**Mental Health and Canadian Older Offenders (excerpt)**

**By Adelina Iftene**

1. **Mental Health Findings**
2. *Demographics*

For this study 197 male offenders over the age of fifty from seven penitentiaries were interviewed. Three of the institutions were medium security and half of the participants were hosted in them (50.3%). The minimum security institutions provided 33.5% of the participants. Offenders from only one maximum institution were interviewed, and they formed 9.1% of the participants. Finally, some offenders in the Assessment Unit were also interviewed (7.1%). From the participants, a slight majority had been to prison (either federal or provincial) before the current sentence (55.4%). The rest were serving time for their first offence.

The highest percentage was that of inmates who were serving a life sentence, followed by the ones who were serving a short sentence, and those who were serving medium length sentences. Roughly 12% were serving an indeterminate sentence. (Table 1)

The majority of people serving life sentences, indeterminate or long sentences had been convicted prior to turning fifty. Almost half of the participants had already served over ten years of their current sentence at the time of the interview, with over 11% having spent between twenty and twenty-nine years and other over 11% had spent over thirty years in prison. Aside from the people serving an indeterminate sentence (where the majority had prior convictions) and the assessment unit (where the majority had no prior convictions) the proportion of recidivist offenders was roughly 50% for each category of sentence length.

1. *Mental Health Issues, Potential Risk Factors, and Institutional Responses*

From 197 participants, 39.1% mentioned being diagnosed with one or more mental illnesses (Table 2). In general, the rates of people reporting receiving help with their condition on a regular basis were much smaller than those of people reporting mental conditions. Only 14.3% of the people with a mental health diagnosis reported seeing the psychiatrist after they turned 50. 26% of the same group said they were receiving some form of therapy counselling.

It appeared that mental health care was available in some institution while it was almost missing in others. For example, in maximum security the rate of mental illness was high (about 60%). Some individuals were placed either on the mental health unit or in protective custody for their protection. However, those who were not on the mental health unit were entitled to three psychological sessions for the duration of their stay. Lifers were supposed to be assessed by a psychiatrist every two years, but the participants mentioned that the consult was a five minute discussion in which they were asked if they had suicidal thoughts. In another institution, there was one psychologist for 600 people. Some were told that if they were not suicidal they had no business asking to see a psychologist. A few people with suicidal ideation, when seeking help, had been sent to segregation.

20.9% of older prisoners reported having *suicidal thoughts* while in prison after the age of fifty. Of the forty-one individuals who reported suicidal thoughts, 1% reported receiving help when these thoughts occurred. Over 10% of the 197 people interviewed had been suicidal but never talked about it, mostly because of fear of repercussions. There appears to be a general consensus among prisoners (whether reporting mental illnesses or not) that those who report suicidal thoughts or “act out” because of a psychiatric conditions, will be put under suicidal watch and segregated for an undefined period of time.

Of particular interest is the fact that there was a statistically significant inverse relationship between the frequency of family visits and suicidal thoughts. Thus, people who never had suicidal ideation tended to report more frequent family contact than those who had suicidal thoughts. (Table 3) These findings suggest that actively encouraging family contact might have therapeutic value in cases of suicidal tendencies. A large number of older prisoners complained about the way their families were treated. For example, one inmate reported that every time his two young sons came to visit, the officer let the dog jump on them, despite the fact that one of the boys was very afraid. The inmates complained that these behaviors acted as a deterrent for family members to come and visit.

The rates of *substance abuse* are also high: 29.4% self-identified as addicts. The rates however might be higher than that. 29.9% of the participants reported drinking alcohol daily at least on the outside, but only 52.5% of them also self-identified as alcoholics. Similarly, 37.6% reported daily drug consumption, but only 41.9% of them self-identified as addicts. Only 5.6% of the participants reported receiving treatment for their addiction, and 8.6% mentioned following at one point a correctional program concerning substance abuse. Numerous offenders complained that aside from AA and NSAP programs there was nothing therapeutically for them. They did not get treated, but were sent to groups. No rehabilitation program was available and this was a reason for complaint for many inmates. However, some of the addicts were in the methadone program and were happy with it. One of them however mentioned that he fears the moment he would be released. The previous time he had been paroled there had been no continuation of the methadone program in the community which led to him relapsing and having his parole revoked.

Properly addressing the substance abuse might turn out to be important not only for the well-being of the individual but also for that of the institution. Substance abuse is one of the factors, together with mental illness, relationship with staff and family relationships that appears to be directly connected to the history of disciplinary charges after turning 50. (Table 4)

*Sleep deprivation* is connected to a decrease in mental health. 46.7% of the participants reported having sleeping problems on a regular basis, and 8.6% stated that they have occasional issues falling asleep. People with mental health issues reported more sleeping problems. Hence, of those reporting mental illnesses, 70.1% reported sleep problems. In contrast, of those with no reported mental illnesses, only 45.8% reported having sleep problems. (Table 5)

In particular there appears to be a connection between depression and anxiety and sleeping disorders. 33.7% of the people with sleeping disorders suffered from depression, and 26.1% from anxiety. In contrast, only 15.9% and 6.8% of those without sleeping disorders suffered from depression and anxiety respectively.

A number of the participants complained that the younger offenders were noisy and listened to loud music at night. This is particularly concerning, considering the high rates of sleep problems among older offenders revealed by the data. One of the older inmates mentioned that in addition to having a hard time falling asleep because of the music, he often got in trouble in the morning. Because he was on medication, he needed to get up at six to pick it up. If it happened that he woke the younger inmates on the range, he got screamed at and pushed, because many of them slept through breakfast. Another offender complained about the fact that his twenty-year old cellmate worked out all the time and he needed the window open afterwards, even in the dead of winter. This might help explain why 81.7% of the participants reported that a seniors’ only unit would substantially improve their life. 97% reported that at the moment such as unit is not available in their institution.

On the other hand, a positive, relevant connection exists between rates of *mental illness and exercise.* Thus people who reported exercising on a regular basis also reported lower rates of mental illness. (Table 6) This might suggest that investing in proper exercise facilities might reduce the costs associated with mental illnesses in prison over the long run. However, a recurring complaint of older offenders was the lack of a place to exercise. Numerous offenders felt that the gym or the weight pit were inaccessible because of the presence of younger offenders who would ridicule them. In one institution, an inmate described the gym as a dangerous place, “that is where things go down.” The majority of seniors were using the courtyard. However, in winter it was always problematic. In some institutions the yard was not shoveled, and it could not be used after dark. A number of offenders complained about the lack of cardio machines or walking/jogging tracks. When asked what programs they would like to see in prison, 21.8% of the participants requested age-appropriate fitness programs.

Finally, some concerns were raised by the participants from the Assessment Unit (AU). Unfortunately however, there were not enough participants from this unit to quantify the data on its own. It is still relevant to look into the qualitative findings, with an exploratory mindset. Medical care was problematic and very limited. Inmates were told that resources were limited since they had to share them with the medium security population. Some of the individuals had been in there for over a month, and did not get access to their community medication or items such as eye glasses. They were told they can only receive them once they see a doctor. When asking for a doctor or a consult, they were told that will only happen once classified and sent to their “mother institution” (the institution where the inmate will serve his sentence once his security risk is assessed). The issue with health care in the assessment unit was recently identified in a not yet released investigation of the Office of the Correctional Investigator. The document reported that people in the AU were abruptly discontinued the medication they were on in the community and were left without any for thirty days or more. Of particular concern was the discontinuance of the pain and mental health medication (Editorial, 2015; White 2015).[[1]](#footnote-1)

Fortunately, this population was in better health than the other participants. They had just entered prison and they had a smaller number of conditions. As well, it appeared that mental illnesses were much reduced compared to those among classified inmates who had been incarcerated for a longer time. Only one of the fourteen people interviewed in the AU reported a mental illness diagnosis. This may suggest either that they were not checked in the community or that prison itself is what triggers numerous mental conditions. It might be both.

1. *Correlations between Mental Health Issues and Institutional Behavior*

Mental conditions seem to be of particular relevance for the capacity of the prisoner to adapt to the prison environment. Thus, an individual who graded his overall health in the middle or poor was more likely to also report suffering from mental illness than someone who considered his health relatively good. (Table 7)

Mental illness appeared to have repercussions on the *general behavior of prisoners.* While the rate of disciplinary incidents was relatively low (about 31% have been charged with disciplinary offences, mostly non-violent and 23% have spent time in segregation since turning 50), those who had disciplinary charges (especially violent ones) tended to also report suffering from mental illness. (Table 8) It appeared that the mentally ill were more often sent to segregation than their healthier counterparts (36.4% as opposed to 15%). (Table 9)

As well, more prisoners who have been sent to segregation for disciplinary reasons were more likely to report having a mental illness diagnosis than their healthier counterparts (59.5% as opposed to 40%). Similarly, of the people who have requested segregation for their own safety, the majority reported suffering from a psychiatric condition (72.7%).

Some prisoners reported being afraid of their poorly treated mentally ill peers. Each institution seemed to have its infamous “schizophrenics” that “could snap at any time.” One inmate recalled one of these individuals regularly attacking other inmates “in one of his moments.” Most offenders agreed that those people needed help and that as long as “they are not treated or sent elsewhere, it is unsafe for everyone in the institution.”

It also appeared that mental illness, like physical illness and mobility issues, made prisoners more *vulnerable* to peer abuse. 70.1% of those with psychiatric disorders mentioned being abused by peers. (Table 10) However, a similar relationship did not exist between mental illness and staff abuse.

This appears to justify the feelings of vulnerability and fear of danger that are displayed by this population: of the almost 44% of older prisoners who reported feeling unsafe and in danger, over 56% reported a mental illness.

The qualitative and quantitative data presented above points to an unsettling situation. First, prison appears to foster certain risk factors that may enhance or trigger mental health problems. Such factors may include the strict regime associated with some levels of security, sleep deprivation, substance abuse that has been inappropriately addressed, loss of family contact, lack of sufficient physical activity, and solitary confinement. Second, it appears that, confirming the reports of the OCI, segregation is the most common response to mental illness, and in particular to suicidal tendencies. Third, mentally ill prisoners are held in segregation more frequently than the inmates who did not report mental illnesses for both disciplinary and un-disciplinary matters. That suggests that mentally ill are isolated not only for their protection but also because they misbehave. Thus, it appears that the most common response to behavior that at least in part may be caused by mental illness is segregation as opposed to treatment. It is possible that once placed in segregation, an individual’s mental health status deteriorates further. In addition, the data shows that access to mental health specialists is not readily available or of substantial quality in all institutions.

Improving the mental health care system, especially for older offenders who are already at risk of psychiatric illnesses due to the normal aging process, is mandatory. The first argument is a pragmatic one. Controlling mental illness will likely decrease the disciplinary incidents and will make for better behaved prisoners. The second argument is both legal and moral. Failing to appropriately respond to these individuals’ needs endangers their lives and those of their peers and officers who work with them. It accelerates their health degradation, it makes them sicker than they were when they entered prisons and makes them more vulnerable to peer abuse.

**Tables**

Table 1: Distribution of sentences

|  |  |
| --- | --- |
| Length of sentence | Percentage |
| Short sentences (2 – 5 years) | 29.9 (n=59) |
| Medium sentences (6 – 10 years) | 27 (n=27) |
| Long determined sentences (<10 years) | 21 (n=10.7) |
| Life sentence | 33.5 (n=66) |
| Indeterminate sentence | 12.2 (n=24) |

Table 2: Self-reported distribution of mental health illnesses (not mutually exclusive in an individual)

|  |  |
| --- | --- |
| Mental Health Conditions | Percentage |
| Depression | 24.4% (n=48) |
| Bipolar Disorder | 3.6% (n=7) |
| Schizophrenia | 3% (n=6) |
| Anxiety Disorder (other than PTSD) | 17.3% (n=34) |
| Dementia | 4.6% (n=9) |
| PTSD | 4.1% (n=8) |
| Other (including intellectual disabilities) | 11.2% (n=22) |

Table 3: Distribution of suicidal thoughts per frequency of family visits

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Suicidal thoughts | Frequency of family visits | | | | Total |
| Weekly or more | Monthly or more | A few times per year or less | None |
| No | 56.8% (n=88) | 18.7% (n=29) | 10.3% (n=16) | 14.2% (n=22) | 100% (n=155) |
| Yes | 36.6% (n=15) | 17.1% (n=7) | 26.9% (n=11) | 19.5% (n=8) | 100% (n=41) |

Chi-square = 9.574, df = 3, p = .022

Table 4: Disciplinary charges (due to misconduct) per daily substance abuse (including alcohol) or self-report addict rates

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Disciplinary charges % | Daily substance abuse on the outside or self-report as addict | | | Total |
| Neither | One or the other | Both |
| No | 53.7% (n=73) | 25.7% (n=35) | 20.6% (n=28) | 100% (n=136) |
| Yes | 29.5% (n=18) | 45.9% (n=28) | 24.6% (n=15) | 100% (n=61) |

Chi- square = 10.989, df = 2, p = .004

Table 5: Distribution of mental health illnesses per sleep problem

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mental Health Illnesses reported | Sleep problems | | | Total |
| No | Yes | Sometimes |
| No | 54.2% (n=65) | 36.7% (44) | 9.2% (n=11) | 100% (n=120) |
| Yes | 29.9% (n=23) | 62.3% (n=48) | 7.8% (n=6) | 100% (n=77) |

Chi-square = 12.920, df = 2, p = .002

Table 6: Distribution of rates of regular exercise per mental illnesses rates

|  |  |  |  |
| --- | --- | --- | --- |
| Regular exercise rates % | Mental Illnesses Reported | | Total |
| No | Yes |
| No | 51.5% (n=35) | 48.5% (n=33) | 100% (n=68) |
| Yes | 65.9% (n=85) | 34.1% (n=44) | 100% (n=129) |

Chi-square = 3.889, df = 1, p = .049

Table 7: Distribution of self-reported overall health per inmates mentioning mental illnesses

|  |  |  |  |
| --- | --- | --- | --- |
| Overall Health % | Does prisoner mention mental illness | | Total |
| No | Yes (one or more) |
| Relatively poor | 54.7% (n=29) | 45.3% (n=24) | 100% (n=53) |
| Middle | 47.2% (n=34) | 52.8% (n=38) | 100% (n=72) |
| Relatively good | 78.9% (n=56) | 21.1% (n=15) | 100% (n=71) |

Chi-square = 16. 110, df= 2, p < .001

Table 8: Disciplinary charges per mental health rates

|  |  |  |  |
| --- | --- | --- | --- |
| Disciplinary charges since turning 50 | Does prisoner mention mental illness | | Total |
| No | Yes (one or more) |
| No | 66.2% (n=90) | 33.8% (n=46) | 100% (n=136) |
| Yes | 49.2% (n=30) | 50.8% (n=31) | 100% (n=61) |

Chi-square=5.109, df = 1, p=.024

Table 9: Mental Illnesses per segregation rates

|  |  |  |  |
| --- | --- | --- | --- |
| Mental Illnesses reported % | Segregation since turning 50 | | Total |
| No | Yes |
| No | 85% (n=102) | 15% (n=18) | 100% (n=120) |
| Yes (one or more) | 63.6% (n=49) | 36.4% (n=28) | 100% (n=77) |

Chi-square = 11.961, df = 1, p = .001

Table 10: Distribution of mental illnesses reported per peer abuse rates

|  |  |  |  |
| --- | --- | --- | --- |
| Mental Illnesses Reported % | Abused by Peers | | Total |
| No | Yes |
| No | 60% (n=72) | 40% (n=48) | 100% (n=120) |
| Yes (one or more) | 29.9% (n=23) | 70.1% (n=54) | 100% (n=77) |

Chi- square = 17.053, df = 1, p < .001

1. The press obtained access to the unreleased document. [↑](#footnote-ref-1)