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Agony behind bars

Most Canadians are familiar with the shocking video footage that was presented in a coroner's court in 2012 as part of an inquest into the Oct. 19, 2007 self-strangulation of teenager Ashley Smith inside a solitary confinement cell at the nation's only federal women's prison, the Grand Valley Institution for Women in Kitchener, Ontario.

It's hard to imagine that any of the verbal evidence to be presented this month at the inquest will be more plaintive than the chilling "how can it get worse?" Smith asked as Royal Canadian Mounted Police bound her wrists together with duct tape during a 2007 prison transfer between Saskatoon, Saskatchewan and Montréal, Quebec.

But the fact is that for thousands of other mentally ill inmates in Canada's prisons, experts say, things are altogether likely to get much worse.

While the deinstitutionalization movement and the "get-tough-on-crime" agenda of Prime Minister Stephen Harper's government have contributed to the rising number of mentally ill people who are incarcerated (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4390), that doesn't begin to account for the effects of deficiencies in care provided to the mentally ill who are incarcerated.

The critics charge that correctional facilities are no form of therapeutic haven for the afflicted and that once in prison, mental health needs typically go undetected or untreated. Mentally ill inmates are left to decompensate psychiatrically.

Or as Correctional Investigator of Canada Howard Sapers notes: "Many mentally disordered inmates do not manage well in a prison environment."

"Some manifest symptoms of their illness through disruptive behaviour, aggression, violence, self-mutilation, suicidal ideation, withdrawal, refusal or inability to follow prison orders or rules," Sapers earlier stated in his 2011-12 report (www.oci-bec.gc.ca/rpt/annrpt/annrpt20112012-eng.aspx#s4). "Within corrections, these symptoms of mental illness are often misunderstood as manipulative or malingering behaviour, and are regularly met by a range of inappropriate responses including disciplinary sanctions, transfer to higher security institutions and separation from general population. This state of affairs is especially prevalent in the maximum security and multi-level institutions where it is not uncommon for more than half of the offender population to be receiving institutional mental health services and/or presenting some degree of mental health dysfunction."

Sapers is blunt in his assessment of the federal government's provision of mental health care for inmates. "The Correctional Service of Canada is responsible by law for being health care providers for federally incarcerated inmates, and they are falling short in meeting that requirement for the provision of mental health services."

For its part, the Correctional Service of Canada indicates that it has made several multi-million dollar investments into mental health care as part of its 2007 *Comprehensive Mental Health Strategy* (www.csc-scc.gc.ca/text/pblct/lt-en/2007/32-1/2-eng.shtml).That initiative was structured around five core components:

• voluntary intake screening and assessment for mental illness

• primary mental health care within correctional facilities
• intermediate care in an "accommodation unit" where offenders "can still work on their correctional plan, but have the treatment and support they need to manage their illness"
• intensive care regional treatment centres for offenders with acute mental disorders, such as schizophrenia, and
• transitional care that would "ensure continuity of care once they [offenders] left the institution."

How effective has it been over the course of five years?

A "mixed report card," Sapers says. "It's doing a better job than ever of assessing new admissions to penitentiaries. There's a new computerized program that screens for mental health issues and needs and creates a record of mental health issues of inmates."

But the progress stops there, he adds. "Where things begin to go off the rails is in implementing the strategy and responding to those assessed needs."

Major gaps in the treatment of acutely mentally ill offenders remain, Sapers says. "Those offenders with the most significant mental illness are not being able to access treatment beds and physician care, and increasingly are being held in higher security levels and segregation."

The setting itself is an obstacle to treatment, says Dr. Graham Glancy, assistant professor of psychiatry and adjunct professor of law at the University of Toronto in Ontario, and one of handful of Canadian psychiatrists who consult on mentally ill inmates in correctional facilities.

"You work in difficult conditions for a psychiatrist," he says. "Basically you're dealing with severe and persistent mental illness, in a setting where you don't have access to social workers and psychiatric nurses and family members for support. You have one foot in the door and you have to work on very small cues."

Psychiatrists are further handcuffed by rules governing treatment in correctional facilities, he adds. "You can't use coercive treatment under the Mental Health Act, meaning that you should not treat people against their will even if they're deemed incompetent. At the same time, hospitals haven't always been available to help out."

At all times, security is the "number one priority," Glancy notes. The federal prisons themselves, are primarily staffed by "correctional officers who get some training and have some natural acumen in dealing with mental illness but they're not psychiatric nurses in psychiatric facilities. There's always going to be problems there."

Sapers concurs. "Often the first responders to these individuals in these medical crises are correctional officers as opposed to health care professionals. We will often see people who are acting out, being responded to as security issues rather than mental health issues."

But there's also a lack of professional expertise to provide quality mental health care at every level of need, Sapers adds.

"For those who are less acutely mentally ill, we're also seeing a lack of capacity. It's not uncommon to find as much as a 20% vacancy rate in psychology positions. And many of those psychology positions that are filled, are being staffed by people who are not registered psychologists."

Intermediate care, meanwhile, "has not been funded," Sapers adds. "There is only one facility in the whole country for women with mental illness. It's a twelve-bed unit in Saskatoon [Saskatchewan] in an otherwise male facility."

There's also increased pressure on the system because of growing demands for mental health services within prisons. According to the Correctional Service of Canada, the proportion of offenders with mental health needs identified at intake doubled between 1997 and 2008. Wait times for services also lengthened. In British Columbia, for example, the average time for inmates certified under the Mental Health Act to be transferred to a forensic psychiatric hospital increased from 4.5 days in fiscal 2001/02 to 10 days in 2007/08 (*Behav Sci Law* 2009;27:811-31).

Hardly surprising then, that there has been a parallel increase in self-inflicted injuries, with the number of such incidents having more than doubled over the past five years. According to the Correctional Service of Canada data, there were 822 incidents of self-injury in fiscal 2010/11, involving 304 offenders, including 54 suicide attempts (www.oci-bec.gc.ca/rpt/annrpt/annrpt20112012-eng.aspx#s4).

The growing incidence of such self-harm disturbs Sapers. "Every day I receive reports on people who are self harming themselves, and responded to by emergency response teams with pepper spray and left in restraints for hours," he says. "Not the most therapeutic responses."

Little wonder then that the suicide rate among the federally incarcerated is seven times higher than the national per capita average. In the system's 2010–11 reporting period used by Sapers, there were four completed acts of suicide, with 3 of those occurring within segregation cells. For 2011-2012, that doubled to eight suicides (www.oci-bec.gc.ca/rpt/annrpt/annrpt20112012-eng.aspx#s4).

That broadens the stakes, says Ivan Zinger, executive director of the office of Correctional Investigator of Canada. "Addressing the criminalization and warehousing in penitentiaries of those who suffer from mental illness is not simply a public health issue, it's a human rights issue." — Nathan Stall MD, Toronto, Ont.

Editor's note: Third of a multipart series on health in the hoosegow.
Part I: **Health and hard time** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4389).
Part II: **Imprisoning the mentally ill** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4390).
Next: **Black eyes and barriers**

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