

Challenges for Canada in Meeting the Needs of Persons with Serious Mental Illness in Prison

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The number of prison inmates is predicted to rise in Canada, as is concern about those among them with mental illness. This article is a selective literature review of the epidemiology of serious mental illness (SMI) in prisons and how people with SMI respond to imprisonment. We review the required service components with a particular focus on care models for people with SMI in the Canadian correctional system. An estimated 15 to 20 percent of prison inmates have SMI, and this proportion may be increasing. The rate of incarceration of aboriginal people is rising. Although treatment in prison is effective, it is often unavailable or refused. Many of those with SMI are lost to follow-up within months of re-entering the community. There is much policy and service development aimed at improving services in Canada. However, the multijurisdictional organization of health care and the heterogeneity of the SMI population complicate these developments.

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Canada's 2008 incarceration rate of 116 per 100,000 people has been stable over recent years, and while similar to many Western European countries, is 15 percent of the U.S. rate of incarceration.¹ The Canadian rate is predicted to increase, however, with the government's tough-on-crime legislative reforms.² With this, the mental health of Canadian prison inmates is a community concern and the Mental Health Commission of Canada has made it a matter of strategic importance.³

The purpose of this review is to summarize the current knowledge regarding serious mental illness (SMI) in prisons, with particular focus on Canadian prisoners. The findings of several recent meta-analyses covering aspects of SMI, substance misuse, and personality disorders in prisons, provide the context for discussion of the particular challenges for Canada in developing its service response to SMI in prisons. This review of the current provision of mental health

services in Canadian prisons highlights the need for a coherent strategy to improve them.

In this article, the term prison inmates includes pretrial and sentenced inmates. SMI refers to psychotic, bipolar, and major depressive disorders, although we will also discuss the risk and management of suicide in custody. Although substance use and personality disorders are very common in prisons and are often comorbid with SMI, this article does not cover treatment needs for those disorders.

Epidemiology of SMI in Prisons

Prevalence

The prevalence of SMI in prisons was the subject of a comprehensive meta-analysis by Fazel and Seewald in 2012.⁴ Their review of 109 samples included 33,588 prisoners in 24 countries. Of the male prisoners, 3.6 percent had psychotic illnesses, and 10.2 percent had major depression. Of the females, the prevalence rates were similar, at 3.9 and 14.1 percent, respectively. These results are consistent with those reported in a 2002 meta-analysis by Fazel and Danesh.⁵ However, the 2012 study reviewed rates of psychosis in prisoners in low- and middle-income countries and found that the rates were significantly

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higher than in high-income comparators. Commonly, 15 to 20 percent of prison inmates have disorders that require psychiatric treatment, such as psychosis, major depression, and bipolar disorder.^{6,7} These studies and other recent reviews have indicated that the rates of SMI are substantially higher in prisons than in the general population.^{8,9}

In the United States, this overrepresentation may be attributable to the significantly higher likelihood that persons with SMI will be jailed rather than hospitalized.¹⁰ Teplin¹¹ reported that individuals who display symptoms of SMI have a 67 percent higher probability of being arrested than do individuals who do not display such symptoms. Following arrest, individuals with SMI are more likely to be detained in jail (as opposed to being released on their own recognition or having their cases dismissed) and, once jailed, they stay incarcerated 2.5 to 8 times longer than their non-mentally ill counterparts.¹²

Suicide is the cause in up to 75 percent of pretrial inmate deaths and 50 percent of sentenced inmate deaths. These rates are 3 to 11 times higher than in the general communities from which the prisoners are derived.¹³ Canadian prison suicide rates are similar to those in New Zealand and Australia and are generally lower than in Europe. The suicide rate of released inmates remains higher than that of the general population.¹⁴ Factors most strongly related to prison suicide include solitary cell placement, a life sentence, pretrial status, recent suicidal ideation, current psychiatric diagnosis, and treatment with psychiatric medication.¹⁵

Is Mental Illness Becoming More Common in Prisons?

It remains unclear whether the absolute number of persons with SMI in prison is rising simply because more people are being imprisoned, because more mentally ill people are being detected through better screening of those entering prison, or because the prevalence of SMI among those incarcerated is increasing. Three major studies have examined this question. In Washington state, Bradley-Engen *et al.*¹⁶ found no increase in the prevalence of major mental disorders from 1998 to 2006, although they did find a rise in comorbid substance misuse. Sawyer *et al.*¹⁷ found no difference in the prevalence of mental disorder in young people in detention in 2008–2009, compared with that reported 10 years prior. However, a Finish study of psychiatric hospitaliza-

tions of prisoners¹⁸ found that 2.6 percent of prisoners had a diagnosis of psychosis in 1984–1985, whereas 6.5 percent had the diagnosis in 1994–1995. There was also a significant increase in substance use, but rates of depression remained stable.

Fazel and Seewald⁴ noted that in the 17 U.S. cross-sectional samples, there appeared to be a trend of increasing prevalence of depression over the 31 years from 1975 to 2005. However, no statistically significant increase in the prevalence of either psychosis or depression was found.

What Happens to the Severity of Illness During Imprisonment?

Being imprisoned is a stressful experience, and prisons are inherently stressful environments. However, the effects of these stressors on people with SMI have not been rigorously investigated. There are studies showing that acute psychotic symptoms^{19,20} and overall levels of distress^{21,22} decrease during the early period of incarceration. Hassan *et al.*²⁰ noted that there was a reduction in symptoms among the sentenced men but not among pretrial male and female inmates, who continued to report persistent levels of distress.

Longer periods of incarceration of SMI inmates may lead to more mental health symptoms.²³ If SMI is left untreated, lengthy imprisonment may lead to disruptive, noncompliant, and aggressive behavior in the inmate in reaction to the requirements of prison life.²⁴ Psychiatric instability may be increased by placement in solitary confinement²⁵ or sexual and physical assault while in custody.²⁴ Further, institutional misconduct prevents individuals with SMI from participating in programs, thus limiting parole eligibility.²⁶ In contrast, Fazel and Seewald⁴ reported that there was no significant overall difference in the prevalence rates of depression or psychosis between pretrial and sentenced prisoners in pooled cross-sectional studies.

Does Treatment in Prison Work?

Despite the availability of mental health treatment, inmates with SMI may choose not to participate in treatment because of concerns about reputation and confidentiality, prior experience, and individual demographics (e.g., minorities in prison report more negative attitudes about mental health services) or because of symptoms of mental illness.²⁷ The presence of SMI often limits the individual's insight into his illness and the need for medication

Table 1 Prevalence Studies of Serious Mental Illness in Canadian Prisons

Study	Sample and Measure Used; Tool	Prevalence of SMI (Lifetime)
Bland <i>et al.</i> ³⁵	180 Provincial inmates, random sample; DIS	Schizophrenia (2.2%) Mania 3.3% (4.4%) Depression 13.9 (16.7%)
Motiuk and Porporino ³⁶	2812 Stratified federally sentenced males, random sample; DIS	Psychosis 3% (10.4%) Depression 5% (21.5%) dysthymia included
Gingell (unpublished data)	317 Consecutive city jail admissions; 107 random federal inmates; BPRS, DIS	Schizophrenia 8%
Hodgins and Cote ³⁷	495 Federal inmates, random sample; DIS	Psychosis 5% BAD 2.8%, MDD 7.5%
Roesch ³⁸	790 Remand inmates, consecutive sample; DIS	Schizophrenia 5%
Arboleda-Florez <i>et al.</i> ³⁹	1151 Remand inmates, random sample; SCID	Schizophrenia 1% Mania 0.4%, MDD 3%
Blanchette and Motiuk ⁴⁰	76 Female federal (57% of total female population) inmates, non-random sample; DIS	Depression 33%
Wormith and McKeague ⁴¹	2500 Offenders, survey of parole files; File review	Psychotic disorder (8.9%) Mood disorder (15.5%)
Corrado <i>et al.</i> ⁴²	192 Male remanded inmates, random sample; DIS	Schizophrenia 4.9% Mania 4.1% Major depression 6.1%
Brink <i>et al.</i> ⁴³	202 Male federal newly sentenced inmates, random sample; SCID	Psychosis (5.5%) MDD 4.5% (18.3%) Bipolar 0.5% (2%)

BAD, bipolar affective disorder; BPRS, Brief Psychiatric Rating Scale; DIS, Diagnostic Interview Schedule; MDD, major depressive disorder; SCID, Structured Clinical Interview for DSM Disorders.

and other health services.²⁸ Skogstad *et al.*²⁹ and Howerton *et al.*³⁰ found that inmates who are suicidal may intentionally hide their mental state out of concerns about restrictions. Two studies found that about half of the most disturbed inmates received no services for a period of up to one year.^{31,32} A national U.S. survey conducted from 2002 to 2004 showed that a third of prisoners with diagnoses of schizophrenia or bipolar disorder were not treated with psychotropic medication.³³

In terms of efficacy, a recent review by Morgan *et al.*³⁴ suggested that interventions for offenders with mental illness effectively reduces symptoms of distress, improves offenders' ability to cope with their problems, and results in improved institutional adjustment and behavioral functioning.

Mental Illness in Canadian Prisons

Canadian prevalence studies of SMI in prisons are summarized in Table 1. These findings are generally similar to those of international studies. Overall, SMI rates are as much as three times higher than in the general population,^{43–45} yet there is some variation between studies, given the smaller sample sizes.

Similar to meta-analytic findings, there is no significant gender difference in SMI inmate prevalence rates.

From 1996–1997 to 2009–2010, the average annual suicide rate among Canadian federal inmates was about 3.7 to 7.4 times higher than in the age-matched general population.⁴⁶ This rate is similar to the increased risk found in most Western nations.⁴⁷ Serious self-injurious behavior with suicidal intent has been found to be similar across pretrial and sentenced populations and is higher in women (35%) than in men (20%) (Brown GP, unpublished data).

Evidence from self-reported data and rates of prescriptions given for psychotropic medications suggest that the problem of SMI in prisons is getting worse. A recent federally commissioned report⁴⁸ using self-report data found that 12 percent of male inmates and 21 percent of female inmates have significant symptoms of SMI on admission to a federal correctional institution. This rate is an increase of 61 and 71 percent, respectively, since 1997. However, the data have not yet been validated against a research-based diagnostic tool, and it is therefore unclear whether this rising rate of reported distress

translates into increased rates of specific disorders. As regards prescription rates, the number of persons entering the federal system who are given psychotropic medication has nearly doubled in the past decade, to a 2008 rate of 21 percent of inmates receiving these medications while incarcerated.¹

A comparison of needs assessments conducted by Correctional Services of Canada (CSC) in 1996 and 2002 also indicated that SMI is an increasing concern for federally sentenced women. A 1996 needs assessment for federally sentenced women found there were very few female inmates with a major mental illness (e.g. schizophrenia, psychotic depression, bipolar disorder, or an organic syndrome).⁴⁹ By 2002, a report⁵⁰ indicated that incarcerated women had a lifetime prevalence of schizophrenia of 7 percent and a lifetime prevalence of major depression of 19 percent (compared with community prevalences of 1% and 8.1%, respectively), in contrast to the “very few” mentioned in the 1996 assessment.⁴⁹

The factors accounting for an increased prevalence of SMI in prisoners in Canada are very likely the same as those found in the rest of the developed world. As previously noted, inmates with a diagnosis of a mental disorder are less frequently granted full parole and, once released, are more likely to be reincarcerated for technical breaches of the conditions of release.⁴³ In an Ontario, Canada study, Brown found that having a high number of severe symptoms of SMI correlated with a lower mean time to reincarceration; that is, those individuals with multiple symptoms were reincarcerated more quickly than those with fewer symptoms. However, time to reincarceration was not related to the severity of symptoms among SMI inmates (Brown GP, unpublished data).

A factor that may contribute to increased rates of SMI in Canadian prisons is the growing aboriginal prison population. While the First Nations, Métis, and Inuit aboriginal peoples comprise less than 4 percent of the general population, they account for 20 percent of the federal prison population.⁴⁶ Aboriginal women offenders comprise 33 percent of the female inmate population under federal jurisdiction, which represents an increase of almost 90 percent in the past 10 years. The proportion of aboriginal inmates with SMI at admission increased from 5 percent in 1996–1997 to 14 percent in 2006–2007, but was down to 9 percent in 2008–2009.⁵¹ Male and female aboriginal inmates reported similar rates of

serious self-injurious acts (30%) (Brown GP, unpublished data).

Necessary Service Responses

Livingston⁵² described minimum standards and best practices of mental health services in prisons. He noted that prison inmates have full rights to receive care appropriate to their health needs in accordance with internationally recognized principles.^{53,54} The U.S. Supreme Court⁵⁵ has reaffirmed in California that medical and mental health care for prisoners is a right guaranteed by the Fourteenth Amendment of the U.S Constitution.

Essential services for inmates include screening for mental disorders at reception, acute and nonacute treatment services, programs to meet their needs while in custody, and preparation for release and engagement with community mental health services on release. In shorter stay prisons, the major functions are screening, assessment, and stabilization, with handover to community agencies on release. In longer stay (federal) institutions, services must include a full continuum, including pharmacological treatment, services for special populations, residential treatment for offenders with serious mental illness, crisis observation and intervention (which may take place in psychiatric wards at local hospitals), disciplinary housing treatment (higher security prisons or areas), inpatient psychiatric hospitalization, and pre-release treatment services.

Screening for SMI is a crucial component of prison mental health services and is usually performed by a primary health care professional at the point of reception into custody. The aim of screening tools is to detect persons likely to have an SMI who require more detailed mental health assessment. There are three major tools developed for this purpose. The Brief Jail Mental Health Screen (BJMHS)⁵⁶ is widely used and comprises eight questions (six symptom questions and two historical questions). It has been validated against the Structured Clinical Interview for DSM-IV (SCID-L) for men and women.⁵⁷ Another is a mental health screen of only five questions on past treatment and current criminal charge developed by Grubin⁵⁸ in the United Kingdom. The third tool is the Correctional Mental Health Screen,⁵⁶ which has a structure similar to that of the BJMHS, but with 12 items.

Evans *et al.*⁵⁹ found that either the BJMHS or the Grubin tool worked adequately for detecting psy-

chotic illness, but neither performed well at detecting depressive disorders, because inmates commonly endorse depressive symptoms at entry into prison. Screening for suicide risk and follow-up assessments are essential, and policies for suicide risk reduction should be built into the design and function of prisons.⁶⁰

Bauer *et al.*²⁴ defined treatment for inmates with SMI as including basic mental health and rehabilitation services, the latter focusing specifically on reducing criminal behavior and recidivism. Rehabilitation should attend to both mental health treatment and criminogenic factors most commonly embraced by the risk-need-responsivity model.⁶¹ Sawyer and Moffitt⁶² noted that, although reducing recidivism is an important goal for those working within the criminal justice system, correctional treatment is often focused on more proximate goals, such as symptom reduction and assisting inmates with mental illness to cope in the correctional environment.

Specialized psychiatric care units, also known as residential treatment centers, have been identified as best practice for dealing with the difficulties associated with mainstreaming inmates needing mental health services.^{52,63} Specialized care units are most appropriate for inmates with mental health problems who are unable to function adequately in the general offender population, but do not require hospitalization.^{64,65} The purpose of these specialized care units is to enable adequate observation of inmates with SMI and to stabilize and transition them into the prison mainstream. These units have been associated with reductions in institutional crises and management problems and improvements in inmate quality of life.⁶⁴

Preparation for release and engagement with follow-up are essential. In a systematic review, Fazel and Yu⁶⁶ found that persons with SMI have a moderately higher risk of repeat offending than do persons without SMI and noted that improvements in their treatment and management while in custody and after release have the potential to make a positive impact on public health.

Comprehensive discharge planning should follow community standards and include a guaranteed supply of medication and appointments with outpatient clinics, psychiatrists, or other counseling services. The involvement of prison and parole authorities is vital in achieving successful care transition into the community. A recent study found that nearly all of

those with SMI are lost to follow-up after six months in the community.⁶⁷ This population can be difficult to engage on a long-term basis and may require special assertive community treatment (ACT) team involvement.

After release and while on parole, traditional ACT models may improve engagement and symptom reduction, but they do not appear effective in keeping persons with mental illness out of the criminal justice system.^{68,69} Enhancing ACT to include criminogenics (so-called forensic ACT or FACT) has a limited, but promising, body of literature to support it. Lamberti *et al.*⁷⁰ performed a national survey of FACT teams in the United States and identified a set of common structural elements that distinguish them from traditional ACT models. These elements include the goal of preventing arrest, receiving referrals from local jails, incorporating probation officers as FACT team members, and having a supervised residential component for consumers with SMI and substance abuse disorders. Jennings⁶⁸ argues that emerging research from the forensic continuum of care model suggests that community aftercare programs such as ACT can be enhanced by pretreatment in prison or in a community residential treatment precursor.

Challenges

There are two main challenges in meeting the mental health care needs of prisoners in Canada. The first relates to the multijurisdictional context of health care provision, and the second relates to the demand for services that outstrip the current resources.

In Canada, the provision of health services is a provincial responsibility, and each province and territory has its own health system and legislation, including civil commitment laws. Mental health care in all correctional institutions is governed by the mental health act of the province or territory in which it is located, regardless of whether the institution is a federal or a provincial one.

The Criminal Code derives from federal legislation, but pretrial inmates and all inmates serving sentences of less than two years are a provincial responsibility. Federal corrections, known as Correctional Services of Canada (CSC), provide services for all prisoners sentenced for two years or longer. Service and delivery of health care in federal prisons are man-

dated by the Corrections and Conditional Release Act of 1992.⁷¹

There is no Canadian health service entity that could undertake delivery of services in all correctional institutions; to create one would most likely require legislative change. Thomas⁷² concluded that a full transfer of health care provision to a new pan-Canadian body is untenable at this time and that the focus should be on extending the partnership models where CSC maintains full responsibility for health care, but partners with the regional Ministries of Health for the delivery of specialized services.

As it stands now, federal regulations require the provision of “essential health care” and “reasonable access to mental health care.” Every institution is required to provide an appropriate clinical response for inmates with an SMI, which includes being placed under close observation of trained staff, assessed by a health professional, and provided support and treatment. A specialist should be available for consultation “at all times.” Transfer to an appropriate health care facility should be available “as soon as possible.” Before disciplinary action is imposed on an inmate identified as having an SMI, consultation should take place with a mental health professional. Inmates with serious acute or chronic mental health problems should be housed in an environment that offers a safe and therapeutic milieu.⁴⁶ In recent years, this CSC mandate has necessitated significant increases in resources for mental health services in federal institutions.

Progress

In 2004, the CSC instituted a Mental Health Strategy that included an Institutional Mental Health Initiative (IMHI) focusing on intake screening, assessment, and primary mental health care teams. Included in the IMHI is a computerized intake screening system to signal inmate mental distress, which can then be further assessed with a view toward developing an individualized plan by a Primary Mental Health Care Team. To assist in SMI inmates’ reintegration into the community, the CSC implemented a Community Mental Health Initiative (CMHI), which included hiring new staff (discharge planners, mental health care specialists, and parole officers), providing staff training, and working with community health organizations. The IMHI coordinates with the CMHI teams to provide a continuum of care.⁷³

CSC has also established five specialist psychiatric care units, called regional treatment centers. CSC acknowledges that bed capacity in these centers meets only 50 percent of the identified need,⁴⁶ resulting in occasional double bunking of inmates in segregation. Notably, three of the five women’s facilities in the Atlantic, Quebec, and Prairie regions have an exemption that allows double bunking of women offenders in their secure (maximum security) units. In some provinces, CSC has an arrangement with a provincial hospital to accept transfer of inmates needing acute mental health intervention. This model has shown positive results, and the CSC has recommended expanding this availability for SMI inmates who cannot be treated at specialized psychiatric care units.⁷²

The tragic death by suicide in 2007 of Ashley Smith, a 19-year-old woman detained in a federal institution, has been a significant stimulus to improve services. Several investigations produced broad recommendations for change and spurred dialogue between the CSC^{48,72} and its critics.^{74,75} Correctional Investigator Howard Sapers⁷⁴ recommended a broad review of the provision of mental health care in correctional environments and the consideration of alternative models of care. Needs identified for improvement include training for correctional staff regarding care provision for inmates with mental health needs, triggers for notification and investigation (including self-injurious acts and lengthy segregation periods), consultation by mental health professionals, and improvement in the ease of transfer to a specialized care unit or a hospital.

CSC responded to the call for considering alternative models of care.⁷² Given the complexities of geography and differing provincial health systems, a one-size-fits-all approach was not feasible across Canada. Instead, a continuum of care was presented that ranged from having CSC be responsible for the health service but contracting various mental health professionals to staff clinics (the usual service model) to the full transfer of responsibility of all health service delivery to provincial health authorities. The latter has been accomplished in some provincial institutions in Nova Scotia and Alberta, as it has in other international jurisdictions such as Norway and the United Kingdom. These transfers, not only of services but also of the legislative responsibility of health care provision, have been costly; a similar proposal in New Zealand failed primarily because of funding

concerns. The transfer of health services from corrections staff to health-trained and dedicated staff seems, *prima facie*, to be beneficial with respect to access, quality, and standards of care. Such a shift in responsibility allows for more effective transition on reintegration into the community, and a strengthening of the voice of mental health services in the correctional environment.

As noted, the multijurisdictional context of the Canadian health system makes planning for prison mental health services complex. It was only in 2007 that the government of Canada mandated that the Mental Health Commission develop a national strategy for mental health care.³ This document was released in 2012. It included recommendations to reduce the overrepresentation of persons living with mental health needs in the criminal justice system and to provide appropriate services, treatment, and support to those who are in the system.

Although progress has been made in meeting the mental health care needs of Canadian prisoners, further resources and planning are necessary. For example, a proposal to create dedicated intermediate care units on a regional basis to support specialist psychiatric care units has not been funded. These units fall between care provided at a mainstream correctional institutions and acute inpatient care offered at the specialist psychiatric units.⁴⁶ Further, barriers to providing mental health care in the correctional system include poor recruitment and retention of mental health professionals, inadequate bed space at specialist psychiatric care units, lack of funding, underutilization of clinical management plans to treat high-needs mentally disordered offenders, and overreliance on segregation to manage offenders with mental health problems.^{46,76} Wait times for psychiatric assessment have been increasing in the past decade because the increasing number of persons to be assessed is outstripping the forensic mental health services' ability to respond.⁷⁷

Discussion

This review touches on some key points in the large and expanding area of public policy, clinical need, and research. Persons with SMI in the criminal justice system are some of the most marginalized, disenfranchised, and underserved patients in need of mental health care. Their increasing number appears to be a result of both tougher criminal justice policies and limited community mental health services. They

are hard to engage, frequently receive few or no services, and can rapidly drop out of care after release into the community. The lack of continued care leads to problems of disability, social instability, substance misuse, illness, and criminality. These problems are not insurmountable. Inmates with SMI respond to treatment and benefit from well-coordinated services. These services must be run in partnership between health and correctional systems.

Given current government policies that cause an increase in the number of prisoners, the need for service development is becoming more acute and demands a coherent service and policy response.

We know too little about the trends, needs, and service models for persons with SMI in prisons. We also have limited understanding of the effects of incarceration on persons with SMI. We cannot assume that the problems will be the same for male and female inmates, for pretrial and sentenced populations, and for aboriginal groups. However, as most people are cycling through prison for short periods, imprisonment represents a vital opportunity for detecting the need for mental health treatment and attempting to link people with local community mental health services in concert with probation services after release. The successful FACT models point to a way of doing this more effectively than simply expecting mainstream community mental health services to provide care.

This article has focused on in-prison and point-of-release concerns, but comprehensive services in this area must include diverting minor offenders before incarceration through court and jail diversion programs and liaison with police services. Further, substance misuse treatment must be included along with the package of care that inmates receive during incarceration and on release.⁵²

This is a challenging but very important area of service development. Unfortunately, too often the health and correctional sectors place the blame on each other for these problems. Corrections attribute the increased prevalence of mental illness in prisons to a failure of the health care system. Health says that it is a result of criminal justice policy and poor social environments. Regardless of the explanation, prison inmates with SMI require integrated health and correctional responses. This problem is not the responsibility of one sector or another; it is a human challenge for both.

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