

Registered Nurses' Association of Ontario (RNAO)

**Transforming Ontario's Correctional Services:
Starting, But Not Stopping, with Segregation**

Written Submission to the Segregation Review
conducted by the Ministry of Community Safety and
Correctional Services

February 22, 2016



RNAO Recommendations

- RNAO reiterates that a foundational aspect of a comprehensive Mental Health Strategy for Correctional Services is that our provincial facilities comply with international human rights law. To be consistent with United Nations (UN) standards, the UN Committee on Torture clearly stated that Canada must:
 - strengthen its efforts to adopt effective measures to improve material conditions in prisons, reduce the current overcrowding, properly meet the basic needs of all persons deprived of their liberty and eliminate drugs;
 - increase the capacity of treatment centres for prisoners with intermediate and acute mental health issues;
 - limit the use of solitary confinement as a measure of last resort for as short a time as possible under strict supervision and with a possibility of judicial review; and
 - abolish the use of solitary confinement for persons with serious or acute mental illness.
- To comply with the UN Committee on Torture prohibition on segregation for people with "serious or acute mental illness," ensure timely and appropriate mental health screening by qualified health professionals upon admission to provincial correctional facilities. As lack of privacy is a disincentive to disclosure, ensure screenings and assessments are done with adequate privacy protections.
- As recommended by the Ashley Smith inquest, abolish indefinite solitary confinement. Inmates without serious or acute mental illness must not be placed in segregation for more than 15 days at a time. There must be a wait period of at least five consecutive days between each placement in segregation. Ensure that an inmate is not placed in seclusion for more than 60 days in a calendar year. If an inmate is transferred to a different institution, the calculation of consecutive days must continue and not be considered a break from segregation or seclusion.
- Implement the recommendations by the Office of the Provincial Advocate for Children and Youth arising from their systemic review of secure isolation in Ontario youth justice facilities.
- Implement justice-related recommendations of the Truth and Reconciliation Commission of Canada. Top priority must be given to:
 - recommendation #30 that calls on all levels of government to eliminate the overrepresentation of Aboriginal people in custody over the next decade accompanied by detailed annual monitoring and reporting of progress; and
 - recommendation #31 that calls on all levels of government to provide stable and sufficient funding to implement and evaluate community sanctions that will provide realistic alternatives to imprisonment for Aboriginal people and respond to underlying causes of offending.

- Implement recommendations on moving towards decriminalization of mental health issues prepared by the John Howard Society of Ontario.
- Implement recommendations from numerous coroners' inquests in a systematic and transparent fashion, including providing access to 24/7 nursing services. RNAO urges for a focus on improving access to registered nurses and nurse practitioners specifically.
- Increase capacity of primary care, mental health, and other required health services by strengthening recruitment and retention of correctional nursing workforce by addressing compensation disparities with other sectors.
- Transition governance of health services from the Ministry of Community Safety and Correctional Services to the Ministry of Health and Long-Term Care. Ensure transparency and improvements in health equity through ongoing evaluation by Health Quality Ontario.
- Increase transparency and accountability for health and human rights for inmates in segregation and the general population within the provincial system equivalent to the federal Office of the Correctional Investigator of Canada.

Introduction

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses (RN), nurse practitioners (NP), and nursing students in all roles and sectors across Ontario. Since 1925, RNAO has advocated for healthy public policy, promoted excellence in nursing practice, increased nurses' contributions to shaping the health system, and influenced decisions that affect nurses and the public they serve.

RNAO appreciates the opportunity to provide feedback to the Ministry of Community Safety and Correctional Services (MCSCS) in response to the Segregation Review. RNAO staff and representatives from our Ontario Correctional Nurses' Interest Group (OCNIG) and the Mental Health Nursing Interest Group (MHNIG) found a briefing on the Segregation Review by MCSCS staff on January 5, 2016 to be helpful as context. Responses to the questions provided by MCSCS have been incorporated in the sections below followed by RNAO's recommendations.

Segregation and Its Challenges

Whether called segregation, the hole, close confinement, or solitary confinement,¹ segregation is the physical isolation of individuals confined to their cells for 22 to 24 hours per day.² Removed from the general population, inmates in segregation have minimal human contact with correctional staff or other inmates. Typically, the meals of such inmates are passed through a slot in their cell door. They face "escalated deprivation of liberties, programming and privileges."³ The attributes of segregation-reduced environmental stimulation, social isolation, and loss of control over most aspects of daily life are each harmful in themselves and together create "a potent mix."⁴ Being in segregation is "an inherently punishing experience," regardless of whether the rationale for segregation is for administrative or disciplinary purposes.⁵

The evidence is clear: segregation has profoundly negative health impacts, especially for those with pre-existing mental health challenges, and it may also cause mental illness.⁶ Changes in brain activity with symptoms may start to occur within seven days of solitary confinement and some effects may be long-term or permanent.⁷ An inmate's ability to reintegrate into society upon release may be compromised by these long-term effects, which can include depression, confusion, phobias, impaired memory, and personality changes.⁸ Although a range of physiological effects are also recorded, acute and chronic psychological effects commonly include anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia and psychosis.⁹

Increased risk of self-harm and suicide is of particular concern with solitary confinement.¹⁰ Of 30 cases of suicide in the federal correctional system between 2011-2014, 14 occurred in segregation.¹¹ In his review of federal inmate suicides,

the Office of the Correctional Investigator of Canada (CIC) found that segregation itself is an independent risk factor for suicide.¹² The United Nations Special Rapporteur of the Human Rights Council has called for an absolute prohibition on the use of segregation in excess of 15 days, and further described the "practice of solitary confinement of persons with known mental disabilities of any duration as being cruel, inhuman, or degrading treatment, and as such, in violation of international law."¹³ The CIC recommends that "long-term segregation of seriously mentally ill, self-injurious or suicidal inmates should be expressly prohibited."¹⁴ Ten of the 14 inmates who committed suicide in segregation cells were beyond the 15 day mark, and five had been held in segregation more than 120 days before their deaths.¹⁵ The CIC reports that administrative segregation is still "significantly overused" to manage behaviours associated with mental illness as well as a "population management tool to address tensions and conflicts" within the system.¹⁶

Comparable data for Ontario's system is not publicly available, however, in the most recent annual report of the province's Ombudsman "at least three segregated Ontario inmates are believed to have taken their own lives."¹⁷ The Ombudsman reported a 54 per cent increase in complaints about segregation placements in 2014-2015 (at 225 complaints compared with 146 complaints the previous year).¹⁸ In his report, the Ombudsman also flagged that one facility could not find its records for 60 per cent of segregation placements for periods during 2014. The lack of accurate and complete data means we don't know how widespread this practice really is.¹⁹

The international consensus is that solitary confinement should not be used at all with children and young people.²⁰ A systemic review of secure isolation in Ontario youth justice facilities conducted by the Office of the Provincial Advocate for Children and Youth found that there is a pattern of high use in some facilities; concern about the number of young people segregated beyond 24 hours; and immediate need for increased vigilance and examination of conditions of confinement.²¹ This report noted disproportionate numbers of Aboriginal and racialized youth in criminal justice settings, as well as increased rates of those with mental health challenges. However, information is unavailable on whether these populations were placed in secure isolation and for what length of time.²² It is critical that the province track segregation for adults and youth over time by key demographic factors. An analysis of 10-year trends of administrative segregation in the federal system shows that "over-reliance on segregation is not uniform; certain incarcerated groups are more affected than others, including federally sentenced women with mental health issues, Aboriginal and black inmates."²³ While the average length of stay in segregation has decreased from 40 days in 2005-2006 to 27 days in 2014-2015, Aboriginal inmates consistently have the longest average length of stay in segregation over that time period.²⁴

As RNAO has previously advocated, from a health and human rights perspective, segregation is a harm in itself. It merits urgent government action.²⁵ Beyond

these compelling reasons to act, the relationship between mental illness and solitary confinement can also be viewed as a vicious cycle feeding on itself and requiring ever-increasing resources.²⁶

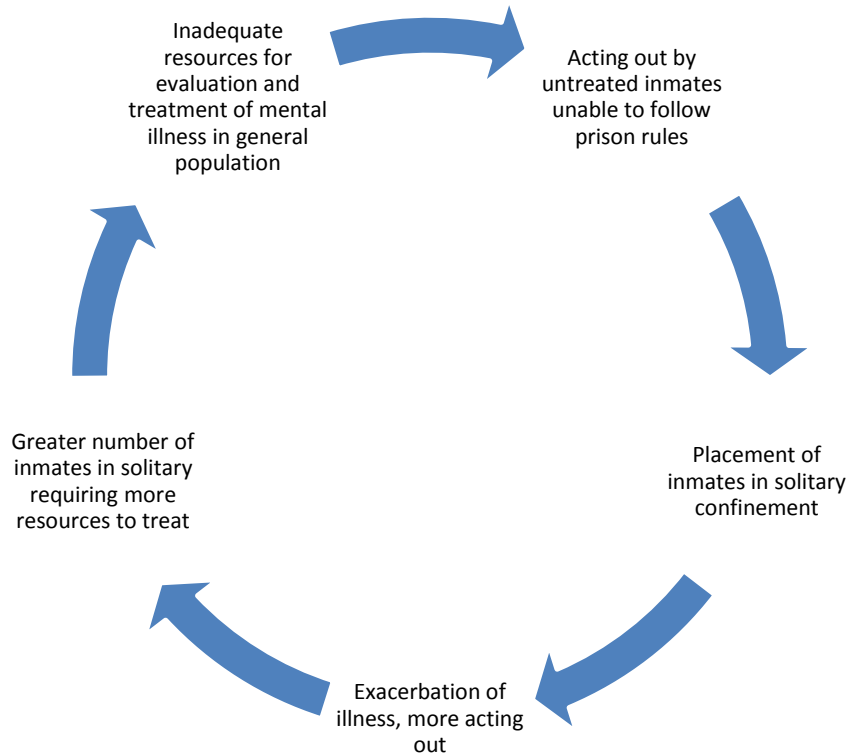


Figure 1 Cycle of solitary confinement and mental illness (Adapted from Kapoor 2014: 5)

Breaking the cycle of segregation is a key, but partial, component of transforming a correctional system frequently characterized as "crisis-ridden" and "plagued by lockdowns, understaffing, overcrowding, and violence."²⁷ Chronic understaffing has resulted in a tripling of lockdowns from 259 in 2009 to more than 900 lockdowns in Ontario's provincial correctional facilities in 2014.²⁸ Characterized by inmates being confined to their cells without access to showers, communal dining areas, fresh air, visits, or programming, lockdowns increase frustration that may be linked to escalating numbers of assaults by inmates on staff during that time period.²⁹ Recent legal proceedings have highlighted that lockdowns are much like solitary confinement and that Ontario has no policies limiting the use or scope of lockdowns.³⁰

Figure 2 below reframes segregation as "the final common pathway in a grossly inadequate mental health system."³¹

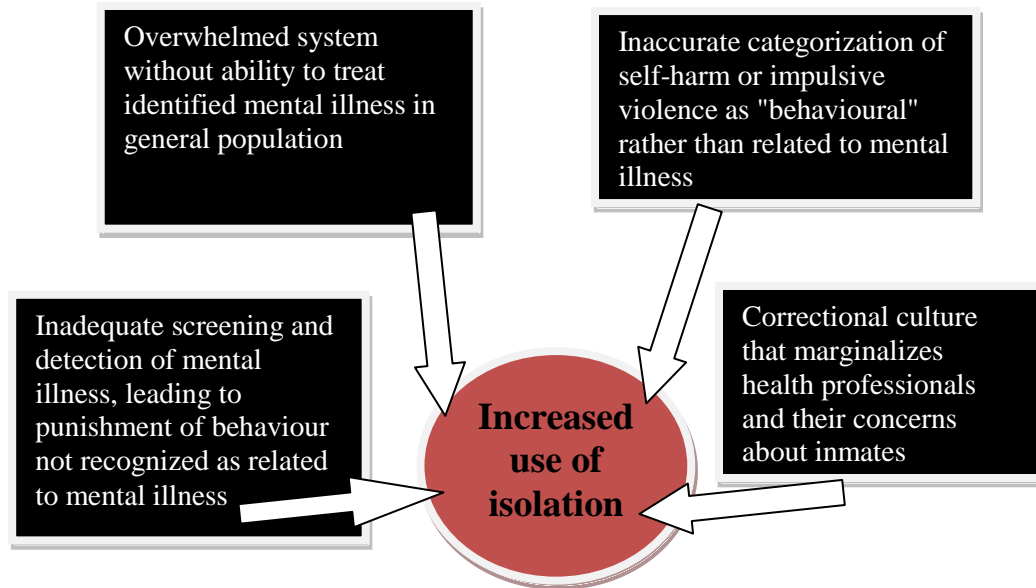


Figure 2 Solitary Confinement as a final common pathway in inadequate correctional mental health systems (Adapted from Kappor 2014:4)

Increasing Contributions of Nursing to Improve Health and System Outcomes

RNs, NPs, and nursing students across Ontario are committed to advancing health equity. Nurses work to improve the conditions that determine health in their collective advocacy for healthy public policy supported by investments in the public good.³² Through excellence in their nursing clinical practice, research, education, administration, and policy domains, each nurse has the opportunity to make a difference in promoting health, preventing harm, advancing healing, and being with people throughout their life journey.

RNAO believes that improved utilization of nursing knowledge, skill, and expertise will increase effectiveness and capacity of health services to improve inmates' health outcomes, and so improve community health and safety. In short, it will assist the Minister Naqvi with his goal "to shift the system away from a 'warehousing' model, with more help for inmates with mental health issues, better health care and improved integration programs for inmates leaving the system."³³

Consistent with a RNAO's 2012 resolution to the Canadian Nurses Association³⁴ and a March 2015 meeting with Minister Naqvi,³⁵ RNAO urges that health care services provided within correctional services be governed by and responsible to

the Ministry of Health and Long-Term Care (MOHLTC). Such a transformation would be congruent with international trends^{36 37} arising from the global challenge of meeting unmet health needs in prisons^{38 39} and human rights obligations to provide equivalent care to those in the community. While such a transfer is a complex process, evaluations indicated that the standard of care provided to inmates improved in four jurisdictions that had made the change: France, Norway, England and Wales, and New South Wales in Australia.⁴⁰ In addition to learning from these countries, lessons may also be gleaned from the experiences of Nova Scotia and Alberta, which have already integrated prison health care within the public health system.⁴¹

Improvements to health services brought about by changes in governance can be attributed to: a decreased ad-hoc approach; decreased professional isolation; improved recruitment, retention, and expertise of health human resources; and increased transparency.^{42 43} In particular, changing governance models helps to address the problem of "dual loyalty" where health professionals experience clinical role conflicts between obligations to their patients and a paramilitary culture where the needs of patients may be subordinated by the rationale of security concerns.^{44 45} Enabling health professionals to fulfill their ethical and professional responsibilities to those in their care will not only improve clinical care but also decrease conflict between health personnel and correctional authorities.^{46 47}

Improved access to and utilization of nursing services, especially in a governance model reporting to a health body rather than correctional services, has the potential to positively impact the screening, detection, treatment, and care of inmates leading to segregation outlined in figure 2. In 2015, there were approximately 710 RN positions⁴⁸ and six NP positions⁴⁹ in federal and provincial correctional facilities across the province. While those working in corrections make up only a small percentage of employed RNs, their absence is keenly felt when their services are not available. The in custody death of 33-year-old Robert Clause from a narcotic overdose is one example of at least 15 inquest recommendations to the MCSCS over the years recommending 24/7 on-site nursing services.⁵⁰ In addition to the challenges already discussed, recruitment and retention of nursing staff in corrections is hindered by inequitable compensation compared with nurses employed in other sectors, such as acute care.

Status Quo is Not an Option

In contrast to the federal system where the Office of the Correctional Investigator provides independent oversight and reporting, a lack of transparent, timely, and reliable evaluation and reporting mechanisms makes it difficult to understand the full scope of health and safety issues within Ontario's correctional system, including challenges with segregation.

Without substantive transformation of the correctional system, including segregation practices, more marginalized and often mentally ill people will die prematurely and/or experience negative health outcomes. Preventable injury, illness, and death arising from out-of-date correctional models has an impact not just on those directly touched by provincial institutions (inmates, families, staff), but also on the health and well being of the larger community. Acute or chronic health conditions that are exacerbated or initiated while incarcerated, such as mental illness or infectious disease, can have a ripple effect when inmates are released.⁵¹ A revolving door in and out of correctional facilities without sufficient opportunities for rehabilitation and treatment of underlying issues leaves our communities more violent and fragmented than they need to be. Maintaining the status quo will likely also lead to further legal challenges; human rights complaints; and erosion of trust in correctional services as a public institution.

We know that change is possible. Sweden is reducing its prison population, closing prison facilities, and the country's latest drug screenings showed less than a one per cent intoxication rate among inmates.⁵² Nils Oberg, Director of Sweden's prison service describes three key principles of the Norwegian Strategy: "control the prisons; make every day count; and treat human beings, not criminals."⁵³

RNAO Recommendations

- RNAO reiterates⁵⁴ that a foundational aspect of a comprehensive Mental Health Strategy for Correctional Services is that our provincial facilities comply with international human rights law. To be consistent with United Nations (UN) standards, the UN Committee on Torture clearly stated that Canada must:
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- Increase transparency and accountability for health and human rights for inmates in segregation and the general population within the provincial system equivalent to the federal Office of the Correctional Investigator of Canada.

Conclusion

We thank MCSCS for the work being done on the Segregation Review. We look forward to seeing many of RNAO's recommendations reflected in your final report and in government policy. Please do not hesitate to be in touch with us if additional information would be helpful in supporting action on this important issue.

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