    If yes, how often are they required to upgrade their skills?
    - ☐ Weekly
    - ☐ Bi-Weekly
    - ☐ Monthly
    - ☐ Quarterly
    - ☐ Yearly
    - ☐ Bi-Annually
    - ☐ In response to incidents

37. Does this facility provide ongoing training in matters relating to (tick all that apply):
    - ☐ Behavioural management
    - ☐ Adolescent health care
    - ☐ Adolescent psychological functioning
    - ☐ Adolescent motivation
    - ☐ Other: _____

If ongoing training is provided for any of the above, how often is that training provided?

- ☐ Weekly
- ☐ Bi-Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Yearly
- ☐ Bi-Annually
- ☐ In response to incidents

Part 8: Emergency Care

38. Are non-medical staff members trained in basic first aid?
    - ☐ All
    - ☐ Most
    - ☐ Some
    - ☐ None

39. Are any non-medical staff members trained beyond basic first aid?
    - ☐ All
    - ☐ Most
    - ☐ Some
    - ☐ None

    If any are trained beyond basic first aid are they present at all times?
    - ☐ Yes
    - ☐ No

40. Are staff members trained in the management of violent and confrontational behaviour?
    - ☐ All
    - ☐ Most
    - ☐ Some
    - ☐ None

41. Are the staff members with training in the management of violent and confrontational behaviour present at all times?
    - ☐ No
    - ☐ Yes

42. Is there a clearly detailed 24-hour 7-day per week emergency care plan for:
    a) Medical emergencies?
        ☐ No
        ☐ Yes
    b) Behavioural emergencies?
        ☐ No
        ☐ Yes
    c) Psychiatric emergencies?
        ☐ No
        ☐ Yes

43. Have training sessions on implementing emergency plans been provided for:
    ☐ All Staff
    ☐ Most Staff
    ☐ Some Staff
    ☐ None

44. How often are training update sessions undertaken?
    ☐ Monthly
    ☐ Quarterly
    ☐ Bi-Annually
    ☐ Yearly
    ☐ In response to an incident
    ☐ Never

45. Is there a health care manual listing all available on-site and off-site resources?
    ☐ No
    ☐ Yes

46. Is there a list of around the clock emergency resources posted?
    ☐ No
    ☐ Yes

47. Are there first aid kits available for emergency care?
    ☐ No
    ☐ Yes

48. Are there oxygen tanks available for emergency care?
    ☐ No
    ☐ Yes

If yes, are staff members trained in the use of oxygen tanks?

- ☐ All staff
- ☐ Most staff
- ☐ Some Staff
- ☐ No Staff

49. Is there a fire drill procedure in place?

- ☐ No If no, please go to Question 52.
- ☐ Yes If yes, please complete parts *i* and *ii* below.

i. If yes, how often is the procedure practiced by the staff?

- ☐ Never
- ☐ Weekly
- ☐ Bi-Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Bi- annually
- ☐ Yearly

ii. If yes, how often is the procedure practiced by the youth in the facility?

- ☐ Never
- ☐ Weekly
- ☐ Bi-Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Bi- annually
- ☐ Yearly

Part 9: Nutrition

50. Are the meals provided in accordance with Canada's Food Guide suggestions for teens ?

- ☐ No
- ☐ Yes

51. Do youth have any input regarding the types of food served?

- ☐ Always
- ☐ Frequently
- ☐ Sometimes
- ☐ Never

52. Did a dietitian or comparable medical professional have input in the current food choices served at this facility?

- ☐ No
- ☐ Yes

Part 10: Health Education

53. Is there an ongoing health education program for the youth?

- ☐ No If no, please go to Question 59.
- ☐ Yes If yes, please complete parts *i* through *iv* below.

i. How often are health education sessions conducted?

- ☐ Daily
- ☐ Weekly
- ☐ Bi-Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Other: _____

ii. Do health education sessions include information on:

- ☐ Food and nutrition
- ☐ Sexual health
- ☐ Mental health
- ☐ Exercise and sports
- ☐ Dermatology
- ☐ Hygiene
- ☐ Pre-natal classes
- ☐ Parenting classes
- ☐ Drug and alcohol abuse
- ☐ Other: _____

iii. Are these programs usually administered by experts in the particular areas?

- ☐ Always
- ☐ Frequently
- ☐ Sometimes
- ☐ Never

iv. Are program schedules for these health education sessions usually maintained?

- ☐ Always
- ☐ Frequently
- ☐ Sometimes
- ☐ Never

54. Do the youth have access to relevant health information through books and pamphlets at the facility?
    - ☐ No
    - ☐ Yes

55. Are there health promotion posters, pamphlets, or information sheets on display throughout the facility?
    - ☐ No
    - ☐ Yes

Part 11: Physical Activity

56. Is physical activity compulsory for the youth at this facility?
    - ☐ No
    - ☐ Yes

57. Are physical fitness assessments performed on youth when they enter the facility?
    - ☐ Always
    - ☐ Frequently
    - ☐ Sometimes
    - ☐ Never

58. What form of physical activity is most common at this facility?
    - ☐ Outdoor
    - ☐ Indoor

59. Are organized sports activities undertaken at this facility?
    - ☐ No
    - ☐ Yes

60. Are team sports undertaken at this facility?
    - ☐ No
    - ☐ Yes

61. Is there a sports or fitness coordinator at the facility?
    - ☐ No
    - ☐ Yes

62. Do staff members experience challenges encouraging youth to attend physical activity session?
    - ☐ Always
    - ☐ Frequently
    - ☐ Sometimes
    - ☐ Never

63. How many minutes per day are allotted for the youth to engage in physical activity?
_____

64. Please indicate which of the following sports facilities or activities are available at your facility:
- ☐ basketball court & equipment
- ☐ football field & equipment
- ☐ swimming pool
- ☐ treadmills
- ☐ tennis court & racquets
- ☐ volleyball court & equipment
- ☐ aerobics classes
- ☐ dance classes
- ☐ weight training classes
- ☐ swimming classes
- ☐ athletic competitions
- ☐ organized team sports
- ☐ Other: _____

65. Please indicate which of the following recreational facilities and activities are available at your facility:
- ☐ recreational room/area with TV
- ☐ recreational room/area with video games
- ☐ lounge area for quiet meditation or reading
- ☐ computer facility
- ☐ music listening area or resources
- ☐ art classes or resources
- ☐ drama classes or resources
- ☐ cooking classes or resources
- ☐ books or magazines
- ☐ variety of board games
- ☐ Other: _____

Part 12: Mental Health

66. Do all youth entering this facility undergo a psychological assessment?
    - ☐ No
    - ☐ Yes

    For those who undergo assessment under what circumstances are they usually performed? (Tick all that apply)
    - ☐ When requested by staff
    - ☐ When requested by legal process
    - ☐ In follow up to an incident
    - ☐ When no mental health record is available
    - ☐ If youth are known to have mental health issues
    - ☐ Other: _____

    ii. Is the assessment always performed by a licensed psychometrist or psychologist?
    - ☐ No
    - ☐ Yes
    - ☐ Other _____

    If yes, is he/she trained in child or adolescent mental and social care issues?
    - ☐ No
    - ☐ Yes

67. Is there a written suicide prevention plan or policy in place at this facility?
    - ☐ No
    - ☐ Yes

68. Are staff at this facility trained in suicide prevention measures?
    - ☐ All staff
    - ☐ Most staff
    - ☐ Some Staff
    - ☐ No Staff

69. Do all youth undergo a suicide risk assessment?
    - ☐ No If no, please go to Question 70.
    - ☐ Yes If yes, please complete parts *i* through *ii* below.

i. Under what circumstances is the assessment performed? (Tick all that apply)
- ☐ Routinely at intake
- ☐ When requested by staff
- ☐ When requested by legal process
- ☐ In follow up to an incident
- ☐ When no mental health record is available
- ☐ If youth display or communicate risk
- ☐ Other: _____

ii. Is the assessment performed by:
- ☐ Licensed psychometrist or psychologist
- ☐ Nurse
- ☐ Trained other
- ☐ Untrained other _____

70. Do the youth have regular access to trained counselors?
- ☐ Always
- ☐ Frequently
- ☐ Sometimes
- ☐ Never

71. Please indicate if mental health counseling is provided in any of the following situations (Tick all that apply):

- ☐ To each youth who enters the facility
- ☐ To those with long term sentences
- ☐ To those with short term sentences
- ☐ In response to a youth's request
- ☐ Only as deemed necessary
- ☐ In response to an incident
- ☐ Only those with a known history of mental health issues
- ☐ To those with long disposition wait times
- ☐ Only to those youth who appear to be having a difficult time
- ☐ When counseling is mandated by the court for the youth
- ☐ Other: _____

72. For those receiving counseling, approximately how many minutes/week are allotted for counseling? _____

73. Are youth screened for recent/past substance abuse?
- ☐ Each youth is screened
- ☐ As deemed necessary
- ☐ Only those with a known history of substance abuse
- ☐ Never
- ☐ Other

74. Are youth experiencing withdrawal symptoms seen in a medically supervised setting?
- ☐ Always
- ☐ Frequently
- ☐ Sometimes
- ☐ Never

This final section applies only to those youth who are sentenced to long term care.

75. Are plans of care, typically completed within 30 days?
- ☐ Always
- ☐ Frequently
- ☐ Sometimes
- ☐ Never

76. Are the recommendations of the plan of usually implemented?
- ☐ All recommendations
- ☐ Most recommendations
- ☐ Some recommendations
- ☐ None

77. How long after a youth's arrival is a personal care officer or social worker typically assigned?
- ☐ Within 24 hours
- ☐ Within 48 hours
- ☐ Within 72 hours
- ☐ Within 3 to 7 days
- ☐ Beyond 7 days
- ☐ Only assigned in certain situations; please explain: _____
- ☐ Never

78. When post-release plans are designed, is a nurse or doctor familiar with the youth's health status involved in the design of the plan?
    - ☐ Always
    - ☐ Frequently
    - ☐ Sometimes
    - ☐ Never
    - ☐ Only if there is a serious health problem

79. Are the youth medically evaluated before leaving the facility?
    - ☐ All youth
    - ☐ No youth
    - ☐ Only those with known health problems
    - ☐ Only those who request evaluation
    - ☐ Other: _____

80. Is a medical health care plan constructed for those with health care issues and forwarded to their community care officer?
    - ☐ Always
    - ☐ Frequently
    - ☐ Sometimes
    - ☐ Never

81. Is a mental health care plan constructed for those with mental health issues and forwarded to their community care officer?
    - ☐ Always
    - ☐ Frequently
    - ☐ Sometimes
    - ☐ Never

Thank you for completing this questionnaire. Your assistance is greatly appreciated.
If there are any comments or additional information regarding any aspect of the questionnaire that you would like to share with us, please use the space below.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Appendix B

UWO Ethics Approval

Ministry Approval and Memorandums

RECEIVED

RECEIVED

SEP 15 2008

SCHOOL OF GRADUATE AND POSTDOCTORAL STUDIES

Office of Research Ethics

The University of Western Ontario
Room 4180 Support Services Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. L.T. Miller
Review Number: 15402E **Review Level:** Expedited
Review Date: August 13, 2008
Protocol Title: A Survey of Health-Related Services in Ontario's Young offender Institutions
Department and Institution: Occupational Therapy, University of Western Ontario
Sponsor:
Ethics Approval Date: September 11, 2008 **Expiry Date:** June 30, 2009
Documents Reviewed and Approved: UWO Protocol, Letter of Information.
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Victor Han

Ethics Officer to Contact for Further Information			
☐ Janice Sutherland	☐ Elizabeth Wambolt	☑ Grace Kelly	☐ Denise Grafton

This is an official document. Please retain the original in your files.

cc: ORE File

Office of Research Ethics
The University of Western Ontario
Room 4180 Support Services Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. L.T. Miller
Review Number: 15402E **Revision Number:** 1
Review Date: July 24, 2009 **Review Level:** Expedited
Protocol Title: A Survey of Health-Related Services in Ontario's Young offender Institutions
Department and Institution: Occupational Therapy, University of Western Ontario
Sponsor:
Ethics Approval Date: July 24, 2009 **Expiry Date:** December 31, 2009
Documents Reviewed and Approved: Revised Study End date, Questionnaires, Letter of Information and Consent
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

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Chair of HSREB: Dr. Joseph Gilbert

Ethics Officer to Contact for Further Information			
☐ Janice Sutherland	☐ Elizabeth Wambolt	☐ Grace Kelly	☑ Denise Grafton

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cc: ORE File

Office of Research Ethics
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Room 4180 Support Services Building, London, ON, Canada N6A 5B8
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Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. L.T. Miller
Review Number: 15402E **Revision Number:** 2
Review Date: November 05, 2009 **Review Level:** Expedited
Protocol Title: A Survey of Health-Related Services in Ontario's Young offender Institutions
Department and Institution: Occupational Therapy, University of Western Ontario
Sponsor:
Ethics Approval Date: November 11, 2009 **Expiry Date:** December 31, 2009
Documents Reviewed and Approved: Revised methodology. Email / Telephone Script.
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

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Chair of HSREB: Dr. Joseph Gilbert

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cc: ORE File

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Room 4180 Support Services Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. L.T. Miller
Review Level: Expedited
Review Number: 15402E
Revision Number: 3
Review Date: February 17, 2010
Approved Local # of Participants: 0
Protocol Title: A Survey of Health-Related Services in Ontario's Young offender Institutions
Department and Institution: Occupational Therapy, University of Western Ontario
Sponsor:
Ethics Approval Date: February 17, 2010
Expiry Date: June 30, 2010
Documents Reviewed and Approved: Revised Study End Date
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

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b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

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Chair of HSREB: Dr. Joseph Gilbert
FDA Reg. #: IRB 00000940

Ethics Officer to Contact for Further Information			
☐ Janice Sutherland	☐ Elizabeth Wambolt	☑ Grace Kelly	☐ Denise Grafton

This is an official document. Please retain the original in your files.

cc: ORE File

Ministry of Children and Youth Services
Research and Outcome Measurement Branch
Strategic Policy and Planning Division
15th Floor
56 Wellesley St. W.
Toronto, ON M5S 2S3
Tel: (416) 325-3567
Fax: (416) 327-0570

Ministère des Services à l'enfance et à la jeunesse
Direction de la recherche et de la mesure des résultats
Division des politiques et de la planification stratégiques
15e étage
56, rue Wellesley Ouest
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Téléc. : (416) 327-0570

Ministry of Children and Youth Services
Youth Justice Services
Director of Operational Support
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Ministère des Services à l'enfance et à la jeunesse
Services de justice pour la jeunesse
Directeur soutien opérationnel
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Tél.: (416) 313-6296
Téléc. : (416) 327-2418

Ontario

March 13, 2009

Ms Lisa Cossy
MSc Candidate
Elborn College
University of Western Ontario
London, Ontario
N6G 1H1

RE: Research Project: "A Survey of Health-Related Services in Ontario's Youth Custodial Facilities"

Dear Ms Cossy:

On the recommendation of the Correctional Services/Youth Justice Research Committee, we have approved the participation of the Ministry in the research you have proposed.

Please complete the attached *Research Agreement* with your supervisor and return it to:

Ms Julie van Nood
Program Effectiveness, Statistics and Applied Research Unit
Ministry of Community Safety and Correctional Services
200 First Avenue W.,
North Bay, ON
P1B 9M3

If you require assistance in making arrangements to carry out your research, contact Dr. Greg Brown, Chair, Correctional Services/Youth Justice Research Committee at XXX XXXXXXXXXX

....cont'd.

We wish you much success in your research, and look forward to receiving a report of your findings.

Yours truly,

Jeff Wright
Director
Research and Outcome Measurement Branch

JoAnn Miller-Reid
Director
Operational Support

Attachment

cc. Loretta Eley, Director, Strategic and Operational Initiatives Branch, MCSCS
Nadia Mazaheri, Manager, Effective Programming, Operational Support, MCYS
L. Guzzo, Manager, Program Effectiveness, Statistics and Applied Research

Ministry of Children and Youth Services
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Ministère des Services à l'enfance et à la jeunesse
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BayToronto ON M5S 3A9
Téléphone:(416)212-7609
Télécopieur:(416)327-2418

DATE: September 25, 2009

MEMORANDUM TO: Regional Directors

FROM: JoAnn Miller Reid
Operational Support Branch

RE: Research Project: Lisa Cossy (MSc Candidate) and Dr. Linda Miller (Supervisor) University of Western Ontario, *"A Survey of Health-Related Services in Ontario's Youth Custodial Facilities"*

As you may recall, ~~in June~~ on September 4, 2009, you received correspondence from myself regarding a Ministry approved health-related services survey in Ontario's youth detention and custodial facilities. The principle investigator of *A Survey of Health-Related Services in Ontario's Youth Custody Facilities* is Ms. Lisa Cossy of the Health and Rehabilitation Sciences Graduate Program of the University of Western Ontario.

Attached you will find a memorandum (in French and English) to be distributed to your directly operated and transfer payment secure and open youth custody facilities. The memorandum includes Ms Cossy's contact information and notes that as the principle investigator for this research, she will contact facilities directly regarding this project and also provide them with any materials necessary to complete the survey.

In future, all research projects will follow this process- regions will be provide with memorandums (in French and English) explaining the project and containing contact information for the principle investigator(s). The principle investigator(s) will contact the relevant parties directly to gain information they need or to coordinate access to informants for the project. If applicable, the investigator(s) will provide relevant parties

with materials necessary to complete their project; this material will no longer be sent from the regions to the facilities/agencies.

If you require further information about this proposed study or the new process, please contact xxxxxxxxxxx or phone xxx xxx xxxx.

Thank you for your support.

*Original Signed By:*JoAnn Miller-Reid

C Dr. Greg Brown, Chair, MCYS/MCSCS Research Committee

Nadia Mazaheri, Manager, Effective Programming Unit

Ministry of Children and Youth Services
Youth Justice Services
Operational Support Branch
6th Floor 800 Bay Street
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Ministère des Services à l'enfance et à la jeunesse
Services de justice pour la jeunesse
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Télécopieur:(416)327-2418

DESTINATAIRES : Administratrices et administrateurs des centres pour jeunes
Directrices générales et directeurs généraux
Établissements de garde en milieu fermé ou ouvert

EXPÉDITRICE: JoAnn Miller-Reid
Directrice, soutien opérationel

DATE : Le 25 septembre 2009

OBJET : Enquête sur les services connexes à la santé auprès des établissements de détention et de garde pour jeunes de l'Ontario

---

Les services connexes à la santé qui sont fournis aux jeunes dans nos établissements de détention et de garde font partie intégrante d'une gestion de cas efficace et ils contribuent à veiller à ce que ces jeunes soient en sécurité. Ainsi, il est important de déterminer si les services connexes à la santé que nous fournissons sont conformes aux normes de soins nationales et internationales.

Mme Lisa Cossy, du programme d'études supérieures en santé et en réadaptation de l'Université Western Ontario, a été autorisée à réaliser un projet de recherche intitulé *A Survey of Health-Related Services in Ontario's Youth Custodial Facilities*. Cette étude vise à recueillir de l'information concernant les services connexes à la santé fournis aux jeunes dans les établissements de détention et de garde de l'Ontario. L'étude permettra

également d'évaluer dans quelle mesure les services de santé actuels satisfont aux normes de soins des jeunes sous garde recommandées par la Société canadienne de pédiatrie et l'Organisation mondiale de la santé.

M^{me} Cossy communiquera avec votre établissement au cours des semaines à venir afin de solliciter votre collaboration. Elle vous remettra également un exemplaire du questionnaire concernant les services connexes à la santé offerts dans les établissements de détention et de garde pour jeunes de l'Ontario, qui a été revu et approuvé par le Comité de recherche de la Division des services de justice pour la jeunesse. Toute communication au sujet de cette étude doit être adressée à M^{me} Lisa Cossy.

Les résultats de l'enquête seront publiés lorsque la recherche sera terminée. Ces résultats pourront servir à améliorer la prestation des services connexes à la santé. La recherche de M^{me} Cossy pourrait représenter une importante contribution à nos efforts visant à assurer l'excellence des soins de santé fournis aux jeunes dans les établissements de détention et de garde de l'Ontario. Je vous invite à donner votre entière collaboration à M^{me} Cossy dans le cadre de ses activités de recherche.

Je vous remercie d'appuyer cet important travail.

L'original signée par:

JoAnn Miller-Reid

MEMORANDUM TO: Youth Centre Administrators
Executive Directors
Secure and Open Detention/Custody Facilities

FROM: **xxx**
Regional Director

DATE: **xxx**

SUBJECT: Health-Related Services Survey for Ontario's Youth Detention and Custody Facilities

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The health-related services that are provided to youth while in our custodial settings are an integral part of effective case management and help ensure that youth are safe while in our care. As such, it is important to determine if the health-related services that we provide are consistent with national and international standards of care.

Ms Lisa Cossy of the Health and Rehabilitation Sciences Graduate Program of the University of Western Ontario has been granted approval to proceed with a research proposal entitled *A Survey of Health-Related Services in Ontario's Youth Custodial Facilities*. The purpose of her study is to gather information regarding the current health- related services provided to youth in custodial facilities within Ontario. This study will also assess how current health care services compare with the standards of care recommended for youth in custody by the Canadian Paediatric Society and the World Health Organization.

Ms Cossy will contact your facility in the coming weeks to request your support with this work. She will also provide you with a copy of the survey that has been reviewed and approved by the Research Committee of Youth Justice Services Division regarding health-related services available in Ontario's youth detention and custodial facilities. All communications regarding this study are to be directed to Ms Lisa Cossy:

Survey results will be available following the completion of this research; these results may be used to support enhanced health-related service provision. Ms Cossy's research stands to make an important contribution to our efforts to provide an excellent standard of health care to young persons in Ontario custodial facilities. I trust that you will provide your full support to Ms Cossy in her research activities.

Thank you for your support of this important work.

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