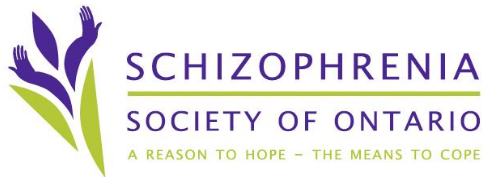


Schizophrenia Society of Ontario Submission to the Provincial Segregation Review Team

May 5, 2016

The Schizophrenia Society of Ontario (SSO) appreciates the opportunity to respond to the Ministry of Community Safety and Correctional Services' provincial segregation review as the practice of segregation negatively impacts inmates living with mental illness.

We commend the ministry for recognizing the impact segregation can have on an individual's mental health, and for its ongoing commitment to strengthening inmate supports in this area.

A charitable health organization, SSO has been providing supports to individuals, families, caregivers and communities affected by schizophrenia and psychosis across the province for over 30 years. We are one of very few organizations that provide schizophrenia and psychosis-specific supports in the community, filling a critical service gap when individuals and families have nowhere else to turn.

SSO has identified the criminalization of mental illness through our Justice and Mental Health Program (JAMH) as a key advocacy area; specifically, we have prioritized segregation as an issue that significantly affects people with schizophrenia and other serious mental illness.

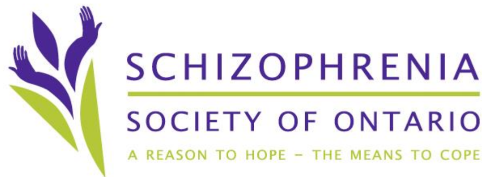
As such, SSO welcomes the opportunity to share our expertise to support the development of a segregation policy that recognizes the vulnerability of all people entering the correctional system, particularly those with mental health issues and serious mental illness.[*]

To provide context for this submission, we have provided a brief overview of schizophrenia and psychosis followed by our feedback on segregation that is structured in accordance with the provincial segregation review questions.

<u>About Psychosis and Schizophrenia</u>

The term "psychosis" describes a group of symptoms that affect how one perceives reality and affects one's ability to tell the difference between what is real and what is not real. It is estimated that 3% of the population[1] will experience at least one episode of psychosis during their lifetime, with about 80% of people experiencing their first episode between the ages of 16 and 30. Although the symptoms of psychosis may vary from person to person, the majority will experience social withdrawal, lack of

[*] In this submission, the terms "mental health issues" and "serious mental illness" refer to symptoms and conditions which may take the form of changes in thinking, mood or behaviour, or some combination of all three, that impact a person's ability to function effectively over a period of time. These terms were chosen because they align with the language used in the provincial segregation review. It should be clarified that not all individuals living with a mental health issue would identify with these labels.



motivation, communication challenges, hallucinations (e.g., seeing, hearing, feeling, smelling or tasting things that others do not perceive) and delusions (e.g., false personal beliefs not grounded in reality).

"Psychotic illnesses" are conditions in which a person experiences psychosis (e.g., schizoaffective disorder, bipolar disorder, substance-induced psychosis and major depression). The most prevalent psychotic illness is schizophrenia, affecting 1% of the population worldwide. Schizophrenia can alter the way people think and feel, resulting in disturbed thinking and significant changes to perceptions and behaviour. Onset of schizophrenia usually occurs in young adults, and relapses of acute episodes of psychosis can occur throughout one's lifespan, particularly if the illness is left untreated.

Schizophrenia is a serious – but treatable – illness that has a profound impact on people's day-to-day functioning. For various reasons, many people with schizophrenia do not receive a diagnosis until later on in life and hence, are not connected with necessary services and supports in a timely manner, which can lead to a compromised recovery. In some cases, early symptoms of the illness are often overlooked because they resemble the manifestations of benign health issues and/or "normal" experience.[2] As a result, individuals may not seek help, and even when they do, the possibility of an emerging serious disorder is rarely considered. Other people may be deterred from seeking help because of stigma and discrimination toward mental illness.

About Recovery

Despite the presence of symptoms or diagnoses, living as part of a community and individual recovery is possible. Overall, recovery is based on the ideas of self-determination and self-management, and emphasizes a person's right to build a meaningful life for themselves, with or without the continuing presence of symptoms of mental illness. It involves growth, setbacks, periods of change, and can occur even though symptoms reoccur.

Recovery is supported by a combination of social supports (e.g., family, friends, self-help and support groups, etc.); social determinants of health (e.g., stable income and housing, employment, etc.); community-based services (e.g., psychotherapy, case management, etc.); and medical supports (e.g., psychiatrists, medications, etc.).

Schizophrenia and Criminal Involvement

Many people living with symptoms of schizophrenia often go undiagnosed for years and contact with the criminal justice system due to untreated mental illness is not uncommon. There is general consensus in the literature that individuals with mental illness who lack access to services and supports often come into contact with the criminal justice system due to negative stereotypes and misconceptions about their risk of violence;[3] crimes which are directly related to the symptoms of their conditions, such as

causing a disturbance, mischief, or minor theft;[4] and their overall increased visibility associated with exhibiting behaviours, which often fall outside of social norms. In addition, police are often the first responders to situations involving people experiencing a mental health crisis and have powers, and responsibilities prescribed under the *Mental Health Act*, to apprehend and transport these individuals to the hospital.

This increased contact with police further leads to an increased representation of individuals with mental illness in provincial and federal correctional settings. Estimates vary on the prevalence of mental health issues in prisons, however, it is estimated that mental health issues are two to three times more common in prison than in the general community.[5]

1. From your organization's perspective, what does segregation mean to you?

Segregation (also referred to as solitary confinement or isolation) entails the physical and psychological isolation of inmates through separation from the broader inmate population, with minimal human contact and severely limited access to activities, programs and other liberties and privileges. It is used both as a disciplinary measure and as a means of controlling inmate behaviour to reduce safety concerns.

According to a recent report by the Office of the Correctional Investigator, inmates who have been identified in their correctional plans as having mental health issues are much more likely to have a history of being segregated than those who have been identified as having no mental health issues (63.2% vs 48.0%).[6] Although this report represents federal corrections, it speaks to an apparent trend in corrections of responding to behaviours that may be related to one's mental health through the use of segregation.

The Canadian Human Rights Commission notes that individuals with mental illness are highly vulnerable within the inmate population.[7] Existing mental health conditions are aggravated by stress, and a lack of appropriate treatments and supports can further exacerbate this situation.[8] At the same time, individuals exhibiting strange behaviours and those with known diagnoses are at an increased risk of being placed in administrative segregation, instead of receiving clinical interventions.[9]

This use – and overuse – of administrative segregation to respond to behaviours associated with mental illness in federal and provincial correctional facilities is alarming. It has been noted that segregation and segregation-like units have become de facto intermediate care services[10] for individuals with mental illnesses who are not able to access care through Regional Treatment Centres or specialized psychiatric hospitals in the community.

Individuals who are deemed to be suicidal are also often placed in isolation[11] and it is unknown whether there are specific policies to ensure appropriate follow-up care upon their return to the general inmate environment.

The use of segregation, especially for people with symptoms of mental illness, is a severe deprivation of liberty as evidenced by the United Nations Committee against Torture's call on Canada to limit the use of solitary confinement as a measure of last resort, and to abolish its use for persons with serious or acute mental illness.[12] It also completely contradicts the principles of recovery by in effect punishing a person for behaviours that may be directly related to their mental health, and by placing a person in an environment that is known to aggravate and contribute to extraordinary stress and to symptoms of mental illness.

2. What are the biggest challenges with the current state of segregation from your organization's perspective?

We have outlined three major challenges with the current state of segregation: the immediate effects of this practice on mental health; potential long-term effects; and the disproportionate impact on sub-groups within the general prison population.

1. Effects of segregation on mental health

There is a body of empirical evidence documenting segregation to be psychologically harmful to any inmate, often resulting in increased incidences of anxiety, depression, perceptual distortions, cognitive disturbances and psychosis.[13] Indeed, for individuals with mental illness, segregation can significantly exacerbate their symptoms resulting in an increased need for crisis care or emergency psychiatric hospitalizations.[14] There is also a documented increase in the prevalence of self-harming behaviours[15] as well as attempted and completed suicides in individuals with mental illness subject to administrative segregation,[16] particularly in the remand populations.[17] In fact, a 2014 review by the Office of the Correctional Investigator found segregation placement to be an independent factor that elevated suicidal risk among inmates.[18]

While there is a plethora of empirical evidence attesting to the negative effects of administrative segregation, provincial correctional authorities have yet to abolish this practice, even when it comes to incarcerated individuals with identified mental illnesses.

2. Potential long-term effects

Individuals leaving prison face numerous challenges with reintegration, including accessing employment, education and volunteer opportunities, housing, and mental health services and supports; what is more, contact with the criminal justice system has also been shown to increase the severity and frequency of

symptoms of mental illness.[19] Although there is limited longitudinal research on the effects of solitary confinement, there is evidence to suggest that people who have experienced segregation are at risk of experiencing long-term effects, which may further impact their successful reintegration upon release. For instance, although the effects of solitary confinement vary depending on the individual, sleep disturbances, nightmares, depression, anxiety, emotional dependence, confusion, impaired memory and concentration, and difficulties forming interpersonal relationships,[20] have been identified as long-term effects. Research also suggests that solitary confinement appears to increase recidivism[21] and has broad implications for long-term outcomes for detainees as well as public safety.

3. High-risk groups

The following groups do not represent all of the vulnerable groups within the inmate population who are disproportionately affected by segregation policies; however, they represent some of the high-risk groups that we work with and/or that we have noted in our previous research in the area of justice and mental health.

Remand population

Numerous reports highlight the dire situation of individuals held on remand (i.e., people in custody awaiting bail, trial, or sentencing, including individuals who are eventually found not criminally responsible). Specifically, there are concerns with access to rehabilitative services and supports,[22] release and reintegration procedures,[23] and overall living conditions.[24] Further, there are numerous human rights and equity concerns as evidence shows that individuals on remand often face discrimination. Impoverished, homeless and otherwise disadvantaged, individuals on remand are more likely to be denied bail and held in detention due to risk of flight assessment criteria which are mainly focused on employment status and residential stability.[25] In addition, research shows that remanded populations complete suicide and engage in self-harm at higher rates compared to sentenced populations and that this is almost always while in isolation.[26]

Aboriginal population

Aboriginal peoples continue to be over-represented in Ontario's correctional system, as is the case nationally. Aboriginal adults accounted for nearly one-quarter (24%) of admissions in 2013/2014 in provincial/territorial correctional facilities while representing 3% of the Canadian adult population.[27] Aboriginal women accounted for a higher proportion of female admissions to provincial/territorial sentenced custody (36%) than did Aboriginal males for male admissions (25%).[28]

Little is known about the experiences of Aboriginal peoples with mental illness in the provincial correctional system. In general, the examined literature documents that Aboriginal peoples have lower

parole grant rates, are over-represented in segregation populations,[29] and are more likely to be classified as higher risk.[30] At the same time, evidence shows that Aboriginal individuals need more assistance with community reintegration and family reconnection.[31]

Immigration detainees

People in immigration detention with severe mental illness, including psychosis and suicidality, as well as physical illness, are often sent to provincial correctional facilities which are managed by the Ministry of Community Safety and Correctional Services, rather than to a dedicated Immigration Holding Centre (IHC), which are managed by the Canada Border Services Agency (CBSA). In addition, outside of Toronto, Vancouver and Montreal, where IHCs are located, all immigration detainees are sent to provincial correctional facilities. Immigration detainees with major mental illness are commonly sent to prisons despite having no criminal history. Once in prison, immigration detainees with major mental illness often end up in isolation, with the justification that symptoms of their illness make them inappropriate for inclusion within the general population.

Women

Incarcerated women experience greater prevalence of mental illness when compared to their male counterparts. Yet, the number of services targeted to this particular population does not reflect this demand. Notably, a 2015 report from the Office of the Correctional Investigator found that female offenders who were admitted to segregation in 2013-2014 were much more likely than males to have a history of self-injury (31.2% vs 12.8%).[32] While numerous reports stress that women's needs are unique from the needs of men, these two gender groups are assumed to be identical within the context of corrections.[33]

3. What does short-, medium- and long-term success look like from your organization's perspective?

Short-term recommendations (within 1-2 years)

1. Ensure that mandatory screening is timely and consistent across provincial correctional institutions and that people have timely access to a psychiatrist as needed:

    - **Screening** of all inmates entering Ontario's correctional facilities should occur immediately upon admission in order to ensure that appropriate follow-up, including assessment and treatment, is initiated as soon as possible;
    - **Assessment** of individuals who are identified as having mental health issues through screening should be performed by a psychiatrist as soon as possible; the Canadian Psychiatric Association has published wait-time benchmarks for people with serious mental illness, which can be used as a guideline to ensure that individuals have access to timely psychiatric care;

- **Information** about compliance with screening and assessment measures across all provincial correctional facilities should be made public as there is concern that traditionally these have been applied inconsistently across institutions.

2. End disciplinary and administrative segregation of people with serious or acute mental illness:

    - **Alternatives** to housing inmates should be considered, including increasing transfers of very ill inmates to forensic hospitals or other psychiatric hospitals in the community;
    - **De-escalation** and mental health skills training should be increased for all correctional staff.

3. Ensure that all provincial correctional facilities are proactively offering access to the Inmate Information Guide and Segregation Handout in formats that are easily understood by the individual.

4. End indefinite detention for all inmates and ensure that limits on – and reasons for – segregation are clearly defined and enforced across provincial correctional facilities.

    - In accordance with the Ashley Smith Inquest jury recommendations, individuals should not be placed in isolation for more than 15 consecutive days at a time and never for more than 60 aggregate days in a year; there must be a mandatory wait period of five consecutive days as a minimum before each placement in segregation.[34]

5. Employ processes to ensure transparency and accountability across all provincial facilities:

    - **Regular reviews** of provincial facilities should be conducted by independent third parties such as those conducted by the Office of the Correctional Investigator at the federal level;
    - **Independent office** or position that reviews and reports on all segregation stays should be established;
    - **Accessibility of information** about the use of segregation should be available to the public, including the number of times segregation is used and the general reasons why segregation was used as the "only viable option" for people identified as experiencing serious or acute mental illness;
    - **Accountability measures** for correctional officers and institutions that overuse segregation should be established and implemented.

6. Increase training and supports for correctional officers and management staff.

    - **Correctional officer and management training curriculum should include:**
        - **De-escalation** techniques;

    - **Training** on mental illness and anti-stigma that is developed and delivered in conjunction with people with lived experience of mental illness;
    - **Information** about the impacts of segregation on mental health;
    - **Compassion**, empathy and non-violent communication skills-training;
    - **Alternative** options for housing inmates with serious or acute mental illness;
  - **Training infrastructure** which can be implemented across facilities to support and sustain regular training for current and new correctional officer staff;
  - **Ongoing training** with a regular formal evaluation to monitor progress and to identify gaps and make appropriate amendments;
  - **Psychological and emotional supports** for correctional officers through peer support programs as well as professional services, such as those offered by Employee Family Assistance Programs.

7. Increase investments in community-based supports and diversion programs in order to address issues of overcrowding in provincial correctional facilities.

Medium-term recommendations (within 3-5 years)

8. End disciplinary and administrative segregation for other vulnerable groups, including but not limited to:
   - **All persons with mental health issues**, not just those identified as having acute or serious mental illness (i.e., as determined by mandatory mental health screening);
   - **People on remand** who are awaiting trial or sentencing;
   - **Immigration detainees** – although this group is under the oversight of the CBSA, provincial correctional services should work with the CBSA to determine an appropriate process for ending segregation for individuals being detained in provincial correctional facilities.

9. Direct resources to preventing and diffusing situations that could lead to disciplinary or administrative segregation (i.e., increased training and supports for correctional staff; increased access to mental health services and psychosocial programs within correctional facilities; increased work and education programming).

Long-term recommendations (within 5-7 years)

10. End the use of segregation for all detainees.

4. Are you aware of any successes in any other jurisdictions/parts of Canada?

<u>Germany and the Netherlands</u>

Evidence from countries such as Germany and the Netherlands indicates that the use of segregation can be minimized as an option of last resort. In these countries, reports indicate that isolation is only used for a short period of time, and disciplinary detention cannot exceed four aggregate weeks in a year in Germany, and two aggregate weeks a year in the Netherlands.[35] Correctional staff are also taught about the negative impacts of segregation as part of their training.

Independent Inspection of Prison Conditions in the United Kingdom

Evidence shows that in a true best practice environment, correctional facility treatment and rehabilitation outcomes should be assessed regularly and made public. In the United Kingdom, inspection of correctional facilities is performed by independent inspector Her Majesty's Inspectorate of Prisons, whose primary role is to provide independent scrutiny and to report on conditions and treatment to promote positive outcomes for those detained as well as the public.[36] Adult Correctional facilities are inspected once every five years and all inspections are conducted against the Inspectorate's published inspection criteria, "Expectations", which are based on international human rights standards, Prison Service orders and standards, and overall issues considered essential to the safe, respectful and purposeful treatment of individuals in custody.

The findings from the inspection are reported back to the correctional management and reports are published within eighteen weeks of inspection. The correctional facility is then expected to produce an action plan, based on the recommendations identified in the report, within two months of publication. This is followed by a progress report on the action plan after a twelve month period. While there is a parallel process established in Canada at the level of federal corrections through the Office of the Correctional Investigator, the inspection of provincial corrections is seldom subject to independent audits aside from the investigations performed by the Office of the Auditor General and the Office of the Ontario Ombudsman. A structured oversight function for Ontario correctional facilities could be considered under the scope of the recently formed Correctional Services Oversight and Investigations Unit.

5. What do you believe would happen if we stay status quo with our segregation practices?

- Potentially worse outcomes for people being discharged from prison who endured solitary confinement – especially those with mental illness;
- Potentially increased rates of recidivism among people who have endured solitary confinement;
- Higher suicide rates within and outside of correctional facilities;
- Continued cycle of using segregation to deal with other systemic/structural issues (e.g., prison overcrowding, over-use of remand, immigration detention, criminalization of mental illness);
- Ongoing incongruity with international human rights standards and inquest recommendations;

- Potential for increased human rights claims and legal challenges.

6. If you had to change one or two things, what would you change?

- Immediately end the use of segregation for people with serious or acute mental illness;
- End the use of disciplinary and administrative segregation for all detainees by, for instance, addressing systemic issues related to prison overcrowding, lack of consistent training and support for correctional officers, and lack of diversion and other community supports.

7. What are the circumstances under which you believe segregation is acceptable (i.e., what would you keep?)?

In light of the evidence of the detrimental effects of segregation, and its impact on mental health, there are no circumstances under which segregation is acceptable. Besides separating individuals for very brief periods to address immediate safety concerns, there is no justifiable reason for enforcing isolation for any extended period of time. However, as long as segregation continues to be used among the general prison population, while in segregation, the person should continue to have access to meaningful, daily human interaction (e.g., through programs, access to the outdoors and to spaces outside of their cells, visits with other detainees, inmates, etc.). In addition, when placed in segregation, a person should be visited daily by a mental health professional to monitor their mental health and to assess any concerns or deterioration.

8. What other changes are happening in your organization that may impact this review? (Looking for opportunities for collaboration, integration, sharing of best practices)

Through SSO's Justice and Mental Health Program (JAMH), we support individuals and families affected by mental illness who have come into contact with the law. JAMH provides support, advocacy, and training for professionals who serve the mental health population.

Specifically, we have provided skills-based training for the Toronto Police Service on how to respond to individuals experiencing acute symptoms of mental illness, which has been developed and delivered in collaboration with people with lived experience. We have also partnered with the Immigration and Refugee Board of Canada (IRB) to provide designated representative services to individuals who have been identified as requiring mental health accommodation support for IRB hearings. SSO is one of the only mental health organizations to have a formalized partnership to provide this service, and is often consulted by the legal community for assistance and support with mental health-related immigration cases. In addition we have provided training to frontline staff as well as CBSA personnel on issues related to immigration and mental health.

Through this work we are well aware that the lack of timely access to quality mental health services and supports, inadequacy of available social supports, and lack of coordinated response between the health

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and criminal justice systems, leads to the over-representation of people with mental health issues in the correctional system.

We are a lead expert in the effects of the criminalization of mental health on persons living with schizophrenia and psychosis, and would welcome the opportunity to continue to inform the review and provide information and/or formal training to ministry and correctional staff as needed.

We are committed to helping the ministry ensure that people are getting the right supports while in prison, and to reducing the impact of harmful segregation practices on individuals with mental illness.

Thank you for considering our submission. For further discussion, please contact Erin Boudreau, Manager of Policy and Community Engagement, at eboudreau@schizophrenia.on.ca or 1-800-449-6367 ext. 255.

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