MOVING TOWARDS A TRAUMA-INFORMED CANADIAN CORRECTIONAL SYSTEM

by

Shannon Maddalozzo Tou

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Name: Shannon Maddalozzo Tou
Degree: Master of Arts (Criminal Justice) Degree
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Examining Committee

Zina Lee, PhD
GPC Chair
Director, School of Criminology and Criminal Justice

_____

Amanda McCormick, PhD
Senior Supervisor
Associate Professor, School of Criminology and Criminal Justice

_____

Yvon Dandurand, MA
Second Reader
Professor Emeritus
School of Criminology and Criminal Justice

_____

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Abstract

Marginalized and stigmatized peoples characterized by social, economic, and psychological disadvantage are overrepresented within the prison population. Many offenders have various, complex, and inter-related needs that often include a combination of substance abuse, mental health issues, childhood trauma or Adverse Childhood Experiences (ACEs), and Post Traumatic Stress Disorder (PTSD).

These complex populations have historically been managed through the overuse of segregation placements. However, courts in Ontario and British Columbia (BC) recently found segregation to be unconstitutional, prompting the federal government to abolish segregation in Canadian federal institutions and create Structured Intervention Units (SIUs). Yet there are concerns that SIUs do not go far enough in protecting vulnerable in custody offenders and that more effort is needed to prevent the need for segregation through a better understanding of trauma and mental health needs of inmates.

This paper will provide recommendations for prevention based interventions and assessments directed towards offenders with complex needs, including training for all frontline staff in trauma-informed practice, present-focused trauma programming, and utilizing actuarial tools to screen offenders at intake to assist in preventing SIU placements. These recommendations will provide agencies like the Correctional Service of Canada with clear strategies to implement in moving towards a trauma-informed system.

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Dedication

This paper is dedicated to all Public Servants who dedicate their time, energy, and talents in helping to keep Canadians safe.

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Glossary, or acronyms and symbols

ACEs: Adverse Childhood Experiences Scale
APD: Antisocial Personality Disorder
BC: British Columbia
BCCLA: British Columbia Civil Liberties Association
CBT: Cognitive Behavioral Therapy
CDSA*: Criminal Code* and *Controlled Drugs and Substances Act*
CCLA: Corporation of the Canadian Civil Liberties Association
CCRA: *Corrections and Conditional Release Act*
CMAJ: Canadian Medical Association Journal
CRI: Criminal Risk Index
CRISM: Canadian Research Initiative in Substance Misuse
CSC: Correctional Service of Canada
DBT: Dialectical Behavioural Therapy
EIM: Engagement and Intervention Model
HPA: Hypothalamic-pituitary-adrenocortical
OCI: Office of the Correctional Investigator
PDSD: Post Traumatic Stress Disorder
SIR-R1: Revised Statistical Information on Recidivism Scale
SIU: Structured Intervention Units
SUD: Substance Abuse Disorder

Introduction

The Canadian government, through its administration of correctional practices, has historically paved the way for other nations in setting examples for how to successfully rehabilitate and humanely manage offender populations. However, societal and political dynamics have changed the demographics of the Canadian federal offender population, increasing the complexity of challenges to manage and rehabilitate. In the decade between March 31, 2005 and March 31, 2015, the overall federal inmate population increased by 13.6% (from 12,623 to 14,335). The highest rates of growth were observed in vulnerable populations, in particular for women, whose overall numbers increased by 77% (from 368 to 653), 60% (391) of which was observed among Indigenous women.[1] While the population of male inmates also grew, it was at a much smaller rate, at 11.6% (from 12,255 to 13,682). Yet similar to the female population, a significant portion of the increasing number of male inmates were Indigenous men, whose population in federal corrections increased by 35% (from 2,296 to 3,109). Caucasian male and female offenders were the only group to decrease, at -6.1% (from 8,815 to 8,281) (Office of the Correctional Investigator, 2015). Similarly, other vulnerable populations have seen an increasing presence in custody. For example, between 1997 and 2010 the population of offenders entering federal institutions who reported symptoms of serious mental illness increased by 61% for males and 71% for females (Sorenson, 2010). These increases in vulnerable populations with multifaceted and complex needs have implications for correctional programming and,

[1] Although the population of Black offenders has also grown substantially, by 77.5% (from 792 to 1,406), this population will not be discussed in this paper as the reasons for their increasing numbers is beyond the scope of this paper.

correspondingly, for the training of staff who work with and deliver programming to these populations.

As will be discussed in this major paper, several policy changes over the last few decades provide at least partial explanations for the changing demographic makeup of federally incarcerated inmates. These include deinstitutionalization, the expansion of mandatory minimum sentences, and, relatedly, the previous Conservative government's 'tough on crime' agenda. As a result of these policy changes, marginalized and stigmatized peoples who are commonly characterized by social, economic, and psychological disadvantage have become overrepresented within the prison population. As will be discussed in depth in this paper, these individuals typically have various, complex, and inter-related issues, including a combination of substance abuse, mental health issues, childhood trauma or Adverse Childhood Experiences (ACEs), and Post Traumatic Stress Disorder (PTSD) (Martin et al., 2015; CSC, 2014 & 2015).

The multifaceted needs presented by federal inmates present challenges for correctional settings to effectively respond to. As this paper will argue, policies and practices within the institution appear to have been slow to respond to these changing needs. Consequently, offenders with complex needs all too often have been managed through use of force and the overuse of segregation placements (Saper, 2015; Zinger, 2013; Zinger, 2019). The Office of the Correctional Investigator (OCI), which provides independent oversight over the federal correctional system in Canada, has expressed concern with use of force in general, and more specifically at the regional treatment centres (Sapers, 2019). The CSC committed to address these concerns and in 2018 implemented what is called the Engagement and Intervention Model (EIM), which emphasizes the importance of non-physical and de-escalation and the need to take into consideration the in custody offender's mental and/or physical health and well-being, as well

as the safety of other persons and the security of the institution (Commissioner's Directive [CD] 567, 2018). However, according to Zinger (2019), use of force incidents were at an all-time high in 2019 and were still, in his opinion, too high at the regional treatment centres. This will be discussed in much more detail within this paper. Similarly, segregation for this population is considered overused (Office of the Correctional Investigator, 2015; Zinger, 2013). Research has shown that segregation can cause damaging psychological effects, especially to those with pre-existing mental health issues and/or a history of trauma who, unfortunately, appear to be one of the populations most commonly subjected to segregation (Haney, 2018; Haney & Lynch, 1997; Grassian, 2006; Helmus et al., 2019; Knowles, 2015; Scott & Gendreau, 1969; Shalev, 2011; Zinger, 2013).

In one previous investigation of federally incarcerated inmates in Canada, Zinger (2013), who wrote a report for the Office of the Correctional Investigator, reported a disproportionate number of suicides and self-injury in segregation, as well as the overrepresentation of Indigenous, female, and black offenders in segregation. The OCI has therefore expressed concerns about the overreliance on segregation to manage mentally ill, self-injurious, and offenders at risk for suicide.

The detrimental effects of segregation on inmates have also been the subject of several recent court cases, with the judiciary in both Ontario and British Columbia (BC) determining that segregation was unconstitutional. In January 2015, the Corporation of the Canadian Civil Liberties Association (CCLA) began a case focusing on the negative consequences of segregation and isolation methods used by the Correctional Service of Canada (CSC; CCLA v. Her Majesty the Queen, 2017). Then in January 2018, the British Columbia Civil Liberties Association (BCCLA) filed a lawsuit with the John Howard Society of Canada against the

federal government stating that long-term or indefinite durations of administrative segregation were unconstitutional, and that segregation was correlated with suffering and death, discriminated against the mentally ill and Indigenous offenders, and deprived offenders of fundamental protections (British Columbia Civil Liberties Association v. Canada 2018 BCSC 62). These two court cases will be discussed in detail further along in the paper.

As a result of the provincial court findings that segregation was unconstitutional, and the efforts of advocates for prisoners' rights who have fought to have the segregation laws changed in Canada, such as the John Howard Society, Bill-C83-An Act to amend the *Corrections and Conditional Release Act*-was introduced to Parliament in October 2018 and passed into law June 2019. Bill C-83 prompted the government to amend the *Corrections and Conditional Release Act* (CCRA) to change how it manages in custody offenders who pose a risk to themselves, others, or the safety of the institution. In order to address the legal requirements posed by this Bill, the CSC closed all segregation units and replaced them with Structured Intervention Units (SIU) (Standing Committee on Human Rights, 2019).

SIUs have some built in safeguards including four hours of meaningful interactions through correctional programming, school, leisure, and visits. The CCRA amendments also built in several layers of accountability through reporting and reviews, including the creation of an independent review body. The bill and the amendments to the CCRA will be described in detail throughout this paper, however, it still appears the bill and the subsequent amendments are missing some fundamental components: (1) CSC has not implemented processes to prevent SIU placements in the first place; (2) no extra funding is being allocated to offenders with mental health needs who remain in the general population; (3) the SIUs run the risk of being segregation 'lite', and (4) Bill C-83 did not introduce a maximum length of time for SIU placement.

While much of the current discussion around SIUs has focused on the latter two points, this paper will focus on the first two, by describing the profile of vulnerable offenders in federal custody and how they came to be overrepresented in correctional institutions before providing some suggestions for transitioning the correctional system to a more trauma-informed system. This paper will provide recommendations in the areas of prevention based interventions and assessments directed towards offenders with complex needs including training for all frontline staff in trauma-informed practice, present-focused trauma programming, and utilizing actuarial tools to screen offenders at intake to assist in preventing SIU placements. These interventions and initiatives can aid the CSC in preventing SIU placements, decreasing use of force incidents, increasing staff understanding of the background and circumstances of each offender, and providing offenders with trauma related programming, referrals, and services with the goal of contributing to crime prevention through reduced recidivism rates. Prevention and treatment are key to allow for safe, timely, and successful reintegration back into the community (Sapers, 2015).

Deinstitutionalization

One of the major causes of the high rates of mental illness among incarcerated offenders has to do with the criminalization of people with mental illness resulting from the practice of 'deinstitutionalization'. As many scholars have argued, deinstitutionalization and the lack of community preparedness for the surge of people with mental health issues moving out of psychiatric institutions and into the community created a need for the criminal justice system to act as a de facto mental health system, causing an influx of persons with mental illness to be incarcerated at all levels of the system (Michalski, 2017; Rothman, 2002;Wallace et al., 2011).

Throughout the 19th and 20th centuries, people with mental health issues were commonly housed in psychiatric institutions. They were kept out of sight and therefore out of mind of the general public and, given the lack of effective treatments at the time, were essentially confined in these institutions (Rothman, 2002). Over time as institutions became overcrowded, concerns were raised about the welfare of the institutionalized population, and as advancements in pharmacological treatment occurred, there were increasing demands to release patients back to their communities (Rothman, 2002). Due to medical advancements and anti-interventionist and neoliberal ideologies, in the 1970s, many jurisdictions throughout the world began to deinstitutionalize mental health patients (Michalski, 2017; Wallace et al., 2011). The goal of the deinstitutionalization movement was to humanize mental health treatment by abandoning asylums as care facilities and limiting the number and duration of hospitalizations (Chambers, 1993; Michalski, 2017). The largest psychiatric hospital in BC, Riverview, which at its peak in the 1950s housed 5,000 people, began to downsize and finally closed its doors in the 1990s. The implementation of modern pharmacologic and psychotherapeutic approaches and the beginning of regionalized mental health services saw a decrease in bed space at Riverview through to the 1980s (Chambers, 1993; Jutras, 2017). The BC provincial government, in the 1970s, initially provided adequate funding for mental health; however, by the late 1980s fiscal restraint became part of government policy (Chambers, 1993; Jutras, 2017). This was caused by a shift in political ideology. Neoliberal policy discourse began to take shape with the NDP government in the 1980s, followed by the Liberal government in 2001 (Teghtsoonian, 2009). This political discourse was the catalyst to reductions in government funding for many social services. The emphasis was on privatized service delivery, tax cuts that benefited those who were financially secure, downsizing the number of provincial public servants, and decreasing their wages.

Thus, while the idea to transition people back into their communities, as opposed to isolating and warehousing them in mental health facilities, was both promising and well-intended, unfortunately the expansion in treatment services and community supports fell short and the necessary staffing, services, and supports were ultimately underfunded and overwhelmed (Chambers, 1993). Due to the decrease in staffing of mental health professionals and the further downsizing of Riverview, increased pressure was added to community care teams and general hospitals to provide assessments and acute care (Markowitz, 2006). Hospitalization of people with mental illness became the role of general hospitals with emergency rooms and psychiatric units providing acute treatment (Markowitz, 2006). Hospitals contributed to social control as respite but they were not a long-term solution. General hospitals served to stabilize, often provided medication, and then released patients often without adequate follow-up treatments and support (Markowitz, 2006).

Historically, psychiatric hospitals often served as important systems of social control for those persons who are unable to care for themselves and whose behaviour may be threatening to the social order (Rothman, 2002). A consequence of deinstitutionalization was therefore that a large number of persons with severe mental illness now lived in urban areas with less supervision and support, but increasingly came to the attention of the criminal justice system as a result of their acute conditions and under controlled symptoms. Higher rates of police contact with persons showing symptoms of mental illness led to rising rates of correctional inmates with mental illness (Weaver, 2018). The prison system, in turn, has consequently replaced, to some degree, the psychiatric hospitals as a primary system of social control (Markowitz, 2006; Michalski, 2017). Indications of insufficient increases in mental health services and supports in the community for those released from psychiatric institutions, has prompted a suggestion that

the deinstitutionalized is in a sense trans-institutionalized, moving from mental health institutions to correctional institutions (Weaver, 2018).

However, while research shows higher rates of mental illness among the incarcerated, it cannot be assumed that mental illness alone is the reason for their criminality. Markowitz (2006) found a statistically significant correlation between deinstitutionalization and homelessness, and a more pronounced correlation between homelessness and criminal activity. In addition, other demographic correlates found in individuals with mental illness who have criminally offended include unemployment, family history of incarceration, substance abuse, lower education level, lower socioeconomic status, male gender, comorbidity with other disorders, and variances in treatment status and hospitalizations (Bo et al., 2011; Galanek, 213; Hatchel et al.; Heinrichs & Sam, 2012; Large & Nielssen, 2011; Morgan, Morgan, F, Valeri, Ferrante, & Belinsky, 2012). Therefore, there are many correlates and life circumstances that adversely affect mental health and simultaneously contribute to engaging in criminal behaviour. The combination of co-morbid mental illness, substance abuse, and inadequate services and supports lead some persons to lack in supervision, access to adequate medication and services, guidance, and social supports to acquire basic skills for daily activities (Michalski, 2017). Because of the dynamics, it has been argued the police, courts, and corrections are compelled to act as de facto frontline mental health care providers.

Mandatory Minimum Sentences

While deinstitutionalization was one governmental policy change that contributed to increasing numbers of incarcerated people with mental health issues, the introduction of mandatory minimums has also played a significant role, specifically towards Indigenous persons. The key point to take away from mandatory prison sanctions is that they require a sentencing

judge to incarcerate an offender for not less than a prescribed period of time, meaning it removes their discretionary power to choose non-custodial sentences (Sewrattan, 2013), which are often more appropriate for certain subgroups of offenders, such as women and Indigenous offenders.

Harper's 2006-2015 legacy was called the "tough on crime" agenda (Chaster, 2018; Newell, 2013; Sewrattan, 2013). Within this agenda, the mandatory minimum sentence legislation that had the largest consequences to Indigenous persons was introduced in 2012 under the large omnibus Bill C-10, the *Safe Streets and Communities Act (SSCA)* which amended a number of criminal statutes, one of which is the *Controlled Drugs and Substances Ac*t (Newell, 2013; Sewrattan, 2013). The amended *Controlled Drugs and Substances Act* prescribes mandatory minimum prison sentences in certain circumstances for the production or trafficking of drugs listed in Schedule I or Schedule II of the Act. These drugs include heroin, cocaine, methamphetamine, cannabis, and marijuana (Sewrattan, 2013).

Harper's agenda reflected that his government perceived that sentences had become too lenient and that the rights of accused and convicted persons came at the expense of victims and law-abiding citizens; his resulting policy response unfortunately relied upon empty tough-on-crime rhetoric not founded on evidence (Chaster, 2018; Newell, 2013). The Attorney General Rob Nicholson introduced the SSCA in 2011 as a reflection of "the strong mandate that Canadians have given us to protect society and to hold criminals accountable" (House of Commons Debates, 2011). By the end of 2012, between the *Criminal Code* and the *Controlled Drugs and Substances Act* (CDSA), there were close to one hundred infractions for which mandatory minimum sentences were to be imposed (Chaster, 2018).

Minimum mandatory sentences typically affect Indigenous peoples in a disproportionate manner and the introduction of the SSCA imposed particularly harsh effects on this population

(Sewrattan, 2013). Currently, Indigenous person account for 29% of all admissions into adult federal correctional facilities, yet they represent just 5% of the entire Canadian population (Zinger, 2019). Notably, these policies have continued to exert detrimental effects long after their introduction. For instance, the number of Indigenous offenders in 2019 was 5,914, which increased by 40% from 4,239 in 2011 (Motiuk, 2019; Public Works, 2013).

Essentially, the crime control agenda perpetuated an already existing problem of increasing inequities among Indigenous persons. Indigenous persons experience intergenerational trauma stemming from a number of devastating colonialization practices, including forced residential school, community displacement where entire communities were removed from their land to less desirable places, and the sixties scoop where Indigenous children were removed from their families and placed in non-Indigenous foster care. More recent challenges include over-representation in foster care, lower rates of employment and education, higher rates of substance abuse and mental health challenges, cultural and community fragmentation, systemic oppression, poverty, and discrimination (Chartrand, 2016; Isobel, Goodyear, Furness, & Foster, 2019; Newell, 2013; Sewrattan, 2013; Sotero, 2006).

These colonial polices have caused significant intergenerational trauma, or trauma that is transmitted across generations, either directly or indirectly that creates a discrete process and form of psychological trauma transmitted within families and communities. Intergenerational trauma can be transmitted through attachment relationships where the parent, who experienced relational trauma, transfers their unresolved trauma to their children through dysfunctional interaction patterns, resulting in the effects of trauma being experienced without exposure to the original traumatic events (Isobel, Goodyear, Furness, & Foster, 2019). This can have a

significant negative influence upon an individual across the lifespan, including predisposition to further trauma.

According to Sotero (2006), populations subjected to long-term and mass trauma (e.g., historical occurrences such as colonization, slavery, war, and genocide) show higher rates of disease. For Indigenous people, whether the trauma was experienced directly from attending a residential school, the loss of culture and language, and the experiences of physical and sexual abuse at the hands of authority, or indirectly, from being raised by those who experienced direct trauma, the results are the same. Psychological problems and destructive behaviours associated with maladaptive coping mechanisms, such as addictions, suicide, and violence are noted to be elevated. The symptoms of intergenerational trauma as a disease are the maladaptive social and behavioural patterns, created in response to the trauma experience, absorbed into the culture, and transmitted as learned behaviour from generation to generation (Sotero, 1996). Therefore, while the harmful policies of colonization are (for the most part) no longer practiced, they continue to have devastating effects on Indigenous populations, raising the risk as a whole for their continued contact with and overrepresentation in the criminal justice system. A shift to trauma informed systems is critical to understand and address the underlying reasons for Indigenous persons overrepresentation.

Yet even prior to the introduction of mandatory minimum sentences, Indigenous offenders were overrepresented in correctional settings, based on three explanatory theories: cultural differences; socio-economic deprivation; and the ongoing effects of colonialism (Newell, 2013; Sewrattan, 2013). Regarding cultural differences, divergent and paradoxical cultural conceptions of criminality and societal responses have contributed to Indigenous alienation from the Canadian criminal justice system. While the overarching objective of the

Canadian criminal justice system is the protection of society, with the main mechanism mainly being the rehabilitation and punishment of the offender, Indigenous societies generally make restoration of the peace and equilibrium of the community the priority (Newell, 2013; Sewrattan, 2013). These conflicting perspectives of justice may have contributed to the overrepresentation of Indigenous persons.

Indigenous persons and communities frequently also suffer from socio-economic deprivation and high rates of mental health issues (Newell, 2013). The poverty endemic has persisted for generations and continues to grow. The current wage gap for Indigenous persons living on reserve is approximately 62% for men and 37% for women compared to non-Indigenous persons (Lamb, Yap, & Turk, 2020). The Vancouver Police Department reported that in 2017, 39% of homeless persons in Metro Vancouver were Indigenous peoples, despite comprising just 2.5% of the population in Vancouver (Vancouver Police Department, 2018).

Nelson and Wilson (2017), conducted an analysis of literature on the topic of mental health relating to Indigenous persons in Canada. Of particular interest, they reported that caution should be taken when drawing conclusions about the prevalence of mental illness without taking into consideration the colonial processes and structures. Colonialism has been implicated in both the cause of mental illness but also as a structure that can define mental illness based on its own set of norms and definitions. In other words, historical research used colonial and non-Indigenous concepts and disregarded Indigenous perspectives thus creating the potential to misrepresent rates and types of mental illness problems in Indigenous communities. For example, much mental health research on Indigenous persons is heavily focused on suicide and addictions, which while may be related to a mental illness, is arguably a symptom of colonialism. Eilas et al. (2012) found in their qualitative study that a pattern exists between a history of

trauma, suicidal ideations, and suicide attempts and those who attended residential school as well as their extended family (children and grandchildren), agreeing with the theory that trauma can be transmitted intergenerationally and that these outcomes are not necessarily related to a mental illness per se.

Mandatory minimum sentences perpetuated the over-representation of Indigenous persons for several reasons. First, introduction of mandatory minimums took away the discretionary power afforded to judges through what is known as the Gladue principles of sentencing. These were introduced in 1999 when the Supreme Court of Canada determined that Indigenous overrepresentation was a crisis (Newell, 2013). This sentencing framework for Indigenous offenders has two components. First the judge must consider the unique systemic and background factors that may have contributed to the Indigenous person's offending and second, the judge must consider the types of sentencing procedures and sanctions that may be most appropriate in the circumstances for the offender. The judge is to use both components and exercise restraint, where possible, when determining whether the person shall be incarcerated with the ultimate goal being to avoid incarceration for Indigenous offenders whenever possible. Unfortunately, the protective factors inherent in Gladue were counteracted by the implementation of mandatory minimums which prevented judicial consideration of these principles.

Second, mandatory minimums target criminal activity for which Indigenous persons are likely to be charged and convicted for. For example, all drug related offences are subject to minimums. This disproportionately targets young Indigenous males who are associated with gang activity and who are trafficking drugs for criminal organizations, to support themselves financially, or to support their substance abuse addition (Newell, 2013; Sewrattan, 2013). A

disproportionate number of young Indigenous adults are involved in organized crime due to the intergenerational effects of colonialism, through the loss of culture and community fragmentation and healthy family connections. Indigenous persons have lower employment levels compared to their non-Indigenous counterparts. The current unemployment rate for non-Indigenous persons is 5.5%, while it is nearly double at 10% for Indigenous persons (Statistics Canada, 2019 & 2015). Thus, gangs serve as a source of support and belonging and a means to make an income.

Third, Indigenous peoples are often subjects of racial profiling by law enforcement and they are five times more likely to be arrested than their non-Indigenous counterparts (Newell, 2013; Sewrattan, 2013). The Vancouver Police released recent data indicating that in 2017, Indigenous people accounted for over 16% of street checks, despite making up just over two percent of the population in Vancouver. (Vancouver Police Department, 2018). In June 2018, the Union of BC Indian Chiefs and the BC Civil Liberties Association submitted a Service or Policy Complaint to the Office of the Police Complaint Commissioner. The complainants argued that street checks were being conducted in a discriminatory manner and that the street check data is statistical evidence of discrimination (BCCLA, 2018).[2]

Chief Adam Palmer of the Vancouver Police Department provided a counter argument stating the overrepresentation of Indigenous people in the rates of street checks are not the result of discrimination, but rather the result of Indigenous people committing more crimes than the general population (Vancouver Police Department, 2018). However, this is not an accurate reflection of the realities faced by Indigenous person and a connection exists between racial bias

[2] While it is beyond the scope of this paper to address, it should be noted that a recent report by an independent consulting firm found that there was no conclusive evidence of profiling by the VPD (https://bccla.org/wp-content/uploads/2020/02/VPD-Street-Checks-Final-Report-17-Dec-2019.pdf).

and the overrepresentation of Indigenous persons. In fact, the Supreme Court of Canada's Gladue decision found just this. The verdict read, "There is evidence that this widespread racism has translated into systemic discrimination in the criminal justice system" (*R v. Gladue*, 1999, p. 721). The court further stated that the problem exists in all parts of the justice system, "[t]he excessive imprisonment of Aboriginal people is only the tip of the iceberg insofar as the estrangement of the Aboriginal peoples from the Canadian criminal justice system is concerned. Aboriginal people are overrepresented in virtually all aspects of the system" (*R v. Gladue*, 1999, p. 721). It is clear that the overrepresentation of Indigenous people in prisons and their overrepresentation in encounters with police are closely linked, and this pattern is a contributing factor to their overrepresentation in custody settings.

Complex Needs of the Offender Population

The circumstances and backgrounds of offenders often include a combination of substance abuse, mental health issues, childhood trauma or Adverse Childhood Experiences (ACEs), and Post Traumatic Stress Disorder (PTSD) (Martin et al. 2015; CSC, 2014 & 2015). The CSC (2015) reported that 26.6% of in custody offenders had mental health needs, including mood disorders (16.9%), alcohol or substance use disorders (49.6%), and anxiety disorders (29.5%) with many of these disorders co-occurring. The consensus in the research shows that Indigenous offenders have a slightly higher prevalence of mental disorder compared to their non-Indigenous counterparts and higher rates of co-morbidity with substance use disorder and antisocial personality disorder (Beaudette, Power & Stewart, 2015; Derkzen et al., 2012; Dolan, Rodas & Bode, 2015). As will be discussed below, these complex backgrounds pose significant challenges to correctional management and successful intervention and rehabilitation, and point

to the need to shift towards a more trauma informed system that reduces the historical overreliance on segregation to manage offenders with complex mental health challenges.

Adverse Childhood Experiences

The original longitudinal ACE's study conducted by Felitti et al. (1998) involved over 17,000 patients at the Kaiser Permanente Medical Care Program in San Diego. The authors developed a questionnaire with seven categories of childhood exposure to adverse childhood experiences, including psychological abuse, physical, and sexual abuse, emotional and physical neglect, and questions about household dysfunction, including substance abuse in the home, a member of the household with a mental illness, exposure to violence between caregivers, and criminal behaviour by household members (Felitti et al., 1998). The researchers assessed the relationship between childhood exposure and measures of adult risk behavior, health status, and disease using the answers to the ACEs questionnaire and the patients' medical records. The results showed a strong graded relationship between the between the breadth of exposure to abuse or household dysfunction during childhood and numerous risk factors for many leading causes of death in adults (Felitti et al., 1998). As the number of childhood exposures to dysfunction increased, so did the prevalence and risk for smoking, severe obesity, physical inactivity, depressed mood, and suicide attempts (Felitti et al., 1998). The ACEs scale has since become a standardized scale used in member organizations of the Centre for Disease Control, the World Health Organization, and other public health officials around the world (Anda et al., 2010).

Research has demonstrated that the cumulative effect of chronic exposure to ACEs inhibit the healthy development of social, emotional, and cognitive function, which correspondingly leads to increased risk of engaging in unhealthy, unsafe, or antisocial behaviours, increased risk of victimization, and increased rates of disease, disability, and

premature death (Anda et al., 2010; Felitti et al., 1998; Khoury et al., 2010; Martin et al., 2015). These early life experiences can therefore have long lasting effects that increase the risk for future contact with the criminal justice system.

Neurodevelopmental research has found that exposure to different experiences during childhood influences brain growth and the development of neurological pathways (Bruce, Gunnar, Pears, & Fisher, 2013). Childhood trauma weakens the brain structure and its function, leaving a person susceptible to later cognitive deficits and psychiatric illness, including schizophrenia, major depression, bipolar disorder, and PTSD (Bruce, et al., 2013; Khoury et al. 2010; Randall & Haskell, 2013). Being raised in an environment with exposure to chronic and cumulative ACEs can negatively affect important developmental processes due to the overproduction of stress hormones. Research has found that exposure to chronic and cumulative traumatic experiences creates an extended activation of the stress response systems (Anda et al, 2010; Bruce et al., 2013; Kraaijenvanger et al., 2020). More specifically, exposure to trauma can overwhelm the hypothalamic-pituitary-adrenocortical (HPA) axis, which regulates the body's response to cortisol (the stress hormone). This can lead to toxic stress that is harmful to brain development (Anda et al., 2006).

Kraaijenvanger et al. (2020) conducted a meta-analysis of MRI neuroimaging studies that investigated the effect of ACEs on neurobiological alterations in the limbic region, frontal cortex, and anterior cortex which can broadly be categorized into four domains: emotional processing, inhibitory control, memory processing, and reward processing. They found a consensus in the research that ACEs can leave a person vulnerable to future psychopathologies related to alterations in socio-emotional brain functioning. Exposure to ACEs was correlated with a significant decrease in function in the left superior frontal gyrus or the ridge on the

cerebral cortex. This area is responsible for various functions including risk and decision making, pain, emotion, and memory processing, and reward processing. Emotional processing was further compromised by dysfunction in the amygdala, which is responsible for emotions, survival, and memory (Kraaijenvanger et al., 2020). The dysfunction causes hyperactivity in the amygdala, leading to heightened awareness to potential threats, or increased emotional sensitivity. Amygdala hyperactivity and increased threat sensitivity is linked to PTSD, anxiety, depressive disorders, and addiction (Kraaijenvanger et al, 2020). This dysfunction has also been associated with reduced motivation and increased negative mood. This information regarding brain function offers critically needed explanations into the maladaptive behaviours of offenders, such as decreased emotional regulation, cognitive impairments (poor decision-making skills, impulsivity, lack of consequential thinking), substance abuse, and self-harm, all of which the research now suggests are likely related to early childhood trauma and the subsequent development of mental health issues, including PTSD.

The results of the original ACEs study prompted a plethora of subsequent research that demonstrated the cumulative and dose-response effect of chronic exposure to ACEs and how they inhibit the healthy development of social, emotional, and cognitive functions, which correspondingly leads to increased risk of cognitive deficits, psychiatric illness, including schizophrenia, major depression, bipolar disorder, and PTSD, as well as SUD (Khoury et al. 2010; Lee, Lynn, Oswald, & Wand 2018; Moore & Tatman, 2016; Weber et al., 2008). Furthermore, there are high levels of comorbidity between PTSD and SUD (Lee et al, 2018; Khoury et al., 2010). Early traumatic events may increase the risk of SUD as an attempt to self-medicate to lessen the symptoms associated with the acute and chronic exposure to trauma and

the resulting cognitive deficits, emotional dysregulation, and heightened awareness to potential threats.

Anda et al. (2006) examined the accumulation of ACEs and their association to emotional functioning, unhealthy, unsafe, and antisocial behaviours and found that the accumulation of four or more ACEs put individuals at significant risk for various adverse outcomes. This dose or building block effect has been found many times over, in that higher ACE scores are associated with long-term adverse outcomes (Khoury et al., 2010). Anda et al. (2006) also found a strong graded relationship to the prevalence of mental health and somatic disturbances and ACEs with persons who experienced four or more ACEs and compared those with person with no ACEs with those with four or more ACEs showing higher rates of alcoholism (15% compared to 2.5%), depression (49% compared to 18%), illicit drug use (35% compared to 8%), injection drug use (3.7% compared to 0.2%), hallucinations (4% compared to 1%), panic reactions (21% compared to 8%), anxiety (8% compared to 19%), sleep disturbances (56% compared to 1.3%), the risk of smoking (15% compared to 7%), and severe obesity (56% compared to 6%). Lastly, the respondents' perceived stress, difficulty controlling anger, and risk for perpetrating intimate violence increased 2.2, 4, and 5.5 times respectively for persons with four or more ACEs (Anda et al., 2006). The findings complement the original study but also demonstrate the pervasiveness of the cumulative effects of ACEs. Overall then, the initial research on ACEs demonstrated that early traumatic life experiences routinely lead to higher rates of engaging in unhealthy, unsafe, or antisocial behaviours that increase risk for criminalization, as well as increased risk of victimization, and increased rates of disease, disability, and premature death (Anda et al., 2006; Anda et al., 2010; Martin et al., 2015).

Martin et al. (2015) conducted a study of 5,154 of Canadian federally offenders admitted to custody in 2011. They examined the relationship between trauma, mental health, substance abuse, youth criminal convictions, and institutional violence during the first 180 days of incarceration. They utilized secondary data obtained from the offender intake assessment, substance abuse assessment, and mental health screening to collect data. Four items from the intake assessment were relevant: whether the individual was a victim of childhood abuse, witnessing intimate partner violence as child, if they had a history of youth convictions, and substance abuse assessment.[3] Data regarding institutional incidents was gathered using data from the Offender Management System, which records type of incident, the inmate's role as the instigator, and type of involvement (e.g., commit or attempt to commit). The substance abuse screening for alcohol and drug use determined if an offender was no to low, moderate, or high needs utilizing a screening tool that includes Michigan Alcoholism Screening Test, the Drug Abuse Screening Test, the Alcohol Dependence Scale, and the Severity of Dependence Scale (Martin et al., 2015). The mental health screening, which was administered using the Brief Symptom Inventory, consisted of a 53-item inventory that gathers the frequency with which a person experiences symptoms of psychological distress within the past seven days, focusing on anxiety, depression, obsessive-compulsive behaviours, somatization, interpersonal sensitivity, hostility, phobia, paranoia, and psychosis.

Within their sample of 5,154 inmates, Martin et al. (2015) found 59% of the inmates had substance abuse issues. Breaking down by demographics, of the 339 women, 60% had substance abuse issues, 59% men (4, 815), and 83% of Indigenous (1,128). Of the entire sample 45%

[3] As Martin et al. (2015) were using secondary data for their analysis they were unable to collect additional ACEs information from the offender population.

experienced trauma and broken down by demographics, women and Indigenous persons had much higher rates of trauma compared to men, with 58%, 67%, and 44% respectively. Of the total sample, 45% had youth charges, 30% women, 46% men, and 63% Indigenous. Lastly, 34% of the total sample had elevated distress, with 48% of women, 33% men, and 36% Indigenous.

Traumatic experiences were more common among women (58%) than men (44%) and Indigenous (67%) than non-Indigenous (38%). Women (48%) were more likely than men (33%) to report mental health distress, whereas similar numbers of Indigenous (36%) versus non-Indigenous (34%) offenders reported elevated mental health distress. Indigenous (83%) offenders were more likely to have moderate to severe substance abuse issues, while there was no difference between men (60%) and women (59%) offenders. Institutional violence was also higher for Indigenous (8%) and women (12%) offenders, than for men (5%).

Martin et al. (2015) also found that being a victim of childhood abuse and witnessing intimate partner violence as a child is common among in custody offenders, and that trauma often co-occurs with other risk factors such a substance abuse, youth crime, and mental health distress. For instance, 59% of inmates with histories of trauma reported at least two additional risk factors compared with 35% of inmates without histories of trauma. Offenders with co-morbidity with substance abuse or youth criminal charges were nearly twice as likely to have a violent institutional incident compared to offenders who have no risk factors. Conversely, offenders only reporting mental health distress were no more likely to have a violent incident (Martin et al., 2015).

Unfortunately, this appears to be the only study of its kind in Canada, and it was limited in that the researchers were not able to assess for most types of ACEs and their relationship with institutional violence and substance abuse needs, mental health issues, or youth convictions as

CSC does not currently gather information on ACEs. However, the findings were important in that they established that trauma, substance abuse, mental health issues, and youth offending is prevalent amongst offending populations and may increase an offender's likelihood of participating in institutional incidents. The involvement in institutional incidents may be considered actions that jeopardize the safety and security of the institution and may require the offender to be placed in SIU.

Although Martin et al. (2015) was unable to gather more data on ACEs in the Canadian federal in custody offender population, it is likely this group has many more ACEs than reflected in this study. This is based on international research demonstrating that both youth and adult offenders have high rates of ACEs and those adult offenders who have high ACEs also have a history of youth offending (Anda et al. 2006; Anda et al., 2010; Fox et al., 2015; Fleming & Nurius, 2019; Miley et al., 2020; Puszkiewicz & Stinson, 2019). Thus, the complex risks and needs among in custody offenders indicate a need for rehabilitative programming to address trauma.

The most common, and believed to be the most effective, form of rehabilitative correctional intervention is cognitive behavioural based; however, Miller and Najavits (2012) found that offenders with trauma histories struggle with the traditional cognitive behavioural therapy (CBT) based interventions and suggest incorporating understanding the effects of trauma through education and skills. Research demonstrates that ACEs alter brain function, offering an explanation of the maladaptive behaviours of offenders, as well as decreased emotional regulation and cognitive impairments (poor decision-making skills, impulsivity, lack of consequential thinking, substance abuse, and self-harm). CBT focuses on restructuring anti-social thinking and developing coping skills, through learning how thoughts and emotions

connect to behaviour (Clark, 2010). This implies that CSC should consider trauma when assessing an offender's responsivity factor within the risk-need-responsivity model and create or incorporate trauma education in existing programming curricula (Andrews et al., 1990). When providing treatment in custody, that treatment needs to address the in custody offenders level of risk, their specific needs, and that most importantly, it needs to be done in a way that responds to the in custody offender's learning style or ability (Andrews et al., 1990). Therefore, implementing a program that has the principles of CBT, with the focus on understanding thoughts and emotions related to trauma, could assist this population of offenders with overall institutional behaviour and a level of readiness to participate in rehabilitative correctional programming.

Co-morbid Mental Health Needs in Federal Correctional Populations

The CSC (2014 & 2015) has reported that approximately one-quarter of all in custody offenders have documented mental health needs. Most commonly these include lifetime alcohol or substance use disorders (49.6%), anxiety disorders (29.5%), and mood disorders (16.9%) (CSC, 2014 & 2015). In addition, lifetime disorder rates for antisocial personality disorder (APD) were 44.1% and borderline personality disorder (BPD) were 15.9% (CSC, 2015). These rates far exceed those found in the general population with 21% of the general Canadian population having a lifetime alcohol dependency, 18% cannabis dependence, and 7% other drug dependence, 9% anxiety disorders, and 13% with mood disorders, while between 6% to 15% of the population are affected by APD and rates of lifetime BPD in the general Canadian population are between 1% to 2% (Statistics Canada, 2012).

Male and female in custody offenders have different rates of mental illness, with women generally demonstrating higher rates than men (Brown, Barker, McMillan, Norman, Derkzen, &

Stewart, 2018). However, the following data produced by the CSC should be viewed with caution for a few reasons. Firstly, the sample sizes in two mental health studies conducted by CSC were quite small and not representative of the population. For instance, the research project conducted with female offenders in 2016 only had a sample size of 154 women (Brown et al., 2018). The entire population of in custody women in 2016 was 1,279 (Public Works, 2017). This suggests only 23% of the population of women were represented. Only 48 of the women were Indigenous while the general population of Indigenous women was 251, so representing only 19%. Similarly, a study with male in custody offenders was conducted in 2012, where 695 men participated (Stewart & Wilton, 2017). As Public Works (2017) showed there were 14,702 men in custody in 2016, this equates to only 5% of the population. Similarly, the number of Indigenous male offenders in 2012 was 3,532 (Public Works, 2017) while the study only had 56 Metis offenders and 173 First Nations offenders, resulting in only 6% of the Indigenous accounting for the entire sample (Stewart & Wilton, 2017).

In addition, the data on the prevalence of mental illness for male and female offenders was not gathered and collated at the same time by CSC. Furthermore, the CSC does not have well documented historical data on mental illness or co-occurring mental illness leaving it very difficult to draw comparisons over time. Data was collected by CSC on female offenders in May 1995, however there was no similar data set collected during that time for male offenders (Blanchette & Motiuk, 1996). Also, the 1995 data on female offenders was collected using version III-A of the Diagnostic Interview Schedule (DIS), the most commonly used tool at the time, which makes comparing the rates of mental illness over time rather difficult due to changes in diagnostic criteria. For example in 1995, a major mental disorder included schizophrenia, schizophreniform disorder, or mania, whereas the current definition of a major mental disorder

includes major depressive disorder, bi-polar I, bi-polar II disorder, or any psychotic disorder. Therefore, for the purposes of this paper only the current data on mental illness for male and female in custody offenders will be provided. Lastly, the data did not present well when attempting to compare Indigenous men and women. Indigenous men were broken up into subcategories of Metis and First Nations, while the study conducted with women considered all groups in one category of Indigenous. With all of this in mind, the following results must be read with caution and used in conjunction with alternate sources of information such as international and non-CSC Canadian data.

Between February 2016 and October 2016, Brown et al. (2018) collected data from 151 Canadian federally incarcerated women. As discussed a notable issue with this data is the overall small sample size and, despite the overrepresentation of Indigenous peoples in custody, the sample sizes were too small to generate reliable and valid significance tests and therefore, the subsequent differences between groups should be interpreted with caution. In the study by Brown et al. (2018), 100% (48) of Indigenous women met the lifetime criteria for any disorder, compared to 90% of non-Indigenous women. The lifetime prevalence of major mental illness for Indigenous women was 54% versus 63% for non-Indigenous women (major depressive disorder, bi-polar I disorder, bi-polar II disorder, or any psychotic disorder) (Brown et al., 2018). Conversely, the rates of PTSD for Indigenous women was 33% compared to 27% for non-Indigenous women. Similarly, the lifetime prevalence rates for Indigenous women was higher for SUD at 81% compared to 77% of non-Indigenous women. Co-occurring diagnoses were common, with 64% of women in custody having another mental disorder in combination with a personality disorder and 82% in combination with SUD. Furthermore, co-occurring disorders

were higher among Indigenous women (89%) with SUD occurring in combination with APD and borderline personality disorder (Brown et al., 2018).

Turning to the research on male in custody offenders, as with female in custody there appears to be notable issues with this data. Despite the overrepresentation of Indigenous peoples in custody, the sample sizes were too small to generate reliable and valid significance tests and therefore, the subsequent differences between groups should be interpreted with caution. Between March 2012 and September 2014, 70% of men admitted into federal custody met criteria for at least one lifetime mental disorder (Beaudette, Power, & Stewart, 2015). The rates of SUD was 50%, while 13% had PTSD, 3% had a major mental illness (major depressive disorder, bi-polar I disorder, bi-polar II disorder, or any psychotic disorder), 44% had APD, and 40% had a mood disorder. Again, co-morbid diagnosis was common with 13% of Caucasian men in custody having a personality disorder in combination with a substance abuse disorder and 7% with any Axis I disorder (mood disorders, psychotic disorders, anxiety disorders and eating disorders) and SUDs (Stewart & Wilton, 2017). The sample of First Nations and Metis men also demonstrated that co-morbid diagnosis was common with 22.5% and 38% respectively having personality disorder in combination with a substance abuse disorder and 10% and 9% respectively with any Axis I disorder and SUDs (Stewart & Wilton, 2017).

Although the data out of CSC had some methodological issues, research in the area clearly demonstrates that offender populations have significantly higher rates of mental illness, mental disorders, and co-morbidity (Statistics Canada, 2012). The prevalence and complexity of comorbid disorders presents challenges when it comes to effective treatment and rehabilitation as mental illness can create maladaptive coping mechanisms through substance abuse relapse, self-injurious behaviour, and criminal recidivism after release (Kubiak, 2004; Messina, Burdon,

Hagopian, and Prendergast, 2004; Smith & Trimboli, 2010; Tam & Derkzen, 2014). The integration of trauma-informed practices can assist with these challenges by offering staff training and awareness in both trauma and mental health and provide offenders relevant treatment to learn skills to manage the symptoms of mental illness.

Drug Use in Custody

The previous section identified that SUDs are common to in custody offenders, one reason potentially being their association with ACEs and other co-occurring disorders, as substances like drugs have been identified as maladaptive coping mechanisms in response to early trauma (Altintas & Bilici, 2018; Kubiak, 2004; Messina, Burdon, Hagopian, and Prendergast, 2004; Smith & Trimboli, 2010; Tam & Derkzen, 2014). Maladaptive coping mechanisms continue into incarceration and research suggests that offenders who are exposed to trauma tend to use substances to cope even while incarcerated (Kraaijenvanger et al., 2020; Sotero, 1996). For instance, the CSC keeps account of all overdose incidents within federal institutions. The data drawn from these incidents show that among those who intentionally overdosed nearly half engaged in self-injurious/suicidal behaviours in their lifetime, the majority of whom were considerably more likely to have at least one mental health disorder and histories of substance misuse (McKendy, Biro, & Keown, 2018). In addition, those who experienced overdose had histories of institutional and/or disciplinary issues related to drugs, contraband, and disobedience as well as compatibility issues with other in custody offenders and staff, while the vast majority of offenders had histories of administrative segregation. Lastly, nearly 40% of all overdose incidents involved Indigenous offenders. This is likely due to the higher overall rates of SUD for Indigenous offenders and because Indigenous offenders were somewhat more likely than non-Indigenous offenders to have at least one mental health disorder (75% versus 67%).

As discussed above, trauma experiences from the intergenerational effects of colonization for Indigenous persons and ACEs for the offender population in general, including Indigenous persons, has significantly contributed to psychological problems, including mental illness, SUDs, and PTSD (Sotero, 1996). These complexities lead many offenders to choose substances as a way to cope and may inadvertently overdose, or go so far as to wish to end their lives. In recognizing the vast number of offenders with SUDs and in support of the Liberal government's Canadian Drugs and Substances Strategy, the CSC has recently put in place improved harm reduction options for federal offenders.

Harm Reduction

The Canadian Drugs and Substances Strategy is focused on prevention, enforcement, treatment, harm reduction, funding and evidence (Government of Canada, 2019b). The strategy is a multi-faceted approach focusing on the importance of addressing substance abuse from multiple angles, in more holistic ways than simply focusing on enforcement. Under this strategy, harm reduction options have been increased, such as the availability for opioid agonist treatment (OAT)[4] in the community, naloxone[5] became a non-prescription drug and thus became widely available, there was rapid expansion of supervised injection sites, streamlining the application process for communities that wish to open supervised consumption sites, and harm reduction

[4] Opioid agonist treatment (OAT): Long-term treatment with an opioid agonist medication recognized for use in the treatment of opioid use disorder (CRISM, 2018).

[5] Naloxone is a harm reduction intervention used for the prevention of opioid overdose deaths and is a standard of care for temporarily reversing opioid overdoses. The intent of managing an opioid emergency with naloxone is to move the continuum of care forward prior to the arrival of emergency medical services. *Previously, naloxone was only accessible by CSC medical staff in the form of injectable naloxone. In fall of 2016, CSC acquired the nasal spray version of naloxone (Narcan™) to be stored in the Correctional Manager's office for use by correctional officers. Narcan™ nasal spray is also now available for use by nurses in addition to the injectable version (McKendy et al., 2018)

measures to federally funded health services for First Nations and Inuit communities (Government of Canada, 2019).

The OAT program has been offered as a harm reduction measure for 20 years for federal offenders (CSC, 2019). OAT is considered an important harm reduction intervention in the prevention of hepatitis C and HIV and is considered the treatment of choice for opioid dependency (Artenie et al., 2019; Bruneau et al. 2018; Nordt et al., 2018). This is most commonly provided to those with an opioid dependence through a prescription for methadone or buprenorphine (Nordt et al., 2018). Further, Bruneau et al.'s (2018) clinical practice guideline strongly recommends against withdrawal management in isolation and OAT is pivotal in providing withdrawal support. They found that those who attempted detoxification from opioids without an immediate transition to long-term addiction treatment were associated with elevated risk of relapse, and death from overdose (Bruneau et al., 2018).

In keeping with the Canadian Drugs and Substances Strategy and in recognizing the high rates of SUDs in custody, the CSC recently began offering needle exchange programs and safe injection sites in custody (CBC, 2018; Zinger, 2019). In contrast to the OAT programming, which is more focused on managing withdrawal from substance addiction, the primary focus of needle exchange and safe injection site programs is to prevent or reduce negative health or other consequences associated with drug misuse (Sawangjit, Mehnmood Khan, & Chaiyakunapruk, 2016). Unfortunately, the guidelines for their use in custody are not publicly available at this time and there is no publicly available research on their use. However, needle exchanges, safe injection sites, and OAT programs have very promising outcomes in the community (Government of Canada, 2018; Kennedy et al., 2019; Lazarus et al., 2018).

The first safe injection site in North American opened in Vancouver in 2003 and since that time more than 90 now exist worldwide (BC, 2017; Jozaghi, Kennedy et al., 2019; Andresen, & Martin, 2013). This is due to the very positive health outcomes researchers have found coming out of the Vancouver site. Kennedy et al. (2019) followed a community-recruited cohort of 811 people who injected drugs in Vancouver, for 6 years. The longitudinal study assessed the association between frequent supervised injection site use and all-causes of mortality. Kennedy et al. (2019) found a high premature death rate as a total of 112 participants (13.8%) died during the six year follow-up. However, they also found that individuals who reported using supervised injection sites at least weekly had a reduced risk of dying compared to those who reported less than weekly or no use at all meaning the program seems to reduce the negative health implications associated with drug use. This association held after statistical adjustment for potential variables that could influence the outcome including age, sex, HIV, unstable housing, at least daily cocaine injection, public injection, incarceration, enrolment in addiction treatment, and calendar year of interview.

Needle exchange services in the community can be provided through pharmacies, primary health clinics, vans, vending machines and via health workers who provide a one-on-one exchange to reduce the harm in a specific community (Sawangjit, Mehnmood Khan, & Chaiyakunapruk, 2016). A recent meta-analysis by Sawangjit and colleagues (2016) was completed to systematically appraise the existing evidence on the effectiveness of pharmacy-based needle exchange programs, which generally are a free one-for-one service to clients who return a used syringe. Of the 14 studies meeting the inclusion criteria, eight were from the United States, three from Australia, and one from Estonia, Canada, and the United Kingdom. The analyses revealed that those who used pharmacy-based needle exchanges reported they were less

likely to share syringes and also used safe syringe disposal. However, the effect on transmission of blood-borne pathogens, including HIV, hepatitis B virus (HBV), hepatitis C virus (HCV) and human T cell lymphotrophic viruses was inconclusive due to the limited number of studies and variances in definitions, outcomes, and the reporting practices of services provided. Still, the results of their analysis are helpful for the purposes of this paper, as needle exchange in the prison environment is facilitated through institutional health care and only a trained medical expert can provide the exchange (Zinger, 2019). As with pharmacy-based needle exchanges, the exchange only occurs through a pharmacist.

While promising in terms of the harm reduction implications, the implementation of needle exchange and safe injection site programs in federal institutions has come with scrutiny from security staff, likely due to a lack of staff awareness surrounding the benefits of such programs. The prison needle exchange and safe injection sites were vehemently objected to by correctional officers and their union. The union president stated that, "[t]his program represents a dangerous turning point. Correctional Service Canada has decided to close its eyes to drug trafficking in our institutions. It has chosen to encourage criminal activity inside the walls instead of investing in the care and treatment of in custody offenders who are drug addicts or carriers of infectious disease" (CBC, 2018, par 15). Managing OAT, needle exchange, and safe injection site programs in an institution does require a balance between harm reduction and ensuring the safety and security of the institution. It is essential for health and security partners to operate according to their specific roles; however, this is likely where the areas of enforcement and harm reduction within the Canadian Drug and Substances Strategy converge and may conflict within the correctional setting.

The OCI has expressed some concerns with how the prison needle exchange and safe injection sites have been implemented in CSC. Zinger (2019), said that "[h]arm reduction strategies can only be successful if there is uptake on the part of the user and so far [there] seems to have built-in restrictions to enrolment" (p.15). He reported that according to the contract in custody program participants are required to sign, they accept that disciplinary measures will continue to be implemented if the in custody offender is found to be possession of illicit drugs or drug paraphernalia (except for the kit and supplies provided). Kits can be seized if the syringe or needle is altered, missing, or observed outside the kit. Therefore, it is safe to say that despite the introduction of safe injection sites in their institutions, the CSC continues to subscribe to a zero tolerance approach to drug possession. This seems quite counterintuitive when one will have to carry their illicit drugs to the safe injection site within the institution, or if they choose to use in their cell, an officer could seize and discipline the offender for this choice. Zinger (2019) further stated that "harm reduction cannot be effective without buy-in of both users and providers" (p.16). Harm reduction informs and empowers individuals in reducing the harms associated with drug use. Yet Zinger (2019) believes that the CSC will fail to reach the objectives of harm reduction if it continues to stigmatize and punish drug use. It is relevant that drug use is often used to manage the symptoms associated with trauma and mental illness (Maté, 2009). This again demonstrates the importance of implementing a trauma informed system that recognizes the underlying reasons for why these behaviours exist and exemplifies the need for more training for staff.

To aid in changing the culture of zero-tolerance and the punitive approach to illicit drug use and to bring a level of consistency to all harm reduction measures within the CSC, the organization should consider updating the prison needle exchange program, safe injection site,

and OAT guidelines to include trauma informed care practices. The National Clinical Practice Guidelines were used as best practices in both the prevention and harm reduction pillars of the Canada's Drug and Substances Strategy (Government of Canada, 2019b). The guidelines were created through the Canadian Research Initiative in Substance Misuse (CRISM) (2018), the National Guideline for the Clinical Management of Opioid Use Disorder, and the Canadian Medical Association Journal (CMAJ)

Best practice guidelines suggest implementing trauma informed practice and processes to avoid withdrawal from substances in isolation and strongly recommended the inclusion of harm reduction services, such as OAT, take-home naloxone, sterile needle distribution programs, and supervised consumption or injection services, in the continuum of care for opiate use disorder (CRISM, 2018). According to the National Guideline for the Clinical Management of Opioid Use Disorder (CRISM, 2018), "due to the higher prevalence of trauma history and comorbid post-traumatic stress disorder among individuals with substance use disorders compared to the general population, clinicians should incorporate the principles of trauma-informed practice (e.g., trauma awareness; safety and trustworthiness; choice, collaboration and connection; strengths-based approaches and skill building) where appropriate" (p. 39).

The CSC could implement trauma informed awareness training for all frontline staff to increase their understanding of the connection between trauma experiences and substance abuse and the benefits of harm reduction. This may help reduce the concerns associated with prison needle exchange programs and safe injection sites. Research has found that trauma informed services and training also increases awareness of vicarious trauma and staff burnout (Canadian Centre on Substance Abuse, 2014). Vicarious trauma is an indirect result of being exposed routinely to the traumas experienced by the population they supervise. It leads to a sense of

identification with trauma that may result in staff experiencing trauma-like symptoms (Miller & Najavits, 2012). Many providers have experienced trauma themselves and may be triggered by clients' responses and behaviours. Experiencing vicarious trauma or being triggered by others' trauma can affect workplace decision making. In the absence of effective trauma informed tools, prison systems can become highly reactive and reliant on management by crisis, which has historically resulted in the over use of segregation and use of force for vulnerable and complex offenders. Important elements of trauma-informed services include staff education, clinical supervision, and policies and activities that support staff self-care.

Engagement and Intervention Model

According to the correctional investigator, CSC implemented the *Engagement and Intervention Model* (EIM) in 2018 after considerable criticism was directed towards the agency surrounding the use of force specifically towards those with mental health issues (CD 567, 2018; Zinger, 2018). CSC developed and implemented the EIM which is a "person-centred" approach to managing security. The EIM emphasizes the importance of non-physical and de-escalation responses to incidents and the need to clearly distinguish response protocols for situations involving physical or mental health distress. As outlined in Commissioner's Directive (CD) 567, *Management of Incidents*, these responses include taking into consideration the offender's mental and/or physical health and well-being to promote the peaceful resolution of the incident. Use of force is to be limited to only what is necessary and proportionate and continually assessing the situation for change, and staff presence will be used to prevent and resolve incidents through the demonstration of positive attitudes and behaviours (CD 567, 2018).

It difficult to determine if an attempt was made to incorporate a trauma informed philosophy within the EIM, as is the case for the OAT guidelines, publicly available information pertaining to the implementation and impact of the EIM is limited. Beyond what is available in

the CD, the only available information has been provided by the Correctional Investigator, who observed that despite the introduction of EIM, the rate of use of force incidents increased in 2018-19 (Zinger, 2019). In fact, use of force incidents were the highest ever recorded in CSC facilities (Zinger, 2019). For instance, the deployment of the Emergency Response Team was identified in 7.8% (121) of all recorded use of force incidents in 2018-19, compared to 5.9% (77) in 2017-18. Overall, 181 (11.7%) use of force incidents involved an allegation of excessive, unnecessary, and/or inappropriate use of force, compared to 114 (8.7%) in 2017-18. CSC identified "healthcare issues" in 666 (43%) of recorded use of force incidents compared to 435 (33.4%) in 2017-18. Lastly, 14.1% (219) of incidents occurred in segregation, compared to 8.4% (110) in 2017-18 (Zinger, 2019).

The Correctional Investigator reported that some of the most troubling use of force incidents involved inmate-patients residing at the Regional Treatment Centres (RTCs) or psychiatric hospitals (Zinger, 2019). The five Treatment Centres accounted for roughly 20% of all use of force incidents in 2018-19 (296 out of 1,546) (Zinger, 2019). One out of ten incidents at the Treatment Centres was deemed unnecessary and/or inappropriate. Millhaven RTC accounted for 80% of these. This begs the question whether there are necessary competencies and training for security staff (Zinger, 2019). The Correctional Investigator raised concerns in the 2018 annual report stating that "CSC ensure security staff working in a Regional Treatment Centre be carefully recruited, suitably selected, properly trained and fully competent to carry out their duties in a secure psychiatric hospital environment" (Zinger, 2018, p. 22). Yet the CSC reports that all correctional staff, including those who are working in Regional Treatment Centres, are carefully recruited, selected, and trained (Zinger, 2018). Still, during site visits, OCI investigative staff have noted the trend of front-line security staff at Treatment Centres

sitting behind a desk or barrier largely disengaged with inmate patients. In fact, the majority of interactions between patients and correctional staff appear to be prompted by patients. This kind of security position reinforces the existing culture of "us-versus-them" which is at odds with a trauma informed ideology (Zinger, 2018).

There is little research on the issue of use of force within the correctional setting, with the majority of research focused in policing literature, leaving such topics as use of force by correctional officers as well as officers' attitudes toward use of force relatively unexplored (Varrette & Archambault, 2011). According to Varrette and Archambault (2011) the focus of these few studies is most often on correctional officers, examining such factors as their attitude, demeanour, or the approach they take to particular situations. Interestingly an older qualitative study by Hemmens and Stohr (2001) found correctional officer subcultural norms supported use of force against inmates; these norms were based on correctional officer's mistrust of inmates leading to an inability of officers to establish meaningful relationships with inmates. It seems as though this finding is still relevant today based on the OCI's observation of the us-versus-them position.

The CSC defines use of force as verbal orders, physical handling/escort, and the use of restraint equipment (soft restraints, handcuffs, leg irons, or body belts), Institutional Emergency Response Team presence, and chemical agents/inflammatory sprays (Varrette & Archambault, 2011). As noted above, use of force incidents are quite high within the correctional regional hospital settings, which houses offenders with severe mental health disorders similar to persons housed in psychiatric hospitals or psychiatric wards in general hospitals in the community. Individuals housed in regional treatment centres are generally evaluated as high needs and high risk, have a history of self-injurious behaviour, and have documented lifetime psychiatric

diagnoses. The most common diagnoses included substance abuse disorders, antisocial personality disorders, and schizophrenia/psychotic disorders (Varrette & Arhambault, 2011). Varrette and Arhambault (2011) reported that there are two types of use of force: spontaneous and planned. Spontaneous use of force usually involves an immediate intervention by staff requiring at least one of the aforementioned use of force measures to safely resolve a situation (Varrette & Archambault, 2011). Whereas, a planned use of force requires the deployment of line staff and emergency response team in conjunction with a minimum of one of the use of force measures to properly handle a security incident (Varrette & Archambault, 2011). Of particular interest, Regional Treatment Centres had higher rates of spontaneous use of force compared to planned. For example in 2009, there were 143 spontaneous use of force compared to 81 planned (Archambault, 2009). Unfortunately, there is no other publicly available data to compare spontaneous versus planned use of force. However, it is clear based on the data provided by the OCI that use of force has increased overall and is still high at the Regional Treatment Centres, allowing for the summation that staff at the treatment centres may be continuing to engage in spontaneous use of force, which may be the result of inadequate training and understanding.

A trauma-informed framework has been used to reduce and eliminate the use of coercive practices in some mental health services and systems (Azeem et al., 2011; Borckardt et al., 2011). There is no research specifically focused on use of force reduction using trauma informed practice within a prison or in a prison hospital setting; however, the following two studies both took place in a hospital setting in the community and the results may be transferable to the prison hospital settings given similarities in both environments.

Azeem et al. (2011) conducted a study to see what effect trauma informed training had on the rate of restraint and seclusion in a hospital setting with youth. Hospital staff received training in March 2005 in strategies that are based on trauma informed care. Medical records were reviewed for youth admitted between July 2004 and March 2007 (Azeem et al., 2011). Data was collected on demographics, including age, gender, ethnicity, number of admissions, type of admissions, length of stay, psychiatric diagnosis, number of seclusions, and restraints. 458 youth (females 276/males 182) were admitted between July 2004 and March 2007. In the first six months of study, the number of seclusions/restraints episodes were 93 (73 seclusions/20 restraints), involving 22 children and adolescents (females 11/males 11) (Azeem et al., 2011). Comparatively, in the final six months of study following the training program, there were 31 episodes (6 seclusions/25 restraints) involving 11 children and adolescents (females 7/males 4). The major diagnoses of the youth placed in seclusion and/or restraints were disruptive behavior disorders (61%) and mood disorders (52%). This study shows a downward trend in seclusions/restraints among hospitalized youth after implementation of the National Association of State Mental Health Program Directors six core strategies based on trauma informed care (Azeem et al., 2011).

Borckardt et al. (2011) conducted a similar study using a sample of adult patients and staff in a large state funded hospital in the southern US. A model designed to reduce seclusion and restraint was implemented in five inpatient units and was randomly assigned to implement the intervention components in a different order, with each unit serving as its own control. There was a total of 89,783 patient-days over a 3.5-year period from January 2005 through June 2008 (Borckardt et al., 2011). The intervention components included trauma-informed care training, changes to unit policy, and involvement of patients in treatment planning. The

rate of inpatient psychiatric seclusion and restraint (per patient day) was tracked continuously during the 3.5-year period. There was a significant reduction of 82% in the rate of seclusion and restraint observed between the baseline phase of January 2005 through February 2006 and the follow-up, post-intervention phase of April 2008 through June 2008 (Borckardt et al., 2011). The results suggest that substantial reductions in use of seclusion and restraint are possible in inpatient psychiatric settings and that changes to the environment, including trauma informed training, policy change, and empowering client's involvement in their treatment may have a significant effect on use of seclusion and restraint (Borckardt et al., 2011).

While not all use of force incidents can be avoided, it seems they should be reduced and virtually eradicated from a hospital setting given the new EIM policy framework. This leaves some questions unanswered; were staff sufficiently trained in this new model? Do staff have an adequate understanding of the purpose of the model? Were staff given the opportunity to participate in its development and if they were not, does this perpetuate an us-versus-them attitude? Further down in this paper, potential solutions to these issues using a trauma informed ideology will be provided with the overarching philosophy of trauma informed practice being, to build knowledge, change attitudes, and develop policies and practices conducive to creating an environment that is supportive for those with complex needs including those with histories of trauma, and mental health issues including PTSD and substance abuse issues.

Policy Changes Regarding Segregation

As with use of force, those with mental health issues were highly overrepresented in segregation placements and research has demonstrated that segregation can heighten those symptoms. Segregation can also cause psychological damage to those with no prior indication of such. At least two literature reviews have noted that researchers from diverse backgrounds,

across several continents, and over many decades, have reached almost identical conclusions about the negative effects of isolation (Haney & Lynch 1997; Grassian, 2006).

For instance, Canadian researchers Scott and Gendreau (1969) conducted a study where experimental subjects were placed in isolation for seven days and were then compared to a control group. The differences noted between the two groups were based on electroencephalogram (EEG), which is used to evaluate the electrical activity in the brain. Brain cells communicate with each other through electrical impulses and an EEG can be used to help detect potential problems associated with this activity. The researchers found there was a decline in EEG levels in the isolated group. They found that the physiological differences correlated with apathetic and lethargic behaviour and the longer the isolation, the greater the withdrawal. They asserted that offenders subjected to isolation did not receive adequate stimulation and suggested that this sensory-deprivation could not adjust to sudden release into free society because their mental and emotional mechanisms were adjusted to deprivation. They suggested that adequate stimulation should be introduced into isolation environments, as well as programs such as education, shop training, instruction in trades, and physical exercise, and that the lack of such programs was detrimental to health and long-term rehabilitation.

These findings are consistent with more recent research suggesting the importance of meaningful social contact for the maintenance of mental and physical health. For instance, the American Psychological Association (2016, p. 1), asserted that “solitary confinement is associated with severe harm to physical and mental health among both youth and adults, including: increased risk of self-mutilation, and suicidal ideation; greater anxiety, depression, sleep disturbance, paranoia, and aggression; exacerbation of the onset of pre-existing mental illness and trauma symptoms; [and] increased risk of cardiovascular problems.”

Prior mental health issues and trauma may predispose an individual to a higher risk of psychological distress while in segregation (Shalev, 2011). According to Knowles (2015) persons in segregation have restricted access to treatment options. Psychotropic medications are less effective in confinement and the lack of privacy and restricted environment limits the ability for consultation with mental health professionals. As previously noted, correctional institutions have a significant number of mentally ill offenders and because of this, it is expected many would be placed in segregation (Stuart, 2018). Fellner (2006) contends that this originates from disruptive behaviours that are a symptom of mental illness and that they are the same disruptive behaviours that would meet the requirements for a placement in isolation.

In a special report, the Office of the Correctional Investigator expressed numerous concerns with the use of segregation for those with mental illness, including the over reliance on segregation to manage mentally ill, self-injurious, and offenders at risk for suicide (Zinger, 2013). The report outlined that between 2011 and 2012, there were 8,700 placements in segregation, which was an increase of 700 from the previous five years (Zinger, 2013). Of the 8,211 segregation placements in 2013, Indigenous offenders were over-represented accounting for 30% (2,402) of all segregation cases compared to 71% (5,819) for non-Indigenous persons. These numbers need to be understood in the context of the overall inmate population, where Indigenous persons, at the time, accounted for 4,463 (20%) of the entire in custody offender population of 22,138 (Public Works 2017). Despite previous recommendations to reduce the duration of time held in segregation, 44% were held for greater than 30 days and 16.5% were held for less than 120 days (Zinger, 2013). The average length of stay for men was 35 days and seven for women.

In line with previous research the chief correctional investigator at the time further stated that segregation may escalate behaviour among those with mental illness (Haney & Lynch, 1997; Grassian, 2006; Helmus et al., 2019; Knowles, 2015; Scott & Gendreau, 1969; Sapers, 2014; Shalev, 2011; Zinger, 2013). For example, between 2011 and 2014, there were 30 suicides in custody with 14 occurring while in segregation. Only one segregated inmate was being actively managed on suicide watch (24-hour monitoring via video) at the time of his death, while at least three were being monitored (30 minute visual checks). Nearly all segregated inmates had known significant mental health issues; most were or had been referred and/or seen by mental health staff while on segregation status, some on a regular basis. The majority of segregated inmates had a history of previous suicide attempt(s), suicidal ideation, and/or self-harming behaviour (Sapers, 2014). At least half had spent a previous period in segregation on mental health monitoring. The difference between those who committed suicide while in segregation versus those in the general inmate population is that all those in segregation had known mental health issues. The general population inmates may have had mental health issues but they were yet to be disclosed. Sapers (2014) concluded that suicides in the general offender population were likely related to institutional adjustment issues as many were not yet through the intake process or they were on temporary detainment status after a suspension from the community.

Ethical concerns regarding the use of segregation have been raised and these were precipitated by the highly publicized suicide deaths of federal inmates, Ashely Smith and Eddie Snowshoe (Bromwich & Kilty, 2017; Wright, 2019). Sapers (2008) reported that the death of Ashley Smith was attributed to long-term administrative segregation and was preventable. Ashley's death was a result of multiple individual and systemic failures of CSC (Sapers, 2008), and her death was ruled a homicide by a Coroner's inquest in Ontario in 2013 (Chief Coroner,

Province of Ontario, 2013). Edward Snowshoe committed suicide after spending 162 days in segregation while the site he was residing in claimed they were unaware he had had previous suicide attempts while in federal custody (White, 2014).

The Corporation of the Canadian Civil Liberties Association (CCLA) in Ontario and the British Columbia Civil Liberties Association (BCCLA) and John Howard Society brought forth legal challenges to the constitutionality of segregation and argued that the sections pertaining to segregation in the CCRA were counter to the *Charter of Rights and Freedoms* (the Charter). Specifically, the Ontario CCLA challenged the constitutionality, under article 7 of the Charter, of sections 31-37 of the CCRA, which authorizes CSC to remove inmates from general population and place them in segregation (*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491).

Firstly, the Ontario court judgment discussed the Mandela Rules, the United Nations Standard Minimum Rules for the Treatment of Prisoners (United Nations, General Assembly resolution 70/175, annex, adopted on 17 December 2015). The Mandela Rules "set out what is generally accepted as being good principles and practice in the treatment of prisoners and prison management" (p.7). It is important to acknowledge that they do not constitute an obligation for Member States. Rather, the Mandela Rules provide a framework for nations to consider adopting and apply to the detention and imprisonment of any individual. Rule 1 mandates that no prisoners shall be subjected to torture, or cruel, inhumane, or degrading treatment, and that all prisoners shall be protected from punishment. Rule 1 also states that safety and security must be ensured for all those within an institution, including inmates, staff, service providers, and visitors. Under Rule 44, solitary confinement is defined "as the confinement of prisoners for 22 hours or more a day without meaningful human contact" (United Nations General Assembly,

2015). Rule 45 provides that the use of solitary confinement for individuals that are mentally ill or disabled should be prohibited when their conditions would be exacerbated by the conditions of confinement. Prolonged or indefinite solitary confinement for disciplinary reasons is prohibited under Rule 43, whereby prolonged is defined as greater than 15 consecutive days under Rule 44.

In a previous report submitted to the United Nations General Assembly, Professor Mendez, the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment, between November 2010 and October 2016, stated that "solitary confinement reduces meaningful social contact to an absolute minimum and that the resulting level of social stimulus is insufficient to allow the individual to remain in a reasonable state of mental health" (*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491, para 42). The judge specifically summarized Dr. Mendez's report stating that, "[the] research indicates that when individuals are deprived of a sufficient social stimulation they become incapable of maintaining an adequate state of alertness and attention to their environment. He stated that, if this occurs for even a few days, brain activity shifts toward an abnormal pattern" (*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491, para 42).

The government contended that it did not practice what the Mandela Rules consider as solitary confinement. They government relied on the fact that inmates were allowed out of their cell for more than two hours a day for recreation and other meaningful contact plus additional time for a daily shower (*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491, 2017, para 38). The judge, however, did not accept the government's submission, stating time spent in the shower is a small increase to the two hours per day that segregated inmates are allowed out of their cells. Furthermore, the judge said the

contact with CSC staff was not persuasive evidence of 'meaningful' contact. The judge determined that, "Canada is using administrative segregation to isolate prisoners in a way captured by the term solitary confinement as that term is defined in the Mandela Rules" (*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491, para 46).

Once this was determined, the issue moved onto the constitutionality of the CCRA specifically looking at section 7 of the Charter, which provides that 'everyone has the right to life, liberty, and security of the person' and to not be deprived of those rights unless 'in accordance with the principles of fundamental justice'. Interpretation of a section 7 infringement of the Charter requires a two-part analysis. First, there must be an infringement of life, liberty, or security of the person. Second, that infringement must be inconsistent with the principles of fundamental justice (*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491). The CCLA asserted that administrative segregation constituted a deprivation of liberty and of security of the person for three reasons: 1) the legislation is not in accordance with the principles of fundamental justice; 2) it is arbitrary; and 3) it is procedurally unfair (*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491). They maintained that this constituted "the most serious deprivation of liberty" (para 85). The judge was satisfied that the evidence presented by the CCLA established that segregation placements imposed psychological stress, "quite capable of producing serious permanent observable negative mental health effects" (*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491, para 89).

The court found that the decision-maker, i.e. the Institutional Head, was insulated from being required to conduct a meaningful review and was not meeting the basic principles of

fundamental justice and procedural fairness by lacking in a robust review, which the judge contended are the basic principles of the Canadian judicial system and legal process. Essentially, the justice found that procedurally the Institutional Head was both the decision maker concerning decisions to admit and to release an inmate from administrative segregation and was also the person to choose who participated in segregation review boards. Moreover, the Institutional Head did not have to heed the recommendations made by the review board. This process was considered inherently problematic as it is a basic principle of the Canadian judicial system and legal process that a decision maker should not sit as a member of a tribunal hearing an appeal from his or her own decision (*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491). A procedure which mandates that the Institutional Head is both the decision maker and the only person who can vary the decision ignores this basic principle. The judge was therefore satisfied that the review of the decision to segregate was procedurally unfair and contrary to the principles of fundamental justice because the procedure chosen provides that the Institutional Head is the final decision maker for admission, maintenance, and release from segregation (*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491).

Furthermore, the judge accepted evidence by various medical professionals when considering if the various review periods were constitutional, including the fifth working day review described above and 60-day regional review where the Head of Regional reviews cases at least once every 60 days to determine if continued segregation is justified (*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491). In the court's opinion, this was not considered a prompt review. This finding was based on evidence provided by Dr. Martin, Dr. Chaimowitx, and the Canadian Medical Association Journal

(*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491). Dr. Martin, a family physician and prison physician, provided evidence that the harmful effects of sensory deprivation caused by solitary confinement could occur as early as 48 hours after segregation. Dr. Chaimowitx, the Head of Forensic Psychiatry at St. Joseph's Healthcare in Hamilton and a Professor in the Department of Psychiatry and Behavioural Sciences at McMaster University, provided evidence that solitary confinement for more than 15 days posed a serious risk of psychological harm. Lastly, the Canadian Medical Association Journal, in an editorial published in December 2014, stated that a growing body of literature showed that solitary confinement can change brain activity and result in negative symptoms within seven days (*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491). The main ruling of the court stated that essentially the fifth working day review did not provide adequate procedural safeguards needed to ensure CSC was allowing offenders their rights under the Charter. Therefore, any use of segregation after the fifth working day is unconstitutional (para 272).

Following the Ontario case, the BCCLA and the John Howard Society filed a similar claim in BC in 2018 alleging that the administrative segregation sections of the CCRA (1992) were unconstitutional under the Charter. In addition to section 7, the BC challenge also made reference to section 9 of the Charter which affirms "the right not to be arbitrarily detained or imprisoned", section 12, "the right not to be subjected to any cruel and unusual treatment or punishment", and section 15, affirming every individual equality before and under the law and the right to equal protection and benefit of the law without discrimination, including discrimination based on mental disability. In turn, the government contended that segregation in Canadian federal institutions was not solitary confinement since offenders had the opportunity

for meaningful human contact daily, that the psychological effects of segregation is an ongoing scientific debate, and that segregation is a necessary management tool to maintain the safety and security of the institution (*British Columbia Civil Liberties Association v. Canada*, 2018 BCSC 62, para 3).

The BC court proceedings also discussed the Mandela Rules, specifically Rule 44. Bruce Somers, a recently retired Assistant Deputy Commissioner for CSC, was a witness for the Government and offered testimony on the 'meaningful human contact' the government believed disqualified CSC's use of segregation as isolation. Conversely, Dr. Craig Haney, a witness for the plaintiffs', described the greatest harm of segregation was the loss of meaningful social contact and in his view the interactions between inmates and CSC staff were not sufficient for adequate meaningful human contact (*British Columbia Civil Liberties Association v. Canada*, 2018 BCSC 62, para 133). The court determined that CSC's attempt at meaningful human contact was limited and superficial (*British Columbia Civil Liberties Association v. Canada*, BCSC 62, para 124). Therefore, they determined that Canadian federal institutions' practice of segregation met the definition of solitary confinement set out in the Mandela Rules (*British Columbia Civil Liberties Association v. Canada*, 2018 BCSC 62, para 137).

Following this determination, the courts heard testimony by experts in the field. The court used this information as a foundation to determine a verdict. Although sections 7, 9, 12, and 15 were challenged, the verdict declared that the laws authorizing administrative segregation of inmates were invalid on the grounds that they violated section 7 and 15 of the Charter (*British Columbia Civil Liberties Association v. Canada*, 2018 BCSC 62). Therefore, only the reason for the verdict respecting sections 7 and 15 will be discussed via a summary of the expert's opinions.

Dr. Grassian, a psychiatrist and witness for the plaintiffs, testified that minimal stimulation and social interaction can cause severe psychiatric harm and is "strikingly toxic" to mental functioning (para 164). Prolonged placements, even to those who are psychologically resilient, can result in severe psychological pain. The harm caused by segregation can create prolonged or permanent psychiatric disability (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 164).

Dr. Haney, also a witness for the plaintiffs, has studied the psychological effects of living and working in institutional environments and how mentally ill inmates are affected by their conditions of confinement. Dr. Haney testified that those placed in segregation are at serious risk of psychological harm, including mental pain and suffering and increased incidences of self-harm and suicide, and that the risks are intensified for those with pre-existing mental health issues (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 180). According to Dr. Haney, the reduction of meaningful human contact in solitary confinement causes the greatest harm and social isolation can undermine health and psychological well-being (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 182). Dr. Haney further contended that there is "widespread recognition of the harmful effects of solitary confinement", which has resulted in three recommended limitations: 1) the use of segregation must be limited to the briefest amount possible; 2) it must be used only when no other option is available; 3) vulnerable groups should be exempted from the prolonged use of solitary confinement (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 192). He testified that the international standard is a 15-day maximum (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 183).

Dr. Mills provided testimony on behalf of the government and argued that segregated inmates without mental illness do not experience debilitating psychological/psychiatric symptoms and after a period of adjustment, most function as they normally do. He further stated that those with mental illness do not deteriorate over the time they are in segregation (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 198). Dr. Gendreau also testified for the government, arguing that solitary confinement does have an effect on inmates but that it is milder than the plaintiffs' experts asserted and no greater than the usual stressors of prison experiences. He further testified that the effects of solitary confinement are not well understood and that more research is needed over longer periods of time in segregation (90 days or more). It seems Dr. Mills and Dr. Gendreau were attempting to bring counter arguments citing some research that did not demonstrate the debilitating effects outlined by the plaintiffs' experts. However, during cross examination Dr. Gendreau did agree that segregation can cause psychological harm and that some inmates cope negatively with the conditions of solitary confinement (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 219). While Dr. Gendreau agreed that limits should be placed on the duration of placements, he stated the suggestion of a 15-day limit, albeit well intended, is naïve as the decision-making process of segregation is complex (*British Columbia Civil Liberties Association v. Canada*, 2018 BCSC 62, para 222). He recommended a 60-day limit based on literature on sensory deprivation. When presented with a study he himself had published in 2018, that segregation longer than 30 days could produce negative mental health outcomes, he did say to the court that a 30-day limit was his opinion, however he had extended the limit up to 60 days (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 223 and 224).

The issues presented by the experts to court were clearly complex, leading the court to carefully consider all evidence provided. In the end, the court found the evidence citing research outlining the debilitating effects of segregation more robust and compelling. The following is a summary of the court's determination of invalidity of the law based on section 7 and 15 of the Charter. To be found in breach of section 7, the plaintiffs' must show that the law interferes with, or deprives of life, liberty or security of the person, and that the deprivation is not in accordance with the principles of fundamental justice (*British Columbia Civil Liberties Association v. Canada*, 2018 BCSC 62, para 257). The court found that the prolonged and indefinite use of segregation infringed on the right of security of the person and that segregation causes serious psychological suffering and physical harm (*British Columbia Civil Liberties Association v. Canada*, 2018 BCSC 62, para 276-310). The court further stated that the law infringed upon the principles of fundamental justice by being "overbroad". While the temporary placement of an inmate rationally connected to the need to maintain the safety and security of the institution as the law prescribed, the law was overbroad based on the unnecessary overly restrictive and prolonged nature of segregation when other lesser forms of restrictions could have been achieved (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 326).

Section 7 also guarantees procedural fairness. The feature of procedural fairness under examination in this case was the right to an impartial decision-maker. The concern of the plaintiff was that the Institutional Head, who made the decision on the initial placement, also retained the authority to disregard recommendations from the segregation review board and essentially made the final decision on his or her own decision (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 353). Due to this, the court contended that the "lack of impartiality in the review process is contrary to the principle of procedural fairness guaranteed

in s. 7 of the Charter" (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 355). The court further pointed out that despite numerous calls for external oversight, the CSC has rejected independent adjudication. The argument for independent oversight includes objective consideration of facts, pressure for CSC to more rigorously look for alternatives to segregation, increased accountability, and compliance with policy (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 381). The court concluded that to ensure procedural fairness, reviewing segregation decisions, in part, must be done so independently of CSC (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 410). Furthermore, the courts found that there was a deprivation of inmate's right to counsel at hearings and reviews and concluded that procedural fairness requires that any inmate who wishes to be represented is entitled to such (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 421).

Pursuant to section 15 of the Charter which provides equality under the law, the court stated that laws surrounding the use of segregation failed to respond to the needs of Indigenous inmates and placed burdens and denied benefits that perpetuated their disadvantage. The court specifically discussed the over-representation of Indigenous persons within the criminal justice system and CSC, due to such systemic issues as the effects of colonization, racism, and racial profiling (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 490).

The court also determined that those with mental disabilities are over-represented in segregation. As discussed earlier in this paper, the court also found that the CSC does not keep track of the number of inmates with mental disabilities in segregation or the general offender population. The courts relied upon statistics provided by the OCI which the government did not dispute. As with Indigenous offenders, the law was determined to have a more burdensome

effect on those with mental illness and imposed burdens that reinforced, perpetuated, or exacerbated their disadvantage (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62, para 522).

In summary, for the reasons stated above the laws authorizing segregation were considered invalid under sections 7 and 15 of the Charter. The court stated that should segregation continue to be utilized, placements could not exceed 15 days, inmates retain the right to have legal counsel, and CSC should be subject to external oversight (*British Columbia Civil Liberties Association v. Canada,* 2018 BCSC 62). The court granted a 12-month suspension of the declaration to allow adequate time for the government to craft appropriate legislative response (*British Columbia Civil Liberties Association v. Canada*, 2018 BCSC 62, para 610).

Bill C-83, a Bill to Amend the CCRA

Bill C-83 to amend the *CCRA* (S.C., 1992) received royal assent on June 21, 2019. The enactment stated that the service shall eliminate the use of segregation, create SIU locations for the confinement of inmates who cannot be maintained in the mainstream inmate population for security or other reasons, and affirm the CSC is obligated to support the autonomy and clinical independence of registered health care professionals (CCRA, SC 1992).

According to the amendments to the CCRA, the purpose of SIUs are to: (a) provide an appropriate living environment for an inmate who cannot be maintained in the mainstream inmate population for security or other reasons; and, (b) provide the inmate with an opportunity for meaningful human contact and an opportunity to participate in programs and to have access to services that respond to the inmate's specific needs and the risks posed. The CSC is also directed to end confinement in a SIU as soon as possible (CD 711, 2019).

It is important to note that, according to statute, those placed in the SIU must have access to legal counsel at all times throughout the process (CD 711, 2019). When transferred to a SIU, the inmate must be given an opportunity to contact legal counsel in a private area outside of their cell. In addition, offenders housed in a SIU are to be given the opportunity to spend a minimum of four hours outside the cell daily. This includes a minimum of two hours, with others, through programs, interventions and services, and leisure time (CD 711, 2019). All staff and contractors working and providing services in a SIU must continually explore and consider all reasonable alternatives to confinement in a SIU, such as informal resolution and mediation, with a focus on returning the inmate to a mainstream inmate population at the earliest possible time (CD 711, 2019).

In addition, the amendments put in place layers of oversight by health care staff to make recommendations, the creation of an internal review committee, a higher-ranking committee to oversee Institutional Head decisions, and an independent external review body. The external review body was also given the authority to oversee all SIU placements in general to ensure the requirements outlined in the amendments are being met. The independent external decision-maker can also direct the CSC to remove an inmate from the SIU and provide a notice of the direction to the *Correctional Investigator* if they are not satisfied that all reasonable steps were taken to provide the inmate with the opportunities (CD 711, 2019). These changes to the Act do seem to have remedied the courts' concerns that the Institutional Head was insulated from conducting a meaningful review, thus allowing for a decision-making process that is no longer arbitrary.

The amendments to the CCRA did heed many of the directions from the courts including allowing for meaningful interaction that reduces isolation from 23 hours per day to 20 for

exercise, leisure, participation in correctional programming, outside visits, phone calls, and time with support staff (Elders, mental health staff, Chaplin's, etc.) (CCRA, SC 1992). The timeframes meet the required hours of meaningful human contact under the Nelson Mandela Rules (Rule 44). The amendments also ensured that showers are not considered part of the four hour meaningful human contact and that every alternative to the transfer of an inmate to a SIU should be attempted and if transferred the inmate is to be released back into general population at the earliest time.

Bill C-83 has made some critical changes in the administration of the management of offenders who cannot be managed in the general offender population. However, concerns with the amendments to the CCRA were generated after reviewing the court judgements, Bill C-83, and relevant Commissioners Directives related to the amendments. For instance, a thorough reading of CD 711 provides no clarification of what measures are taken as alternatives to transfer to a SIU, nor does it stipulate what the expectation of 'earliest time' for a release back to general population is.

Advocates argue that time limits ordered through the court will not be enforced (Wright, 2019). The BC Supreme Court's decision which deemed segregation unconstitutional also determined that a person could not be in segregation for more than 15 days (*British Columbia Civil Liberties Association v. Canada*, 2018 BCSC 62). It seems the government is circumventing the ruling through the creation of SIUs and potentially utilizing the same argument they made in both the Ontario and BC proceedings by stating that Canada did not practice the Mandela Rules referred to as solitary confinement because it meets the requirement of meaningful human contact. (*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491, para 38; *British Columbia Civil Liberties Association v.*

Canada, 2018 BCSC 62, para 3). The argument presented by the government during the court proceedings was that inmates housed in segregation were allowed two hours per day out of their cells. Now with the creation of SIUs, inmates are allowed four hours out of their cell (*Corporation of the Canadian Civil Liberties Association v. Her Majesty the Queen*, 2017 ONSC 7491).

Lastly, the amendments make it appear as though offenders who are residing in a SIU are continuing to participate in their correctional program, but according to Commissioner's Directive 711 (2019), only those who had already began their program prior to the transfer may continue their correctional programming. The majority will be offered the Motivational Module - Structured Intervention Unit or the Motivational Module - Structured Intervention Unit – Indigenous (CD 711, 2019). There is no publicly available information on what this module consists of. Earlier, concerns were raised that segregation placements delayed program participation, thus delaying reintegration. The same concern exists regarding SIU placements delaying reintegration, as the correctional programming identified at intake to address the offender's risk to reoffend are likely not being offered.

The Standing Senate Committee on Social Affairs, Science and Technology (Bill C-83, 2019), was tasked to review Bill C-83 prior to the Senate readings. Of significant relevance for this paper, the committee expressed a concern that Bill C-83 did not prescribe mental health training programs and relevant competencies for CSC staff to assist them in identifying and supporting individuals with mental illness, which is important to their rehabilitation (Standing Senate Committee on Social Affairs, Science and Technology, 2019). These concerns were not addressed in legislation prior to its adoption. Rather than going to training, the initial $450 million was invested into regional facilities to build the necessary infrastructure and to run the

SIUs. The Standing Senate Committee on Human Rights (2019) reported that there will be an ongoing funding of $70 million to run the SIUs and to provide enhanced services to those in the SIUs. However, it is not clear whether and how much funding will be dedicated to the training of staff.

In summary, Bill C-83 did build in some safeguards to mitigate some of the harmful effects of isolation including four hours of meaningful contact and an improved review process with layers of accountability. However, there are still concerns with the new system, including no coinciding funding for offenders with mental health issues who remain in the general population, concerns that SIU is rebranding of segregation, correctional programming still is not being offered to all offenders placed in the SIU, and staff continue to lack adequate training and relevant competencies to assist them in working with the complex population. This, it will be argued in the next sections of this paper, is inconsistent with the shift to trauma informed practice that is being widely encouraged for criminal justice system agencies.

Trauma Informed Practice

As previously outlined, many health and social problems are interrelated and connected to trauma. Increased public awareness of trauma's harmful effects and its prevalence among society's most vulnerable populations has led to calls from key stakeholders for the creation of trauma-informed public service systems (Branson, Baetz, Horwitx, & Hoagwood, 2017).

Trauma informed practice is a service provision model that can be implemented into organizational policy through work force development (training, awareness, secondary traumatic stress), trauma focused services (standardized screening measures and evidence-based interventions), and organizational environment and practices (collaboration, service coordination, safe physical environment, written polices, defined leadership) (Hanson & Lang,

2016). Trauma informed practice is a process by which staff are trained to understand and address the complex needs of the people they work with and understand the trauma they themselves are exposed to by virtue of the work (Knight, 2018; Webb, 2016). The overarching goal of trauma informed practice is to incorporate knowledge about the neurobiological, social, and psychological effects of trauma into policies, procedures, and practices that guide a safe, compassionate, and respectful service environment (Levenson & Wills, 2019).

It is important to distinguish between trauma informed practice and trauma therapy, which is practiced through a certified clinical professional. Trauma informed practice is being aware, sensitive, and responsive to the potential impact of trauma in everyday practices and policy (Hanson & Lang, 2016). Trauma informed practice also assists staff in recognizing the impact their work has on them and their colleagues and encourages proactive self-care practices (Knight, 2018). Trauma informed practice is a framework that conceptualizes an individual's problems as maladaptive coping mechanisms viewed as a collective of past experiences and views positive therapeutic alliances as a powerful tool to address the long-term effects of trauma (Levenson & Wills, 2019).

While the importance of trauma informed practice is increasingly recognized, correctional institutions are typically not developed to be sensitive to trauma. Correctional environments can simulate oppressive family or community dynamics that created the antisocial characteristics in the first place, which only perpetuates the maladaptive responses discussed above, which include self-harm, suicide, substance abuse, and violence (Hales et al., 2017; Levenson, 2018; Miller & Najavits, 2012). There are existing models that can be used to shift to a trauma informed framework.

Harris and Fallot (2001), pioneers of trauma informed practice, identified five fundamental principles to guide an organizational policy framework: safety, trust, collaboration, choice, and empowerment. Safety refers to efforts to ensure users' physical and emotional safety, reasonable freedom from harm or danger, and to prevent further traumas from occurring (Bowen & Murshid, 2016). Trustworthiness includes organizational transparency in its policies and procedures to build trust among stakeholders such as staff, clients, and community members. Staff must maintain clear and appropriate boundaries, protect confidentiality (as far as practicable and informed when they cannot), and interact with service users in ways that are consistent, predictable, and transparent (Knight, 2018). Collaboration means that organizational staff view service users as active partners and experts in their own lives. This can be operationalized through the use of peer support or peer mentoring. Having meaningful choice and options allows service users a level of control (Bowen & Murshid, 2016). Feelings of powerlessness are prevalent in trauma survivors, and therefore, as much as possible, service users must have some degree of choice in deciding upon interventions, including information on the advantages, disadvantages, and purpose of various courses of action (Knight, 2018). Lastly, empowerment is very much connected to choice and collaboration and is intended for service providers to share power with service users, providing them the opportunity to have a voice in decisions that affect them (Bowen & Murshid, 2016; Knight, 2018).

The common result of traumatic experiences is the loss of an individual's safety, sense of autonomy, freedom, and empowerment, which leads to the distrust of others (Hales et al., 2017). To ensure safety in an institutional setting, it is immensely important to avoid re-traumatizing and re-creating maladaptive interactions (Miller & Najavits, 2012). For instance, people with a history of childhood trauma have their trauma rooted in negative interpersonal relationships and

re-traumatization may result in re-confirming their lack of trust in authority or persons in a helping role (Webb, 2016).

Hales et al. (2017) were curious how the principles of trauma informed care related to one another and if it was necessary to achieve safety before all others to be successful, as traditionally thought. This thought is based on Maslow's (1943) hierarchy of human needs, with the physical foundation required before the remaining principles can be built. However, their research found that all dimensions are of equal importance and interrelated; therefore, it is likely that development within any of the domains will lead towards enhancements in the others and that interventions do not need to initially give focus to safety. These findings are particularly helpful given that correctional authorities may question the benefit of implementing trauma informed interventions due to a correctional environment's security policies that may, at times, create an atmosphere of vulnerability.

The way in which the five principles are manifested will vary depending upon the environment. Although rehabilitation is emphasized in the Canadian correctional setting, the prison environment is structurally not a therapeutic environment and the processes it mandates can re-traumatize those with historical trauma and PTSD as well as cause trauma to those working in the system (Levenson & Willis; Miller & Najavits, 2012; Wallace et. al., 2011; Webb, 2016). The correctional environment is full of unavoidable triggers, such as pat downs and strip searches, discipline from authority, restricted movement, in custody offender against in custody offender violence, and use of force. However, the principles of trauma informed care allow for greater focus of attention and resources on the prevention of trauma to mitigate adverse outcomes (Hales et al., 2017; Levenson & Willis; Miller & Najavits, 2012), which might include decreased emotional regulation and cognitive impairments (poor decision-making skills,

impulsivity, lack of consequential thinking) that result in coping through substance abuse, self-harm, suicide, and violence. Fewer adverse outcomes means less need to rely on procedures that further traumatize, such as SIU placements, transfers, or use of force.

There are various inter-related steps to infuse trauma informed practice into CSC policy, such as by incorporating ways to identify those offenders who have experienced trauma through screening, implementing training for correctional staff, and incorporating proactive interventions through treatment for offenders. The CSC currently screens offenders at intake for substance abuse, risk for suicide and self-harm, and risk factor assessments to determine programming need and reintegration potential. In addition to the current assessments and actuarial tools used by CSC, which evaluates offenders on risk and needs, it is necessary to also screen for complex needs to provide CSC information on which offenders have experienced childhood trauma and who are at risk for PTSD in order to put in place interventions to assist offenders in coping with the adverse effects of trauma and to learn skills to manage them (Bryan, 2019; Miller & Najavits, 2012).

Risk of Administrative Segregation Tool (RAST)

Identifying and diverting inmates from segregation benefits the inmates, the organization, and the public by reducing the negative psychological effects on inmates, reducing the number of management interventions required, and increasing the likelihood of timely releases from custody. To this end, Helmus, Johnson, and Harris (2019) have designed a six-item static risk assessment tool or the Risk of Administrative Segregation Tool (RAST), based on Andrews et al.'s (1990) Risk/Need/Responsivity model. Using a risk scale for early identification of inmates who are at risk of being placed in SIU creates important opportunities to provide offenders with additional supports and interventions in their adjustment to incarceration, such as programming,

frequent contact with the case management team, and referrals to mental health professionals, elders, and chaplains.

The RAST can assist in prevention efforts to reduce segregation/SIU placements by identifying and targeting those risk factors related to segregation/SIU (Helmus et al., 2019). The six-item tool assesses risk factors that increase the likelihood of an in custody offender being placed in segregation during their stay. These are age at first conviction, number of prior convictions, any admission to administrative segregation in a previous federal sentence, sentence length, criminal versatility, and prior violent conviction (Helmus et al., 2019). While this tool accurately predicted segregation rates for male, female, and Indigenous inmates, it should be noted that it was largely built on static factors and therefore once assessed at high risk, the offender will always be a high risk for segregation, notwithstanding changes to mental health, substance use profile, or other factors affecting risk of segregation. Thus, Helmus et al. (2019) highlight the importance of identifying the offender's dynamic risk factors related to segregation placements in order to target appropriate interventions. Helmus et al. (2019) determined the criminogenic risk factors that correlated to segregation placements were: many criminal friends, combined the use of different drugs, past mental health diagnosis, frequently acts in aggressive manner, attitudes that support instrumental/goal oriented violence, impulsivity, no employment history, and disrespects personal/public/commercial property. The dynamic factors associated to the above risk factors include associates, attitude, substance abuse, personal/emotional orientation, education/employment. Therefore, the RAST can be used, along with the other actuarial tools, to determine which criminogenic/dynamic factors need to be targeted in correctional programming to avoid SIU placements by providing the offender information to

understand how their thoughts and emotions influence their behaviours and teach skills to manage those behaviours.

Present-Focused Approach

Screening is essential to understand the diverse population of offenders and is an important policy component of trauma informed practice (Hanson & Lang, 2016). Following screening, offenders identified as having a history of trauma will need carefully planned treatment interventions focused on trauma. Research shows that the best approach for a trauma informed treatment in a prison environment is a present-focused approach, which is effective because it does not cause distress or decompensation (Barrett et al., 2015; Miller & Najavits, 2012; Wallace et. al, 2011; Webb, 2015). Present-focused programs look at the current effects, symptoms, and related problems associated with trauma and build coping skills without exploring distressing memories. In contrast, past-focused approaches, such as exposure therapy,[6] may put the offender at risk of destabilization and the security response (pat downs, strip searches, use of force, segregation, etc.) to such destabilizations can re-traumatize the offender (Miller & Najavits, 2012).

The CSC currently runs cognitive-behavioural based interventions that are present-focused to address the emotions, thoughts, and behaviours associated with an offender's risk factors (CSC, 2018). Programming is determined based on the seven criminogenic risk factors

[6] Exposure therapy is a specific type of cognitive behavioural therapy technique that is often used in the treatment of PTSD and phobias (Grohol, 2018). Exposure therapy is a safe and proven technique when used by an experienced, licensed therapist who specializes in these kinds of conditions and treatments. It is intended to help the patient face and gain control of the fear and distress that was overwhelming in the trauma, and must be done very carefully in order not to re-traumatize the patient (Miller & Najavits, 2012). CSC does not have the funding for additional formally trained staff to run past-focused treatments and currently mental health staff are not available evenings and weekends (Standing Senate Committee on Social Affairs, Science and Technology, 2019). Should a mental health expert choose to utilize this form of treatment, they are running the risk of emotionally destabilizing offenders who are already vulnerable, which will likely be responded to by correctional staff not mental health staff given the current lack of funding (Miller & Najavitis, 2012).

identified from the Case Needs Identification and Analysis (CNIA) assessment conducted at intake (substance abuse, anti-social attitude, personal/emotional factors, negative associates, problems in marital or family relationships, deficits in education and/or employment, and community functioning issues). Although the current programming is cognitive-behavioral based, it does not address trauma specifically. In contrast, Seeking Safety is a manualized modular present-focused cognitive-behavioural based trauma intervention that may be of interest to CSC.

Seeking Safety is designed to address co-occurring PTSD and SUD (Barret et. al, 2015; Lynch et al., 2012; Miller & Najavits, 2012; Wallace et al., 2011; Webb, 2017). Seeking Safety was first developed in 2002 by Lisa Najavits and to date is the only evidence-based treatment for PTSD/SUDs that has been extensively evaluated. The goal of Seeking Safety is to improve safe coping skills without having the offender explore distressing memories (Miller & Najavits, 2012). The aim is to provide psychoeducation about the consequences of trauma and its links to substance abuse and other maladaptive coping strategies. The program offers 25 treatment topics to address cognitive, behavioural, and interpersonal domains. It was designed for flexible use and can run in a group setting or one-to-one. Topics can be facilitated in any order and it is modularized meaning participants can come into the program at the start of any module, which allows for optimum efficiency with participant intake. The materials and concepts are presented in simple terms and does not require a high level of literacy to participate. This program can be facilitated by a broad range of staff and does not require any formal education in psychology, which means it can be run at a low-cost and more frequently (Miller & Najavits, 2012).

Lynch et al. (2012) conducted an evaluation of the Seeking Safety program among a group of 59 American female offenders. The Seeking Safety program was run twice a week for

two hours over a 12-week period. Eight groups were offered with between eight to 15 participants. The criteria for participation was a history of trauma, SUD, and moderate to severe PTSD and a release date within three years. This was not a random trial in that research staff visited each of the prison cell blocks and briefly described Seeking Safety and the criteria. Those women who were interested and believed they met the criteria were invited to sign up. The list was given to prison officials to help determine release date. Most of the women were cleared to participate by prison officials. Women were then screened through an interview for demographical information, Trauma History Questionnaire, PTSD Checklist-Civilian Version, Alcohol and Drug Use History Questionnaire, Centre for Epidemiological Studies-Depression scale, Brief COPE and Inventory of Interpersonal Problems. The women had extensive histories of trauma with 72% reporting experiences of forced sexual intercourse, 56% were attacked with a weapon, and 86% were attacked without a weapon. The majority, at 81%, were psychologically distressed and above the cut off (16) for the depression scale and 62% were above the above the cut off of 50 for the PTSD scale. During the screening interviews conducted by the researchers, 16 women did not meet the criteria, nine women were below cutoffs for the PTSD scale, and seven reported no history of substance misuse. The remainder were invited to either participate in Seeking Safety (59) or be waitlisted (55) in what became the comparison group. The women attended an average of 18 of the 24 sessions. They found that the Seeking Safety group benefited significantly when compared to the comparison group and at the end of the program had decreased symptoms in depression, improved interpersonal functioning, and decreased maladaptive coping (disengagement, denial, and self-blame). Although all of the women in both groups had similar outcomes in all the scales, the study group had lower initial ratings in the Brief COPE, indicating a lower initial level of positive coping skills. As stated above, Seeking

Safety is a psychoeducational program intended to provide information about the consequences of trauma while teaching coping mechanisms (Miller & Najavits, 2012; Barrett et al., 2015; Wallace et al., 2011; Webb, 2015). The improvement in symptoms may be a result of the study group learning and utilizing the coping mechanisms taught.

Needs Assessment, Staff Training, and Evaluation

Screening and the facilitation of interventions cannot occur without a shift in organizational culture and practices; this is accomplished through collaboration, service coordination, written polices, and defined leadership. The organizational culture will not shift without successful work force development, which includes assessing need, training, awareness, and support for secondary traumatic stress (Hanson & Lang, 2016).

Given the unique structure of a correctional environment, the implementation of trauma informed practice can be difficult for many reasons. Buy-in from middle management and frontline staff is necessary for the implementation of new programs and policy (DeHart & Iachini, 2018). Miller and Najavitis (2012), have suggested that many correctional environments have their own staff subculture of vicarious trauma, fear for personal safety, and conflict between enforcement, responsibility, and compassion. Therefore, a thorough assessment of readiness is necessary (DeHart & Iachini, 2019). In order to a conduct a readiness assessment, DeHart and Iachini (2019) suggest reviewing existing educational and training resources, related policies, and best practice literature, interviews with stakeholders to gain an understanding of the current skill set related to mental health and trauma, and identifying the type of curriculum content and training delivery formats.

Needs Assessment Scales

The first two steps of a readiness assessment could be accomplished through utilizing pre-existing trauma informed needs assessment tools: the TICOMETER (Bassuk, Unick,

Paquette, & Richard, 2016) and the ARTIC (Baker et al., 2016). These are both promising empirically researched tools that can assist organizations in assessing staff training, procedure, and policy needs. Utilizing evidence based tools tested for validity and reliability can aid organizations during the needs assessment process by eliminating wasted time creating their own tool, offering a level of consistency in administering the needs assessment throughout the organization, and the data can be compared with other organizations who have used the same tool. In addition, these tools can be used by multiple staff at all levels within the organization, and takes only 15 minutes of their time. They both can be used at a single point or repeatedly to measure change in trauma informed practice over time, thus it can be used as an evaluation measurement.

The TICOMETER was created specifically to assess an organization's readiness for trauma informed practice and provides information on staff training needs, procedure, policy change, and monitors progress (Bassuk et al., 2017). This tool is comprised of 35 items grouped into five domains including, trauma informed knowledge and skills, establish trusting relationships, respect for service users, foster trauma informed service delivery, and promote trauma informed procedures and policies. To test for reliability and validity, Bassuk et al. (2017) conducted a survey to elicit data with the strongest psychometric properties. The survey was issued to 667 service providers representing 68 unique organizations across America, with 424 responses. Relatability and validity of items in each domain were tested using the Rating Scale Models, internal consistency, and test-retest reliability, confirmatory factor analysis, and receiver operating characteristic curves (Bassuk et al., 2017).

The ARTIC scale was developed to connect the theoretical principles of trauma informed practice with research, practice, and policy (Baker et al., 2016). Baker et al. (2016) conducted a

literature review and found there was a need for a clear definition of trauma informed care and for psychometrically strong instruments to evaluate trauma informed practices within systems or organizations (Baker et al., 2016). The ARTIC was designed using extensive mixed method process using experts in the field of trauma informed care, trauma and stress, mental health, and study design and methodology (Baker et al., 2016). The final version of the ARTIC included 45-items and seven subscales (five core and two supplementary sub-scales). The subscales included a) underlying cause of problem behaviour/symptoms, b) responses to problem behaviour/symptoms, c) on the job behaviour, d) self-efficacy at work, e) reactions to the work, f) personal support for trauma informed care, and g) system wide support for trauma informed care. The first, second, and third sub-scales meet the foundational principles of trauma informed practice through understanding how trauma affects individuals and responses are driven to enhance feelings of safety and promote recovery. The fifth sub-scale represents the importance of understanding vicarious trauma and engaging in self-care to maintain the capacity to continue to client engagement in the frontline (Baker et al., 2016). The six and seventh sub-scales tap into sentiments of staff's feelings towards trauma informed care and if they feel supported by their organization to take on this process. As stated earlier, it is imperative staff feel supported in their day to day activities from leadership and from their colleagues as they move through organizational cultural change to being trauma informed. The resulting data from the ARTIC can assist in determining the needs for training within the organization (Baker et al., 2016).

The CSC is in the preliminary stages of incorporating trauma informed policies into certain areas of correctional administration. As outlined earlier, it appears EIM's person centered approach may be based on trauma informed principles. However, it appears that something may have gotten lost in translation, either through policy implementation, training, communication, or

potentially all of the above, as use of force has actually increased since the inception of the EIM. There is no publicly available evidence to show if CSC conducted a needs assessment or assessed readiness to embrace change in ideology, which could also explain the evidence of lack of culture shift through the use of force data. The CSC must bear in mind the concept of trauma informed practice is inherently different than the traditional way of managing offenders; therefore, it is of particular importance to assess for readiness and to determine where training is needed and how supported staff feel from leadership.

The ARTIC scale could be used to measure the attitudes relevant to trauma informed care for staff working in human centered organizations. The ARTIC scale can therefore be used as a tool to test for an organization's readiness to innovate and also help determine what barriers exist to innovation while the TICOMETER can measure an organization's overall readiness for change and changes made. Both can be used for evaluation purposes. Therefore, the two tools can be used in conjunction to get an overall picture of policy, staff readiness, training needs, and for evaluation purposes.

The stakeholders who should participate in the needs assessment and be included in completing the TICOMETER and ARTIC are front line correctional staff from all levels of security from various institutions as well as parole officer, programs staff, teachers, and others who work closely with the population (DeHart & Iachini, 2019). Other stakeholders working with the offender population include experts from community corrections, mental health and trauma, substance abuse, and non-profit mental health advocacy persons.

Following the needs assessment process, DeHart and Iachini's (2019) suggest using the information gleaned from the assessment to create a trauma informed curriculum and training delivery formats for correctional staff. Although the information gathered from the needs

assessment process will be somewhat unique to the organization, there is general essential information related to a trauma informed curriculum that would apply to any correctional environment. DeHart and Iachini (2019) recommended providing education on mental health issues through information on the prevalence and characteristics of mental health disorders and trauma, the rights of offenders with mental disorders, challenges with daily living, and common mediations and side effects. Staff should be informed about the typical screening tools and monitoring of mental disorders by mental health staff, crisis prevention and intervention techniques, self-injury and suicidal ideation, trauma informed responses, and collaboration and inter-disciplinary approach. While also highlighting the importance of self-care for staff and identifying areas of stress, resources, and stress management strategies.

The needs assessment results will then be the criteria used in developing a curriculum utilizing scholarly, evidence based literature. DeHart and Iachini (2019) suggest that drafts of the proposed training curriculum be prepared and reviewed by a selection of correctional staff and the content be set out in a way that engages learners and facilities skills building. Seasoned and respected correctional staff are essential to take the lead in reviewing drafts because generally, correctional staff are more receptive to experience rather than research (Miller & Najavits, 2012).

Running a pilot of the curriculum is a helpful way to test the content of the curriculum. In order to test the value of the novel content, DeHart and Iachini (2018) suggest presenting to a group with no prior knowledge of the content facilitated by non-professional facilitators. They also suggest choosing participants from multiple sites to attend one of two training sessions with participants divided into two groups based on previous training. One session for participants with prior crisis intervention training and the second session with none. An ideal number of

participants is around 30 in each group to allow for a sufficient response rate. The participants in both groups are required to take a multiple choice pre and post-test consisting of questions taken directly from the modules taught. A program evaluation should also be conducted at the end with all participants, to ask basic demographic questions and a Likert assessment of the ability to apply the concepts to their job, the level of novelty of the content, clarity, meaningfulness, and length of training. Facilitator feedback is also helpful to gather information on their perceptions about what worked or did not, needed revisions, oral feedback from participants, and ease of use of media. Pilot evaluation allows developers the opportunity to make revisions to improve clarity and flow.

DeHart and Iachini (2018) conducted such a project in conjunction with the United States Department of Justice. The final curriculum was tested with two groups of 25 correctional officers working in various sites in South Carolina. Interestingly, there was no differences in the knowledge on trauma and trauma informed corrections between participants who had previous crisis intervention training compared to those who did not (DeHart & Iachini, 2018). This would indicate that traditional crisis intervention training does not offer enough information on trauma and the adverse effects. However, the pre-post tests with the current program showed that all officers who attended the pilot demonstrated increased knowledge in both trauma and trauma informed practice from the pretest to the posttest. The evaluation results demonstrated that the content was highly regarded by participants who said they found the content meaningful, maintained engagement from the realistic and high-stakes stories, and felt they had a proficient foundation to use the skills learned in a practical setting.

This study did have its limitations, as there was no assessment of change in behaviour or testing to see how long the participants retained the information they learned. Should CSC

attempt to implement trauma informed practice and create a trauma informed curriculum, it would be beneficial to add longitudinal aspects to the research through post-test administration three months, six months, and one year after the pilot to test for retention. In addition, it would be helpful to gather information on behavioural change, through a variety of sources such as pre and post use of force data, employee annual evaluations, and anonymous surveys issued to the offender population to gauge whether they see a change in organizational policy and staff engagement in trauma informed principles of safety, trust, collaboration, choice, and empowerment. Longitudinal research could be incorporated into the ongoing evaluation process which is intended to continually assess for staff attitude toward trauma informed practice, and staff training, procedure, and policy needs.

Recommendations

As discussed throughout this paper, it does appear as though federal governmental policy and correctional administration are attempting to be more trauma informed, as evidenced by the implementation of the Engagement and Intervention Model (EIM), prison needle exchange and safe injection sites, and the creation of SIUs. However, the research for this paper has identified areas where the CSC could improve on the implementation of trauma informed practice and policy. The research also identified concerns with the amendments to the areas of the CCRA for the administration of the SIU. The following recommendations are made to help improve CSCs management of vulnerable offenders and to offer suggestions as to how to move towards a more trauma informed system.

Recommendation 1: Increase Public Access to Correctional Data

While conducting the research to write this paper it became apparent that CSC is not as transparent with data and procedural information as it could be. The lack of publicly available

information is a limitation to this paper and to developing evidence-informed policy recommendations. For instance, there is little in the way of publicly available statistical data on the prevalence of mental illness in the offender population. The reason for such is unclear and the data that is available carries methodological flaws that makes is difficult for comparison. For instance, the data for male and female offenders was not gathered and collated at the same time and way. CSC gathered data for Indigenous men slightly differently than how they gathered data for Indigenous women offenders in that all Indigenous women were considered as one group whereas with men it was broken down by First Nations and Metis offenders. It is assumed mental health information is gathered at intake for all offenders during the intake and assessment period.

Furthermore, the guidelines for the OAT, prison needle exchange, safe injection sites, and information on EIM are also not publicly available. Therefore, it is recommended that CSC publicly share anonymized mental health statistics, including demographic information, in order to demonstrate transparency as per the government of Canada's Open Government policy. The Government of Canada is committed to open government, which is being pursued along three streams: open data, open information, and open dialogue. The goal is to promote transparency, empower citizens, fight corruption, and harness new technologies to strengthen governance (Government of Canada, 2020).

Recommendation 2: Incorporate Trauma Informed Practice into OAT, Prison Needle Exchange and Prison Safe Injection Site Guidelines and Provide Take Home Naloxone Kits to In Custody Offenders.

Due to the limited publicly available information it is difficult to know for sure if any of the harm reduction measures have included a trauma informed approach within their guidelines as they are not publicly available. The Canadian Research Initiative in Substance Misuse (CRISM) National Guideline (2018) identified trauma informed practice as an essential

ingredient to successful OAT and strongly recommended the inclusion of harm reduction services, such as take-home naloxone, sterile needle distribution programs, and supervised consumption or injection services, in the continuum of care for opiate use disorder. The CSC has maintained OAT in institutions for 20 years and recently implemented prison needle exchange and prison safe injection sites. However, take home naloxone kits are not available to in custody offenders and it is unclear if the harm reduction measures within federal institutions include trauma informed practice. Therefore, it is recommended the CSC make take home naloxone kits available to offenders and adapt OAT, prison needle exchange, and safe injection site polices to include trauma informed practice principles. With the goal of decreasing prison overdose through increasing awareness of the benefits of harm reduction to both staff and offenders and increase understanding of the connection between trauma experiences and substance abuse.

Recommendation 3: Implement Trauma Informed Practice into CSC Policy and Procedures, including the use of an Organizational Needs Assessment Process and Staff Awareness Training

Trauma informed ideologies appear to be a promising systems approach in managing and treating offenders with complex needs. The elements of trauma informed practice include trauma informed policy/procedures, staff training, client screening, and trauma specific interventions/treatments (Hanson & Lang, 2016). Trauma informed practice has the potential to change organizational culture and create behavioural change through knowledge and attitude change, so long as the system is supportive and works towards the facilitation of trauma informed practice (Baker et al., 2016; Barrett et al., 2015; DeHart & Iachini, 2018; Kubiak, 2004; Levenson & Willis, 2018; Miller & Najavits, 2012; Wallace et al., 2011; Webb, 2015).

As outlined throughout the paper, for trauma informed practice to take hold, it needs to be supported in its implementation into organizational policy through work force development (training, awareness, secondary traumatic stress), trauma focused services (standardized

screening measures and evidence-based interventions), and organizational environment and practices (collaboration, service coordination, safe physical environment, written polices, defined leadership) (Hanson & Lang, 2016).

It does appear the CSC, as an organization, is shifting towards a more trauma informed process. Yet it appears frontline staff have not embraced the culture shift, given the rates of use of force actually went up after the implementation of the EIM and correctional officers' vehement opposition to both prison needle exchange and safe injection sites. In addition, it is too soon to see if the SIU will be a place where marginalized and stigmatized offenders are placed in a similar faction as segregation. However, given the lack of change in staff behaviour since the implementation of the EIM and the opposition to improved harm reduction methods, there is a good likelihood SIUs will continue to be used to house offenders whose behaviour is difficult to manage due to their experiences of trauma and related mental health.

The CSC may have been remiss in assessing for readiness through an evidence-based needs assessment process such as the ARTIC and the TICOMETER (Baker et al., 2016; Bassuk et al., 2017). Choosing to implement policy to staff who have limited knowledge and understanding of trauma informed principles means they therefore have little to no buy in. In order to achieve a culture shift, an assessment for readiness may be necessary to determine where training is needed, assess how supported staff feel from leadership, and measure for vicarious trauma. CSC can use this information to provide a system that supports its staff in learning and practicing new concepts, while ensuring staff wellness is a pivotal factor in performing their duties when working with the offender population with complex needs.

The information gathered from the needs assessment process can then be used to create a trauma informed training curriculum (DeHart & Iachini, 2019). Including education on mental

health issues relevant to the correctional environment, characteristics of mental health disorders, rights of offenders with mental disorders, challenges with daily living, common mediations and side effects, information on the typical screening tools and monitoring of mental disorders by mental health staff, crisis prevention and intervention techniques, self-injury and suicidal ideation, trauma informed responses, and collaboration and inter-disciplinary approach; and of course, highlighting the importance of self-care for staff and identifying areas of stress, resources, and stress management strategies.

Recommendation 4: Screen all Offenders at Intake for ACEs and RAST and follow up PTSD screening for those High ACEs by a Clinician.

Trauma focused services such as standardized screening measures and evidence-based interventions are an essential component to trauma informed practice. It appears the CSC is not tracking ACEs, PTSD, or the risk for SIU placements within the offender population. The current mode of assessing risk and need includes the Criminal Risk Index (CRI) and the Revised Statistical Information on Recidivism Scale (SIR-R1). Neither the CRI nor the SIR-RI assessments consider history of trauma as part of the static factor assessment nor are they used to assess for future risk of SIU placements. The ACEs scale is a promising tool for predicting risk and is highly correlated with PTSD and SUD; therefore, those with high ACEs scores should be screened for PTSD. The PTSD screening tool is intended to be completed under the supervision of a clinician, therefore it may not necessarily be completed as part of the intake assessments, but as a follow up screening by a mental health professional (Weathers et al., 2013). The ACE scale, PTSD checklist, and a segregation screening tool (RAST) are complementary tools as many of the adverse outcomes from trauma overlap with the risk factors associated to segregation placements. The screening tools can provide CSC a clear picture of which offenders are at risk for maladaptive coping through substance abuse, self-harm, suicidal ideation, or behaviour akin

to isolation placements such as incurring debt due to substance abuse resulting in acting out violently or being a victim of violence. In addition, risk scales can be used for early identification to provide offenders with additional supports and intervention to their adjustment to incarceration such as frequent contact with the case management team, referrals to mental health professionals, elders, and chaplains in order to support them in staying in the general population.

Recommendation 5: Provide Present Focused Intervention Treatment such as Seeking Safety for those Offenders with a History of Trauma.

Following screening, offenders identified as having a history of trauma through the ACEs scale, PTSD through the PTSD checklist, and those who are at risk for SIU placement, assessed through the RAST, will need appropriate present focused evidence-based intervention to assist in managing the adverse effects of trauma and to address the factors associated to placements in isolation. One such present focused intervention is Seeking Safety, through psychoeducation, provides information about the consequences of trauma while teaching coping mechanisms and has been found to decrease symptoms in depression, improved interpersonal functioning, and decreased maladaptive coping (disengagement, denial, and self-blame) (Miller & Najavits, 2012; Barrett et al., 2015; Wallace et al., 2011; Webb, 2015).

Recommendation 6: Place a Maximum Limit of 15 Days to all SIU Placements.

As stated above there were concerns noted while conducting the research for this paper with respect to the amendments to the CCRA and implementation of SIU. The legal criteria to place an offender into the SIU are the same two reasons used to place offenders in segregation - for jeopardizing the safety and security of the institution or for personal safety. Therefore, in theory, the same types of vulnerable offenders will be at risk of being placed in SIUs (CD 711, 2019). SIUs have only existed since November 30, 2019 and therefore it is too early to access data on whether offenders transferred to the SIU are participating in and completing correctional

programming, if they are cascading to minimum, or if they are being supported for conditional release. In other words, it is too soon to tell if SIUs are improving or creating the same delays as segregation placements.

Segregation placements historically created delays in program participation and reintegration opportunities. Federally incarcerated offenders in Canada have the ability to earn early release from custody, such as through escorted or unescorted temporary absences, day parole to a staffed community residential facility or halfway house, or full parole. Typically, these types of release are earned when the offender can exhibit some degree of rehabilitation, such as through program completion. When programs are not completed, which can be a direct consequence of spending time in segregation, offenders are less likely to cascade to lower security levels or receive an early release (Sapers, 2015). Most offenders would then be automatically released at the two-thirds point of their sentence (statutory release). This usually means an offender is released back into the community to live in their own accommodations where they are supervised by a parole officer. Offenders who do not gradually reintegrate have higher recidivism rates and pose an increased risk to public safety (MacPhail, 1987; Motiuk & Cousineau, 2006). Given this, it can be concluded that placement in segregation increases the length of time an offender remains incarcerated and can increase their risk of recidivism following release. The amendments to the CCRA allow for meaningful interaction for those offenders who are placed in the SIU, including four hours of daily time outside their cell to exercise, participate in correctional programming, receive outside visits, take phone calls, and spend time with support staff, such as Elders, mental health staff, or Chaplains (Bill C83, 2019). However, the CCRA makes it appear as though offenders residing in a SIU are continuing to participate in their correctional program, but that is only for those who had already began their

program prior to the transfer. The majority will be offered the Motivational Module - Structured Intervention Unit or the Motivational Module - Structured Intervention Unit – Indigenous (Commissioner's Directive, 2019). Therefore, if the CSC chooses not to put a limit on SIU placements of 15 days, all offenders placed in the SIU should have the opportunity to participate in the rehabilitative correctional program that was identified for them at intake.

The amendments to the CCRA do not stipulate what the expectation of 'earliest time' for a release back to general population is nor did it stipulate what the alternative measures are that must be attempted prior to a SIU placement. CD 711 (2019) simply states, all staff and contractors working and providing services in an SIU must continually explore and consider all reasonable alternatives to confinement in an SIU, such as informal resolution and mediation, with a focus on returning the inmate to a mainstream inmate population at the earliest possible time, unfortunately, these measures are suggested for after a placement not before. Therefore, the CCRA and subsequent CD should outline what alternative measures are required.

According to the CBC and the National Post (2020), the Supreme Court of Canada has decided to hear two cases launched by the Attorney General against the Canadian Civil Liberties Association and another by the British Columbia Civil Liberties Association (to be heard together) to contest the Ontario and BC supreme court decisions that rendered segregation in Canada as unconstitutional. However, the court has also decided to grant a cross-appeal outlining that the amendments to the CCRA continue to allow prolonged, indefinite solitary confinement as there is no hard limit on how long inmates can be held in SIUs. The challenge will push for a 15-day limit on solitary confinement, consistent with international standards (CBC, 2020). This information was verified through the Supreme Court of Canada (2020) applications for leave, docket numbers 38814 and 38574 (Attorney General of Canada v. British Columbia Civil

Liberties Association and John Howard Society of Canada and Corporation of the Canadian Civil Liberties Association JSCC 38814 and 38574). Therefore, the CSC may want to consider proactively implementing and facilitating a 15 day cap on SIU placements.

Conclusion

This paper provided recommendations in the areas of prevention based interventions and assessments directed towards offenders with complex needs, as well as training for all frontline staff in trauma-informed practice, present-focused trauma programming, and utilizing actuarial tools to screen offenders at intake to assist in preventing SIU placements. These interventions and initiatives can assist CSC in preventing SIU placements, decrease use of force incidents, increase staffs understanding of the background and circumstances of each offender, and to provide offenders trauma related programming, referrals, and services with the intention of contributing to crime prevention through reduced recidivism rates. Prevention and treatment are key to allow for safe, timely, and successful reintegration of offenders into the community, and for enhanced personal wellbeing amongst some of the most vulnerable subgroups in Canada.

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