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Unlocking the doors to Canadian older inmate mental health data: Rates and potential legal responses

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ABSTRACT

This article is based on a quantitative study investigating the quality of life of older Canadian prisoners. For this study, social science methodology was used to answer certain legal questions, such as: what are the mental health issues of older male offenders and how are these needs influencing the exercise of their legal rights? Are institutions prepared to deal with the increased needs of older offenders? If no, is this an infringement of this group's rights?

In this article, the mental health problems of older offenders are first outlined. Second, the legal, policy, and institutional limitations in responding to these problems are described. Based on these findings, it is maintained that a change in the treatment of older offenders is needed. Third, statutory and constitutional challenges are explored. If change does not come voluntarily, it is the duty of the courts to have a flexible and open-minded approach toward different actions that challenge the current prison regime.

1. Introduction

The World Health Organization (WHO) pointed out that one million prisoners worldwide suffer from psychosis or depression. Of the nine million people incarcerated around the world, half struggle with personality disorders. Nearly all experience depressed moods and stress symptoms, while thousands commit suicide annually. 4% of male and female prisoners suffer from psychotic disorders; 10% of male and 12% of female prisoners have major depression; 42% of women and 65% of men struggle with personality disorders (including 47% of men and 21% of women who have antisocial personality disorder); 89% present with depressive symptoms, while 74% have stress related somatic symptoms. WHO considers that the main contributing factors are loss of liberty, limited connections to family and friends, overcrowding, dirty and depressing environment, poor food, inadequate health care, aggression, lack of purposeful activity, availability of illicit drugs, solitude, lack of privacy, and guilt or shame (Moller, Stiver, Jurgens, Gatherer, & Nikogosian, 2007, pp. 133–134).

In Canada, mental health care in prison is an issue that has received a good deal of publicity. The Office of the Correctional Investigator (OCI) is a statutory institution that plays the role of an ombudsman for the federal prisons (which are operated by the Correctional Service Canada). The OCI has produced numerous reports related to the status of inmates incarcerated by the Correctional Service Canada (CSC) and their main problems. The Correctional Investigator (CI) focused on the issue of mental health in his 2009–2010 report. He reported that there is a 20% vacancy in mental health staff positions, while 37% of male prisoners and 50% of females have some symptoms of mental health problems and need an additional assessment (Sapers & Office of the Correctional Investigator, 2010). In the 2012–2013 report the CI reiterated his concerns regarding the improper care for mentally ill prisoners, the fact that they are being segregated, pepper-sprayed, and restrained instead of being sent to a community hospital for help (Sapers & Office of the Correctional Investigator, 2013). In a study made with 1300 incoming prisoners, the results described 38.4% as having mental problems. Of these, 20% were suicidal, 29.9% suffered obsessive–compulsive disorder, 36.9% had depressive symptoms, 31.1% suffered anxiety, 30.6% had paranoid ideation, and a startling 51% had a form of psychosis (Sapers & Office of the Correctional Investigator, 2011).

The use of segregation by the CSC in dealing with mentally ill prisoners is notoriously wide-spread and has been making headlines in the last 3 years. The cases of Ashley Smith and Edward Snowshoe, two of the CSC inmates known to had suffered of mental illnesses and who committed suicide while in segregation, brought this problem to the attention of the Canadian public (Fine & Wingrove, 2014; MacKinnon, 2014; Picard, 2014; White, 2014; Wingrove, 2014). The press has not been the only one to push for a change in the use of solitary confinement for the mentally ill. The OCI has issued reports and made recommendations on this matter (Howlett, 2014; Mackarel, 2015). In a 2014 report on inmate suicides, the OCI established that almost half of the suicides were committed while the prisoner was in segregation. The OCI's investigation found that segregation was the number one way of dealing with suicidal inmates even though it was a fact that segregation was a risk factor. The report concluded that all of the suicides investigated could have been prevented had a better strategy been in place (Office of the

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Correctional Investigator, 2014). Currently, a challenge to the use of solitary confinement is before the courts in British Columbia due to the action brought by the BC Civil Liberties Association and John Howard Society (Fine & Wingrove, 2014).

In addition to the burdens placed by mental health issues on the correctional systems, a new problem has arisen especially in the last decade: the aging of the prison population. In the last few years, the problems associated with aging have been noted in correctional environments. While in the US substantial studies have been conducted since the '90s (Aday, 2003; Ardnt, Turvey, & Flaum, 2002; Colsher, Wallance, Loeffelholz, & Sales, 1992; Delgado & Humm-Delgado, 2009; Ornduff, 1996), Canada has been slow in recognizing the problems associated with the aging of the prison population. A change of direction occurred 5 years ago at least at a theoretical level, when the Office of the Correctional Investigator published in the Annual Report serious concerns regarding the needs and the treatment of older prisoners in Canadian Federal Corrections facilities (Sapers & Office of the Correctional Investigator, 2010). The Correctional Investigator continued to express these concerns in the years that followed, albeit with a limited response from the Correctional Service Canada (Sapers & Office of the Correctional Investigator, 2013). The CSC published in 1998 the results of a brief study titled "Managing Older Offenders: Where Do We Stand" (Correctional Service Canada, 1998). This was followed by "Older Offenders in the Custody of Correctional Service Canada," (Correctional Service Canada, 2014a,b) a study that brings demographic and criminogenic data about older offenders. The only study conducted in Canada outside the CSC that considered the problems of male older offenders was completed two decades ago. It was conducted with a small sample in BC (Gallagher, 2001). There have been no other Canadian studies conducted with older offenders until now.

Because of a lack of data, there is very little information known about the particularities of older adults' mental health status in Canadian federal corrections. The present study was intended to bring some data regarding the health and well-being of older Canadian federal prisoners. This article deals with data collected in regard to the mental health status of inmates over fifty, the care they receive and their self-reported needs. Fifty is used as the lower limit of seniority because this is the threshold employed by the Correctional Service Canada, who established that an incarcerated offender has the health problems of an individual 10 to 15 years older than him in the community (Correctional Service Canada, 1998). The ultimate purpose of this article is to interpret the data collected from a legal perspective. Hence, the data is a means of identifying the mental health issues of older offenders. The goal is to use these means to trigger the improvement of the management of mentally ill inmates. Based on the findings, an argument is advanced that an efficient legal action based on s. 12 of the Canadian Charter (the right to be free from cruel and unusual treatment or punishment) is a sensible approach to protecting the needs of older offenders when they are not institutionally met. By comparison with other jurisdiction, it will be shown that a better application of this section is possible within the Canadian framework and that some of the issues faced by the mentally ill older offenders fit within the description of "cruel and unusual treatment or punishment."

2. Methodology

The study on which this article is based was focused on determining the general quality of life of incarcerated older offenders in order to better understand the extent to which their rights were being upheld. For the purpose of this study, quality of life included the satisfaction of prisoners with their own health, the perceived quality of the treatment received in prison, of programming available, adjustment to the prison environment, the maintenance of family relations, as well as the presence or absence of abuse. The issues explored by this study lie at the crossroads of law, policy, social and health sciences. More exactly, social science empirical methodology was employed to answer legal questions pertaining to the protection of prisoners' rights. As such, the main research questions were: What are the needs of older offenders and how are these influencing their legal rights? Are institutions prepared to deal with the potentially increased needs of older offenders? If no, is it an infringement of this population's rights? Is the Canadian legal framework adequate to offer protection to the vulnerabilities of the older prison population?

In order to answer all of these questions, methodology was developed to determine the needs (health, social, environmental) reported by older offenders (which were presumed to be similar to or greater than those mentioned in the existing literature regarding the older community population) and to discover how the institutions were meeting these needs.

After receiving ethics approval from Queen's University General Board of Ethics Board, 197 interviews were carried out in 7 federal institutions. In 2012, when the study commenced, the population of male offenders over fifty in federal corrections was roughly 2000, according to data provided by the Correctional Service Canada. All institutions were from Ontario. All levels of security were represented: there were three medium security (both lower and high medium), two minimum security and one maximum security institution, as well as an assessment unit. In Canada, in maximum security individuals are locked-up in their cells for most of the day. The most dangerous offenders who cannot be managed elsewhere are supposed to be housed in such institutions. Medium security is characterized by strict control, but offenders have more time out of their cells, and have access to more programs and activities than in maximum security institutions. Some lower forms of medium security even provide house-style accommodation, where prisoners prepare their own food. Minimum security is the most relaxed level of security, where offenders are generally free to move around the perimeters of the institution, often live in house-style quarters and prepare their own meals. Escorted and unescorted passes in the community, as well as community work permits are more common at this level. These institutions are meant to prepare the offender for release.

Recruitment was carried out in each institution separately, either via posters and recruitment letters or via group presentations. Participation was purely voluntary and nobody who asked to be interviewed was turned down. On average, 1/3 to 1/2 of the eligible offenders (offenders over 50) were interviewed in each of the institutions visited. The smallest number of participants in one institution was seven and the largest was thirty six. The youngest interviewee was fifty and the oldest was eighty two. It was impossible to obtain a truly random sample. Initially the hope was to do group presentations for all eligible individuals and offer them the possibility to sign up if interested. Afterward thirty to thirty three of the individuals were to be randomly picked. However, it was possible to employ this type of recruitment only in two institutions. For the rest, recruitment was done by posters or letters. While in the two institutions where group presentations were given the volunteering rate was high, in the rest it was much lower. As a result, everybody who signed up was interviewed. The other main recruitment issue was that the presentation, be it verbal or through letters, probably did not reach the people who did not speak English, who were bedridden, had severe mental illnesses, or were illiterate. It was not possible to carry out interviews in the inmates' units. Hence the people with serious mobility problems were from the start precluded from participating. While many of the participants were seriously ill, none was terminally ill. In each institution there were rumors about terminally ill people being in excruciating pain. However, this was all second hand information.

The interviews were carried out over a six month period. Each interview was pre-scheduled and took between 30 and 60 min. The interviews were based on a structured protocol of seventy-one questions. The protocol had a number of sections and the questions in each section were developed based on similar studies that have been conducted elsewhere (especially in the USA and the UK) (Aday, 2003; Howse & Centre for Policing and Ageing Trust Reform, 2003) and on problems associated

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