PROVINCIAL CORRECTIONAL RESPONSE TO INDIVIDUALS WITH MENTAL ILLNESSES IN ONTARIO:

A REVIEW OF LITERATURE

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Table of Contents

Executive Summary

Individuals with mental illnesses are a growing segment of the correctional population in Ontario. At the same time, there is overwhelming evidence that the needs of this population are not being adequately addressed within the correctional system. When examined alongside the fact that individuals with mental illnesses already encounter multiple social and systemic barriers and are exposed to a wide range of human rights violations, this raises a number of significant concerns.

To increase understanding about correctional response to people with mental illnesses in Ontario and to initiate a dialogue on how the system can be improved, the Schizophrenia Society of Ontario performed a thorough review of available academic, gray and policy literature. As part of this review, we identified key issues in the way that the current system responds to mental illness. These issues are explored under the following themes:

1. **Philosophy of Corrections:** The philosophy of corrections which emphasizes public safety, security, and risk management is in contradiction with the therapeutic approaches used in the mental health sector. As a result, individuals with mental illnesses are more likely to incur disciplinary sanctions than receive therapeutic interventions for the behaviours related to their conditions. This decreases chances of parole and limits access community supports, housing and employment.

2. **Screening and Assessment:** Effective screening and assessment measures are needed to identify persons with potential mental health concerns upon admission to the correctional institution and ensure that their treatment needs are adequately addressed. Yet, due to security-focused classification protocols, lack of trained staff and inconsistent screening of remand populations, there is general inadequacy and inconsistency in screening measures for mental illnesses at both federal and provincial correctional institutions. This has serious implications as disruptions in treatment and lack of follow-up care often have a negative effect on one's mental health recovery and institutional adjustment.

3. **Access to Treatment and Programming:** Ongoing access to comprehensive and individualized treatment and supports is essential in mental health recovery. At the correctional level, however, there are significant gaps in service delivery and program availability across the provincial institutions. For remanded individuals there is general paucity of mental health services and supports. For sentenced individuals mental health treatments and supports are provided through programs offered by MCSCS, on-site mental health professionals, provincial treatment centres and community agencies. Yet these services are offered inconsistently across provincial institutions thus leaving many individuals with mental illnesses without access to needed treatment and supports while incarcerated.

4. **Safety of Incarcerated Individuals with Mental Illnesses:** The safety of individuals with mental illnesses within correctional settings is often compromised. Pre-existing mental health conditions can be aggravated by stress of incarceration and lack of access to treatment. Individuals exhibiting behaviors associated with mental illnesses are also at an increased risk of abuse by other inmates and correctional staff. Segregation is commonly used as a disciplinary measure which has been shown to exacerbate symptoms of mental illnesses and has been connected to increases in suicides and suicide attempts.

5. **Release Planning and Access to Community Supports:** Release planning is essential for individuals with mental illnesses given that they have unique needs and often require a wide range of specialized services and supports to effectively manage their conditions and successfully reintegrate into the larger community. Due to insufficient release planning procedures at the institutional level and concurrent deficiencies in the community mental health sector, recently released individuals with mental illnesses experience notable challenges with community reintegration. This often has detrimental effect on their mental health and contributes to increased rates of homelessness and re-incarceration.

6. **Special Populations:** There are many marginalized groups in provincial correctional settings. In Ontario, three subpopulations of inmates with mental illnesses were identified through the available literature: women, Aboriginal peoples and individuals on remand. These subgroups have unique needs and are disproportionately affected by gaps in the current correctional system.

In order to facilitate further discussion on how the above noted issues can be addressed, promising practices from other jurisdictions were identified. Overall, all of the examined practices emphasize need for system-wide, holistic approaches to mental health which go beyond immediate healthcare needs; support and governance for the mental health personnel; external support and internal integration with other correctional staff and services; effective identification of service needs; and effective screening measures at the time of admission and during the period of incarceration.

While there is still a general paucity of research looking at the experiences of individuals with mental illnesses in provincial correctional facilities, the ultimate goal of this paper is to initiate further dialogue on what can be done to facilitate better response and service provision for sentenced and remanded individuals with mental illnesses.

The Schizophrenia Society of Ontario will undertake further research into this matter over the course of next year to identify practical policy and practice recommendations to improve the system for people with mental illnesses.

Foreword

The Schizophrenia Society of Ontario (SSO) is a non-profit charitable organization with a mission to make a positive difference in the lives of people, families and communities affected by schizophrenia and psychotic illnesses. SSO has a long history advocating for the rights of individuals with mental illnesses who come into contact with the criminal justice system. As part of our Justice and Mental Health Program, we often hear about the numerous challenges that individuals and families encounter when dealing with Ontario's correctional system. In turn, SSO identified the issues of persons with mental illnesses in the correctional facilities as one of our policy priorities for the years 2011-2013.

Scope and Focus

The population of focus in this research paper is individuals with mental illnesses and criminal involvement. While SSO uses many terms interchangeably, such as mental health issue, mental health condition and mental illnesses, the latter term was chosen because it is the closest in aligning to the language used by academia and by the Correctional authorities. It should be clarified that not all individuals living with a mental health issue would identify with this label.

Likewise, this paper is written with a premise that there is no single mental illness but rather a range of mental health conditions with an array of different symptoms and experiences[1]. The term "mental illnesses" is used to describe presence of conditions which have an impact on a person's ability to function effectively over a long period of time and may take the form of changes in thinking, mood or behavior, or some combination of all three, with the symptoms varying from mild to severe. Despite the presence of symptoms and/or diagnoses, mental health recovery is always possible and it is a nonlinear, individual process.

Project Overview

The review of literature is Phase I of a larger research project on issues of persons with mental illnesses in Ontario's correctional facilities. The purpose of this review is to identify challenges that these individuals face within the current system as evidenced from the available research. Due to lack of Ontario-specific data on the subject, we also reviewed information from the federal corrections with a goal to provide a comparative analysis between these two systems and fill in knowledge gaps, where appropriate.

Phase II of this project will comprise of an analysis of correctional policies; surveys with agencies working with past inmates and interviews with persons with mental illnesses who have been through the provincial correctional system. These data sources will be used in combination with the evidence attained through the review of the literature to help us understand what the needs of persons with mental illnesses are during the incarceration period and after the release, and establish practical policy and practice recommendations to ensure that these needs are effectively addressed. These findings and recommendations will be released as a discussion paper in 2013.

Introduction

In Canada, it is well established that individuals with mental illnesses are coming in contact with the criminal justice system at increased and disproportionate rates.[2] The relationship between mental illnesses and criminal involvement is complex. While people with mental illnesses sometimes may commit serious crimes, the causes of violent behaviour amongst this population are as varied and complex as those in the general population[3]. Overall, there is general consensus in the literature that individuals with mental illnesses who lack access to services and supports often come in contact with the criminal justice system due to negative stereotypes and misperceptions about their risk of violence[4]; crimes which are directly related to their conditions, such as causing a disturbance, mischief, or minor theft[5]; and their overall increased visibility associated with exhibiting behaviors which often fall outside of social norms. This is referred to as criminalization of mental illness.

The consequences of criminalization are severe. Federal and provincial statistics indicate that persons with mental illnesses are overrepresented within institutional correctional settings when compared to the general population.[6] At the same time, numerous reports produced by inmate advocates, federal and provincial Correctional authorities, academia and mental health providers emphasize that the needs of these individuals are not adequately addressed within correctional systems in Canada.

For Aboriginal peoples, individuals from racialized communities and immigrant/refugee populations these issues are even more pronounced. Members of these groups are often overrepresented in correctional settings and this overrepresentation has been attributed to systemic racism within the criminal justice system[7], over-policing through increased police presence in areas populated by these groups[8], and racial profiling in the law enforcement and judicial system[9]. Presence of a mental illness further compounds this situation as research shows that members from these communities experience barriers to mental health services[10] and are often misdiagnosed and discriminated against within the mental health system.[11] When examined alongside the fact that individuals with mental illnesses already encounter multiple social and systemic barriers[12] and are exposed to a wide range of human rights violations[13], this raises a number of significant concerns.

Many of the concerns have been echoed in reports which examine federal corrections.[14] Parallel to this examination of the federal correctional system, there are some policy reports and academic articles which look at these issues at the provincial level. However, there are notable gaps in understanding the multi-faceted circumstances of persons with mental illnesses in Ontario's provincial correctional facilities. Additionally, while there is evidence indicating specific issues with how Canada's current correctional system addresses needs of persons with mental illnesses; there is limited research on how this system can be improved with respect to the needs of this marginalized population.

In turn, this literature review presents an opportunity to consolidate the available research on this population in the context of Ontario's provincial corrections and inform further action to bridge some of the current knowledge gaps in this area. In order to accomplish this goal, this review will begin with a snapshot of the current state of provincial corrections in Ontario and how it responds to mental illnesses. It will then explore the issues with the current system as indicated in the available academic and policy literature. The final section of this review will examine promising practices from other jurisdictions to initiate discussion on how Ontario's system can be improved to facilitate better response and service provision for sentenced and remanded individuals with mental illnesses.

Overview of Ontario's Provincial Correctional System

In Ontario, the responsibility for adult inmates, including remanded persons and those serving sentences of two years less a day, falls under the Adult Institutional Services (AIS) division of the Ministry of Community Safety and Correctional Services (MCSCS). This Ministry currently operates and oversees 14 jails, 7 detention centres, and 10 correctional centres, 4 of which also function as specialized treatment centres.[15] MCSCS is further responsible for provision of community corrections and operates 119 probation and parole offices across the province.[16] AIS provides custody and supervision of inmates until they are discharged by a court, transferred to another jurisdiction, granted parole, or complete their sentence.

Over the last ten years, there has been a drastic shift in the nature of the population in the custody of the MCSCS. Where a decade ago almost 70% of inmates were sentenced and 30% were remanded in custody, today MCSCS estimates that approximately 63% of its inmate population is on remand.[17] When compared to the rest of Canada, Ontario ranks highest in terms of proportion of remand relative to total correctional population.[18] The growth of remand population has been noted to create bottlenecks in the system and overcrowding in correctional facilities, which according to a review by the Auditor General affected every aspect of operations, ranging from programming to infrastructure renewal.[19]

Mental illnesses in Ontario's Correctional Institutions

In Ontario, provision of health care services, including mental health care, in provincial correctional institutions falls under the jurisdiction of MCSCS, and not the Ministry of Health and Long Term Care (MOHLTC). Within its Strategic Plan for 2008-2013[20], MCSCS has identified people with mental illnesses as one of the largest client groups served by this Ministry. According to the MCSCS estimates, about 15% of inmates under their jurisdiction require a clinical intervention for a mental illness and over the last decade, the number of remanded individuals with mental health alerts increased by 44.1%.[21]

There is also indication of gender-specific increase in incarcerated individuals with mental health concerns. A recently conducted study on Ontario's correctional institutions showed that

incarcerated females had a greater prevalence of psychiatric admission over a lifetime (41.5% compared to 29.3% male) and in the last two years (17.9% compared to 13.7% male).[22] This study further showed that 6% of men and 5.7% of women had a diagnosis of schizophrenia, and 12.7% of men and 24.5% of women had a diagnosis of mood disorder.[23] These figures are consistent with other studies which show that when compared to their male counterparts, incarcerated females exhibit higher prevalence of psychoses, mood and anxiety disorders.[24]

With regards to the profile of this specific population, evidence indicates that incarcerated individuals with mental illnesses are more likely to be members of marginalized groups, specifically Aboriginal and racialized communities.[25] When compared to individuals with mental illnesses in the community, incarcerated individuals with mental illnesses are more likely to be homeless, unemployed and in need of greater social supports.[26] They are also more likely to be younger, have experience of trauma and history of violence and substance use, and have earlier contact with the psychiatric hospital system.[27] At the same time when compared to general mental health population, incarcerated individuals with mental illnesses are *less* likely to receive mental health services.[28]

Correctional Capacity to Respond to Mental Illnesses

It has been noted that both federal and provincial corrections lack the needed capacity to adequately respond to sentenced and remanded individuals with mental illnesses. Indeed, a recent report from the MOHLTC notes that "once incarcerated, individuals are unlikely to receive adequate treatment for their mental illness" (p. 261).[29]

Within its correctional facilities, MCSCS has nine Special Needs Units for vulnerable inmates with cognitive and/or mental health needs, in addition to three infirmary units, which are designated for attending to more intensive health care needs of the inmates.[30] The Ministry also operates four treatment centres: Algoma Treatment & Remand Centre in Sault Ste. Marie, Ontario Correctional Institute in Brampton, St. Lawrence Valley Correctional and Treatment Centre in Brockville and Vanier Centre for Women in Milton. According to MCSCS, these centres are staffed by professional clinical personnel employed by, or under contract to, the Ministry who provide "specialized and intensive treatment for motivated offenders with clearly identified problems relating to substance abuse, sexual misconduct, impulse control and anger management."[31]

Based on data from 2009, MCSCS had 251 full-time health care employees, including 11 psychiatric nurses[32], to cover 2,809 adult sentenced inmates and 5,718 remanded individuals in Ontario's provincial institutions.[33] However, there are no set staffing formulas to determine health care staffing in correctional institutions and it is unclear whether all correctional facilities under MCSCS jurisdiction have on-site designated mental health staff. With regards to training on mental health, in 2009, four correctional staff attended Correctional Service of Canada (CSC) mental health train-the-trainer program and these materials were to be incorporated into basic training for

correctional staff.[34] There is no publicly available data on current progress of this initiative is and how many past and current staff received this training.

At the federal level, individuals with severe mental illnesses are treated at the Regional Treatment Centres (RTCs), in-patient mental health facilities located in each of the five regions.[35] The RTCs offer acute and chronic mental health care to inmates with most serious conditions who require in-patient treatment and have a total capacity of 675 beds and employ 781 fulltime positions.[36] The RTCs are co-located within CSC institutions (with the exception of the Prairies Region) and constitute a detention centre but operate as accredited psychiatric hospitals under applicable provincial mental health legislation.[37]

With regards to staff capacity, health professionals represent only 3.7 % of CSC's workforce[38] and many professionals hired to deal with people with mental illnesses have little or no clinical mental health knowledge or experience.[39] This, paralleled with limited mental health training for correctional workers[40], further jeopardizes the correctional ability to address the increasingly complex array of mental health issues in correctional populations.

Initiatives Currently in Place

While there are certain initiatives in place which are supposed to provide a framework for provision of services to sentenced and remanded individuals with mental illnesses, these initiatives are too few and most do not translate from policy to practice. At the federal level, there is the CSC Mental Health Strategy which was announced in 2006.[41] This strategy includes improved intake screening and assessment, provision of primary mental health care, development of intermediate care units, enhancement of clinical staff at RTCs, improved community partnerships and provision of mental health training to correctional staff.[42] However, as noted by the Office of the Correctional Investigator (OCI), there is currently no official and comprehensive strategic planning document that has been approved by the appropriate CSC authorities with regards to this strategy which seriously compromises its funding, implementation, accountability and evaluation.[43] It is further unclear how this strategy will interact with the initiatives at the provincial/territorial level, and specifically with those under the jurisdiction of MCSCS.

At the provincial level, there is no detailed information available on how MCSCS is addressing the influx of individuals with mental illnesses in its correctional facilities. The latest report from the Office of the Auditor General of Ontario[44] mentions that MCSCS and the AIS division are reviewing and updating their assessment measures and program delivery for individuals with mental illnesses and working closely with other correctional providers across Canada in developing and implementing a national corrections mental health strategy. No update on the progress of these initiatives is currently available to the public.

With regards to investments, MCSCS designated $962.6M or 35.4 percent of its budget to correctional services for the years 2010-2011.[45] Within that, designated mental health funding is mostly directed towards diversion measures to keep individuals with mental illnesses out of the criminal justice system, rather than provision of services at the institutional level.[46] While diversion is extremely important and serves as an effective prevention measure, focusing on diversion alone is not enough to help to resolve the dire situation which this population faces while incarcerated.

Issues

A review of available academic literature and policy reports revealed a number of specific concerns with the way correctional settings respond to incarcerated individuals with mental illnesses. Many of these reports emphasized that these issues often result from lack of dedicated funding for provision of mental health services[47], underdeveloped administrative measures[48] and limited access to programs and services[49], just to name a few. Reports also noted parallel gaps in the community sector services for inmate populations.[50] To facilitate greater understanding, this section will examine the identified issues in detail under the following themes:

1. Philosophy of Corrections
2. Screening and Assessment
3. Access to Treatment and Programming
4. Safety of Incarcerated Individuals with Mental Illnesses
5. Release Planning and Access to Community Supports
6. Special Populations

1. Philosophy of Corrections

There is a direct discrepancy between the philosophy of corrections and the therapeutic approach used in the mental health sector to respond to the needs of people with mental illnesses. In accordance with the therapeutic approach, individuals with mental illnesses require clinical interventions and support for behaviors associated with their conditions. Yet evidence suggests that in the context of correctional settings, behaviors associated with mental illnesses are often categorized as high risk, warranting disciplinary action rather than therapeutic intervention[51] and as a result, persons in emotional distress are seldom provided with counselling or treatment.[52]

This is not surprising considering that both federal and provincial corrections emphasize public safety as their number one priority.[53] This ‘security first’ approach informs the way the correctional staff understand and respond to mental illnesses. This fosters false sense of fear associated with therapeutic interventions where integration of mental health approaches in correctional environments is often believed to undermine correctional staff’s authority. Indeed, studies document that correctional staff express serious concerns over malingering and equate therapeutic approach with providing inmates with “excuses” for misconduct which inadvertently may lead to the “breakdown of order”.[54] While public safety is an important concern, frameworks that focus solely

on security, safety and discipline, provide few options for provision of quality medical and rehabilitative services vital to mental health recovery.

The consequences of this approach are indeed severe. It may be speculated that these conflicting philosophies undermine effective implementation of correctional strategies with regards to mental illnesses. Evidence shows that mental health related procedures and protocols are either underutilized, underdeveloped or non-existent[55] across the correctional settings. In addition, within correctional settings, there is continued marginalization of the roles of clinicians in the organizational decision-making process, which directly impacts clinical services, or lack thereof.[56] The knee-jerk reaction to respond to mental illnesses through disciplinary measures and subsequent lack of access to the needed services and supports results in increased number of sanctions which not only further restricts the few privileges that these individuals have while incarcerated, but also jeopardizes their parole eligibility and ability to access community services, secure housing and employment upon their release.[57] These alarming trends have prompted some response at the federal level, yet little is known about any parallel processes at Ontario's corrections where security concerns continue to trump therapeutic needs of the individuals with mental illnesses.

2. Screening and Assessment

Effective screening and assessment measures are needed to identify persons with mental illnesses upon admission to the correctional institution and ensure that their treatment needs are adequately addressed. While it would be impossible to perform comprehensive mental health assessment on every person admitted to the correctional facility, intake screeners can be used to flag individuals with potential mental illnesses and refer them for a more extensive evaluation. Unfortunately, the reviewed studies and reports show that there is general inadequacy and inconsistency in screening measures for mental illnesses at both federal and provincial correctional institutions.[58] In fact, data from Ontario indicates that mental health problems are rarely identified at intake and current correctional files yield very little information that could be used to determine mental health status.[59]

2.1 Classification Protocols

Screening for mental illnesses is grouped under the general classification measures used to determine the level of supervision that an inmate may require. According to the CSC, the ultimate goal of these classification measures is to "maximize public and institutional safety and to minimize the offender's illegal or otherwise antisocial behaviour in prison and in the community".[60] As such all of the screening measures used in the context of corrections include some form of criminogenic risk assessment.

Emphasis on risk assessments focused solely on public safety and threat of violence towards others are not easily reconcilable with clinical assessment measures whose primary goal is to determine treatment needs. At the same time, stigma associated with mental illnesses and presumptions that this population is inherently violent can influence how risk is determined and assessed. Indeed,

evidence shows that individuals with mental illnesses, cognitive limitations and substance dependency are often classified as maximum security at the onset of their detention with very limited chances of changing their level of security classification[61]. According to the Canadian Human Rights Commission, federally used classification measures also do not include gender-responsive variables and use risk/need indicators based on prohibited grounds of discrimination, including religion, ethnicity and disability status.[62] In turn, these classification measures limit access to programs and treatment[63] since maximum security inmates, unlike their minimum and medium security counterparts, are not eligible to participate in work-release programs, community release programs or other supportive programming designed to enhance their chances of recovery and reintegration.[64]

2.2 Lack of Trained Personnel

Another major gap in the current process used to screen and assess mental illnesses is lack of trained personnel to perform these assessments. Best practice literature shows that mental health screeners and assessment measures at a minimum require designated assessors with mental health training[65] and sensitivity in interviewing persons with these conditions.[66] Yet most of the examined studies and reports indicate that both federal and provincial correctional facilities experience challenges with recruitment and retention of mental health professionals.[67] Indeed, little is known from publicly available evidence about who is responsible for performing intake screening at both federal and provincial institutions and what training these individuals receive.

2.3 Screening of Remanded Individuals

Remanded individuals are disproportionately affected by a lack of comprehensive mental health screening and assessment measures. Until formally charged and sentenced by the court, individuals held on remand are often not screened for mental illnesses nor provided with psychiatric assessments, unless flagged as "unfit to stand trial". However, without an assessment of mental health needs, individuals on remand are precluded from receiving mental health services while awaiting their trial date.[68]

Unfortunately, little is known about how this lack of comprehensive screening and assessment measures effects this particular inmate group as there are no empirical studies which look at the needs and challenges experienced by remanded individuals with mental illnesses in Ontario. However, it may be inferred from the situation of sentenced individuals that lack of appropriate screening and assessment measures impedes remanded individuals' access to primary care services, necessary mental health treatment and other rehabilitative supports.[69] This has serious implications as disruptions in treatment and lack of follow-up care often have a negative effect on one's mental health recovery and social well-being.

2.4 Screening Process at Federal and Provincial Institutions

In order to address the above noted gaps, a number of initiatives are currently being undertaken at both the federal and provincial levels. At the federal level, CSC has recently introduced a two-stage screening and assessment process, a Computerized Mental Health Intake Screening System (CoMHISS). CoMHISS is a set of self-report measures designed to identify individuals with potential mental health conditions at intake and is comprised of the Brief Symptom Inventory (BSI), Depression Hopelessness and Suicide Scale (DHS) and Paulhus Deception Scale (PDS).[70] This screening tool is often used in combination with the Jail Screening Assessment Tool (JSAT), Cognistat, Adult Attention Deficit Hyperactivity Disorder (ADHD) Self-Report scale and Brief Jail Mental Health Screen.[71] According to the report by the Office of the Correctional Investigator, the development and implementation of CoMHISS have been a protracted process, missing several CSC's self-imposed deadlines and only a limited number of intake mental health staff have been hired/trained thus far.[72] While CSC records shows that as of February, 2010, approximately 4300 sentenced individuals completed the CoMHISS[73], the effectiveness of this tool to appropriately identify persons with mental illnesses and the ability of correctional staff to connect identified individuals with treatment and supports is yet to be established.

At the provincial level, according to the MCSCS' website, indicating the categories and source of information used by correctional staff to classify inmates most of information used for inmate classification is sought from criminal and legal sources and focuses on sentence information, criminal and institutional history, and other safety and security factors.[74] Mental health specific information can be potentially obtained from "clinical records", as a part of "Personal history" criteria such as treatment/program participation and medical/psychiatric history, and under "Other Factors" criteria such as motivation and agreement to participate in a treatment program.[75]

According to the information obtained from a Freedom of Information request, MCSCS states that current screening and classification process is consistent across all provincial correctional facilities in Ontario. It is a two stage process consisting of initial preliminary screening which is then followed by a more comprehensive assessment, if determined that this assessment is indeed needed. The preliminary screening is completed by staff in the Admission and Discharge unit and relies on one's disclosure of identified health concerns or presence of observable medical concerns or disturbing behaviors. If these criteria are met, the individual is then referred for additional screening by health care staff and may be subject to a mental health assessment to assist with treatment planning. If the individual is a sentenced inmate, he/she is also screened using the Level of Service Inventory-Ontario Revision (LSI-OR)[76] instrument which is used to assess recidivism and is argued to provide a more thorough classification and assessment of inmate's programming and treatment needs. However, LSI-OR is a tool used to asses criminogenic risk, rather than a tool to assess therapeutic needs; hence, it is difficult to evaluate its effectiveness at flagging mental health concerns and facilitating appropriate referrals for treatment and supports.

The Auditor General report notes that MSCSC is also in the process of reviewing the available mental health screening tools and that this tool would be selected and developed for implementation in the 2010/11 fiscal year.[77] To address the particular challenges with screening remanded individuals, MCSCS received funding for a pilot project for the use of video technology at five correctional facilities to improve the quality and timeliness of assessments for accused persons with possible mental-health issues.[78] However, there is currently no publicly available information to confirm these initiatives and their progress and effectiveness.

3. Access to Treatment and Programming

Individuals with mental illnesses who come into contact with the criminal justice system have a right to the same level of health care as individuals with mental illnesses in the general population. For mental illnesses, treatment and supports can include counselling, medication, peer support and social rehabilitation as well as social supports such as housing, education, employment, income and recreation. People with mental illnesses respond differently to different treatment modalities and what works for one person will not necessarily address symptoms in another. Due to the episodic nature of mental illnesses, relapse is common; however, it does not limit one's chances of achieving stability and mental health recovery. Moreover treatment non-adherence is the norm, rather than an exception, and can result from medication side-effects, poor clinical relationship and/or a mismatch between individual's needs and the available treatment modality. As such ongoing access to comprehensive and individualized treatment and supports is essential to mental health recovery and has been shown to decrease recidivism and increase chances of effective community reintegration.

Unfortunately, for persons with mental illnesses there are significant gaps and inconsistencies in service delivery and program availability across the provincial institutions.[79] A number of obstacles to provision of mental health care arise due to the infrastructure and the nature of correctional settings. For instance, institutional disturbance, weather conditions or an inaccurate count can keep the entire facility locked down which would prevent inmates from accessing mental health related programs and services and/or receiving their medications.[80] Lack of designated strategy further complicates these problems. While specific statutory provisions exist in Canada with respect to necessary care to federal inmates, no similar statutes are in place for provincial detainees.[81] A study by the Canadian Institute for Health Information[82] further shows that that despite the array of programming which is said to be offered at correctional facilities, there are currently no empirical evaluations specific to mental health–related outcome measures or the accessibility of programs to inmates—with or without mental health issues.[83]

3.1 Treatment and Programming at the Federal Institutions

At the federal level, CSC's capacity to respond to the needs of individuals with mental illnesses is limited to the care and treatment provided by RTCs.[84] However, significant proportion of inmate population with mental illnesses do not meet treatment centre admission criteria, and bed capacity in the five federal treatment centres only meets 50% of the identified need.[85] What is more, many

individuals from maximum security institutions are not admitted to the RTCs due to security concerns; and as such, do not receive the necessary mental health care.[86]

Even when individuals are able to obtain treatment at the RTCs, they often encounter significant challenges with transfers between RTCs and correctional facilities. There is a documented under-utilization of clinical management plans which include prevention, intervention and treatment measures and a noted lack of continuity of care or follow-up instructions given to correctional staff after inmates are discharged from the regional psychiatric hospital.[87]

3.2 Treatment and Programming through the MCSCS

At the provincial level, access to treatment and programming is even more compromised when compared to the federal institutions. Overall, sentenced individuals can access mental health treatments and supports through programs offered by MCSCS, on-site mental health professionals, provincial treatment centres and community agencies. Programming offered through federal corrections and the RTCs is generally not accessible to provincial inmates unless they are so disruptive or unstable that correctional workers cannot manage them.[88] Moreover, specialized treatment programs offered by the MCSCS are directed to sentenced offenders with sentences of six months or longer[89] and hence are often not accessible to those who are on remand.

According to the MCSCS, the following treatment programs are offered across institutions[90]:

- anger and aggression control;
- anti-criminal thinking programs (Change is Choice);
- assertiveness training;
- communication skills;
- domestic violence groups;
- rehabilitative work experience programs, such as Tricor Industries;
- job-readiness training;
- life management skills;
- literacy;
- parenting skills;
- sex offender programs;
- sexual abuse counselling;
- stress management training;
- substance abuse groups; and
- victim awareness

These programs are divided by correctional authorities into core rehabilitative programs, non-core rehabilitative programs and specialized rehabilitative programs.[91] Core rehabilitative programs are available across institutions and probation and parole offices and are targeted to men with histories of domestic violence and sexual offences and some women and Aboriginal persons. These

programs focus on addressing criminogenic factors and reducing recidivism. Non-core rehabilitative programs include substance abuse, anger management, anti-criminal thinking, domestic violence and sexual offending and are offered at specific sites only. Similarly, specialized rehabilitative programs are targeted towards sentenced individuals with special needs, including those with serious mental illnesses, and are offered at specific institutions only.

The Offender Program Unit is in the process of developing a new life skills program for individuals with mental illnesses short enough to fit well within the average length of stay for both remanded and sentenced individuals. This program was anticipated to be ready for piloting in 2010/11[92] but currently there is no information available on its progress and effectiveness.

Efficacy of other programs is not known either. Offender Program Tracking Module, an enhancement that enables the recording and tracking of programs and participation, was initiated by MCSCS in 2008 but according to the Auditor General report, many institutions had not yet used this module.[93] As such, it is yet unknown who has access to these programs and how effective they are at meeting the needs and goals of persons with mental illnesses.

3.3. Treatment and Programming Offered by Designated Mental Health Staff

While very limited information is publically available on how mental health care is delivered in Ontario's correctional institutions, according to MCSCS, all correctional facilities are staffed with registered nurses and contract services of a physician[94]. Some institutions have access to a psychologist and/or psychiatrist but psychiatrists often only address medical treatment needs, such as medication management[95]. This is often a barrier to treatment for individuals that enter the correctional institution without a prescription. Likewise, as noted in other provinces, there are many problems with acquiring and dispensing medications for incarcerated individuals, including inconsistency in dispensing protocols, inability to get medications from pharmacies in a timely manner, difficulties obtaining patient histories when transferred from other institutions, and lack of patient information pamphlets accompanying the medication provided.[96] Even when there is access to medications, one's ability to follow through with this treatment may often be compromised due to lack of parallel psychosocial counselling and case management.

There is no publically available information on the extent and quality of care provided by other allied health care professionals, such as psychiatric nurses, social workers and general practitioners.

3.4 Treatment and Programming at the Provincial Treatment Centres

There is very limited information available on the extent of treatment offered at the four treatment centres across the province. Based on what is available, it appears that each treatment centre has different eligibility criteria, bed capacity and programming[97].

For example, St. Lawrence Valley is a Schedule 1 psychiatric facility housed within a correctional centre. It provides specialized assessment and treatment in the areas of sex offending, dysfunctional anger and trauma disorders to address the needs of provincially sentenced males diagnosed with a mental illness.[98] The Algoma Treatment and Remand Centre, offers programs focused on violence and domestic violence to males serving a minimum of a nine-month sentence and addictions and anger management programs to female serving a minimum of a six-month sentence.[99]

At the Vanier Centre for Women sentenced and remanded women can access programs provided by outside agencies which focus on self-care, parenting, violence awareness, addictions, emotion management, and anti-social thinking, and women with major psychiatric disorders, acute depression/suicidality, serious emotional disturbance, and significant cognitive limitations are looked after at the clinical unit.[100] The Ontario Correctional Institute, on the other hand, provides treatment and programming in the areas of emotional and mental health problems, drug abuse, violence and domestic violence, sexual offending and general criminality to incarcerated men.[101]

It is not clear how the referrals are made and how "unwell" an individual has to be for this process to be initiated. There is further very little information available on how services are delivered at these centres and whether other mental health supports are available within each centre.

3.5 Treatment and Services through Community Organizations

In addition to the programs offered by the MSCSC, incarcerated individuals can also access services offered by community agencies that have access to the institutions. However, limited information is available on their eligibility criteria or accessibility of these services across the province. At the same time, anecdotal evidence shows that only a handful of community agencies are granted access to the provincial institutions and that their ability to effectively deliver rehabilitative services is limited due to numerous constraints placed on them by the MCSCS.

It is further unknown under what circumstances incarcerated individuals with potential mental health concerns can receive care from a designated psychiatric hospital or mental health agency in the community and what procedures and protocols must be followed to facilitate this process.

3.6 Impact on Individuals with Mental Illnesses

While little is known about the extent and the effectiveness of treatment and programming offered to individuals with mental illnesses in provincial correctional facilities, evidence shows that lack of accessible treatment and programs has dire consequences for this inmate subgroup. Because incarceration itself results in a tremendous amount of stress for individuals with mental illnesses, lack of appropriate treatment and supports can exacerbate symptoms, impede recovery and undermine successful reintegration into the community.[102] Alarmingly, lack of treatment and supports in the provincial institutions has been shown to lead some individuals to ask for longer sentences just so that they can receive some "therapeutic" intervention from the federal

corrections.[103] Furthermore, inadequacies in delivery of programs and supports also undermine fundamental correctional goals of rehabilitation and have shown to result in readmissions to the correctional facilities, often within a very short timeframe.[104] Individuals with mental illnesses are also at risk of longer periods of incarceration as many miss parole eligibility dates because they cannot access programs.[105]

Research further shows correctional settings generally facilitate hypermasculinity[106] and 'toxic masculinity' in males[107], characterized by tendencies towards violence and domination. Adhering to these norms of masculinity inhibits men from disclosing their mental health issues, despite the over representation of men who experience trauma in prison.[108] This has negative effect on their mental health and wellbeing while simultaneously acting as barrier to seeking help. Impact on women is very troubling as well and will be examined in greater detail further in the paper.

4. Safety of Incarcerated Individuals with Mental illnesses

Civil, political, economic, social and cultural rights of people with mental illnesses are often violated, both within institutions and in the community. According to the World Health Organization, physical, sexual and psychological abuse is an everyday experience for many people with mental illnesses[109] and they are more likely to be victims of violence than perpetrators.[110] Review of the available literature is consistent with these statements and shows that safety of individuals with mental illnesses is often compromised in the correctional settings.

Canadian Human Rights Commission notes that individuals with mental illnesses are highly vulnerable within the inmate population.[111] Existing mental health conditions are aggravated by stress and lack of appropriate treatments and supports can further exacerbate this situation.[112] At the same time, individuals exhibiting strange behaviors and those with known diagnoses are at an increased risk of abuse by other inmates and by correctional staff. They are often separated from the general prison population and placed in administrative segregation, instead of receiving clinical interventions.[113]

This use and overuse of administrative segregation to respond to behaviors associated with mental illnesses in federal and provincial correctional facilities is very concerning. It has been noted that segregation and segregation-like units have become de facto intermediate care services[114] for individuals with mental illnesses who are not able to access care through RTCs or specialized psychiatric hospitals in the community. Individuals who are deemed to be suicidal are also often placed in isolation[115] and it is unknown whether there are specific policies to ensure appropriate follow up care upon their return to the general inmate environment.

There is a body of empirical evidence documenting segregation to be psychologically harmful to any inmate, with common effects including anxiety, depression, perceptual distortions, cognitive disturbances and psychosis.[116] For individuals with mental illnesses, administrative segregation can

significantly exacerbate their symptoms resulting in increased need for crisis care or emergency psychiatric hospitalizations.[117] There is also a documented increase in prevalence of suicides and suicidal attempts in individuals with mental illnesses subject to administrative segregation[118], particularly in the remand populations.[119]

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. Likewise, it is unknown whether there are any specific procedures and protocols at the institutional level which would address the safety concerns of sentenced and remanded individuals with mental illnesses in Ontario.

5. Release Planning and Access to Community Supports

Being connected to necessary community resources upon release increases one's chances of successful community reintegration and is vital for mental health recovery.[120] At the institutional level, this involves comprehensive release planning and gradual release preparation from the time the individual is admitted to the institution. At the community level, this involves system capacity to respond to the service demand of this population in a timely manner.

Individuals with mental illnesses have unique needs and often require a wide range of specialized services and supports to effectively manage their conditions and successfully reintegrate into the larger community. These supports are not limited to specialized medical care and include social rehabilitation, employment, housing and other non-medical interventions.[121] Yet individuals with mental illnesses experience notable challenges with connecting to necessary community supports upon their release.

Recent research indicates that while individuals are incarcerated, they often lose access to their housing, income supports and employment opportunities,[122] and anticipated rates of homelessness increase upon discharge.[123] Individuals who were homeless or marginally housed upon admission require greater level of support and help with transportation, housing, furniture and replacing identification documents.[124] For individuals with mental illnesses, who often experience challenges with accessing and retaining housing and employment due to nature of their conditions and lack of accommodations at societal level, this loss of structural supports is arguably even more pronounced. In addition, the loss of structural supports is often paralleled with the discontinuation in mental health treatment and loss of informal social support networks.

Once released, individuals with mental illnesses are often denied access to community services and supports and are screened out from family physician and psychiatrists' offices due to eligibility criteria which label them as "high risk" based on presence of a criminal history.[125] Research shows that legal problems are among the main factors which predict under-servicing for persons with

mental illnesses.[126] In the presence of the above noted challenges, effective release planning and preparation become paramount for individuals with mental illnesses.

5.1 Institutional Capacity

Evidence shows that many correctional institutions lack internal resources to provide comprehensive release planning.[127] In addition, there is general paucity of designated policies and protocols to inform release planning procedures for incarcerated individuals with mental illnesses. Information from the field indicates that there are also no minimum standards set for effective release planning and community reintegration for individuals with mental illnesses. In addition many correctional staff do not receive adequate training on release planning and receive little on-the-job support when working on release planning for individuals with mental illnesses.[128]

As noted in previous sections, correctional institutions experience challenges with recruiting and retaining mental health personnel which inevitably affects their capacity to provide comprehensive release planning in the context of ever increasing case loads and limited human resources. Overcrowding and frequent transfers further compromise the ability of institutional staff to effectively assist inmates with their return to the community.[129]

The case loads for the probation and parole officers are exceptionally high as well, which often means that they cannot provide effective supports to newly released individuals.[130] Likewise, not all parole sites have designated mental health support.

There are further differences in release planning approaches between CSC and MCSCS. While release planning and gradual release supports are available at the federal level, provincial institutions in Ontario offer very limited services in this area, with a trend away from gradual release.[131] Evidence shows that release planning is often performed as an afterthought once the individual's release date is known without prior planning and preparation. Reviewed studies and reports state that most inmates are currently being released on temporary absences or at the discharge possible date with no support being provided unless there is probation to follow.[132] The extent of support for probationers remains unknown as well. Finally, there is currently no information available about referral processes for provincially incarcerated persons and what transition protocols are in place to ensure continuity of care for these individuals.

5.2 Community Capacity

Release planning is only effective if appropriate community supports are available and the current mental health system does not have the capacity to meet the demand. Mental health care has, and continues to be, chronically under-resourced in Ontario, and only three out of ten people with mental illnesses are able to access appropriate care.[133] For recently released individuals with mental illnesses, these numbers are likely even lower.

When considering the capacity of the community mental health sector, it is important to note that there are lengthy wait lists to access community mental health services, psychiatric care and supportive housing. With regards to other available supports, homeless shelters, drop-ins, and soup kitchens are not mandated to do the work of inmate re-entry and reintegration and community agencies are seldom funded to do this work.[134] Yet without proper supports in the community, many recently released individuals with mental illnesses come into contact with the law and return to the correctional facilities.

Subsequent incarceration often results from inability to abide by probation conditions, fine defaults, and other "administrative" offences.[135] Similarly, cumbersome and isolating parole conditions that disregard myriad of challenges associated with the nature of mental illness and complex co-morbidities such as addictions, poverty, and unstable environment often result in re-incarceration when individuals disclose their inability to follow through with treatment or experience relapse.[136] As such, lack of comprehensive release planning and concurrent insufficiency of community supports undermines effective community reintegration and leads to increased rates of re-incarceration for recently released individuals with mental illnesses.

6. Special Populations

There are many marginalized groups in provincial correctional settings. Unfortunately, due to notable gaps in research, the current examination will be limited to the populations identified in available academic literature and policy reports. Specifically, there are three subpopulations of inmates with mental illnesses that are disproportionately affected by gaps in the current correctional system. These populations are women, Aboriginal peoples and individuals on remand. While a thorough examination of the particular issues and challenges experienced by these groups is beyond the scope of this review, highlighted below are the most prominent challenges and trends in their experience with mental illnesses in provincial corrections.

6.1 Women

Women are the largest growing inmate subpopulation in Ontario's correctional facilities. According to the MCSCS, from 2002/03 to 2007/08, the number of women admitted to custody in Ontario increased by approximately 31 per cent.[137] At the same time, incarcerated females experience greater prevalence of mental illnesses when compared to their male counterparts. Yet the number of services targeted to this particular population has not increased to meet this new demand. On the contrary, 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.[138]

Screening and assessment measures do not account for gender variables and the unique service needs of women.[139] For instance, women who are classified as maximum security tend to earn this designation because of problems with institutional adjustment, rather than because they pose a risk to public safety.[140] This trend is even more pronounced for females with mental illnesses who are

already at an increased risk for adjustment problems in correctional settings. What is more, some tools used to screen for mental illnesses, while empirically validated, have been shown to generate greater rates of false negatives when screening female inmates.[141] This means that mental health concerns of incarcerated females are more likely to be overlooked when compared to their male counterparts.

With regards to release planning, evidence shows that women have higher needs than men but opportunities to access services such as educational upgrading, employability training, vocational skills and secure housing and childcare are often insufficient or non-existent.[142] In turn, many females are released to homeless shelters, co-ed facilities and halfway houses located in neighborhoods where some of them previously engaged in drug use and/or sex trade.[143] For recently released females this can lead to higher rates of re-incarceration and greater rates of relapse, in both mental illness and substance use.

Isolation and lack of social supports further compromise mental and emotional well being of incarcerated females. In Ontario, female inmates are centralized at Vanier Centre for Women in Milton (formerly Maplehurst Jail) which limits their ability to stay in touch with their families and other informal supports.[144] Because most incarcerated women are also mothers[145], not only does this have adverse effect on the women's mental health but research shows that maternal incarceration is highly destabilizing for their children as well. Indeed, stresses and changes associated with incarceration impact on children's emotional wellbeing and also increase their vulnerability to future criminal behaviours[146].

Overall, women and particularly women with mental illnesses, experience unique challenges in the provincial corrections and require separate policies and services to ensure not only their rehabilitation but physical and emotional safety and mental well-being.

6.2 Aboriginal Peoples

Aboriginal peoples continue to be over-represented in Ontario's correctional system, as is the case nationally. As noted by MCSCS, in 2006/07, Aboriginal peoples represented 1.8 per cent of the adult population in Ontario, but accounted for 9 per cent of the remand population and 8.5 per cent of the sentenced population.[147] The population of female Aboriginal inmates has grown 90% in the last 10 years.

Alas, little is known about the experiences of Aboriginal peoples with mental illnesses 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[148], and are more likely to be classified as higher risk.[149] At the same time, evidence shows that Aboriginal individuals need more assistance with community reintegration and family reconnection.[150]

Moreover, when serving time in federal and provincial correctional institutions, Aboriginal peoples have very limited access to Aboriginal programming and are often forced to choose between culturally sensitive programming or ability to stay close to their community and maintain family ties.[151] Reports further document that programs provided through Healing Lodges, which are purported to be culturally safe, are not offered in a sensitive manner; yet many Aboriginal individuals are still expected to undergo "healing" in this manner.[152] Overall, Aboriginal peoples have less access to programs and services, and as such are less likely to receive mental health supports during their incarceration and post-release.

6.3 Remand

Majority of the reviewed studies and reports highlight the dire situation of individuals held on remand. Particularly, concerns were raised around access to rehabilitative services and supports[153], release and reintegration procedures[154] and overall living conditions.[155] Further, there are numerous human rights and equity concerns as evidence shows that individuals on remand often face discrimination. Poor, 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.[156] However, there is a general paucity of research on the needs and experiences of remanded individuals with mental illnesses.

With regards to the general remand population, the examined studies and reports identified notable logistical issues when it comes to adequately addressing the needs of individuals who are held on remand. For instance, location of prisons in Ontario often makes it difficult for court transportation and for individuals to get visits, make phone calls and connect with lawyers and community agencies.[157] For accused with mental illnesses, this can create additional barriers to continuity of care and undermine their ability to maintain their social support networks.

In addition to geographic location of Ontario's remand facilities, there are issues with placements of remanded individuals at the institutional level. For instance, remanded individuals are often held at maximum security prisons, regardless of the nature of their offence or their criminal background.[158] For individuals with mental illnesses these living arrangements can potentially destabilize their mental health as well as jeopardize their physical safety.

At the same time, access to mental health programming and support for remanded individuals is very limited or non-existent. Individuals on remand are also not eligible for educational or work programs nor have access to the gymnasium or the library[159]. While these programs are not classified as mental health treatment, access to these social programming is vital to management of mental illnesses and psychosocial recovery. It is hence not surprising that many people facing criminal charges are more likely to plead guilty as a means of escaping the harsh conditions of remand.[160] Unfortunately, this has serious consequences, especially for individuals with mental

illnesses, who not only risk losing their housing and social supports but also experience disruption in mental health treatment and services while on remand.

Promising Practices in Other Jurisdictions

Considering the above noted issues in provincial corrections in Ontario, examination of promising practices from other jurisdictions can provide guidance on how these issues can be addressed. While it is premature to suggest implementation of the below discussed practices, this section is intended to initiate further dialogue about what improvements and models of service delivery can be used for system enhancement in Ontario.

Given that a thorough examination of each of the identified promising practices is beyond the scope of this paper, this section will aim only to provide a brief overview of some of the approaches used to respond to the needs of individuals with mental illnesses. In order to increase the scope of examined approaches, the term 'promising practices' encompasses evidence-informed approaches, practice-informed approaches as well as promising practices which have yet to be evaluated.

Overview of Promising Practice Trends

Examination of promising practice approaches identified trends in effective responses to the needs of individuals with mental illnesses in correctional settings. All of the reviewed studies and reports stressed the importance of a system-wide, evidence-based holistic blueprint for the provision of mental health care within correctional settings. This would entail individualized and comprehensive approach to care which goes beyond immediate healthcare needs; support and governance for the mental health personnel; external support and internal integration with other correctional staff and services; and effective identification of service needs.[161] In addition, ability to effectively screen for potential mental health issues at the admission and during the period of incarceration were identified as essential to effective provision of mental health services to inmate population and continuation of care after release.[162]

Many reports further noted the need to provide comprehensive mental health awareness training to all discipline staff and called for this training to be delivered at a minimum on a biannual basis and have stringent quality controls measures associated with it.[163] Some reports stated that the highest priority should be to educate staff about how to identify people who may be experiencing a psychiatric emergency and to provide training in crisis intervention and de-escalation techniques.[164] Increased communication and information sharing were also noted to be essential in service delivery for individuals with mental illnesses, with continuity of care and the portability of information having a central role in promising practices in correctional mental health.[165]

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, and promote positive outcomes for those detained as well as the public.[166]

Adult Correctional facilities are inspected once every five years. Prison inspections last for at least one week and information is collected from a wide range of sources including correctional staff, incarcerated individuals, and visitors or other stakeholders. 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 and their effective rehabilitation.

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 made in the inspection 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.

Healthcare Delivery Models in Norway, England and Wales

Healthcare to inmate populations has been traditionally delivered by correctional authorities locally and internationally. However, in recent years Norway and England and Wales have transferred the responsibility of health care delivery in correctional facilities from the correctional administration to the health administration.[167]

In Norway, sentenced individuals with mental illnesses are now cared for in psychiatric hospitals run by the regional health administrations, and individuals with less serious mental health conditions are treated in prison by healthcare professionals from the municipality in which they are detained. This may be in part due to the private-public healthcare system instituted in Norway which guarantees that all incarcerated individuals have the legal right to free private health care. It is in the interests of the Norwegian authorities to ensure that individuals receive health care services within the correctional system, as otherwise they would be responsible for paying for private health services at much higher costs.

Similar approach has been implemented in England and Wales. Since April 2006, provision of healthcare services in prisons in England and Wales has been covered by the National Health Service (NHS), the publically funded national healthcare system.[168] As noted in the report prepared by the House of Commons, "the granting of this responsibility was motivated by the government's desire to improve care within the correctional system and to emphasize that inmates, as an integral part of the community, should have access to healthcare services equivalent to those provided to all other British citizens" (p. 56).[169]

Evidence from England has been unequivocal in showing that the transfer of responsibility to the NHS has led to an improvement in the quality of care provided to incarcerated individuals. Moreover, it has done much to facilitate the recruitment of healthcare professionals within the correctional system, two of the current challenges faced by both the CSC and the MCSCS.

This shift in responsibility for health care delivery to correctional populations is not exclusive to Norway and the UK and has been also observed in other countries including Australia and France.

APIC Model for Release Planning

The APIC Model from the Substance Abuse and Mental Health Services Administration National GAINS Centre in the USA was identified as a promising practice model for assessment and release planning.[170] APIC is an acronym used to describe the process for coordinating effective mental healthcare assistance for an individual to successfully transition from the correctional system back into the community. The 'A' in APIC means assessing the one's clinical and social needs, and public safety risks; 'P' is planning for the treatment and services required to address the individual's needs; 'I' is identifying required community and correctional programs responsible for post-release services, and 'C' is coordinating the transition plan to ensure implementation and gaps in care.
This program is targeted to incarcerated individuals with concurrent disorders.

In terms of inter-sectoral collaboration, the APIC model recommends supporting the mental health workers, and ensuring that when an individual is assigned to a community treatment agency, the decision is made cooperatively by this individual, the correctional facility and the community agency itself. This model also recommends explicit communication to the individual, the family, the correctional facility and the community treatment agency about the name and contact information of the person(s) responsible for the care of the individual between the time of release from correctional custody and the first follow-up appointment with the community treatment agency.

A limited application of the APIC model in the form of a reentry checklist has been tested in two jails in Troy, New York and in Rockville, Maryland. APIC approach has shown some promising trends in reducing reincarceration of individuals with mental illnesses and concurrent substance use issues, and improving overall clinical outcomes of this population.[171]

Project LINK as Multi-Point Service Integration

Developed by the University of Rochester Department of Psychiatry in Rochester, New York, in collaboration with five local community agencies, Project Link is a university-led community consortium that spans healthcare, criminal justice and social service systems.[172] It was designed to prevent individuals with mental illnesses from entering the criminal justice system and is a hybrid model of care that incorporates elements of assertive community treatment (ACT), the modified therapeutic community, and jail diversion. The project features a mobile treatment team, a concurrent disorders treatment residence, culturally competent staff, and close coordination with the criminal justice system. In addition to providing direct services to individuals with mental illnesses, it also functions as a central locus of referral making connections between these systems.

Project Link effectively diverts persons with mental illnesses from the criminal justice system; helps recently released individuals connect with community mental health treatments and supports; and helps them with securing housing and income supports. The program receives referrals from law enforcement officers, mobile crisis teams, correctional staff, courts, attorneys, and probation and parole offices. Additional referrals come from local hospitals, emergency rooms, community inpatient and outpatient healthcare agencies, homeless shelters, churches, social service programs and advocacy groups.

Project Link is an innovative model of service level integration at multiple points within the criminal justice, healthcare and community support systems. It has been shown to effectively reduce the rates of reincarceration and ensure that persons with mental illnesses and criminal justice involvement receive comprehensive mental health services and supports.

The Hampden County Public Health Model for Corrections

In partnership with local community health centres, the Hampden County Sheriff's Department in Massachusetts developed a public health model to prevent, detect, and treat various health concerns among the inmate population at the Hampden County Correctional Centre and promote ongoing use of the community health care system upon release.[173] Through this approach a system was created in which correctional health care became an extension of the existing community health system.

Health care providers from community health centres were allowed to continue seeing their patients when they became incarcerated and worked collaboratively with the correctional staff to thoroughly screen other incarcerated individuals and provide early and effective treatment, education, prevention, and continuity of care after release. As a result, when the correctional centre identified an individual in need of medical services, his or her home ZIP code was matched with the closest community health centre. Physician and case manager from that neighborhood centre would then provide care while the individual was incarcerated and continue seeing him/her after release.

The Hampden County Correctional Centre's Public Health Model is recognized nationwide, and due to its effectiveness is being replicated across other jurisdictions in the United States.

START and Correctional Mental Health Programs in British Columbia

British Columbia implemented two innovative measures for incarcerated individuals with mental illnesses.[174] In order to ensure that these individuals are identified upon admission and to capture those who develop mental health issues as a result of being incarcerated, Short-Term Assessment of Risk and Treatability (START) program was developed. START is a risk assessment guide which has been implemented across entire health services in the USA, UK, Scotland, and Scandinavia.

START is a 20-item clinical guide for the dynamic assessment of seven risk domains (violence to others, suicide, self-harm, self-neglect, unauthorized absence, substance use, and victimization) and provides for the differential coding of both individual's strengths and needs, while allowing for the recording of case-specific risk factors.[175] The START team is now working on an electronic version (E-START).

Another initiative adopted in the province of British Columbia was a recent joint effort between correctional staff with the Corrections Branch and researchers at Simon Fraser University to design a mental health program for provincially detained individuals with mental illnesses at the Ford Mountain Correctional Centre (FMCC)[176]. The Program has been designed to be conducted across a five-month (20-week) period, emphasizing treatment and management of the individual's illness as well as the interruption of his/her crime cycle across three distinct phases:

1) Comprehensive psycho-diagnostic phase which includes assessment, monitoring and medication;
2) Intensive treatment phase with psycho-social and educational treatment modules. The teaching techniques in the modules incorporate positive reinforcement, modeling, shaping techniques, and role-play and rehearsal;
3) Community re-integration preparation phase.

At the time when the article documenting this program was written, FMCC program was still under development, and hence ongoing evaluation will be required to determine the extent to which the Program meets the needs of incarcerated individuals with mental illnesses.

Post-Incarceration Programs in Ohio

Post-incarceration programs (such as mental health probation and parole, and forensic assertive community treatment) have been proven to have a moderate to high degree of evidence of effectiveness in reducing recidivism and the number of days incarcerated[177]. Evidence shows that post-incarceration programs also have moderate effectiveness in increasing service utilization for individuals with mental illnesses, but a low degree of effectiveness in reducing substance use[178].

An example of successful post incarceration program can be found in Franklin, Ohio. In this jurisdiction there is a post-incarceration case management program the goal of which is treatment plan maintenance.[179] As part of this program, the case manager visits the local jail each week with referrals to the case management program coming from the central mental health agency in the county. The preliminary evaluation of this program shows promising results. Specifically, program outcomes included reduced time that individuals with mental illnesses have spent in jail, as well as reduced arrest rates.

Anti-Stigma Education in Australia's Corrections

Another promising practice approach used in the international corrections is the implementation of targeted anti-stigma training on mental health for correctional workers. For instance, in Western Australia, this type of anti-stigma training effectively encouraged a shift in correctional staff culture through targeted promotion of respect for individuals with mental health conditions.[180] The results of this approach are promising and have been shown to promote positive inmate – staff relationships. However, the available literature is brief on the details of this approach and reports note that it is yet to be implemented across Australia and other jurisdictions.

Conclusion

The goal of this discussion paper was to highlight current challenges that individuals with mental illnesses face in provincial corrections and to initiate a discussion on how Ontario's correctional system can be improved to better address the needs of this population. The available evidence was unequivocal that:

1. The needs of the individuals with mental illnesses are not adequately addressed in the current correctional system in Ontario.

2. While there is still a general paucity of research looking at the experiences of individuals with mental illnesses in provincial correctional facilities, it is evident that placing individuals with mental illnesses in correctional settings without the aid of the mental health treatments and supports promotes neither rehabilitation nor mental health recovery.

The issues discussed in this paper raised significant concerns with how correctional authorities understand and respond to mental illnesses. During Phase II of this research project, the Schizophrenia Society of Ontario will undertake further examination of the provincial correctional system in Ontario to close the above mentioned knowledge gaps and establish clear recommendations on how the system can be improved. It is our hope that this research project will not only illuminate the situation in Ontario's correctional system but will further lead to concerted and integrated effort from both the corrections and the mental health system to redress the gaps in service delivery to individuals with mental illnesses who come in contact with the law.

Glossary of Terms

Adult Institutional Services (AIS) - Division of the Ministry of Community Safety and Correctional Services that is responsible for adult incarcerated individuals, including remanded persons and those serving two years less a day.

Assessment: Medical, psychological or other examination of an individual, often by a qualified healthcare professional, with regard to a specific health/mental health issue, whether critical, pending, or routine. It is a selective and targeted process and is usually concerned with longer-term treatment planning and service coordination.

Bail - A court order permitting an accused person to be released from custody until their trial date.

Classification (Inmate Classification) – Level of supervision that incarcerated individuals may require in correctional settings that ensures safety and security of correctional institutions and determines most appropriate programming and custodial needs of incarcerated individuals. It is a continuous process that starts on admission and concludes when the sentence has been legally satisfied. In Ontario, all incarcerated individuals receiving sentences of less than two years are classified. (For those sentenced to 30 days or less classification is optional.)

Community Integration/Reintegration – Process of transitioning from the correctional settings back into the larger community. Factors that promote effective integration are: employment, access to affordable and stable housing, financial stability, social/family support, access to mental health services and supports, and sense of belonging.

Concurrent disorder – This refers to when an individual experiences mental health and substance use issues at the same time. In this context, a substance use involves the dependence or abuse of a legal or illegal substance as well as alcohol, but generally excludes nicotine.

Correctional Centre – Correctional institutions that house sentenced incarcerated individuals typically serving sentences from 60 days to a maximum of two years less a day.

Correctional Service of Canada (CSC) – Federal government agency responsible for persons sentenced to two years or more in institutions with varying security levels. CSC is also responsible for supervising persons on conditional leave in the community.

Criminalization – This refers to the process by which certain behaviours are interpreted as ‘crime’ or individuals are transformed into ‘criminals’.

Criminogenic Risk – Risk factors related to causation of crime and probability of re-offending used in offender management, to predict future criminal behavior and assign levels and types of interventions for correctional purposes.

Custody – The confinement, detention, or imprisonment of an accused/sentenced person under the law.

Detention - The act of physically constraining or holding/detaining an individual within a secure facility. This is a term used interchangeably with 'custody', 'hold' or 'confinement'.

Detention Centre – Large, modern correctional facilities built to serve the needs of several regions that operate as the point of entry into the institutional system. They are maximum security and house persons on remand, incarcerated individuals sentenced to short terms (approximately 60 days are less) and incarcerated individuals awaiting transfer to another correctional facility.

Discharge Possible Date - This is the earliest possible date an incarcerated individual may be released from custody taking into account all earned remission. It is equal to approximately two-thirds of the one's aggregate or combined sentence.

Diversion/Mental Health Diversion – Where appropriate, re-directing of people with a mental illnesses from the criminal justice system to mental health services. Diversion is an option for persons whose alleged offence is considered to be low risk and whose mental health needs can be met through services in the community.

Forensic Psychiatric Hospital – Secure facility operated by the province for individuals considered Unfit to Stand Trial or for those found by the court to be Not Criminally Responsible on Account of Mental Disorder (NCR).

Jail - Older, smaller correctional facilities established by counties or municipalities that operate as the point of entry into the correctional system. They are maximum security and house persons on remand, incarcerated individuals sentences to short terms (approximately 60 days are less) and incarcerated individuals awaiting transfer to another correctional facility.

Level of Service Inventory-Ontario Revision (LSI-OR) – An assessment tool used to assess recidivism of incarcerated individuals as well as their criminogenic needs and risks. It is used for institutional classification and release decisions.

Ministry of Community Safety and Correctional Services – Provincial Ontario ministry with jurisdiction over: incarcerated individuals 18 years of age and over who are sentenced to terms of imprisonment of less than two years, and/or; terms of probation of up to three years, or conditional

sentences of up to two years less a day; incarcerated individuals under parole supervision, as granted by the Ontario Parole Board; adults on remand; adults held for immigration hearing or deportation; incarcerated individuals awaiting transfer to federal institutions to serve sentences of two years or more.

Not Criminally Responsible (NCR) – A provision in the *Criminal Code of Canada* which states that no person is criminally responsible for an "act committed on account of a mental disorder" that rendered the person incapable of appreciating the nature and quality of the act or knowing that it was wrong.

Offender Program Unit – This unit is responsible for the design, implementation and evaluation of programming within Ontario's Corrections.

Office of the Correctional Investigator – The Correctional Investigator operates as an ombudsman for federally incarcerated individuals and is responsible for the investigation and resolution of incarcerated individuals' complaints while also addressing systemic issues through making policy and procedural recommendations to the CSC.

Parole – A conditional release from a correctional institution that permits the individual to serve the remainder of his/her sentence in the community under the supervision of a probation/parole officer.

Probation - A sentencing alternative which permits a judge to order that an individual remain in the community under the supervision of a probation officer for a specified length of time, not more than three years.

Provincial Corrections/Provincial Correctional Institutions – Correctional centres, detention centres, jails and treatment centres under jurisdiction of Ministry of Community Safety and Correctional Services that are responsible for supervising all individuals over the age of 18 years that are sentenced to two years less a day.

Racial Profiling – Any action undertaken for reasons of safety, security or public protection that relies on stereotypes about race, colour, ethnicity, ancestry, religion, or place of origin rather than on reasonable suspicion, to single out an individual for greater scrutiny or different treatment. It can occur because of a combination of the above factors and age and/or gender can influence the experience of profiling.

Recidivism - Tendency to relapse into criminal behaviour.

Recovery – Fluid term used most often to describe the ability to have a good quality of life even with the presence of a mental illness.

Regional Treatment Centres – Accredited psychiatric institutions that provide a range of clinical, correctional and related services to meet the needs of federally sentenced adults with severe psychiatric issues.

Release Planning/Discharge Planning – Activities preformed by correctional staff to facilitate transition from correctional setting back into the community to ensure continuity of care and successful community reintegration. Release planning involves identifying necessary community supports (treatment, housing, income supports, etc) and connecting incarcerated individuals with these supports prior to their release from the correctional institution.

Remand Population - Accused individuals held in custody at the correctional institutions while awaiting bail, trial, or sentencing. Remand is a provincial/territorial responsibility.

Risk Assessment - Use of clinical and situational factors together with actuarial risk information to form opinions of risk and strategies to prevent future violent or criminal conduct. Risk Assessments answer two general concerns. First, how likely is an individual to commit a new offence? Second, what can be done to decrease this likelihood?

Screening/Screeners – A screening process is intended to be an efficient way of raising a "red flag" about the possibility of a particular mental health and/or substance use issue or problem area, and a need for a more detailed assessment that informs service and treatment planning. Screening is done universally (i.e., virtually all clients) and the results of the screening inform the need for immediate action (typically additional assessment but perhaps also referral and linkage to other services).

Segregation/Administrative Segregation – Placement of incarcerated individual in an isolated unit out of concerns for the safety and security of the staff and other inmates. It also can be accessed voluntarily when an incarcerated individual is concerned for their own safety.

Sentence - The punishment given to a person who has been convicted (i.e. found to be guilty) of a crime.

Special Needs Units – Units within correctional facilities for individuals who been assessed as having serious mental illness.

Stigma/Stigmatization: Negative attitudes (prejudice) and negative behaviour (discrimination) toward others. People who have identities that society values negatively are said to be stigmatized.

Treatment Centre – Medical facilities under the jurisdiction of Ministry of Community and Correctional Services that provide mental health programming to incarcerated individuals in provincial correctional settings.

Unfit to Stand Trial – If a person is unfit to stand trial, this means that they are unable on account of mental disorder to (a) understand the nature or object of the proceedings, (b) understand the possible consequences of the proceedings or (c) communicate with counsel.

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