Compassion in difficult spaces: Improving support for mentally ill offenders in Canadian federal prisons

by

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Abstract

Incarcerated individuals are more likely to deal with mental health challenges than the broader Canadian public. Mental illness can be a contributor to criminal behavior, while the experience of incarceration can exacerbate underlying mental health conditions. However, there are limited existing supports for these incarcerated individuals, meaning that offenders may become trapped in vicious cycles of recidivism linked to ongoing mental health challenges. This study explores what might be done to this policy problem in Canadian correctional facilities. Drawing on existing literature, case studies and a series of expert interviews, the study presents, and evaluates, four possible policy paths forward. The analysis supports three policy recommendations to begin to tackle this issue: transferring healthcare responsibilities to provincial Ministries of Health; introducing mandatory mental health training for staff; and creating a community program liaison officer pilot project.

Keywords: Canadian corrections; mental health; support; federal prisons; mentally ill

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List of Acronyms

CCRA	Corrections and Conditional Release Act
CSC	Correctional Service of Canada
IICR	International Committee of the Red Cross
NCRMD	Not Criminally Responsible Due to Mental Disorder
NHS	National Health Service
OCI	Office of the Correctional Investigator
PHSA	Provincial Health Services Authority
SCC	Supreme Court of Canada
SHU	Specialized Housing Unit
WHO	World Health Organization

Glossary

Deterrence	Ideology that punishment will deter people from committing crime
Dynamic Security	Concept where staff prioritize creating and maintaining everyday communication and interaction with prisoners
Engagement and Intervention Model	Risk-based model intended to guide staff in both security and health activities to prevent, respond, and resolve incidents
Incapacitation	Removing an offender from the community to protect society
Pains of Imprisonment	A term coined by Graham Sykes to capture the deprivations associated with prison
Rehabilitation	Process of assisting an individual to readapt to society
Regional Treatment Centre	Multi-level security institution that operates as a provincially recognized hospital and/or psychiatric hospital
Restitution	Monetary payment by offender to the victim for the harm caused by an offence
Retribution	Punishment someone receives as revenge for a criminal act
Tough on Crime	Policies focusing on law and order resulting in tougher punishments for criminal behaviour
Trans-institutionalized	The shift in housing people with mental illnesses in asylums to prisons/ streets
Use of force	Amount of effort required by officers to compel compliance by an unwilling subject

Preface

This study was conducted on the unceded territories of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and Sel̓íl̓witulh (Tsleil-Waututh) Nations. While Indigenous people only make up 4.9% of Canada's population, they are vastly over-represented in the criminal justice system as both victims and offenders (Government of Canada, 2018). In 2014, 28% of victims aged 15 and above were of Indigenous decent. Indigenous women's rate of violent victimization is triple the rate of non-Indigenous women (220 violent cases per 1000 vs 81 violent cases per 1000) and Indigenous women report higher rates of sexual assault than non-Indigenous women (Department of Justice, 2019). Indigenous adults are overrepresented in correctional facilities and this rate is on the rise; as of 2018, Indigenous people accounted for 30% of admission to provincial facilities and 29% of admission to federal facilities whereas 10 years ago the rates were 21% and 20% respectively. Supporting Indigenous offenders and evaluating why there is over representation is vital, however this study excludes this area of research due to its limited scope. Further research should explore this topic to address the unique challenges faced by Indigenous populations.

Executive Summary

High rates of mental illness is a moral, legal, and societal issue in federal correctional facilities. This issue is acknowledged by the Government of Canada, the Correctional Service of Canada (CSC), and advocacy groups. Mental health is impacted to some degree by incarceration due to the nature of these facilities and the restrictions on inmates' freedoms. However, the lack of mental health support in institutions further harms an offender's ability to rehabilitate and reintegrate after incarceration.

The Office of the Correctional Investigator (OCI) often criticizes CSC's current programs and policies which attempt to address the issue in federal correctional facilities. Based on these recurrent criticisms, the aim of this study is to discuss ways to improve support of offender's mental health which will impact public safety in the long term.

The findings collected from the literature review, case studies, interviews, and jurisdiction scan highlight mental healthcare pitfalls in correctional facilities. The closure of asylums in the 1960s and 1970s led to the overrepresentation of mentally ill people in the criminal justice system. Currently, mental illnesses are two to three times higher in carceral institutions than in public, and one in seven offenders suffer from a psychotic illness. Inmates with mental illnesses typically do not cope well with adjusting to prison life. Correctional officers receive limited mental health training, and the level of support available to correctional staff varies at each institution. These gaps result in CSC having a security-based approach in addressing mental health concerns, which leads to further exacerbation of mental health conditions.

The federal policy framework encourages offering mental health support to offenders through the *Criminal Code of Canada* and the *Corrections and Conditional Release Act.* As evidenced in some notable cases, failure to address mental health concerns in prison and the unintended outcomes are sometimes pursued as violations of the *Canadian Chart of Rights and Freedoms*. While CSC acknowledges mental health as an issue through their Mental Health Strategy, the research findings of this study report severe gaps in implementing the strategy.

The jurisdictional scan provides insights into the approach other countries have taken to address mental health in correctional facilities. Assessing the policies adopted

in Norway, New Zealand, and England illustrates that each correctional system requires a tailored approach to address mental health concerns in carceral settings.

The research led to an in-depth assessment of three policy options according to their effectiveness, public reaction, stakeholder support, cost, and ease of implementation:

- maintaining the status quo
- transferring healthcare responsibility from the Department of Justice to Ministries of health, and
- creating a pilot project titled “Community Program Liaison Officer,” which creates programs by assessing each institution’s needs and connecting them with organizations in their community.

I recommend a two-pronged approach. First, federal authorities should transfer healthcare responsibility to provincial ministries of health to improve the quality and quantity of mental healthcare in federal carceral institutions. The second phase should look to create a Community Program Liaison Officer position in two facilities and increase the program after assessing its effectiveness. Implementing these policy recommendations will target those with broad and severe mental health conditions, and likely provide some improvement in their condition and chances at societal reintegration.

Chapter 1. Introduction

Mental illness can be a contributing factor to criminal behaviour. Psychiatric disorders are two to three times more prevalent in penal institutions than they are in the public as a result of the relationship between mental illness and criminal behaviour (Office of the Correctional Investigator [OCI], 2015). Many offenders enter institutions with pre-existing mental illnesses. These offenders often experience an escalation of their symptoms during incarceration or develop additional mental health conditions as a result of incarceration (Simpson et al., 2013). On average, mentally ill people remain in prisons longer than their non-mentally ill counterparts (National Alliance on Mental Illness [NAMI], 2021; Torrey et al., 2014). The offenders' illness makes it difficult for them to follow orders from correctional staff. Additional charges that are subsequently received results in longer sentences. The policy problem at hand is that the **current practices in correctional facilities exacerbate offenders' mental health conditions.**

Mental illness is a health condition that refers to any disorder that impacts mood, thinking, and behaviour (The Centre for Addiction and Mental Health [CAMH], 2021). These disorders are often associated with mental distress and/or problems functioning in social, work, or family environments (American Psychiatric Association [APA], 2018). Examples of serious disorders include depression, anxiety disorder, bipolar disorder, and schizophrenia. As well, the symptoms vary from mild to severe. In Canada, one in five people experience some form of mental illness each year, but with the right treatment and support, most will recover (CAMH, 2021; APA, 2018). The majority of mental health problems develop during childhood or adolescence. By the age of forty, 50% of the population will have suffered or are currently suffering from a mental illness (CMHA, 2021). The cause of mental illnesses is complex, as a combination of genetics, biological factors, personality, and environmental factors can trigger a disorder (CMHA, 2021).

There are many factors that exacerbate mental health conditions in prisons, including "pains of imprisonment". Offenders are not included in the *Health Care Act*, so healthcare responsibility is under the jurisdiction of correctional facilities, which results in inadequate health services (WHO, n.d.). Correctional staff do not receive mental health training and are instead trained to respond to mental health situations with a security-

based approach. Structural aspects, such as architectural design of correctional facilities, can also exacerbate offenders' mental health. Prisons are often void of natural light and offenders live in small cells that are shared with other inmates. Difficulties associated with addressing mental health issues in carceral institutions are complex partially due to the "pains of imprisonment" – a term coined by Gresham Sykes in 1958 to capture the hardships that prisoners experience regarding the nature of incarceration (as cited in Rocheleau, 2013). Sykes's original list includes:

- the loss of liberty, or the confinement of offenders to their cells and the inability to communicate with loved ones without supervision from the institution.
- the loss of desirable goods or services, or the inability to access services or purchase items available to them in public.
- the loss of heterosexual relationships.[1]
- the loss of autonomy where the offender is no longer free to make even the simplest of decisions, such as what to eat and what time to eat.
- the loss of security, as prisons can be violent and unsafe (Shammas, 2017; Talay & Pali, 2020).

Additional research since Sykes's original publication shows that "pains of imprisonment" are more nuanced than previously thought. These studies indicate that the list is not exhaustive, as the pains will differ depending on the demographic and jurisdiction (Haggerty & Bucerius, 2020). For example, Norwegian prisoners have more liberty than prisoners in other jurisdictions, while U.S. prisoners have better access to healthcare services than when they were free citizens. Some of these "pains" are non-negotiable elements of incarceration; an offenders' removal from society is the punishment for their crime. Therefore, to a degree, an inmates' mental health will be negatively impacted under imprisonment. However, there is a question of whether there is some degree to which the negative impact on mental health can be mitigated.

[1] Sykes believed that forced celibacy caused emotional, psychological, and physical problems.

While many individuals with mental health issues enter prison with pre-existing conditions, it is likely that the "pains of imprisonment" contribute to mental illness. The effects of incarceration on mentally ill offenders have not been studied at length. However, longer periods of incarceration likely lead to worse conditions since stress is an aggravating factor (Simpson et al., 2013). It is important to remember that it is difficult to conduct empirical research on offenders with mental illnesses due to the many ethical concerns about researching vulnerable populations, as well as concerns with autonomy, privacy, and limitations on access to health care records in correctional settings (Eldridge et al., 2011).

1.1. Justification of study

There are three reasons why the mental health of offenders should be a concern for the public:

1. The Canadian criminal justice system's mandate is to protect the public *and* support offenders' rehabilitation. The majority of offenders will eventually be reintroduced to society as it is unconstitutional and expensive to incarcerate offenders indefinitely. Furthermore, research indicates that rehabilitation is a necessary concept to decrease crime rates, and so if the institution wishes to increase public safety, they must prioritize this (Bandyopadhyay, 2020; Benson, 2003; Law Library, n.d.).

2. Canadian policies and legislation support inmates receiving mental health services, as they have a right to health care. Legislation outlines the government's duty to provide "every inmate with essential health care and reasonable access to non-essential mental health care" (*CCRA*, 1992, S.86). This aspect will be explored in more depth in section 2.2 of this study.

3. There is a moral and ethical obligation of the system to provide health care for offenders, as there is a power imbalance between the offenders and the correctional system. If the institution denies health care to the offender, there is nothing the incarcerated person can do to attend to their medical needs (Paris, 2008).

Mental health and criminality are complex subject matters, and research addressing inmates' mental health is a relatively new field of study. While a panacea is not possible, evidence that details the current system's high cost and its negligible impact on public safety increase understanding of the best and most effective ways to move forward in criminal justice policies.

The following report will explore the aforementioned policy problem and provide recommendations to address the issue beginning in Chapter 2, where background information on mental health, correctional policy, and important factors in correctional decision-making are outlined. Next, Chapter 3 will explain the different methodologies used to understand the issue. Chapter 4 and 5 will highlight the notable cases of Ashley Smith, Matthew Hines, and Joey Toutsaint and major themes from the interviews. Chapter 6 will look to other jurisdictions, namely Norway, New Zealand, and England. Chapters 7 and 8 will outline the policy options, criteria, and measures, followed by an analysis in Chapter 9. The recommendations from the analysis will be presented in Chapter 10. Important considerations and limitations are outlined in Chapter 11 before moving on to the conclusion in Chapter 12.

Chapter 2. Mental Health among Offenders in Canada

This chapter will start by explaining the history of mental health in Canada, followed by an overview of current Canadian policy that provides the framework for health care in correctional facilities. The details of mental illness in Canadian federal prisons will be followed by the types of policies that impact correctional facilities. This chapter will conclude with an explanation of important political factors that impact correctional policies.

2.1. History of Mental Health in Canada

The closure of mental hospitals was meant to deinstitutionalize mentally ill people. Instead, they were "trans-institutionalized[2]" to the streets and into the criminal justice system (Sussman, 2017, pg. 12). In the 19th century, Canadian asylums opened with altruistic intentions of being "of a pleasing and interesting nature … [providing the] tendency … to change delusions and create a feeling very favourable to recovery" (Sussman, 2017, pg. 10). In other words, asylums were created with the ideology that anyone could be cured if they were in a setting that supported their needs. Dorothea Dix, an American advocate for the mentally ill, influenced the creation of asylums in Canada (Allodi & Kedward, 1977). Her principles aspired to reach cure rates of 80 to 90%. However, in reality, they were closer to 40% (Sussman, 2017). While the promise of a haven for the mentally ill were well-intentioned, many problems prevented asylums from successfully supporting people with mental illnesses. The infrastructure required routine maintenance, and the system soon suffered from overcrowding, lack of resources and funding, and concerns about the administration of asylums. Twenty years later, asylums were far from what they were intended to be. Rather than being a sanctuary that provided moral treatment[3], asylums were barely managing caseloads. By the 1950s, asylums were being built to house up to 6000 people rather than 120–200-person

[2] Trans-institutionalization is the process of shifting people with mental illnesses from one institution to the other – ie. from mental hospitals to the criminal justice system (Schildbach & Schildbach, 2018).

[3] An approach to mental health that aims to improve behaviour through recreation and humane discipline

capacity that was originally imagined. The notion of providing a haven for treatment had been reduced to providing basic care to assist with living (Sussman, 2017). In the 1960s and 1970s, there was a push to offer mental health care in the communities rather than in mental health hospital settings in the hopes that it would be more humane (Sussman, 2017). Unfortunately, the community was overwhelmed and could not offer the level of care that people required which resulted in the trans-institutionalization of mentally ill people.

2.2. Current Canadian Policy Framework

Offender mental health care is a complicated subject given that the responsibility is spread across multiple jurisdictions. According to Canada's constitutional division of powers, the federal government has jurisdiction over criminal law. The provincial government has jurisdiction over the administration of justice and healthcare for all citizens. Federal offenders are excluded from the *Canada Health Act,* so their health care needs are Correctional Service of Canada's (CSC) responsibility (OCI, 2016). Each province has developed its own mental health legislation, such as *British Columbia's Mental Health Act* or the *Mental Health Act of Alberta*. These mental health acts apply to all individuals who are receiving voluntary or involuntary treatment. Since penitentiaries and mental health exist under federal and provincial jurisdiction, mental health in penitentiaries is a multi-jurisdictional area. Additionally, some provinces have specialized mental health courts that help address the over-representation of people with mental illnesses by attempting to provide meaningful care during sentencing (Davison, 2010). If an individual receives a sentence of two years less a day, they are under the provincial government's jurisdiction. However, if their sentence is two years or longer, they fall under the federal government's jurisdiction. There are many federal and provincial legislation that provides the framework for the mental healthcare of offenders. The focus of this report will be on federal policies and penitentiaries.

2.2.1. Constitutional Context

In addition to outlining constitutional rights to all Canadians, the *Canadian Charter of Rights and Freedoms* (1982) has been applied to the treatment of inmates,

including those with mental health conditions. The following sections have been used to rule in favour of offenders' rights being violated:

- Section 7 states that all individuals have the right to "life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."
- Section 12 of the *Charter* states that everyone has a right not to be subjected to cruel and unusual punishment.
- Section 15 states, "every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination ... based on … mental disability."

When inmates participate in behaviour that is injurious to themselves or others, or when they fail to follow orders, officers may respond with a security-based approach, which often involves the use of force. Officers may also subject the individual to segregation, denying them access to meaningful contact and causes their mental wellbeing to deteriorate further. This form of response can violate an offender's section 7,12, and 15 rights, as using excessive force or segregation can be viewed as cruel and unusual punishment in certain scenarios, particularly if the inmates' behaviour results from their mental illness and the response causes further psychological harm. The B.C. Civil Liberties Association successfully challenged the constitutionality of indefinite administrative segregation in 2018 on the basis that the policy violates an offender's section 7 and 15 rights (BCCLA, 2018). Additionally, the practice was ruled as a violation of the offender's section 7 and 12 rights in Ontario, and both province's respective Court of Appeals held these rulings (Imrie, 2020). The Supreme Court of Canada (SCC) granted the cases leave and will hear both cases together to determine indefinite administrative segregation's constitutionality (Imrie, 2020).

2.2.2. Legislative Support

There are multiple opportunities during which an offender can be impacted by criminal justice policy and be provided support, such as at the time of arrest, during sentencing, post-sentencing, and post-incarceration. Before an individual is sentenced, section 16 of the *Criminal Code of Canada* (1985) can provide an opportunity for

mentally ill individuals to be diverted from incarceration. Section 16 allows offenders who commit crimes while suffering from a serious mental illness to be found Not Criminally Responsible on account of Mental Disorder, in special circumstances. This is rare and only applies to individuals who cannot appreciate the nature of their actions or are unable to understand that their actions are wrong. If an offender is found Not Criminally Responsible on account of Mental Disorder, the Review Board has the option to apply an absolute discharge[4], conditional discharge[5], or detention in a hospital setting (*Criminal Code, 1985*). If the offender has mental health problems but is found responsible for their actions, Not Criminally Responsible on account of Mental Disorder does not apply. The court may take the offender's mental health into consideration to provide a lesser sentence, which may entail community-based mental health services (Davison, 2010).

If Not Criminally Responsible on account of Mental Disorder does not apply and the offender is found guilty and is sentenced to a federal facility, then the *Corrections and Conditional Release Act* [*CCRA*] (1992) will pertain to them. Section 86 of the *CCRA* (1992) states Correctional Service of Canada (CSC) must provide "reasonable access to non-essential mental health care that will help contribute to the inmate's rehabilitation and successful reintegration into the community" and requires health care in institutions to meet professional standards that are provided to free citizens. Section 87 states CSC "shall take into consideration an offender's state of health and health care needs (a) in all decisions affecting the offenders, including decisions relating to placement, transfer, administrative segregation and disciplinary matters and (b) in the preparation of the offender for release and supervision of the offender." These sections outline the level of support that should be provided in prisons.

2.2.3. Institutional Support

CSC recognizes mental health as an area of concern, which has led to the implementation of various policies designed to address the issue (Table 1), including a Mental Health Strategy. The first part of CSC's two-part framework outlined their vision:

[4] Offender is found guilty, but no conviction is registered

[5] Offender is found guilty, but no conviction is registered as long as they follow conditions provided by the judge

to “provide timely access to essential services” (CSC, 2012, p.7). The framework also states the importance of enabling inmates to have continuity of care, so they are able to continue to take care of their illness beyond their incarceration period. The second part of the framework builds on this vision by focusing on mental health research, improvements in service delivery and human resources management, and stronger partnerships with community members (CSC, 2012). The Mental Health Strategy outlines options for intervention at multiple stages of the criminal justice system (CSC, 2018). During intake, offenders are screened to identify mental health needs and facilitate follow-up appointments. In primary care, the institutions should provide an interdisciplinary team of mental health professionals to support offenders. The Strategy states that the mental health care teams should collaborate with other professionals in the institution to provide a holistic approach[6]. Intermediate care should be provided to those whose needs are not severe enough to require their hospitalization but surpass the care provided in primary care. Each region has a psychiatric hospital where the inmate must agree to be admitted, and then they can receive 24-hour intensive mental health care for offenders. The CSC website states that a plan is created for the offender in their regular carceral institution upon discharge from the psychiatric hospital. When the offender is released, the provinces and territories are responsible for their health care. Post-incarceration, some mental health services are available through CSC for those with serious issues.

While statutory rights exist under the *CCRA* and a Mental Health Strategy was developed, there is evidence to suggest that these rights are more difficult to access in practice (personal communication, OCI, 2018). An internal audit of CSC published in 2015 states that since the inception of CSC’s Health Services Sector in 2007, over 600 commitments related to mental health were made (CSC, 2015). According to this internal audit, many of these commitments were “not specific, measurable, achievable, relevant and time-bound, making their progress difficult to assess” (CSC, 2015, pg. 15). A previous 2009 audit of the Mental Health Strategy’s implementation reports the fully integrated Mental Health Strategy was not available, as CSC had not implemented key aspects of their strategy such as intermediate care, intake assessments, community

[6] While CSC does not define what a holistic approach is, a report commissioned in England by the VCSE Health and Wellbeing Alliance states three key principles prisons should adopt for a holistic approach are: Respond to specific needs of individuals; ensure continuity of care; and create a culture of wellbeing (Clinks, 2019).

partnerships, and an accountability strategy (Service, 2010). Access to care is limited due to significant budget cuts to CSC's funding. With limited resources, there are many barriers to fulfilling CSC's strategy, leading to exacerbated mental health problems.

Table 1. Examples of CSC mental health policies; source: https://www.csc-scc.gc.ca/health/002006-2000-eng.shtml

2001	Structured Living Environments introduced for women offenders; intensive Dialectical Behaviour Therapy support available for 40 women.
2002	Mental Health Strategy for Women Offenders approved (revised version).
2004	Overall Mental Health Strategy approved.
2005	5-year funding of $29.1M received for Community Mental Health Initiative (CMHI).
2007	2-year funding of $21.5M received for Institutional Mental Health Initiative (IMHI) [electronic mental health screening (Computerized Mental Health Intake Screening System - CoMHISS) and Primary Care]. Mental health awareness training for staff begins to roll out.
2008	Permanent funding of $16.6M/yr received for IMHI. Pilot implementation of mental health screening at intake.
2010	Full implementation of computerized mental health screening at intake.
2014	Plans to move forward with creating intermediate mental health care capacity.

2.3. Mental Health in Canadian Federal Prisons

Mental health disorders are estimated to be two to three times more prevalent in federal institutions than in the general public (CSC, 2012). Triggers for serious mental illnesses are similar to the factors that lead to incarceration: a family history of incarceration, poverty, substance abuse disorders, and history of sexual and/or physical abuse (Galanek, 2012; Simpson, n.d). As discussed in section 2.1, mental hospital's closure diverted people with mental illnesses into the criminal justice system. CSC (2012) reports that one in seven federal prisoners has at least one psychotic illness. Many people with mental illnesses do not cope well with the prison environment, leading to disruptive behaviour such as aggression, violence, self-mutilation, withdrawal, and a refusal to follow the rules (OCI, 2012). The responses to mental health incidents in institutions are often security-focused,[7] leading to the exacerbation of mental health conditions (United Nations Office on Drugs and Crime [UNODC], 2015). As a result of

[7] utilizing physical means such as locks, pepper spray, cells, restraints, etc. rather than dynamic-security focused which utilizes communication and staff-prisoner relationships to anticipate and de-escalate situations

retributive policy changes that will be discussed in chapter 2.5, correctional staff treat behaviours indicative of poor mental health as security issues, leading to the use of prolonged segregation, Pinel restraints, and pepper spray as a means of control (OCI, 2013; OCI, 2018). In the Office of the Correctional Investigator's (OCI) report, some correctional officers stated they do not believe they are qualified to handle mental health situations (OCI, 2013). When questioned about their use of force, correctional officers noted that situations could have often been de-escalated through discourse, however, they relied on more punitive measures to control inmates (Shook & McInnis, 2017). The OCI states that the security-based responses contradict the therapeutic approach needed to treat mental illnesses and contradict the current policy supporting mentally ill offender's needs (OCI, 2013; OCI, 2018). The security-based response to inmates with mental illnesses is detrimental to their health, however, officers are limited by their resources and training.

Studies show that mental health disorders are higher among women than men. The OCI performed an investigation on the treatment of women in federal institutions who participate in self-injurious behaviour and reported that almost 80% of incarcerated women in Canada have some form of mental disorder[8] (OCI, 2018). Kilty (2012), who conducted a study with formerly incarcerated Canadian female offenders, reported that women are more likely than men to be treated for psychotic disorders and are also more likely than men to participate in self-injurious behaviour (OCI, 2013; OCI, 2018). Of the 22 women Kilty interviewed, eight were in federal facilities and 14 were in provincial prisons. They all reported similar problems with the institutions, mainly that there was a lack of non-medicinal mental health support available. The medication prescribed to the women required them to be monitored by the psychiatrist, but the women reported only seeing a psychiatrist upon entering the institution (Kilty, 2012). Some of the women requested appointments with psychiatrists to discuss their medication and to seek further assistance for their mental health but were declined (Kilty, 2012). In addition, the power dynamic results in a lack of trust in the correctional workers by the inmates, as the offenders worried the information shared would be used against them in parole meetings.

[8] It is suspected that incarcerated women have high rates of abuse and victimization which is associated with mental health problems (Derksen et al., 2013).

While Kilty's study focused on women offenders, men experience similar grievances in their ability to access mental health care and their willingness to trust correctional staff members. Men, particularly those who are minorities, have the lowest mental health treatment rates (Martin et al., 2018). In a retrospective study of 7965 admissions to the Canadian prison system, Martin et al. (2018) found that only 30.6% of offenders who were identified to have mental health needs received treatment. Minorities had half the treatment rates of Caucasian inmates and were less likely to complete the pre-screening questions[9] (25% minorities did not complete questionnaire vs 13.5% of Caucasians). This study demonstrates the disconnect between the provision of mental health care and needs of prisoners.

Insufficient treatment of mental illness in prison is a contributing factor to the decline of mental health among inmates (Morgan et al., 2011). Inmates are less likely to receive treatment if the illness is not directly related to the individual's crime (Davison, 2010). If an individual is experiencing extreme symptoms of psychosis, they may be relocated to one of the five regional treatment centers. However, the Office of the Correctional Investigator (2018) reports that these centers are inadequate to promote positive mental health and recovery. The centres have less than 200 beds for men and less than 20 for women. An independent review conducted by a well-known Forensic Psychiatrist reported the ratio of mental health staff to patients is below the acceptable standards for inpatient psychiatric hospital care[10] (OCI, 2018). Other concerns with Regional Treatment Centres include the lack of skillset needed to work with mentally ill people among correctional officers and mental health staff, physical infrastructure, assessment tools regarded as limited and not clinically relevant, and the inability to accommodate geriatric forensic patients (OCI, 2018). After the release of the 2017 Budget, the Correctional Service of Canada invested $10 million in the creation of "Therapeutic Units" in maximum security institutions to meet the needs of intermediate mental health concerns, but these came at the cost of intensive care beds (OCI, 2019). Furthermore, the Office of the Correctional Investigator reports that these units are void of nurturing elements that are necessary to support mental health (OCI 2019). The OCI

[9] Allgeria et al. (as cited in Martin et al., 2018) noted that higher rates of incompletion may be linked to language, culture, prior experiences of inadequate care, and inappropriate matching of treatment to patient preferences

[10] Standards based on Mental Health and Addiction Services – a National Standard of Canada

(2020) states that if the unit is being labelled as therapeutic, then its appearance should be distinguishable and include nurturing elements such as vibrant spaces, adequate natural lighting, and adequate yards.

While CSC is obligated to provide healthcare to inmates, the Office of the Correctional Investigator believes they should outsource mental health support to local psychiatric facilities (OCI, 2018). On the recommendation of the College of Family Physicians of Canada and the World Health Organization, British Columbia transferred provincial correctional healthcare responsibility to the British Columbia Mental Health and Substance Use Services (BCMHSUS), an agency of the Provincial Health Services Authority (Provincial Health Services Authority [PHSA], 2017a). This change occurred in late 2017 and is meant to improve the quality of healthcare in correctional centres as well as improve the continuity of care for offenders who transition from correctional facilities to the community (PHSA, 2017b; Sharifi & MacFarlane, 2018). BCMHSUS's team includes doctors, dentists, nurses, psychologists, and mental health and substance use professionals in the correctional facility and in the community to help offenders' transition to their community health care providers (PHSA, 2017c). The transition of correctional health care from the Ministry of Justice to the Ministry of Health is recent, and therefore there is no public research available assessing whether the PHSA is improving health care for offenders. However, an interview participant for this study worked at BC Corrections before and after the transition and noted that the mental health care is better after the transition as the mental health team has access to more support through PHSA.

2.4. Prospective Approaches – Rehabilitation vs Retribution

There is no easy solution to supporting offenders with mental health issues. This issue persists across the globe, and empirical research is sparse, as few programs are being created and tested to address offenders' mental illnesses (Morgan et al., 2012). Through sweeping reforms of their correctional system, Norway has reduced their recidivism rates to 20% despite having identified personality disorders or mental illness in the majority of inmates (discussed in detail in Chapter 6). This level of reform is not possible in Canada at this time due to political considerations. Instead, this report will look at the types of criminal justice policies that could be used to guide potential next

steps. There are five purposes of punishment: Retribution, rehabilitation, restitution, deterrence, and incapacitation. Although punishments can encompass all five elements, policies in Canada are created with the intention of either rehabilitation or retribution. “Tough on crime” policies are grounded in the principle that deterrence and retribution will make communities safer, however, there is little evidence to support the effectiveness of this theory (Comack, Fabre & Burgher, 2015).

2.4.1. Retribution

Before the mid-2000s, there was some consensus among political parties on the type of criminal justice policies Canada adopted (Department of Justice, 2017). In 2006, the government pushed for “tough on crime” policies which increased operational and financial pressures on the correctional system. Bill C-59 abolished accelerated parole review, which had entitled non-violent first-time offenders to apply for parole after one sixth of their sentence. This action further increased the number of individuals in the correctional system despite the lack of empirical evidence that longer prison sentences decrease crime rates (Comack, Fabre & Burgher, 2015; Cook & Roesch, 2012; Doob, 2015; Lynch & Sabol, 1997; Nagin, 2013). Crime rates have been declining since 1991, and the rate did not change after the implementation of “tough on crime” policies (Cook & Roesch, 2012; Doob, 2015). Instead, “tough on crime” policies impact correctional facilities and communities by increasing incarceration rates[11] and slightly increasing recidivism[12] (Cook & Roesch, 2012; Goggin & Gendreau, 2002; Goggin, Gendreau, & Cullen, 1999). Furthermore, interviewees of this study stated that some offenders become worse in institutions by associating themselves with more advanced criminals.

The retributive policies introduced in 2006 drastically increased the budget with a negligible impact on public safety. The policies increased the budget from $1.7 billion to $2.3 billion in 2014/15[13] (Zinger, 2016). In addition to increasing the correctional budget, the increased penalties for drug crimes alone cost the criminal justice system $67.7 million over five years, and policies that changed eligibility to conditional sentences and

[11] Federal incarceration increased by 14% between 2005 and 2015. Notably, incarceration of women, Indigenous people, and Black Canadians increased by 77%, 52%, and 78% respectively while incarceration of Caucasians decreased by 6% (Comack, Fabre & Burgher, 2015).

[12] Prison sentences are determined to increase recidivism rates by 3-7%

[13] Projected 2020/2021 budget is $2.55 billion

access to parole cost $156 million in trial, corrections, and parole costs (Comack, Fabre & Burgher, 2015). The lawsuits that offenders pursue against the retributive policies that are found to violate Charter rights are an uncalculated financial consideration. Offenders have the right to pursue legal action if they believe that their rights are being violated. If the inmate's case is successful, the government is sometimes left with the financial consequences. For example, in 2019, the federal government was ordered to pay $1.12 million in legal fees for a segregation class action lawsuit (Perkel, 2019). Furthermore, in 2018, the John Howard society reported that Canada spends around $20 billion per year on the federal and provincial criminal justice system. Of this $20 billion, $5 billion is spent on provincial and federal prisons and jails. The average cost to house a federal prisoner is $115,000 per year; however, this cost significantly increases in regard to higher security prisoners[14] and women prisoners (John Howard, 2018). Despite the high cost of retributive policies, the impact on community safety is negligible and leaves the Canadian government vulnerable to lawsuits.

2.4.2. Rehabilitation

In addition to CSC's legal obligation to assist in rehabilitation and reintegration of offenders, there is merit in considering a rehabilitative focus as "tough on crime" policies are not proven to decrease crime rates. There are multiple programs and models that are designed to improve an offender's opportunity to rehabilitate, such as the Integrated Correctional Program Model, Good Lives Model of Offender Behaviour, cognitive behavioural treatment, and educational programs. In the U.S., studies found that increasing education programs in prisons cut recidivism rates by ~30% (Esperian, 2010). The Risk-Need- Responsivity (RNR) model is a set of commonly used empirical evidence-based intervention principles that offer assessment and treatment (Bonta & Andrews, 2007; Morgan et al., 2012; Newsome & Cullen, 2017). The core principles of this model are:

- Risk: Match the level of service to offender's likelihood to recidivate
- Need: Assess criminogenic needs and use targeted treatments

[14] Annual cost per offender in Segregation is $463,045 (PBO, 2018)

- Responsivity: Tailor the program to match the offenders learning style, motivation, abilities, and strengths.

When all three principles are applied in a correctional setting, recidivism decreases by 17%, and when they are applied to offenders in the community, recidivism decreases by 35% (Bonta & Andrews, 2007). In addition, services that follow the principles of RNR are ~ 50% more cost effective than those that do not (CSC, 2014). Critics of the RNR model state the emphasis on risk is too high and there should be consideration on the personal goals the offender to account for improvements in their motivation (Looman & Abracen, 2013).

One study attempted to investigate the effects of using RNR principles for mentally ill offenders and stated there was preliminary evidence to support the theory that cognitive behavioural programs targeting risk factors were more effective than medication alone (Skeem et al., 2015). At this time, however, empirical research on the integration of psychiatric and correctional services is sparse, and more research needs to be conducted (Skeem et al., 2015). There is evidence that cognitive treatment programs can reduce recidivism by about 25% (Lipsey, Landenberger, & Wilson, 2007). However, there is not enough programming and mental health staff in prisons to offer such therapies on a consistent basis. Assisting offenders, particularly those with mental illness, is no easy feat, but there is evidence to support the advantages of taking a rehabilitative approach.

2.5. Political Climate

2.5.1. Public Opinion

Rehabilitative policies are not easy to implement as the political climate plays an important role in decision making. Two important factors that shape correctional policies are public opinion and partisanship of government. Schneider and Ingram (1993) theorize that politicians create policies based on their desire for re-election and therefore operate by appealing to powerful voters, as they are the most “deserving”. Offenders are construed in a negative fashion and as “undeserving” voters. Therefore, policies will be rarely created with their benefit in mind, according to Schneider and Ingram. Moreover,

the government will consider potential backlash from “deserving” voters and may have incentive to inflict negative policies on deviants.

Correctional facilities will also consider public perception when making decisions, which impacts the type of policies that are adopted. On a tour of Pacific Correctional Institution in 2018, correctional staff discussed how some policies were implemented to please the public rather than for practicality. For example, while buying cheap cuts of steak would be much more cost effective as it could be used in multiple dishes, correctional facilities buy bologna instead, as the headline “Prisons serve inmates steak” would be detrimental to their public image. Furthermore, one interviewee mentioned that keeping the organization and the Minister “out of the red” – out of the news cycle – is an important decision-making consideration.

Public opinion polling on the correctional system has not been conducted in Canada in over twenty years, so it is difficult to say for certain how the public perceives correctional policies. A 2017 National Justice Survey was conducted with 2019 Canadian participants on the topic of mandatory minimum punishments. Respondents were provided with three detailed scenarios and multiple follow up questions. Average responses showed the majority (82%) of the respondents did not believe that mandatory minimum punishments were fair or appropriate and 89% believed the judges should have the discretion to impose sentences that were less than the mandatory minimum punishments.

Studies show that responses to criminal justice policies vary greatly depending on how information is presented. A 2019 study regarding public opinion and criminal justice policy found that public opinion changed depending on the specificity of the question and knowledge of the respondent (Picket, 2019). After analyzing responses from previous surveys, the author found high support for punitive policies when the question was broadly worded. Support dropped when more information was provided in the question in regard to the type of offenders and other sentencing options available. For example, 76% of respondents were supportive of capital punishment, however, when the question provided other sentencing options, such as Life without Parole, support dropped to 40%. Additionally, 88% of respondents were supportive of a three strikes law, but support dropped to 17% when the questions described eligible offenders. Additionally, when people are asked about specific case examples, they chose

sentences that are similar to or more lenient than what was decided by Judges (Miller & Applegate, 2015; Pickett, 2019). Public opinion on sentencing and punishment also changes depending on their knowledge of costs of incarceration. Aharoni and colleagues' study (2018) found that participants chose substantively lesser punishments when made aware of cost information. The average citizen has very little knowledge on the nature of crimes, legal procedures, sentencing reforms, and punishment. Providing people with accurate information before polling their opinion decreases punitiveness and providing people with victim impact statements increases punitiveness (Hetey & Eberhardt, 2014; Picket 2019; Roberts et al. 2012). Lastly, if there is extensive media coverage on criminal matter, then public preference for punitiveness may increase. In America, support for capital punishment increased from 42% in 1966 to 80% in 1994 and decreased to 55% in 2017, coinciding with the trend of homicide rates and media reports (Picket, 2019). Overall, responses by the public changes vastly demonstrating that gaining knowledge in criminal justice policies results in increased favor of a rehabilitative approach.

2.5.2. Partisanship of Government

In addition to the pressures of public perception, the government in power impacts the type of policies that will be implemented. In an interview for a report by Watson (2014), ex-correctional officers stated that Correctional Service of Canada is required to fulfill policies issued by the government of the day. Sutton (as cited in Shannon and Uggen, 2012) examined trends in economics, welfare spending, and politics in five western countries[15]. Using a time series cross-section regression model, Sutton (2000) found that when right-learning parties are in power there is a 14% decrease in welfare spending, and incarceration rates increase by 12.2% when there is a decrease in welfare spending[16]. This trend is statistically significant for Canada, and although the data used was from 1955-1985, recent shifts in power suggest political affiliation is still impactful.

[15] Australia, New Zealand, Canada, U.S., and U.K.

[16] Welfare spending was calculated as a sum of expenditure on unemployment compensation, work injury benefits, family allowance, and public assistance as a % of GDP (Sutton, 2000)

Canadian right-leaning governments emphasize a “tough on crime” approach, which is evidenced by the $295 million operating budget cut and investment in security-based techniques that occurred in 2011. Correctional Service of Canada considered some harm-reduction techniques, such as an evidence-based pilot project that would reduce HIV transmission rates by providing supplies for safer tattooing. When the Conservative government was elected in 2006, that project was quashed (Watson, 2014). The harm reduction program was viewed merely as the government paying for prisoners to get tattoos rather than reducing HIV transmission rates, which would alleviate pressure on the healthcare industry. While the report from CSC was enthusiastic about the pilot project and its results, the government of the day was not. In short, “political decisions override evidence” (Watson, 2014, pg. 919). In 2011, when the Conservative party won a majority government, they cut the operating budget of CSC resulting in the closure of three prisons and the abolishment of some programs. The closure of the prisons led to overcrowding in other institutions, and the absence of programming decreased the prisons’ capacity to assist the rehabilitation of offenders, which further emphasized a security-based approach to corrections.

Although prisoners’ programs and services were being cut, there was an increase in funding for security features, such as more equipment for staff members. CSC increased spending on security by adding search technologies including ION scanners, x-ray machines, increased their drug-dog program, and urinalysis tests of prisoners. These changes resulted in a 17% increase in inmate assaults and a 20% increase in the number of use-of-force incidents – including an increase in the use of pepper spray and administrative segregation (Mallea, 2015; Shook & McInnis, 2017). The current Conservative party still endorses a “tough on crime” approach. Some policies within Erin O’Toole’s opposition platform includes increasing mandatory minimum punishments and tightening the application of Not Criminally Responsible due to Mental Disorder clause (O’Toole, 2020).

Conversely, left-leaning Canadian federal government platforms demonstrate more lenient criminal justice policies. The NDP proposed removing mandatory minimum sentencing and expunging criminal records for those who have been convicted of minor possession. Since coming into power in 2015, the Liberal government’s center-left leaning policies have leaned away from the “tough on crime” approach and instead made promises to reform the criminal justice system. They engaged with 11,000

Canadians through 19 provincial and territorial roundtables, four community roundtables, and four roundtables with other social systems from 2016 to 2018 (Department of Justice, 2019). One of the key takeaways from the reform engagement was that the current system, at times, is too focused on retribution rather than rehabilitation.

In 2018 a needle exchange program was introduced in some Canadian prisons despite backlash from the public and the Union of Canadian Correctional Officers. There is concern that inmates will attack officers with needles and that the responsibility of tracking the needles will be a further burden on the officers. However, the program was in line with the Canadian Drug and Substances Strategy and was therefore implemented (UCCO-SACC-CSN, 2019). It should be noted that the program is effective in decreasing infectious diseases and there is a lack of evidence that needles were being used as weapons (Bradley, 2019; Filter Staff, 2019; Gerster, 2020; Glauser, 2013). Despite moving forward on the controversial policy, there is no evidence that it impacted the Liberal government's 2019 election. Furthermore, in February 2021 the Liberal government introduced Bill C-22, which will reduce mandatory minimum punishments and encourage courts to consider conditional sentences when public safety is not in question (Tunney & Noel, 2021).

Chapter 3. Methodology

This chapter outlines the methodologies that are used to understand the policy problem and identify possible policy solutions. Multiple methods were used, including a literature review of the existing policies, case studies, a jurisdictional scan, and interviews with people who work with incarcerated people.

3.1. Literature Review

An extensive review of government and correctional policy regarding care for people with mental illnesses was conducted. The review establishes the current framework that determines the rights and policies of assisting this population. This includes a review of Canadian statutes and constitutions, such as the *Canadian Charter of Rights and Freedoms*, the *Criminal Code of Canada*, and the *Corrections and Conditional Release Act*. A review of the history of mental healthcare in Canada was conducted alongside a review of political influence on correctional policy. Due to the Correctional Service of Canada's hesitation to fully share information, literature was mainly sought from Google, SFU's Library resource, and from the Office of the Correctional Investigator website (Piche, 2011; Wright et al., 2015).

3.2. Case Studies

Prominent cases that demonstrate the negative impacts and violation of rights related to the treatment of mentally ill offenders are identified to stress the importance of supporting this population. The stories of Ashley Smith, Matthew Hines, and Joey Toutsaint highlight the different ways that mental illnesses impact an individual's experience within correctional facilities. These stories underscore the gap between correctional practice and policy.

3.3. Jurisdictional Scan

A high volume of incarceration among people with mental illnesses is not an issue that is unique to Canada. Three other jurisdictions were analyzed to understand what policies could potentially have a positive impact on incarcerated Canadians.

Norway was the first jurisdiction to be analyzed, as they successfully reduced recidivism rates. New Zealand attempted to follow in Norway's footsteps, however, recent reports by New Zealand's Chief Ombudsman state that they have fallen short of their goal. Lastly, England was analyzed, as they recently reviewed their decision to transition healthcare responsibilities.

3.4. Expert Interviews

Throughout February 2021, nine semi-structured interviews were conducted with experts, including provincial and federal correctional officers, an ex-BC Board of Parole member, a carceral psychiatric nurse, and an academic expert. The Union of Canadian Correctional Officers was contacted but failed to respond. Therefore, the interviewees were recruited through word of mouth. Additionally, there were some informal conversations with correctional staff due to a reluctance to participate formally. As this paper is critical of CSC, institutional permission was not needed. CSC is known to be hesitant to work with external researchers, and time was of the essence (Piche, 2011; Wright et al., 2015).

Chapter 4. Notable Cases

In the OCI's investigation of women who chronically self-injure, correctional officers stated they did not believe they were trained to assist offenders with mental health concerns (OCI, 2013). There have been many cases that corroborate this statement and demonstrate that the institution as a whole may not be adequately prepared to support the needs of offenders with severe mental illnesses. This study will highlight three cases: Ashley Smith, who required urgent care; Matthew Hines, who had untreated mental illnesses; and Joey Toutsaint, who documented his experience of receiving mental health care while incarcerated. Ashley Smith's and Matthew Hines's deaths are particularly notable as they were focusing events that instigated an investigation in correctional practices and recommendations for policy change.

4.1. Ashley Smith

Ashley Smith's death is one of the most notable cases that brought attention to offenders' mental health care. Smith's behavioural problems began at a young age. While her family tried to get assistance from provincial services, she was eventually expelled from a diagnostic and treatment center for her disruptive behaviour (OCI, 2008). At the age of 15, Smith received a custodial sentence for a juvenile detention centre where she incurred 50 more criminal charges, most of which the OCI (2008) reports are related to her self-injurious behaviour. Smith was forced to spend an extensive amount of time in the "Therapeutic Quiet Unit," where she was isolated. Smith was still incarcerated when she turned 18 and received another sentence for her behaviour, which resulted in her transition to an adult federal penitentiary. Less than a year later, Smith was in a segregation cell without shoes, proper clothing, mattress, or blanket. Smith informed the officers she wanted to end her life and a couple of hours later, she tied a ligature around her throat. Although she was under 24-hour watch, the correctional officers failed to respond to her behaviour, and she died shortly after (OCI, 2008). The Coroner's inquiry determined that Smith's poor mental health, in conjunction with the inadequate resources available from CSC, caused her death (OCI, 2008). The Coroner's Jury concluded that Smith's death could have been prevented with proper intervention and provided 102 recommendations for CSC to prevent similar situations from occurring in the future (Carlisle, 2013; OCI, 2008). While this case occurred over a

decade ago, recent incidents show there has not been an improvement in the institution's ability to care for those with mental illnesses, which has resulted in the occurrence of many similar situations in subsequent years (*Bjorklund v. BC Ministry of Public Safety and Solicitor General*, 2018; *British Columbia Civil Liberties Association v. Canada (Attorney General)*, 2018; Toutsaint, 2018). Shortly after her death, CSC conducted an internal audit on healthcare and found a number of areas for improvement, including an absence of standardization of mental health services at Regional Treatment Centres, no specific mental health procedures, and inconsistent funding allocation (CSC, 2011).

4.2. Matthew Hines

The issues that came up during Ashley Smith's case were mirrored by the death of Matthew Hines. Hines, a 33-year-old inmate at Dorchester Penitentiary, died after a series of use of force incidents. Hines attempted to visit other inmates during lockup, prompting the officers to attempt to control Hines physically. He was attacked with fists and knees and pepper-sprayed from close proximity multiple times. Hines had multiple seizures and spat up blood but was not properly assessed by nurses. An ambulance took him to the hospital around 11:00 pm but stopped to perform futile life-saving measures. The pathologist report indicates that Hines's death was likely due to asphyxia from the pepper spray. The OCI concluded that, like Smith, Hine's death was preventable and urged the CSC to take corrective action to prevent another death (OCI, 2017). The staff response to Hines was security-driven, even after Hines was incapacitated. Although this incident is not directly linked to Hine's mental health conditions, The Board of Investigation stated Hines had untreated mental health risk factors. He had twice been admitted to a local psychiatric treatment centre and had a history of psychotic symptoms (OCI, 2017). This case highlights how inappropriate use of force can result in avoidable medical emergencies and the need for appropriate training for front-line workers (OCI, 2017). Hines's death prompted an audit of use-of-force cases. In the 16-month audit, over 1900 use of force cases occurred, and only 5% of them are randomly selected for investigation. Additional information highlighted that guidance was not consistently provided to officers on using force. Shortly after, CSC transitioned intervention strategies from the Situation Management Model to the Engagement and Intervention Model (more information provided in Chapter 5).

4.3. Joey Toutsaint

Joey Toutsaint is an Indigenous inmate who filed a complaint to the Canadian Human Rights Commission for his treatment in federal institutions. Toutsaint (2018) wrote that his mental illness treatment in the institutions was minimal at best. Instead of being provided with appropriate medication for his illness, he was forced to take tranquillizers. Toutsaint (2018) states that the isolation in segregation increased his urge to self-harm, which resulted in more security-based responses, such as being pepper-sprayed and tied to a Pinel restraint bed. Whenever he was transferred to a new institution, his mental health treatment plan changed. These transfers cut Toutsaint off from medication and programming he received at one institution, further aggravating his mental health conditions. He requested to receive Indigenous treatment, as the cultural connection would help him maintain his mental health. However, some institutions did not or were not able to provide access to culturally appropriate programs. The lack of meaningful care and the extended period in segregation aggravated his mental health condition (Toutsaint, 2018). Toutsaint's letter demonstrates the poor and inconsistent treatment of some mentally ill inmates.

4.4. Key Takeaways

Correctional staff are not equipped to support the needs of inmates with mental illnesses. In investigations and interviews for research, officers often state they are not trained to handle mental health situations. People who suffer from mental illnesses have died at carceral institutions, and while recommendations for change have been made, there are still similar issues occurring. Due to the high volume of security-based responses, the OCI suggests that rather than keeping inmates with illnesses at CSC's regional treatment centres, they should be transferred to psychiatric facilities in the community (OCI, 2013; OCI, 2018). The OCI (2018) reports CSC's regional psychiatric facilities do not support therapeutic efforts. The structures are void of rehabilitative aspects, and the correctional officers at the facilities are "inconsistent with a hospital setting." Despite the recommendation, transfers to community psychiatric facilities occur sparingly (OCI, 2018, p. 22).

Chapter 5. Interview findings

This chapter will highlight themes that were brought up during the interviews. A variety of staff members participated, including federal and provincial correctional officers, an academic, a teacher in correctional facilities, a nurse, and an ex-BC Parole Board member. The relationship between staff and offenders differs greatly depending on the nature of the position. Relationships between officers and offenders impact prison culture, prison order, and prisoners' wellbeing (Beijersbergen et al., 2016). Correctional officer interviewees stated that there is often a polarizing "us vs them" relationship between themselves and offenders. However, mutual respect is still possible. Correctional staff who are not officers stated that their relationship with inmates was more positive, which impacted their interactions and perceptions of offenders. While topical and important for consideration, the findings are not generalizable as there were only nine participants.

5.1. Mental health care is minimal

> "It is very medication focused, but from a psycho-social perspective…having groups, or treatments or counselling – that piece was missing."

> "You got an issue of inmates … who are highly troubled… the extent to which CSC successfully addresses mental health issues in prison and provides what we would call throughcare into the community is questionable."

A registered nurse for Correctional Service of Canada noted that there was only one psychologist for the whole population at their institution when they worked at correctional facilities. Offenders seeking treatment for mental illness received medication but did not receive further treatments, such as counselling. The nurses would inform the doctors if the patient noted suicidal tendencies or if there were extreme behavioural changes. Offenders would see doctors every three to six months at best.

5.2. Lack of information is a roadblock

> "What they get given, what they're on – we have no idea if they're in programming for things. We don't know if the programming comes from

psychology or if it comes from the recommendation of the parole officer. We don't get given any information really about anything, unfortunately… We don't have the information to do the job better."

"[mandatory mental health training] would [result in] less use of force [and would be] less traumatic on staff and less traumatic on the inmates."

Correctional officers identified that they do not believe they have all the information necessary to make best practice decisions. They stated that carceral institutions emphasize using the Engagement and Intervention model, promoting an integrated dynamic security approach to corrections. However, when they contact the health team, they are denied information, so they are at times unaware of an offender's health care needs until it has escalated. For example, sometimes, they will not know that an offender has mental health issues until they are placed on suicide watch. The officers would have paid extra attention to the inmate's behaviour earlier had they been aware of the situation. The officers recognize that health care information is not shared to prevent officers from developing biases but felt frustrated with the lack of trust. Furthermore, some officers identified that there is a lack of training for dealing with offenders who are mentally ill. Officers at both provincial and federal institutions stated that they were provided with only minimal training upon hire and annual suicide prevention training that focused on the preservation of life. Any additional training is up to the discretion of the officer. One officer who pursued additional training stated that offenders with mental illness could not be deescalated in the same manner that the general population of offenders is deescalated. In their opinion, the current mental health training is unfair to the staff and the offenders. Another interviewee stated that they did not believe that it was possible for there to be enough mental health training to support officers. That being said, the interviewee was concerned about officers having to wear "multiple hats" if additional training was provided.

5.3. Institutions with extensive health care teams adopt a "hands-off" approach

"I think it's better now. There's definitely more resources … it's easier as an officer to refer somebody to the mental health team." – In reference to BC Corrections transitioning healthcare responsibilities to PHSA

Correctional officers connected with extensive health teams through Regional Treatment Centres or the Provincial Health Services Authority (PHSA) felt supported when working with mentally ill offenders. They noted that if a mental health concern was raised, a manager and psychiatric nurse were called immediately, and the issue was passed on to the professionals. The provincial correctional officer noted that BC Corrections transfer of health care responsibilities was positive, as before the transition, the mental health team was less extensive. Now they have drug and alcohol counsellors, a liaison officer for the healthcare and corrections team, nurses, two doctors, two psychiatrists, and a health care manager for their facility alone. They noted that before PHSA took responsibility, it was more difficult to refer inmates to psychiatrists or psychologists.

5.4. Perceptions and interactions with offenders vary depending on experience level

> *"There's a big difference in new officers to experienced officers in how we're equipped to handle these situations… when you deal with these guys day in and day out, and you know, you do what you can, and behaviours don't change, and your safety comes into question... I mean, I understand a lot of officers see [the switch to new model] as a negative. They like a hands-on approach."*

Correctional officers in provincial and federal facilities identified that generally, younger officers were better at interacting with mentally ill offenders. One officer attributed this difference to the training style provided to older officers versus what is offered to new officers. They noted that CSC is making a conscious effort to shift to a new Engagement and Intervention Model,[17] which encourages officers to communicate with offenders more often to prevent, respond to, and resolve incidents. The new model states that interventions must comply with law and policy, including considering mental and physical health, using verbal interventions to promote peaceful resolutions when possible, limiting use of force to what is necessary and proportionate, and continuously assessing and reassessing situations as they develop (CSC, 2018c). The previous Situation Management Model that older officers initially learned emphasized securing the

[17] Implemented in 2018

person. It required continuous assessment of a situation as it progressed and provided guidelines for escalating use of force (please refer to appendix A).

5.5. Correctional Officers feel they are secondary to inmates

"The Charter is pretty clear. Everybody has the same rights and freedoms, but ours are always placed lower."

"CSC has pushed for a hands-off approach, and I think a lot of officers don't like that because they feel like almost the inmates being prioritized over the officers … it's better for the inmates in the long term but results in less engaged officers."

Regardless of the institution level, all officers identified that they did not feel that their safety was a priority. Certain policies, such as being unaware if an offender is HIV positive, make officers feel unsafe as they are unable to take precautions to protect themselves. Interviewees identified that some policies and procedures in the institution, such as the emphasis on the Engagement and Intervention model, make it difficult for officers to perform their duties for the inmates' benefit. If a situation of distress was imminent, the Situation Management Model allowed an officer to immediately physically secure an inmate. The new model requires officers to consider an offender's mental and physical health and reach out to other organizations arms for support, which can extend the length of time it takes to resolve an incident. For example, one interviewee stated that an incident that took 30 minutes can now take up to 3 hours.

5.6. Difficult to offer help in the current system

"It's pretty late in the game for me to start asking [the inmate applicant] what do you understand about how you got here? Well, the guy has been in trouble since he was 12, he's 45 and looks across the table and says I have no idea. He's probably telling you the truth."

"We can't fix the problems of these people when they're in the institution. The problems start for some of them in their childhood, for some of them in their teenage years, for some of them in their adult years… Often, it's too late if you're

scooping someone at 40 and throwing them in jail for ten years. It's already ingrained. We need to do something earlier."

"Wellbeing is important, but it comes secondary to security."

Interviewees stated that it was difficult to offer offenders support. Some correctional officers believe that it is impossible to provide both security and rehabilitation in prison due to the setting's nature. The contentious and often contrasting roles make it difficult for officers to assist in rehabilitation while being alert to potential threats. Furthermore, an ex-BC Parole Board member communicated their frustrations regarding attempts to support offenders, as the inmates were not receiving adequate support to work on their problems before being eligible for parole. Additionally, roadblocks, such as stringent halfway house requirements, made it difficult to create a sustainable throughcare plan.

Chapter 6. Offender Mental Health in other Jurisdictions

This chapter will assess how Norway, New Zealand, and England address mental illness among offenders. Studying other jurisdictions may highlight possible policy options Canada could consider implementing. Norway was chosen as a jurisdiction due to their world-renowned policies that result in low incarceration and recidivism rates. New Zealand attempted to achieve Norway's results but have yet to succeed. England was selected because they transitioned their healthcare responsibilities away from the correctional system in 2006 and recently reviewed the impacts of this adjustment. There are external factors that are important to consider, such as diversion and throughcare planning. An overview of New York State's diversion teams and the implications of poor throughcare planning is available in Appendix B.

6.1. Norway

Scandinavian countries, such as Norway, have strong welfare systems where the government invests in social programs to support citizens. Lappi-Seppala & Tonry (2011) report that welfare states are less susceptible to adopt "tough on crime" policies, rather supporting alternatives to imprisonment for offenders. While Norway attempts to divert mentally ill people to alternative programming, there still is an issue of mental illness in prisons. According to the 2014 Victoria Cramer's Survey, 92% of Norwegian prisoners show signs of a personality disorder or mental illness (Moe, n.d.). Kjelsberg et al.'s (2006) study found that 2-4% of the prison population had a serious psychotic disorder. The researchers were surprised by this finding, as Norwegian policy forbids the incarceration of people with serious mental illnesses. Instead, the policy states that people with serious mental illnesses should be sent to a psychiatric hospital, where the setting is more appropriate to treat the cause of the criminal behaviour. Currently, Norway has low recidivism rates (20%) and one of the world's lowest incarceration rates[18].

[18] 49 per 100,000 people imprisoned as of April 2020 (World Prison Brief, 2020).

Norway did not always have low imprisonment and recidivism rates. In the 1980s, the Norwegian government acknowledged that the retributive system, which focused on security and punishment, resulted in high violence, imprisonment, and recidivism rates (Davies, 2020). In the 1990s, the Norwegian prison system went through a rigorous reform that shifted the focus from retribution to rehabilitation and restorative justice. This transition included transferring healthcare responsibilities from the Ministry of Justice to the Ministry of Health and Social Welfare (Kjelsberg et al., 2006; Moe, n.d). Norwegian institutions scan all prisoners for physical and mental illness within a week of their arrival. Due to the transition of healthcare responsibilities, the tests are done by healthcare workers who are independent of the prison institution. While the healthcare workers are economically and administratively separate from correction officers, there is a high level of communication between the two entities (Kjelsberg et al., 2006). In Norwegian prisons, each offender is assigned an officer as a contact person. If the offender has mental health concerns, they inform their primary officer, who arranges a meeting between the offender and their healthcare worker (Bouffard, 2019).

As well as increasing access to programs and education, the role of the correctional officers was reformed. Correctional officers are there to ensure the prisoner serves their sentence, but they shifted away from being there solely for security purposes. Currently, officers believe their duties include role model, coach, mentor, and ensuring the prisoner becomes a better person (BBC, 2019). Correctional officers who worked in the Norwegian prisons before and after the transition state that prison culture before the transition was much like North American prison culture where it is an “us vs them” mentality and the focus is primarily on security (BBC, 2019). In addition to the shift in mentality, Norway transformed the prisons’ physical space to be more conducive to the reformation of prisoners. Halden prison is renowned for its refreshing take on prison architecture as the € 138 million building is meant to decrease the “pains of imprisonment” and increase rehabilitation opportunities. Kielsberg et al.’s (2006) study interviewed six Norwegian prisons that house a third of Norway’s incarcerated population. Out of the six prisons surveyed, five stated they had adequate services, including enough therapists for offenders and adequate experience working with local psychiatric hospitals. Additionally, therapists reported that the offenders’ psychiatric needs were adequately met in 65% of cases. Although there is always room for

improvements, the low recidivism and incarceration rates indicate that Norway's criminal justice system is on the right path for supporting offender's rehabilitation.

6.2. New Zealand

Canada and New Zealand's framework for mental health policies are similar. The Bill of Rights Act states that New Zealanders have fundamental freedoms, such as the right to life and security and to refuse medical treatment. The 1993 Human Rights Act, in conjunction with New Zealand's ratification of the Convention on the Rights of Persons with Disabilities and the Health and Disability Commissioners Act, prohibits discrimination on several grounds, including mental disability (Soosay & Kydd, 2016).

One in five New Zealanders is estimated to experience mental illness in their lifetime. Similar to Canada, the rates for mental illness are higher among incarcerated people (Department of Corrections, 2016). Recognizing the close relationship between substance abuse and mental illness, New Zealand reports the rate concurrently, stating that nine out of ten prisoners are diagnosed with a mental health and/or substance use disorder. The New Zealand Department of Corrections acknowledges that the prevalence of mental illness in institutions is an area of concern and worked with the Office of the Ombudsman to formulate plans to increase support for offenders. A 2016 report by New Zealand's Department of Corrections highlighted that most mentally ill prisoners would not qualify to be transferred to a hospital setting. Thus, they would have to learn to manage the population in institutions. The Department of Corrections stated that the Auckland Prison, where 80 of the 260 prisoners have serious mental health and/or complex behavioural issues, was not ideal for rehabilitation. So, in 2012, reconstruction of the facility was approved. The new facility's goal was to improve rehabilitation efforts, as containment of people no longer fit the purpose of New Zealand's criminal justice system. The new facility opened in 2018 with three central healthcare delivery models: Central Health Centre, a Satellite Health Station, and door-to-door service to improve offenders' healthcare in solitary confinement. All those with mild to moderate mental health concerns are managed in their regular accommodations. However, those with acute issues have a specific unit designed to meet their needs, including a multidisciplinary team (Department of Corrections, 2016). As well as constructing a $300 million new facility, New Zealand invested $14 million in mental health programming to support needs.

Despite the investments and intent to support offenders, the Chief Ombudsman came out with a statement in December 2020 stating their disappointment in the criminal justice system reform (Ombudsman, 2020). According to the Ombudsman, the culture among correctional staff still revolves around the offenders' containment rather than rehabilitation. While the new facility was designed to help rehabilitation and support the reintegration of maximum-security prisoners, the Ombudsman noted that offenders were locked in their cells for 22-23 hours a day, prohibiting them from participating in programs (Ombudsman, 2020). The Ombudsman (2020) also reported two United Nations convention violations when officers pepper-sprayed an inmate and then falsely reported that the offender was not following orders. The Ombudsman noted that staff shortages contributed to the lack of follow-through with the 2016 promise. There were not enough workers available to escort prisoners to appointments and reintegration opportunities. The Ombudsman made 37 recommendations, 33 of which have been accepted by the institution, and four have been partially accepted.

6.3. England

England's correctional system has a rich history and has gone through multiple phases. The first stage focused on retribution and deterrence until the 1895 Gladstone report by the Departmental Committee on Prisons. The second stage recognized the need to reform offenders while still accepting retribution and deterrence as correctional facilities' primary purposes (Radzinowicz, 1939). The third phase came after WW1 and highlighted the importance of rehabilitation to reduce recidivism rates. A recent report on modern-day English prisons highlights the current system's gaps, mainly the deterioration in prison standards over the years (Institute for Government, 2019). Cuts in prison funding and a decline of prison staff in 2009 and 2015 are linked to increased deaths, violence, self-harm, poor behaviour, drug use, and a decrease in rehabilitation efforts (Institute for Government, 2019).

While England has many problems in their correctional facilities, one aspect that should be highlighted is their 2006 transition in healthcare responsibilities. In 1996 the Chief Inspector of Prisons published an article on the poor health care in prisons, showing that needs were not being met across the country (Hayton & Boyington, 2006). This instigated creating a working group comprised of the National Health Service (NHS) and prison administration to assess the issues further. The report aimed to increase care

standards to match what was offered to the community. In 2002 the committee recommended that the justice system transfer responsibility to the healthcare system. There are many benefits identified to this change, including independence in medical staff decision-making, increased trust between prisoners and healthcare advisors, continuity of care, and quality of care. Ten years after the complete transition of care, the public health commission was instructed to review the evidence of the transition. The report found that better partnerships with organizations improved quality of care. Furthermore, there were improvements in healthcare staff, increased transparency, and increased engagement with offenders, liaisons, and diversion services (Public Health England, 2016).

England's transition provides insight into the benefits of working with external organizations that have access and specialized resources to support offenders' healthcare needs. Norway and New Zealand's path provides further insight into what policies Canada could implement to support mentally ill offenders. Norway is the most successful country to support offenders with mental illnesses through an entire shift in cultural outlook, investment, and architectural design. New Zealand aimed to achieve similar goals. Regardless of the multi-million-dollar investment, the relationship between correctional officers and inmates remained tense, which impacted the support inmates receive. This demonstrates that while important, adequate programming and safe spaces are not enough on their own to support the needs of mentally ill offenders. Rather, the relationships between correctional officers and inmates need to shift.

Chapter 7. Policy Options

In this chapter, three viable policy options are identified using the findings from the literature review, jurisdictional scan, case studies, and interviews. The goal of the selected policy is to increase the mental wellness of the offenders so that it may support their rehabilitation into society. The intersection of mental illness and criminality is complex and there is a lot of work to be done, but the goal will not be met if steps are not taken. Therefore, the options should be realistic, recommended by experts, and grounded in success stories.

7.1. Status Quo

Carceral institutions add layers of complexity, making it difficult to address mental health needs. There are many aspects that impact an institution's ability to offer rehabilitation opportunities such as security, dynamics of the prison population, leadership, and motivations of the offenders and officers. There have been efforts by CSC to remedy the gaps in mental healthcare. Medication is offered to those who require it, and when possible, appointments are made with doctors to assess the effectiveness of medication and make changes when necessary. There is evidence to suggest that a degree of psychological care is available in some facilities, particularly to those who are in need of acute care (Toutsaint, 2018). While mandatory mental health training is not provided to officers, they have the ability to pursue additional training on their discretion. Additionally, when an offender is need of acute care, they are transferred to the Regional Treatment Centres as needed. Furthermore, CSC has transitioned away from the Situation Management Model towards the Engagement and Intervention Model to increase the communication between different staff members to promote a culture of mitigation rather than response. Finally, some argue that the healthcare in correctional facilities is more accessible than what offenders are able to access in the communities.

7.2. Transfer Health Care Responsibility to Provinces

The World Health Organization and College of Family Physicians of Canada have recommended that CSC relinquish their health care responsibilities and allow the

provincial health authorities to take over. This recommendation is based on the foundation that the correctional facility cannot both be security and control focused while still meeting the principles that are necessary to supply a meaningful, healing environment needed to support mental health care.

This option would result in the transfer of all healthcare related responsibilities to the provincial health authorities, including primary care, mental health and addiction care, and pharmaceutical services. By doing so, the correctional healthcare budget for facilities in each province would be transferred to the appropriate Ministry of Health and each province would implement their service delivery model. Additionally, all current healthcare staff would be under the jurisdiction of the provincial health authority and obligated to comply to that authority's standards. In Canada, half of the provinces will have transferred responsibility from their Ministries of Justice to Ministries of Health by 2021, including British Columbia, Alberta, Quebec, Newfoundland, and Nova Scotia. Therefore, the federal government can assess provincial transition plans to adopt best practices. For example, British Columbia included five community transition teams throughout the province that assist with addiction recovery and access appropriate treatment services as needed. Their transition plan took a total of two and a half years to implement and involved the following steps:

- July 2015: Project Charter Signed
- April 2016: PHSA conducts a review and develops a service delivery model/ business case
- May 2016: Memorandum of Understanding signed by Ministry of Public Safety, Solicitor General, and Ministry of Health
- December 2016: Ministries submit funding request to Treasury Board to implement the PHSA service delivery model
- February 2017: PHSA board approval
- October 2017: Assumption of services by PHSA (BCMHSUS, 2018).

7.3. Community Program Liaison Officer – Pilot Project

Programming to engage with offenders is an important aspect of prison culture. CSC's website states there are four general categories of programs: Correctional, educational, social, and employment (CSC, 2019). Correctional programs aim to address factors that are linked to criminal behaviour. Educational programs assist offenders in developing basic literacy, academic, and personal development skills. Social programs aim to help offenders gain the skills, knowledge, and experience needed for personal and social growth. Lastly, employment programs help inmates prepare to work in the community once released. Some facilities offer innovative rehabilitative programs created through community partnerships and can include activities such as (Donato, n.d.):

- Fostering puppies to teach responsibility
- Music workshops where offenders sing, play instruments, write poetry, and learn audio engineering
- Assisting Indigenous people to meaningfully engage with their culture through Healing Lodges
- Opportunities to foster positive relationships between mothers and children through the Institutional Mother-Child program
- Teaching offenders to work with crops and livestock through Prison Farms[19]

This policy option proposes to introduce a pilot project where a community program liaison officer position is created under the programming department. This officer would be responsible for assessing what organizations are available in the community and the needs of the prison population at the institution. The prison culture varies at each institution and so there should be flexibility for the facility to decide what type of programs their inmates would benefit from the most. The officer would be responsible for working with the community organization and the institution to establish the logistics of the program, such as where it is taking place, the material and equipment needed, and who is required from each organization to ensure safety and effectiveness of the program delivery. The degree to which each requirement is needed will vary

[19] Prison farms was initially shut down under the previous government in 2011 due to budget cuts but were reinstated in 2018 under the current government (Innes, 2019).

depending on the program. This option should be first implemented as a pilot project at a minimum and medium security prison and should be expanded to other institutions after assessing its effectiveness. An example of this option in action is a potential partnership between William Head Institution, a minimum-security federal penitentiary with John Howard Society of Victoria. John Howard Society offers a community garden project for offenders in Victoria, but there may be some capacity for minimum-security inmates to participate.

Chapter 8. Policy Criteria and Measures

A multiple-criteria analysis was conducted to evaluate the proposed policy options. While encouraging the humane treatment of offenders with mental illnesses is a key concern, other important aspects must be considered as well. This chapter presents the criteria and measures that are used to evaluate the benefits and drawbacks of the proposed policy options, which are presented and described in detail in the following chapter. The evidence used to develop the measures is the combination of insights gained from interviews, as well as knowledge gained from case studies, literature review, and jurisdictional scan. An overview of the criteria and measures are displayed in Table 2.

8.1. Key Objective: Effectiveness

As the goal of this research is to address the negative impacts of incarceration to support the rehabilitation of mentally ill offenders, more consideration is given to the key criterion: effectiveness. Effectiveness must measure how well each policy increases the likelihood that mentally ill offenders will receive appropriate services that impact mental wellness. This criterion is measured from the methodologies used for this study: case studies, interviews, literature review, and the jurisdictional scan. Each methodology contributes to the analysis in slightly different ways due to the ethical limitations of studying inmates. I will indicate the degree to which each methodology supports the effectiveness of each policy option. For the purpose of this analysis, effectiveness is defined as the extent to which a proposed policy option will support the wellness of offenders with mental illness. Each option will be assessed to determine whether the methodologies provided no evidence, some evidence, or stronger evidence to support its effectiveness. An option's effectiveness rating will increase depending on how much evidence is available from the literature review, case studies, jurisdictional scan, and interviews.

8.2. Political Considerations

As demonstrated in chapter 2.5 the government and correctional facilities consider the public's reaction when making decisions. The public can be sensitive to

correctional policy, as many citizens are opinionated on matters of the administration of justice. When a crime is committed, trust between citizens and the offender is broken. Citizens want to feel a sense of justice for being wronged. **Public opinion** will be measured by whether the policy will be perceived as negative, indifferent, or positive. Negative public opinion is defined by any policy that will generate a strong public backlash. Indifferent public opinion is defined by any policy that incites no reaction from the general public. Lastly, positive public opinion is defined by any policy that incites a positive reaction from the general public, such that the organization and government will be viewed positively. The perception of public reaction is drawn from interviews, the literature review, and previous reactions to the implementation of similar policies.

8.3. Stakeholder support

Correctional officers are an important stakeholder as they must work in the correctional facilities and are therefore directly impacted by any policy changes. The consideration of whether correctional officers will be supportive of the policy options is gathered from the interviews conducted. This criterion will be measured by whether there is high support, moderate support, or low support from correctional officers.

Additionally, **advocacy groups** are a key stakeholder as they work with inmates to advance lawsuits and are interested in supporting the rights of offenders. This includes organizations such as Elizabeth Fry Society, John Howard Society, Prison Legal Society, and Civil Liberty Associations. The consideration of whether advocacy groups will be supportive of the policy options is based on whether the option aligns with their values. This criterion will be measured by whether there is high support, moderate support or low support from advocacy groups.

8.4. Cost

Cost is also considered in the analysis of proposed policy options. The total federal correctional budget is $2.55 billion for the 2020/2021 cycle. Of this total, almost 75% of the operating budget is attributable to salaries and employee benefits. The amount of the budget allocated to correctional programming was not available and thus, absolute cost estimates are not available for the proposed policy options. Rather, the cost estimates will be based on proxies such as new infrastructure, renovations,

personnel, equipment, additional training, and other potential expenditure for the option's implementation. Furthermore, short term and long-term costs on the correctional system will be taken into consideration. Some options may require high investment for implementation but will be more cost effective in the long term than other options. While recidivism rates are not clear, it is understood that most convicted offenders have at least one prior conviction (Northcott, 2018). Therefore, if policies support rehabilitation and reintegration, there will be a likelihood of decreasing incarceration rates and thereby decreasing the cost on corrections. The measure of these criteria will be whether the short-term and long-term cost of the option is high, moderate, or low.

8.5. Ease of Implementation

Ease of implementation will consider the complexity associated with the implementation of the proposed policy option. Considerations will include, how much time will be required to create the program, how many stakeholders need to be involved, how much coordination is needed between multiple organizations, and whether legislative change will be required. The less overhaul required to the correctional system, the less complex the implementation process will be. Thus, the proposed options will be measured by low, medium, or high complexity.

Table 2. Summary of Objective, Criteria, and Measures

Objective	Criteria	Measure
Effectiveness (Key criterion: x2)	Effective in supporting the mental wellness of offenders	No evidence of effectiveness (2) Some evidence of effectiveness (4) Stronger evidence of effectiveness (6)
Political Considerations	Public opinion	Negative public reaction (1) Indifferent public reaction (2) Positive public reaction (3)
Stakeholder support (x.5)	Correctional officer support	Low support (1) Moderate support (2) High support (3)
	Advocacy group support	Low support (1) Moderate support (2) High support (3)
Cost (x.5)	Short-term costs	Low short-term cost (1) Medium short-term cost (2) High short-term cost (3)
	Long-term costs	Low long-term cost (1) Medium long-term cost (2) High long-term cost (3)
Ease of Implementation	Complexity of implementation	Low complexity of implementation (3) Medium complexity of implementation (2) High complexity of implementation (1)

Chapter 9. Analysis of Policy options

9.1. Status Quo

Beyond one interviewee who stated that they believe the mental health care of offenders is sufficient, the literature review, jurisdictional scan, and case studies do not support that the status quo is **effective** in supporting the mental wellness of offenders. CSC is taking some steps to address mental illnesses in institutions. However, these changes occur after a major incident that requires the organization to take action, such as the deaths of Ashley Smith and Matthew Hines. Years of reports by the OCI highlight areas for concern that still exist and implore CSC to take action. **Correctional officers** are estimated to be supportive of this option as it requires no changes from them. However, **advocacy groups** will not be supportive of this option as they would like to see more support systems become available for offenders.

The **public reaction** regarding the status quo is likely to be indifferent as the general public is currently unaware of the pitfalls in current correctional practices. Maintaining status quo does not involve additional **costs**, however, as discussed in chapter 2, the current costs of incarceration are high. The high costs are not a result of inflation, but rather policy change that has done little to increase public safety[20]. In late February the government announced Bill C-22, which if passed, will remove mandatory minimum sentencing for certain crimes leading to a decrease in correctional spending as offenders may be sentenced to probation or lesser sentences (Department of Justice, 2021). Lastly, this option has low complexity with regard to **implementation** as no change is required.

[20] Quantitative meta-analytical review of 50 studies involving over 300,000 offenders found prison does not reduce recidivism (Goggin & Cullen, 1999).

Table 3. Summary of Status Quo

Objective	Reasoning	Score
Effectiveness (x2)	Many reports have indicated that status quo is not effective in supporting mental health	No evidence of effectiveness (2)
Political Considerations	No reaction from public	Indifferent public reaction (2)
Stakeholder support (x.5)	Does not require change from correctional officers	High support from correctional officers (1.5)
	Advocacy groups want to see more supports in place for offenders	Low support from advocacy groups (.5)
Cost (x.5)	No additional costs will be required	Low short-term cost (1.5)
	Overall system is expensive as a result of retributive policies	High long-term costs (.5)
Ease of Implementation	No change required	Low complexity of implementation (3)
Total		**11**

9.2. Transfer Healthcare Responsibilities

There is evidence that transferring healthcare responsibilities from CSC to the Ministries of Health would be **effective** in improving the mental wellness of offenders. The interviews, jurisdictional scan, and literature review support the effectiveness of this option, as it would improve quality of care, administration, and access to mental health care – which are all factors that would increase mental wellness (National Collaborating Centre for Mental Health, 2011). Quality of care and administration would increase, as there would be more oversight by healthcare specialists to ensure that best practices are being used. Both the literature review and interviews identified that additional mental health training is required for healthcare staff in Canadian federal institutions. An interviewee identified that there is no oversight as to whether nurses in correctional facilities continue their education, a requirement for nurses in the community. The jurisdictional scan found that transferring responsibilities to health care authorities improved quality of care, as the healthcare authorities had access to more resources and were more knowledgeable about the tools that are required to assist mental health care. Additionally, research states that some inmates did not feel comfortable discussing their mental health care needs with the doctors, as they were concerned that it was going to be used against them in future parole meetings (Kilty, 2012). Some interviewees identified that inmates would feel more comfortable discussing health care needs if the staff was not associated with CSC. Furthermore, access to care for the offenders would increase as there would be more staff dedicated to mental health care and providing therapy. In addition to improving quality of care and access, continuity of care would improve. Currently, when an inmate leaves prison or is transitioned to a new facility, their health care is disrupted, which negatively impacts their health progression. If the province assumes health care responsibilities, the disruption would be minimized. However, if a federal offender is transferred to a facility in another province there may be disruptions in their healthcare plan. It is unclear how many prisoners are transferred each year. Lastly, this option would support offenders in minimum, medium, and maximum-security institutions.

By 2021 half of Canadian provinces will have transitioned healthcare responsibilities. So far, the **public** has not reacted to the ministries of health assuming

responsibility for the care of offenders (John Howard Society, 2019). Therefore, it is presumable that reaction will not change if federal correctional facilities follow suit.

The majority of **correctional officers** were supportive of this option as it would provide them with more support in addressing mental health care concerns. Some correctional officers stated that there are potential limitations with transitioning healthcare responsibilities. They worried that the working relationship between correctional staff and health care staff would change. However, a provincial officer reported that they did not believe the relationship with healthcare staff changed after the transition. Therefore, this option is being rated as moderate support from correctional officers. **Advocacy group** are interested in addressing gaps in healthcare and would be highly supportive of this option.

The exact **cost** of this option is difficult to assess, as it is unclear what measures the provinces used for the difference in quality of care. When BC transitioned healthcare responsibilities, the Public Safety Minister transferred $25 million to the health ministry who invested an additional $10 million to care for 2699 inmates (DeRosa, 2017). It is reasonable to assume that a similar situation would occur federally, where the ministry of justice would transfer funds to the ministries of health. An additional investment will likely be needed if the ministries believe that the current quality of care is not on par with industry standards. Thus, the short-term costs are estimated to be high. Studies show that those who received treatment for their mental health conditions were less likely to return to jail and were more likely to seek similar programs in the community after release (Kubiak et al., 2019). Decreasing recidivism rates would reduce long term costs on the correctional system, however, the exact decrease in costs is not clear, and so long-term costs are rated as moderate.

This option would require coordination between multiple federal facilities and provincial health authorities. When considering this move for Ontario, Howard Sapers (2017) reported that “reforming health services for this population and transitioning responsibilities … is a complex, and multi-step process.” While there is precedence from other jurisdictions and Canadian provinces for this reform, transferring the care of inmates across Canada would take time to coordinate and thoughtfully transition. As a result, this option is **highly complex to implement**.

Table 4. Summary of Transfer Health Care Responsibilities

Objective	Reasoning	Outcome
Effectiveness (x2)	Identified to increase quality and access to mental health support, which improves mental health conditions of offenders	Stronger evidence of effectiveness (6)
Political Considerations	No response from the public when provinces transferred responsibility	Indifferent public reaction (2)
Stakeholder support (x.5)	Some correctional officers were supportive of this option	Moderate support from correctional officers (1)
	Advocacy groups are interested in seeing healthcare needs addressed	High support from advocacy groups (1.5)
Cost (x.5)	When provinces transferred responsibility from Ministry of Justice to Ministry of Health, the Ministry of Justice transferred funds allocated for health care. The Ministry of Health determined additional investment was still needed in tools, personnel, and education	High short-term cost (.5)
	Addressing mental health and improving continuity of care will assist in decreasing recidivism, which will decrease long-term costs on the system	Moderate long-term cost (1)
Ease of Implementation	Multiple steps and coordination between federal and provincial authorities required	High complexity of implementation (1)
Total		**13**

9.3. Community Program Liaison Officer – Pilot Project

There is some evidence from the literature review and interviews that supports the **effectiveness** of the Community Program Liaison Officer option. The evidence for the effectiveness of this option varies on the program's design, the motivations of the offenders, and the motivations of the people responsible for administering the program. For example, one six-month long program in the U.S. taught inmates healthy coping mechanisms of dealing with anger and fear, how to interpret social situations, medication adherence, and other skills (Stringer, 2019). The study found a decrease in the number of participants who experienced depression (31%), anxiety (48%), hostility (10.3%), paranoia (10.7%), psychoticism (13.8%), and criminal thinking (6.5%) (Morgan et al., 2013). On the other hand, interviewees reported the success of prison programs greatly vary depending on the aforementioned factors, and there were cases where they were unsure the inmates were developing the skills the programs aimed to improve. Creating programming and partnerships with the community will support the mental wellness of offenders by increasing the accessibility and variety of programming available in prison. Programming provides offenders with the opportunity to learn new skills. When executed with the assistance of community organizations and volunteers, it provides the inmates with the opportunity to engage with others and build community ties. Furthermore, it provides offenders with an opportunity to be engaged rather than spend the majority of the day in their cell. Correctional officers highlighted that if this option was available to offenders closer to their release date, it could be particularly beneficial in supporting their throughcare plan. However, officers interviewed noted that this option would only provide support to offenders in minimum and medium-security facilities as the restrictions on who may enter maximum security institutions are strict.

Generally, the **public** is indifferent to correctional practices unless there is a direct impact on the communities[21]. However, members of the general public who wish to work with offenders and support rehabilitative efforts will perceive this option positively. In the interviews, **correctional officers** were cautious of supporting this option. They were concerned with possible security risks that may occur with allowing additional community members in carceral institutions. As well, it would require more

[21] An example of public backlash to correctional practices impacting the community includes when inmates were prioritized for COVID-19 vaccinations (Macsweeney, 2021).

work for them to ensure the new programs are safe for both inmates and volunteers. **Advocacy groups**, on the other hand, will be supportive of this option as they are interested in working with offenders to support their rehabilitation. Some advocacy groups already offer programs for offenders in the community and will be well equipped to provide programming in institutions.

This option will require some funding to operationalize. Depending on the program, it may require transportation or new infrastructure. However, the Minister of Public Safety and Emergency Preparedness's mandate letter acknowledged that fulfilling the mandate would require new policy authorities and funding. While there will be some up-front **costs** to this option, if executed well, it will assist in rehabilitation and reduction of recidivism which will reduce the long-term costs on correctional facilities.

The interviewees who were supportive of this option reported that the **implementation** would be quite complex. CSC will have to state the roles and responsibilities of the Officer including designating who they report to and how success of the position will be measured. Consideration will have to be given to security clearances, safety training for volunteers, how engagement with community organizations will proceed, and so forth.

Table 5. Summary of Community Program Liaison

Objective	Reasoning	Outcome
Effectiveness (x2)	Multiple sources, including interviews and literature review, have confirmed that the option would lead to some improvements. However, effectiveness will be dependent on the delivery of the program and motivations of the offender	Some evidence of effectiveness (3)
Political Considerations	This option will be perceived indifferently by the public, except perhaps those who are approached to engage with the correctional system	Indifferent public reaction (2.5)
Stakeholder Considerations (x.5)	Correctional officers will not be supportive of this option, as security will be a concern	Low support from correctional officers (.5)
	Advocacy groups are interested in working with offenders to support their rehabilitation	High support from advocacy groups (1.5)
Cost (x.5)	As the correctional facilities will have to create multiple positions across the country, this option will be expensive. Additionally, facilitating the programs may cost money, even if some are executed with the assistance of volunteers	Moderate short-term cost (1)
	If executed well, this option will provide offenders the opportunity to build relationships with the community. This will support their wellness, which will improve recidivism	Moderate long-term cost (1)
Ease of Implementation	The creation and execution of a community program liaison officer position will be complex	High complexity of implementation (1)
Total		**10.5**

9.4. Summary Table of Policy Analysis

Table 6. Summary of Policy Analysis

Objective	Status Quo	Transfer Responsibilities	Community Program Liaison Officer
Effectiveness (x2)	No evidence of effectiveness (2)	Stronger evidence of effectiveness (6)	Some evidence of effectiveness (3)
Political Considerations	Indifferent public reaction (2)	Indifferent public reaction (2)	Indifferent public reaction (2.5)
Stakeholder support (x.5)	High support from correctional officers (1.5)	Moderate support from correctional officers (1)	Low support from correctional officers (.5)
	Low support from advocacy groups (.5)	High support from advocacy groups (1.5)	High support from advocacy groups (1.5)
Cost (x.5)	Low short-term cost (1.5)	High short-term cost (.5)	Moderate short-term cost (1)
	High long-term cost (.5)	Moderate long-term cost (1)	Moderate long-term cost (1)
Ease of Implementation	Low complexity of implementation (3)	High complexity of implementation (1)	High complexity of implementation (1)
Total	**11**	**13**	**10.5**

Chapter 10. Policy Recommendations

Based on the analysis, the recommended next step is to adopt options two and three in a multi-phase approach. The first phase will be to prioritize transferring healthcare responsibilities to the ministries of health, which will improve access and quality of care for offenders with more serious cases. The second phase focuses on creating a community program liaison officer position, which will assist those who have mental health issues but are not qualified to transition to therapeutic units.

Addressing mental health in the community is an important aspect identified by the Correctional Investigator and by interviewees (OCI, 2018). However, that does not mean that offenders who are currently incarcerated should be ignored. Those who are incarcerated are in a position where the correctional system can offer them support. Transferring healthcare responsibilities will increase dedicated resources, quality of care, continuity of care, as well as increase oversight. While the transition will be administratively complex, there are examples to follow from other countries and Canadian provinces.

Introducing a community program liaison officer will increase relationships between offenders and the community around them. Furthermore, it will allow CSC to leverage current partnerships with organizations in addition to creating new relationships. Caution should be used when implementing this option as there are security risks. Correctional officers shared that the motivations of volunteers can be dubious, as people may volunteer to fulfill their curiosity of offenders rather than provide support. Furthermore, those who work in correctional facilities can sometimes be compromised by nefarious actors in the communities. People may threaten volunteers to carry out illegal activity in correctional facilities on their behalf. Volunteers should be vetted carefully and receive training on how to handle potential safety concerns that may arise.

Chapter 11. Considerations and Limitations

Mental health amongst offenders is a complex subject that is often intertwined with other factors such as poverty, trauma, and addiction. As such, there is no simple solution to addressing mental illness, and the recommendations of this report are meant to be next steps in a long journey. One consideration that this report could not explore is prison design. It is expensive to remodel existing facilities. However, future construction should consider including elements that are associated with mental wellness and reducing impacts of psychosis, such as corridor length, natural lighting, and division of space (Frieden, 2018). Furthermore, interviewees stated that a separate correctional facility should be built specifically for offenders with mental illnesses and include extensive programs and access to mental health care. The government plans to invest $300 million in Structured Intervention Units (SIU) to allow inmates more time outdoors (White, 2019). So far, SIU are demonstrated to be problematic as the inmates are being held for an extended period, and not always being provided with meaningful contact or time outdoors (Ling, 2020). The operationalization of these units should be monitored more closely to ensure prisoners are provided with adequate support.

The lack of appropriate training for correctional officers is an identified issue by the OCI and correctional officers that needs to be addressed in future studies (OCI, 2008; OCI, 2013; OCI 2015; OCI, 2018; Shook & McInnis, 2017; Solomon, 2017). A pilot project in Indiana provided 10-hour training over five weeks for correctional officers who work in Special Housing Units (SHU). They found that even 9 months after the training was completed, the number of use-of-force cases by officers and battery by bodily waste by offenders decreased significantly. In the interviews for this study, one correctional officer believed that the training they had received was adequate, while others indicated more dedicated training should be provided.

The quantity and quality of mental health training federal correctional officers receive is not clear, but interviewees stated that it is minimal. In a 2019 audit of Ontario correctional staff, it was revealed that the provincial officers only received three hours of training during their eight-week training program (Canadian Mental Health Association [CMHA], 2020; Ministry of the Solicitor General, 2019). The curriculum was redesigned in January 2020 to include an emphasis on human rights, mental health, health and

safety, teamwork and communication, and de-escalation skills. While this redesign is only available to incoming staff at provincial correctional institutions in Ontario, if the transition to the Engagement and Intervention Model do not decrease the number of use of force cases, similar training should be provided to all federal correctional officers. Improved training should include mandatory on-going crises intervention training to ensure that staff are trained with the latest information by industry experts. All staff should receive Standards for Mental Health Service in Correctional Facilities training where they will learn how to: recognize signs and symptoms of mental illness, learn non-security-based suicide prevention, best communication practices, and procedures for referring inmates to appropriate programs.

While it is prevalent in prisons, mental health concerns also exist among the general population. Mental health assistance needs to be available at every stage of an individual's life in order for it to be the most impactful. This includes early childhood, adolescence, before individuals become involved in criminal activity, through diversion services when appropriate, during-incarceration, and post-incarceration. In an interview, an ex-BC Parole Board member shared the complications in creating a proper plan for inmates as community services were limited. Many people are precluded from entering halfway houses due to stringent rules, so offenders are not connected with services that they need to increase the success of their reintegration. It is particularly difficult to create a sufficient throughcare plan and place individuals with compounding issues. Assessing pre-incarceration and post-incarceration programs was out of the scope of this project, however, they are important aspects that should be considered in future research. As expensive as supporting mental health needs of individuals is, there is a benefit beyond the moral obligation. For all of Canada, mental illness costs an estimated $50 billion a year (Mental Health Commission of Canada [MHCC], 2016). This number accounts for health care, social services, income support, loss of productivity, and more. An Ontario study of a highly specialized program for mentally ill individuals, Assertive Community Treatment, found an 82% decline in hospitalizations among participants (MHCC, 2016). There is the potential for a return on investment for the efforts made in the mental health care of offenders.

One challenge for this project was access to information, as a lot of the information was not readily accessible online, such as the exact programs available at each facility. It is difficult to retrieve information from CSC. As other researchers have

noted, they are slow to respond and often redact some of the information necessary for research (Piche, 2011; Wright et al., 2015). This is understandable to a degree as CSC is responsible for a vulnerable group of people and so they have a responsibility to protect the inmates. However, this disrupts researchers' ability to study how to better support offenders' rehabilitation. Additionally, it is difficult to assess what programs would be best as there are many gaps in data collection and integrity. To start, there is no consistent definition of recidivism across Canada and so CSC, Justice Research Division, and other non-government groups define it differently, making it difficult to assess recidivism rates (Ahsan, 2019). Furthermore, other information collected in corrections is questionable. The 2015 Auditor General of British Columbia report on corrections found major gaps in the performance and administration of BC Corrections. Some of the concerns highlighted that there were no goals, objectives, performance metrics, or strategies to assess if BC Corrections was meeting its mission (OAGBC, 2019). CSC is not immune to poor performance metric reporting. On an investigation of CSC's departmental results report, some of the organization's performance metrics regarded participation. While participation is an important first step, it may not translate to success. For example, CSC's 2019-2020 target for vocational training was to have 58.2%-60.5% of offenders complete vocational training before release. They succeeded this goal, but do not report on how the completion of this vocational training supported those offenders' ability to obtain employment in their respective fields, or whether the offender was capable of maintaining the position. Without truly understanding the effectiveness of current programs, it is difficult to plan for the future, and thus, the government should consider improving data collection and transparency in reporting.

Many correctional officers were not comfortable participating in this research, making it difficult to get their opinions. Corrections is known to have an "us vs them" culture, which can extend to officers and the community. Many people who were approached to participate in this study were interested in the topic but did not feel comfortable sharing their experiences, as they were concerned about CSC's response. Others did not participate as they believed their participation would not lead to any impactful change. These attitudes made it difficult to capture the full experience of correctional officers who work with mentally ill offenders, as only a selective group of correctional staff participated. All experiences are valuable and can be used to bolster the type of programming or research conducted, therefore correctional staff experiences

should be accounted for in research. Of those who did participate, many mentioned the burnout experienced due to working with a challenging population in a complex setting. Interviewees identified that becoming exhausted by the compounding experiences was unavoidable. It is unrealistic to expect staff to be able to fully support the rehabilitation of offenders if the staff's needs are not being met. Future research should be conducted on how to better support officers without compromising the care offered to offenders.

Lastly, a vital consideration on supporting the needs of mentally ill offenders is understanding the complexities behind implementation. Each institution differs greatly, which impacts how a policy option will be implemented. The recommended policy option may be successful in one institute and less so in another. The factors that can impact the success of an option is politics, culture of institution, personality of correctional officers and of the inmates, correctional population dynamics, classification of inmates, and leadership throughout the ranks.

Chapter 12. Conclusion

Society is becoming increasingly aware of the importance of mental health. Mental illness is more prevalent in carceral settings than they are in the community, which is unsurprising since the conditions for mental illness are often associated with criminogenic factors. This study aimed to address the challenges of the current practices regarding mental health in carceral settings. CSC currently identifies mental health as a concern in the prison system. Mental health is a complex subject clouded by external factors that impact one's ability to rehabilitate. CSC initiated some steps to address mental illness by creating a framework, implementing therapeutic units, and more. The Office of the Correctional Investigator has highlighted in their reports concerns about the effectiveness of the Mental Health Strategy. Addressing mental health among offenders requires a collaborative approach that is available to people throughout the criminal justice system including in the community, during incarceration, and post-incarceration. More research should be conducted about the programs available in the community. Data collection and integrity regarding the correctional system must also improve to ensure that policies are impactful.

Based on the information gathered, this report recommends that CSC should transition the responsibility of healthcare to the ministries of health. Furthermore, the correctional system should increase programming options available to assist offenders' mental wellness by establishing strong community ties. Implementing these options will not end all mental health concerns in prisons. Instead, they offer viable next steps to improve conditions which will ultimately improve wellbeing and the opportunity for rehabilitation, thereby increasing public safety. While taking a rehabilitative approach is not always popular with the public, at a certain point we need to ask ourselves if the high cost and negative impact on public safety is worth the sense of justice associated with harsh criminal policies.

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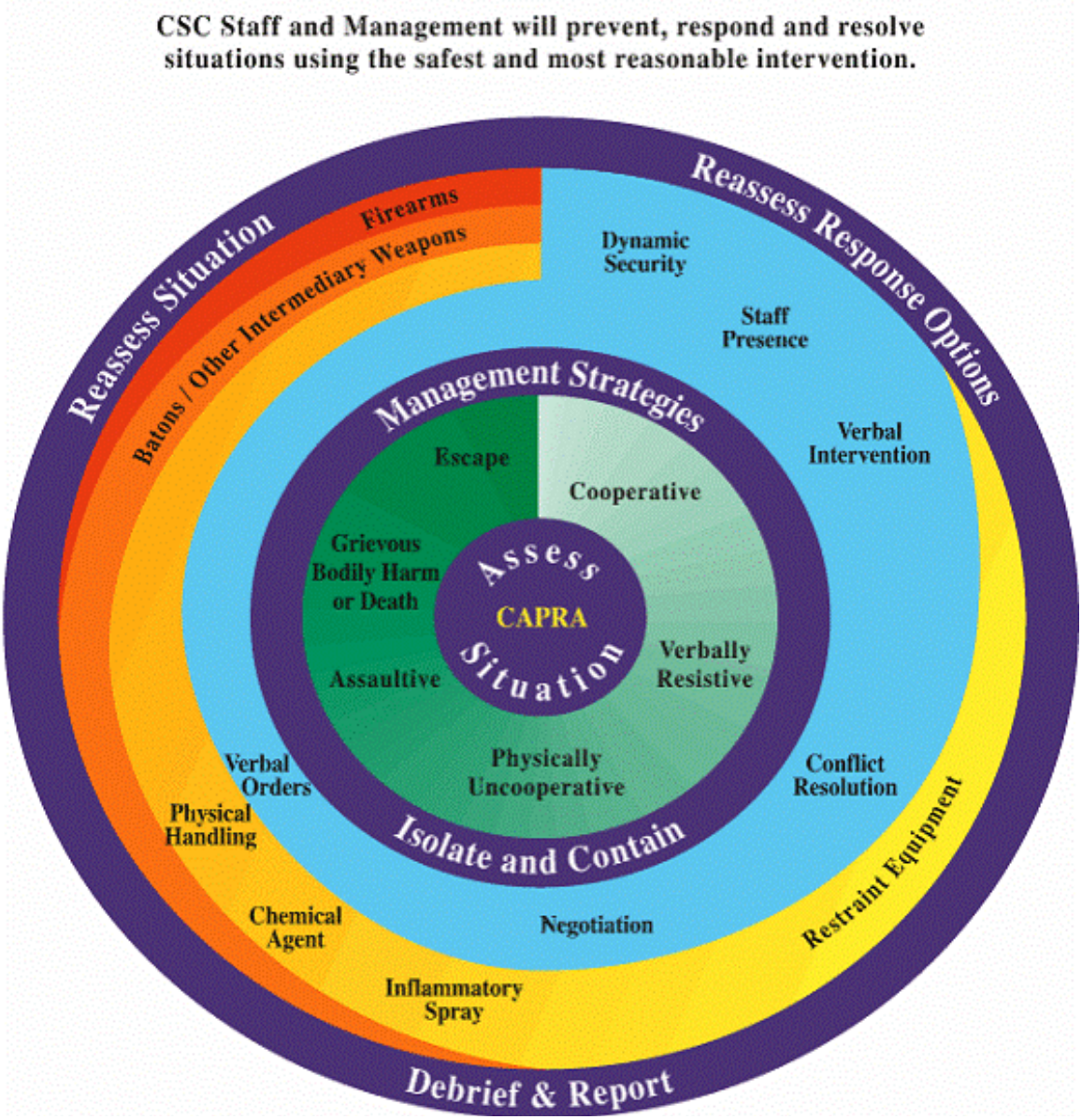
Appendix A. Situation Management Model



Source: https://www.csc-scc.gc.ca/005/007/005007-2546-en.shtml

Appendix B. Jurisdictional Scan- New York State

In the U.S., most inmates are held under state institutions rather than federal institutions, as criminal laws differ on a state-by-state basis. The criminal laws that apply federally impact the whole nation, such as terrorism or federal tax evasion (Marcus, 1996). Some criminal laws, such as narcotics laws, are controlled by both federal and state jurisdictions. Also, some jurisdictions within the U.S. offer alternative courts, such as mental health courts, to provide more meaningful care (Stettin, Frese, & Lamb, 2013). Due to the varying policies across the U.S., this research paper will focus on New York State's criminal justice system. The New York Office of Mental Health (n.d.) reports that mental illness rates are two to three times higher in prisons than in the community. Furthermore, this state offers various support for offenders inside and outside of institutions, such as mental health courts and institutional programming.

New York has two diversion methods to use if an offender has serious mental illnesses: Mental health courts and Crisis Intervention Team Policing. Mental health courts are specialized problem-solving courts that identify an underlying issue to criminal behaviour. This diversion practice is reserved for individuals who would benefit from community-based interventions and does not apply to violent crimes (Stettin, Frese, & Lamb, 2013). The local social service agencies create a treatment plan and propose it to the presiding judge. If the judge and offender agree, the charges are suspended, and follow-up court hearings are organized to monitor the individual's progress. The crisis intervention team is a police-based program that rigorously trains officers to understand and identify acute mental illnesses. The officers are trained to deescalate situations and become mental health specialists (Stettin, Frese, & Lamb, 2013). Rather than booking individuals with mental illnesses, the officer uses their training to take the individual to programs that would be better suited to address their needs. A 2013 state assessment on diversion practices reports New York State utilizes mental health courts often but rarely implements crisis intervention team policing (Stettin, Frese, & Lamb, 2013).

In state correctional institutions, the New York State Office of Mental Health (OMH) is responsible for providing mental health treatment to offenders. The New York State Commission of Corrections is responsible for the oversight of the correctional system. The New York State Commission on Quality of Care and Advocacy for Persons

with Disabilities is responsible for treating mental health in prisons. Due to previous lawsuits, the OMH is required to identify mental health needs and provide treatment options and assist in reintegration planning for post-incarceration (Smith & Parish, 2010). New York State prisons have prison-based mental health units and a maximum-security forensic hospital that provides outpatient treatment to state prisoners. The overall prison population in New York is decreasing, but the number of people with mental illnesses is increasing (Smith & Parish, 2010). Similar to Canadian research, U.S.-based research finds that those with mental illnesses are negatively impacted in correctional facilities as their symptoms will likely lead them to spend more time in solitary confinement (Smith & Parish, 2010). Additionally, U.S. prisons focus on security and control rather than rehabilitation. Smith & Parish's (2010) Guide to Family Members of Prisoners with Mental Illnesses states that while services available to prisoners can be reported, from the authors' experience of speaking with mentally ill prisoners, the actual services available may not reflect those found in the guide.

While access to mental health programming in prison is questionable for some, others may receive medication and programming while incarcerated. However, these inmates are often released without an effective continuation plan (Michaels, 2020; Smith & Parish, 2010). A 2019 lawsuit states that a lack of community-based mental health housing facilities resulted in individuals with severe mental illness being left in prison and solitary confinement beyond their release date (NBC New York, 2019). This failure of the state suggests there is a lack of effective planning for community integration. The OMH reports that New York has a robust investment in community mental health housing. Annually, $500 million is invested in 44,000 housing units. However, the state will request $12.5 million in additional funding for 500 additional units for homeless people and 6,000 units to be constructed by 2021. These specialized mental health units support individuals so they are less likely to reoffend (Michaels, 2020). Upon being sued, state prisons began releasing offenders to homeless shelters where the individuals did not have proper access to care, and their mental health continued to deteriorate (Michaels, 2020).

Appendix C. International Perspective on Mental Health Concerns in Prisons

Borders do not bind the disproportionate number of imprisoned mentally ill people. It is estimated that one in seven prisoners has some form of a serious mental health condition globally (Penal Reform International, 2019). Like Canada, most prisons around the world do not have adequate resources to address inmates' mental health concerns. However, the World Health Organization (WHO) provides a list of policies that countries can adopt to support this population.

The WHO states that suicide is the most common cause of death in correctional settings globally, as it accounts for roughly half of prison deaths. The highest rates of suicide are amongst women, children, and newly released prisoners. The disproportionate number of mentally ill people represented in prison is a notable issue in low, middle, and high-income countries, but a comparatively larger issue in low and middle-income countries (Penal Reform International, 2019). A 2018 article called for global action on mental health in prisons. The authors recognized that many countries, particularly low and middle-income countries, had inadequate mental health services available to the public, which attributed to the rise of mentally ill people entering the criminal justice system (Jack et al., 2018). For example, South Asian countries represent one-quarter of the world's population and report the highest prevalence of common mental disorders (i.e., depression, bipolar disorder, schizophrenia and other psychotic disorders) in the public (Naveed et al., 2020). Despite these high numbers, less than 1% of the total national budgets are allocated to supporting people with mental health concerns. The exact number of mentally ill people in South Asian prisons is unknown as there is no common assessment tool used to identify the illnesses. However, it is thought to be high (Rabiya & Raghavan, 2018).

The full extent of the issue on an international scale is unknown, as data collection on international prison mental health is minimal at best. The lack of data collection may indicate that mental health in prisons is a low priority. Each country is unique in terms of acknowledging mental health as an issue and in the steps they are taking to support this population. Some countries, such as England and Norway, have transitioned health care responsibilities from the Ministry of Justice to the Ministry of

Health/ Social Welfare to support the quality and level of health care provided during and after incarceration. In other jurisdictions, such as Zimbabwe, some U.S. states, and Canadian federal institutions, the responsibility of the health care of prisoners is under the Ministry of Justice rather than the Ministry of Health. This approach adds roadblocks to the continuity of health care when individuals are released from prison (Jack et al., 2018). The European Court of Human Rights states that at a minimum, prisons around the world should transfer inmates to mental healthcare settings, screen individuals upon entry for mental illness, have a prevention strategy, and implement an independent investigation when a suicide does occur (Prison Reform International, 2019). The WHO and the International Committee of the Red Cross (ICRC) (2005) provide a broad list of actions that can be adopted, including:

- divert offenders to the mental health system
- provide prisoners access to appropriate treatment and care
- provide access to acute mental health care in psychiatric wards
- provide access to psychosocial support and mediation
- provide appropriate training to staff
- provide information to prisoners and family members
- promote high standards in prison management
- ensure prisoners needs are included in national mental health policies and plans
- promote the adoption of mental health legislation that protects human rights

Globally, mental illness amongst offenders is a difficult topic, as many countries grapple with the issue in different ways. International organizations, such as the European Court of Human Rights, WHO, and ICRC, certify mental health in prisons as a notable issue. They have introduced possible policies that countries can adopt to address the concern. Some countries have made sizable efforts, while other countries have made negligible changes. It should be noted that policy analysts often recommend that mental health care in prison should be equivalent to what is offered to the public. However, mental health care in the public is often sparse. Most countries have an inadequate number of resources available to the public, a shortcoming which naturally extends to prisons.