2016

Unlocking the Doors to Canadian Older Inmate Mental Health Data: Rates and Potential Legal Responses

Adelina Iftene, *Dalhousie University Schulich School of Law*

International Journal of Law and Psychiatry 47 (2016) 36–44

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

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

Adelina Iftene *

Osgoode Hall Law School of York University, Canada

ARTICLE INFO

Available online 29 March 2016

Keywords:
Mental health
Prisoners
Legal remedies

ABSTRACT

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

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

1. Introduction

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

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

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

* 24 Kingsgate PL, Kingston, ON K7M7K8, Canada. Tel.: +1 613 329 7969.
E-mail address: adeiftene@gmail.com.

http://dx.doi.org/10.1016/j.ijlp.2016.02.032
0160-2527/

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

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

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

2. Methodology

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

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

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

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

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

with aging in the community as identified through a review of the medical literature (Canadian Institute for Health Information, 2010, 2011; Ham et al., 2007).

The general section reviewed demographic issues (such as age, length of sentence, time spent in prison, previous incarcerations, and parole applications). The second section, daily living, was concerned with difficulties regarding activities of daily living and accommodations that have been made to meet those difficulties. The third section, programs and exercise, reviewed aspects related to correctional and recreational activities and their appropriateness to age and needs. The fourth section, health, included questions related to perceived health status, illnesses, medication, medical visits, medical requests, preventive measures available, place and intensity of different medical interventions, pain management and mental problems. The safety section explored aspects related to age segregation, perceived dangers, and abuses suffered at the hands of other inmates or staff members. The relationships section looked at social ties that inmates had inside and outside the institution, as well as their feelings toward them. I finalized my interviews with a qualitative question "Is there something that I did not ask regarding your life in prison and you would like to share?" The answers to this question generated numerous stories that helped give context to the numbers obtained through quantitative methods.

The answers to the 71 questions were quantified by creating variable names and labels based on the similarities of the answers. Some of the questions were multiple choice others (like "What diseases have you been diagnosed with?") were open-ended. The open-ended questions were coded by creating categories for the most common answers mentioned by participants, and placing the unique ones in an "other" category. The codified answers were entered into an SPSS data table. The data was analyzed in SPSS v 12.0 by calculating frequency, distributions, and running cross-tabulations between answers in different sections of the protocol. Their statistical relevance was determined by using chi-square tests.

The study has a number of limitations. Due to administrative reasons, a comparison group was not available for this project. In order to minimize the limitations brought about by the lack of a younger population control group, medical literature on older people in the community was reviewed to offer a solid idea of what the problems recognized as associated with aging are. The fact that all institutions were located in Ontario was another limitation of the study. No doubt, even if they belong to the same federal system, institutions in other regions may differ because of geo-political influences, as well as demographics and access to volunteer agencies. While it would have been ideal to have a sample of institutions from a few provinces, the approach toward older offenders is arguably similar to those this study reflects because the commissioner's directives, as well as the distribution of resources, including financial and health, emanate from the headquarters level. The provinces make no financial contribution to the federal institutions even in the area of health. It would thus be expected that in the area of health care the CSC institutions do not differ greatly based on their location. The medical files of the inmates were not available for review, even upon the inmate's consent. Not being able to corroborate the information received is obviously a limitation: it needs to be kept in mind that the data come from the prisoners themselves. As a result, in order to attempt to compensate for this limitation, the number of questions in the protocol was increased to see if there is internal consistency within individuals.

2.1. Mental health findings

2.1.1. Demographics

For this study 197 male offenders over the age of fifty from seven penitentiaries were interviewed. 55.3% of the participants were between 50 and 59, 33% were between 60 and 69, and 11.7% were 70 or older. The youngest participants was 50, the oldest was 82. Three of the institutions visited were medium security and half of the participants were hosted in them (50.3%). The minimum security institutions provided 33.5% of the participants. Offenders from only one maximum institution were interviewed, and they formed 9.1% of the participants. Finally, some offenders in the assessment unit were also interviewed (7.1%). From the participants, a slight majority had been to prison (either federal or provincial) before the current sentence (55.4%). The rest were serving time for their first offence.

Table 1
Distribution of sentences.

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

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

The majority of people serving life sentences, indeterminate or long sentences had been convicted prior to turning fifty. Almost half of the participants had already served over 10 years of their current sentence at the time of the interview, with over 11% having spent between 20 and 29 years and other over 11% had spent over 30 years in prison. Aside from the people serving an indeterminate sentence (where the majority had prior convictions) and the assessment unit (where the majority had no prior convictions) the proportion of recidivist offenders was roughly 50% for each category of sentence length.

2.1.2. Mental health issues, potential risk factors, and institutional responses

The participants were asked if they currently had a psychiatric disorder diagnosis on their files (whether they agreed with it or not). Some individuals were not able to respond immediately, and they sent a note of their official diagnosis later on, once they checked. Other people simply did not know, so the illnesses may be under reported. From 197 participants, 39.1% mentioned being diagnosed with one or more mental illnesses (Table 2). In general, the rates of people reporting receiving help with their condition on a regular basis were much smaller than those of people reporting mental conditions. Only 14.3% of the people with a mental health diagnosis reported seeing the psychiatrist after they turned 50. 26% of the same group said they were receiving some form of therapy counseling.

It appeared that mental health care was available in some institution while it was almost missing in others. For example, in maximum security the rate of mental illness was high (about 60%). Some individuals were placed either on the mental health unit or in protective custody for their protection. However, those who were not on the mental health unit were entitled to three psychological sessions for the duration of their stay. Lifers were supposed to be assessed by a psychiatrist every 2 years, but the participants mentioned that the consult was a five minute discussion in which they were asked if they had suicidal thoughts. In

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

Mental health conditions	Percentage
Depression	24.4% ($n = 48$)
Bipolar disorder	3.6% ($n = 7$)
Schizophrenia	3% ($n = 6$)
Anxiety disorder (other than PTSD)	17.3% ($n = 34$)
Dementia	4.6% ($n = 9$)
PTSD	4.1% ($n = 8$)
Other (including intellectual disabilities)	11.2% ($n = 22$)

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

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

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

another institution, there was one psychologist for 600 people. Some were told that if they were not suicidal they had no business asking to see a psychologist. A few people with suicidal ideation, when seeking help, had been sent to segregation.

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

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

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

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

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

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

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

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

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

[1] The press obtained access to the unreleased document.

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

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

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

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

2.1.3. Correlations between mental health issues and institutional behavior

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

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

As well, more prisoners who have been sent to segregation for disciplinary reasons were more likely to report having a mental illness diagnosis than their healthier counterparts (59.5% as opposed to 40%). Similarly, of the people who have requested segregation for their own safety, the majority reported suffering from a psychiatric condition (72.7%). In addition, some prisoners reported being afraid of their poorly treated mentally ill peers. Each institution seemed to have its infamous "schizophrenics" that "could snap at any time." One inmate recalled one of these individuals regularly attacking other inmates "in one of his moments." Most offenders agreed that those people needed help and that as long as "they are not treated or sent elsewhere, it is unsafe for everyone in the institution."

It also appeared that mental illness, like physical illness and mobility issues, made prisoners more *vulnerable* to peer abuse. 70.1% of those with psychiatric disorders mentioned being abused by peers (Table 10). The types of peer abuse commonly identified were stigmatization due to age or race (36% of all participants), ridicule (45%), insults (47%), being cut in line regularly (32%), physical abuse (29%), threats (28%), isolation due to age (18%), and sexual abuse (4%).

Table 5
Distribution of mental health illnesses per sleep problem.

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

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

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

Regular exercise rates %	Mental illnesses reported		Total
	No	Yes	
No	51.5% ($n = 35$)	48.5% ($n = 33$)	100% ($n = 68$)
Yes	65.9% ($n = 85$)	34.1% ($n = 44$)	100% ($n = 129$)

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

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

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

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

3. Legal consequences of the findings

The main goal of this section is to argue for a legal cause of action that would enable older offenders to claim better management of their mental health needs. Oftentimes, constitutional challenges are last resort mechanisms to claim legal protection. The purpose of this section is to show that statutory claims (the more common avenues) are not always efficient, while there is a constitutional challenge that could successfully trigger a change in the management of older offenders. The current application of s. 12 of the Canadian Charter of Rights and Freedoms is presented in comparison to the application of similar provisions in other jurisdictions. Based on this, it is argued

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

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

Chi-square = 16.110, df = 2, and $p < .001$.

Table 8
Disciplinary charges per mental health rates.

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

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

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

Mental illnesses reported %	Abused by peers		Total
	No	Yes	
No	60% ($n = 72$)	40% ($n = 48$)	100% ($n = 120$)
Yes (one or more)	29.9% ($n = 23$)	70.1% ($n = 54$)	100% ($n = 77$)

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

here that the use of s. 12 in the case of mentally ill older offenders is a sensible extension of the application of this provision.

3.1. Corrections and conditional release act

Corrections and Conditional Release Act (CCRA, 1990) is the federal legislation that regulates the federal corrections in domains like incarceration, accommodation and programs for prison and community sentences, prisoners' rights, grievances, transfers, health care in prison, paroles and conditional releases. Together with the Corrections and Conditional Release Regulation (CCRR) (1992), it is the legal framework for the CSC.

S. 70 (CCRA, 1990) of the CCRA provides that CSC must take reasonable steps to ensure that the prison environment, living and working conditions are safe, healthful and free of practices that undermine a person's reintegration into the community. S. 76 (CCRA, 1990) directs the service to provide a range of programs designed to address the needs of offenders and contribute to their successful reintegration into the community. According to s. 86 (CCRA, 1990) the service is under the obligation to provide every inmate with essential health care, and reasonable access to non-essential mental health care. As well, the provision of health care must conform to "professionally accepted standards." Accordingly, the CCRA itself provides a framework for litigation.

It is questionable whether medical services available in correctional settings reach acceptable standards of the profession at all times (Iftene, Hansen, & Manson, 2014). While there are serious deficits in caring for seniors in the community, certain services are generally available in Canada for everyone on the outside. Mental health care is the second biggest source of funding by the government in the community. About 61% to 72% people have full coverage when consulting medical health specialists. Across the age groups, seniors seemed to be the most content with the services received for mental health issues. 9% of people over 65 reported having mental health care needs but did not receive help, while the overall unmet needs was 21% (Canadian Institute for Health Information, 2010, p. 19). This is a very different picture than that provided by the data in this study.

The CCRA requires that the services be directed to the reintegration of the offenders, based on needs and vulnerabilities. The study suggested that the needs of older offenders were not regularly met, and that segregation was most often the response to their behavior which appeared to be influenced by both physical and mental conditions. Arguably, this is hardly a practice conducive of reintegration in the community. Similarly, the lack of a prompt medical response may lead to an aggravation of the ailments these very vulnerable people already suffer. In this light, it is also difficult to see how offenders can be rehabilitated and come out as productive members of the society. On the contrary, it appears that the lack of support is conducive of anger and insubordination. If the standards prescribed by the legislation are met in regard to younger offenders who are more numerous and with whom this study is not concerned, it means that different policy and institutional regulations are required when dealing with older offenders.

The provisions presented could and should be interpreted in a manner that protects the rights of the prisoners and ensures that they receive the mental health care they need, according to the professionally accepted standards in the community. Unfortunately, the provisions are vague and oftentimes capable of multiple interpretations. Because key concepts like "essential health care" are not defined, the application of the CCRA provisions is often elusive, with little to no legal consequences. Moreover, when practices are challenged with some chances of success, such cases are settled out of court so they never have the chance of becoming precedents. In addition, even when such an action would get to court and be successful, it is unlikely that the decision would affect more than the claimant, who would be provided compensation.

Table 9
Mental Illnesses per segregation rates.

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

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

3.2. S. 12 of the Canadian Charter of Rights and Freedoms

Since to date actions based in the CCRA seem of little use, it might be the case that a constitutional challenge to the government's treatment of its charges should be made. As presented below, such challenges are supported by the current framework. Enacted in 1982, the Canadian Charter of Rights and Freedoms has since been part of the Canadian Constitution. Hence, all federal and provincial statutes and regulations, as well as governmental policies, need to be in accordance with the Charter. A law or an act of the government may be challenged in court when considered unconstitutional. If the claimant proves the breach of the Charter, the sanction applied by courts will be nullification of the legislation or the court will apply a "just and appropriate remedy" under s. 24 (1) of the Charter. Finding a law or governmental practice unconstitutional would have the effect of requiring that such practice or law is not applied again. In certain cases however, the government may prove that its act reasonably limits the individual rights in accordance with s. 1 of the Charter. The test applied by courts in order to determine if s. 1 applies to that breach is known as the *Oakes* test (R v. Oakes, 1986).

S. 12 of the Canadian Charter of Rights and Freedoms (1982) provides that "everyone has the right to be free from cruel and unusual treatment or punishment." This section encompasses various types of situations. "Barbaric acts" such as torture and corporal punishment would fall un-controversially under this section. Another category has been interpreted as grossly disproportionate sentences (Hogg, 1997, p. 1213). For this category, the threshold is very high, defined as an action that amounts to treatment or punishment so excessive that it "outrages the standard of decency." (R v. Miller & Cockriell, 1997; R v. Smith, 1987). The majority of s. 12 cases have dealt with challenges to the constitutionality of minimum sentences. In a 2015 case, R v. Nur (2015) the SCC refined the test applied to determine when a piece of legislation (here imposing mandatory minimum sentence) would trigger the application of s. 12. This was a refinement of the reasonable hypothetical test previously used. The court maintained the "grossly

disproportionate" threshold. A law would be in violation of s. 12 when the measures it imposes are grossly disproportionate on the individual challenging them, or when it is reasonable foreseeable that it will be grossly disproportionate on other persons (R v. Nur, 2015, para 65).

There is no question that how sentences are served can amount to cruel or unusual punishment if they meet the "grossly disproportionate" standard or are so excessive as to outrage the standard of decency:

> "*One must also measure the effect of the sentence actually imposed. If it is grossly disproportionate to what would have been appropriate, then it infringes s. 12. The effect of the sentence is often a composite of many factors and is not limited to the quantum or duration of the sentence but includes its nature and the conditions under which it is applied. Sometimes by its length alone or by its very nature will the sentence be grossly disproportionate to the purpose sought. Sometimes it will be the result of the combination of factors which, when considered in isolation, would not in and of themselves amount to gross disproportionality. For example, twenty years for a first offence against property would be grossly disproportionate, but so would three months of imprisonment if the prison authorities decide it should be served in solitary confinement. Finally, I should add that some punishments or treatments will always be grossly disproportionate and will always outrage our standards of decency: for example, the infliction of corporal punishment, such as the lash, irrespective of the number of lashes imposed, or, to give examples of treatment, the lobotomisation of certain dangerous offenders or the castration of sexual offenders.*" (R v. Smith, 1987, para 56)

In R. v. Munoz (2006, para 78) it was held that conditions that shock the conscience of the community are a violation of s. 12; the particular circumstances of the individual and the institution must be taken into account. The issue in this case was the awarding of pre-trial credits for prisoners who endured bad conditions in pre-trial detention. Applying a similar analysis, the Alberta Queen's Bench found a breach of s. 12 on two grounds with respect to the Edmonton Remand Centre in the case of *Trang*. The court concluded that forcing inmates to use underwear badly stained by human waste was "grossly disproportionate in that it does not accord with public standards of decency and propriety, and shocks the general conscience. It is degrading to human dignity and worth." (Trang v. Alberta, 2010, para 1046) The court also found that the cumulative effect of the inmates being double-bunked, locked-up for 18 to 23 h daily with little recreational activities available was grossly disproportionate. However, other conditions (such as prolonged segregation, the use of baby-dolls, limitation to visits, forcible cell extraction, exposure to racist taunts and comments, long waiting time for dental care and transportation to medical facilities, and even the cumulative effects of all of these) were found not to raise to the level of severity required by s. 12 (Trang v. Alberta, 2010, paras 1036, 1037, 1041, 1053, 1055, 1060).

Claims of breach of s. 12 based on conditions of confinement have been brought in a number of other cases but they have been largely unsuccessful. For example, irrespective of the circumstances (including when it involved untried prisoners), double-bunking has consistently been found not to raise to the threshold needed for a finding of a breach of s. 12 (Collins et. al. v. Kaplan et al., 1982; Piche v. Solicitor General of Canada, 1984; R v. KRP, 1994; Trang v. Alberta, 2001). Claims of a breach based on the fact that inmates were allowed very little time out of the cell (sometime as little as 40 min per day) were also found not severe enough to engage s. 12 (Maltby v. AG; Soenen v. Edmonton Remand Centre, 1983). Lengthy periods in disciplinary or administrative segregation have also been found not grossly disproportionate, even if they were "hard time" (Munoz v. Alberta, 2004; R. v. Chan, 2005; R. v. Munoz, 2006). The use of "baby-dolls" (restrictive body suit) in segregation was considered serious but justifiable (R. v. Olson, 1987). Serious restrictions to visits were also deemed acceptable (R. v. Chan, 2005). Thus, while findings of cruel or unusual conditions of confinement are within the scope of s. 12, they are currently unlikely in Canada. For s. 12 to be a useful mechanism of protecting inmates against destructive conditions of confinement, the threshold might need to be lowered.

In other jurisdictions prison conditions have more often been found to amount to cruel and unusual punishment. The USA has acknowledged that prison practices can amount to breaches of the Eighth Amendment, the equivalent of s. 12. The leading case is Estelle v. Gamble (1976), which established that "deliberate indifference to serious medical needs of prisoners are a violation of the Eighth Amendment." The "deliberate indifference" test has become the legal standard. In Hayes v. Snyder (2008) the court stated that refusing prescription-strength painkillers to a person suffering from a testicular cyst and delaying a visit to a specialist might amount to a breach of the Eighth Amendment. The same two claims (lack of a timely surgery and lack of proper painkillers) were successful in Brown v Englander (2010), where the complainant was a 72-year-old individual. A similar finding was reached in the case of an older offender who complained of the lack of medical staff at night and of the fact that he fell from a top bunk without a ladder (Guzman v. Cockrell, 2011). An inmate with numerous medical conditions was successful in his Eighth Amendment claim concerning the failure of officers to implement the physician's recommendations (Woods v. Goord, 2002). Successful Eighth Amendment claims were also brought in regard to physical prison conditions. In Goodman v. Georgia (2006) it was found that infrastructure not fit for people with disabilities amounted to inhumane treatment. Lower courts have also decided favorably in similar cases based on breaches of the American Disability Act. These claims were brought forward by older people with different disabilities or mobility problems, many in regard to accessibility (Flynn v. Doyle, 2009; King v. CDCR, 2007; Kutrip v. City of St Louis, 2009; Love v. Westville Correction Center, 1996; Phipps v. Sheriff of Cook County, 2009; Purcell v. Pennsylvania Department of Corrections, 2006; Schmidt v. Odell, 1999).

Art. 3 of the Convention for the Protection of Human Rights and Freedoms (1950) includes an almost identical provision to s. 12. The European Court has been more open to applying this provision to incarceration (GB v. Bulgaria, 2004; Mayzit v. Russia, 2005; Vincent v. France, 2006). The standard used has also been more generous than both the Canadian and the American ones. The threshold employed has been defined as "minimum level of severity," which is to be established by looking at all circumstances of a case including duration of treatment, its physical and mental effects, as well as the sex, age, and state of health of the victim (Valasinas v. Lithuania, 2001). Generally a treatment in breach of art. 3 goes beyond "the inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment" (Dougoz v. Greece, 2001). While the standard is flexible and perhaps less predictable than the US and Canadian ones, European scholars have noted that this may be an advantage, because "it allows the courts to play a much more interventionist role than the American courts, which have insisted on a finding of 'deliberate indifference' on the part of authorities before holding that prison conditions are cruel and unusual and thus in contravention of the Eighth Amendment of the US Constitution." (Zyl Smit & Snacken, 2011, p. 128). Due to this generous threshold, the European Court has developed a whole line of prison jurisprudence based on art. 3, often referred to as "the unwritten art. 3 pertaining to inmates" (Iftene, 2010, pp. 29, 30). The European documents[2] regarding the treatment of prisoners and prisoners' rights are probably the most developed in the world at this moment. They provide for clear standards to be met, while allowing for an expansive jurisprudence that protects prisoners from abusive prison practices and inappropriate living conditions (Committee of Ministers, 1973).

Canadian courts have so far been deferential toward the government where prison treatment and policies are concerned. The "grossly disproportionate" standard allows for a breach of s. 12 finding only occasionally in sentencing matters and rarely in prison condition challenges.

[2] See e.g. Committee of Ministers, European Prison Rules, Res. 73.5/1973.

While this standard might be appropriate in sentencing, in the context of the conditions of a total institution, it might be too high. Prisoners are placed under the full control of the government, whose policies and decisions are administrative rather than legislative. There is little external oversight of decisions that irreversibly affect inmates' lives. In such cases courts should be able to use a lower threshold to evaluate the constitutionality of these practices. This study showed some of the effects and practices that fail to meet the needs of the senior prison population. While not all of them are cruel and unusual, many of them disproportionately harshen the sentence. When certain practices are systemic, or create with regularity more hardship on a certain group of people than on others, those people are suffering punishment that should be covered by s. 12, whether disproportionate or grossly disproportionate.

Reiterating the goals of punishment, an individual is sent to prison in order to protect society from him, to make a statement regarding the community's attitude toward such behavior, and to help the offender to eventually reintegrate into the society, as a better version of himself. In order for this to be accomplished the individual must be segregated from free society, in a stricter or looser environment, depending on the level of risk he presents. He cannot be with his family and friends, he cannot raise his children, he cannot have romantic relationships, he cannot go to work, and he cannot choose the activities he will perform and his company. He rarely decides what he will eat and what he will wear. He cannot choose when he will bath, when he will shave, when he will exercise, and when he will go to bed or wake up. He cannot choose his doctors, and has limited choice over the medical services he will receive. He must work hard to fulfill his correctional plan and to display restrained behavior in order for a chance at release. He must watch his back at all times because prisons are dangerous places. He will have to put up with strict authority and often be humiliated by it. He will always fear physical harm, the possibility of not getting paroled, and the potential that his family will reject him. Simply put, he loses his freedom and all that is associated with it. This is his punishment. Its length will depend on the offence he has committed. That's where proportionality in sentencing comes in. The loss of freedom is not a death penalty. It is also not a slow and agonizing death. It is not a sentence to physical pain caused by physical violence or untreated conditions. It is not a sentence to mental degradation. It is not an identity extraction, a brainwash experiment, or a survival exercise. It is not a sentence to prove one's virility. It is also not a sentence to contamination with infectious diseases that will last a lifetime. Prisons are not martial arts schools, or gladiators' arenas. Any environment that is systematically conducive to these conditions is generating an inhumane and unusual punishment. It is more than what the individual's sentence presupposes; it is often disproportionate and sometimes grossly disproportionate.

The situation of older offenders is bound to engage Canadian courts with a s. 12 challenge at some point. As shown both by this study and by the literature, the most common response to mental illness is segregation. This is particularly worrisome for older offenders, who encounter high rates of psychiatric conditions. This study established a relationship between mental illness and segregation. Most often, segregation negatively affects the mental state of the individual, who is thus a bigger danger to his own life and to that of those around him. In some institutions, an individual is entitled to only three psychological sessions, while he can see the psychiatrist for a 5 min visit every 1 or 2 years. Besides that, his mental health condition is aggravated by a systematic indifference toward environmental factors that would make a difference in the well-being of older offenders. Not only that mentally ill older offenders do not receive appropriate accommodation that would allow them to properly rest at night without being exposed to the threats and noises of younger offenders, but also this group is the most harassed by other inmates. Arguably, their sentence becomes one of mental degradation, which is beyond any acceptable penal response.

If any of the above examples of older offenders' treatment would occur in a hospital, nursing home, or shelter, these would no doubt be considered to be breach of the "standards of decency" referred to in R v. Smith (1987). Prisons are not facilities created to care and treat individuals. However, care and treatment is intrinsically connected to complete control over the prisoner's life. And it has to be done according to our society's standard of decency. For such types of situations, courts should follow the example of other jurisdictions and be prepared to find such excessive treatments as "cruel and unusual." Lowering the threshold used to analyze s. 12 breaches from "grossly disproportionate" to "disproportionate," "deliberate indifference," or "minimum level of severity" would be fully justified in the context of conditions in a total institution, and would allow for a better protection of prisoners against cruel or unusual treatment or punishment.

4. Conclusion

More work needs to be done in the area of mental health in prisons, both in the general population and among older offenders. A comparative study between younger and older offenders would be ideal. However, this study is a first step toward identifying needs among older offenders, and provides data to support the assertion that the treatment of mentally ill seniors in Canadian prison is insufficient.

From the data presented, we know some of the rates of mental illness, substance abuse, and suicidal tendencies among the older offenders. We also know that access to medical specialists is limited, especially in some institutions. Mentally ill individuals tend to be often placed in segregation and this causes individuals to fear reaching out for help. Hence, they tend to be angry and unstable, causing more disciplinary problems than the rest of the older offenders. We also know what appears to work in managing mental problems: family connections, exercise, appropriate sleep and rest time. There are no accommodations made to ensure that older offenders have such needs met. We also know what does not work: segregation, little medical care, maximum security, and allowing individuals to be preyed upon by staff and peers.

Under such circumstances it seems sensible that the CSC approach toward mentally ill offenders, in particular seniors who may be more prone to such issues due to aging, needs to change. Most people would acknowledge that the community standard toward mental illness is not to isolate individuals of family contact, to segregate them for an unlimited period of time, or to limit their access to mental health specialists. While the community health care system is not perfect, such practices do not occur. Most Canadians would also agree that treating someone like this, regardless of their crime, is not in accordance with Canadian values. Whether we consider that such practices are disproportionate or grossly disproportionate, it should be irrelevant in finding that they are harmful, inhumane and cruel. It is time for courts to acknowledge that and decide for the change that the government is slow in bringing about.

Acknowledgments

This study was financed by the Canadian Social Science and Humanities Research Council through an Armand Bombardier Doctoral Scholarship.

I would like to thank my doctoral supervisor, Professor Allan Manson of Queen's University for his continuous support and advice during this research study. I am also grateful to Professor Anthony Doob of University of Toronto for his help with the study in general and for his comments on this article in particular.

References

Aday, R. H. (2003). *Aging prisoners*. Westport: Greenwood Publishing Group, Inc.

Ardnt, S., Turvey, C. L., & Flaum, M. (2002). Older offenders, substance abuse and treatment. *American Journal of Geriatric Psychiatry*, *10*, 733–739.
Canadian Institute for Health Information (2010). Health care in Canada. Retrieved from www.cihi.ca
Canadian Institute for Health Information (2011). Health care use at the end of life in Atlantic Canada. Retrieved from www.cihi.ca
Colsher, P., Wallance, R. B., Loeffelholz, P. L., & Sales, M. (1992). Health status of older male prisoners: A comprehensive survey. *American Journal of Public Health*, *82*, 881–884.
Correctional Service Canada (1998). "Managing older offenders. Where do we stand?". Retrieved from www.csc-scc.gc.ca
Correctional Service Canada (2014, Maya). A descriptive profile of older women offenders. Retrieved from http://www.csc-scc.gc.ca/research/005008-rs14-03-eng.shtml
Correctional Service Canada (2014, Augustb). A brief profile of incarcerated older men offenders. Retrieved from http://www.csc-scc.gc.ca/research/005008-rs14-21-eng.shtml
Delgado, M., & Humm-Delgado, D. (2009). *Health and health care in the nation's prisons. Issues, challenges, and policies*. Lanham: Rowman & Littlefield Publishers, Inc.
Editorial (2015, May 4). Stop messing with inmates' health. *The Globe and Mail*, p. A10.
Fine, S., & Wingrove J. (2014, December 11). I don't understand why we tolerate this. *The Globe and Mail*, p. A1.
Gallagher, E. M. (2001). Elders in prison. Health and well-being of older inmates. *International Journal of Law & Psychiatry*, *24*, 325–333.
Ham, Richard J., Sloane, Philip D., Warshaw, Gregg A., Bernard, Marie A., & Flaherty, Ellen (2007). *Primary Care Geriatrics. A Case-Based Approach* (5th ed.). Philadelphia: Mosby Elsevier.
Hogg, P. (1997). *Constitutional law of Canada*. Toronto: Carswell.
Howlett, K. (2014, December 6). Prison watchdog criticizes rate of segregation. *The Globe and Mail*, p. A1.
Howse, K., & Centre for policing and ageing trust reform (2003). A scoping study on elder prisoners. Retrieved from http://www.prisonreformtrust.org.uk/Portals/0/Documents/Growing%20Old%20in%20Prison%20-%20a%20scoping%20study.pdf
Iftene, A. (2010). *Convicts and human rights: A comparative study on prison treatment in Europe and Canada.* (Retrieved from Queen's University Archives).
Iftene, A., Hansen, L., & Manson, A. (2014). Tort based actions in Canadian prison litigation. *Queen's Law Journal*, *39*(2), 655–683.
Mackarel, K. (2015, January 28). Prison watchdog pushes Ottawa on plans for solitary confinement. *The Globe and Mail*, p. A1.
MacKinnon, M. (2014, December 9). Britain shuns what Canada won't—Solitary confinement. *The Globe and Mail*, p. A1.
Moller, L., Stiver, H., Jurgens, R., Gatherer, A., & Nikogosian, H. (2007). *Health in prisons: A WHO guide to the essentials in prison health*. Denmark: WHO Regional Office for Europe.
Office of the Correctional Investigator (2014). A three year review of federal inmates suicides. Retrieved from http://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20140910-eng.aspx
Ornduff, J. S. (1996). Releasing the elderly inmate: A solution to prison overcrowding. *Elder Law Journal*, *4*, 173–200.
Picard, A. (2014, December 10). Prolonged solitary confinement has no place in Canada. *The Globe and Mail*, p. A1.
Sapers, H., & Office of the correctional investigator (2010). Report of the Correctional Investigator 2009–2010. Retrieved from http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20092010-eng.pdf
Sapers, H., & Office of the Correctional Investigator (2011). Report of the Correctional Investigator 2010–2011. Retrieved from http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20092010-eng.pdf
Sapers, H., & Office of the Correctional Investigator (2013). Report of the Correctional Investigator 2012–2013. Retrieved from http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20092010-eng.pdf
White, P. (2014, December 6). Solitary, a death sentence. *The Globe and Mail*, pp. F4 – F6.
White, P. (2015, April 30). New inmates often denied essential medication for weeks. *The Globe and Mail*, p. A1.
Wingrove, J. (2014, December 12). Solitary. *The Globe and Mail*, p. A1.
Zyl Smit, V., & Snacken, S. (2011). *Principles of European prison law and policy*. Penology and human rights. Oxford: University Press.

Legislation

Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, *being* Schedule B to Canada Act, 1982, c. 11 (U.K.).
Committee of Ministers, European Prison Rules, Res. 73.5/1973.
Convention for the Protection of Human Rights and Fundamental Freedoms, 4 November 1950, 213 UNTS 221.
Corrections and Conditional Release Act (CCRA), S.C. 1990, c. 20 (Can.).
Corrections and Conditional Release Regulation (CCRR), S.O.R./92-620 (Can.).

Case-Law

Brown v Englander, U.S. Dist. LEXIS 126245 (D.N.H. 2010).
Collin et al v. Kaplan et al. (1982), 2 C.R.R. 352 (F.C.T.D., Can.).
Dougoz v. Greece, App. No. 40907/98, Eur.Ct.H.R. (March 6, 2001), available at http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-59338 (Last visited June 21, 2015).
Estelle v. Gamble, 429 U.S. 97, 102 (1976).
Flynn v. Doyle, 672 F. Supp. 2d 858 (E.D. Wis., 2009).
GB v. Bulgaria, App. No. 42346/98, Eur. Ct. H.R. (March 11, 2004), available at: http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-61674 (Last visited May 13, 2015).
Goodman v. Georgia (United States v. Georgia), 546 U.S. 151 (2006).
Guzman v. Cockrell, U.S. Dist. LEXIS 41646 (E.D. Tex. 2011).
Hayes v. Snyder, 546 F3d 516 (7th Circ. 2008).
Love v. Westville Correction Center, 103 F3d 558 (7th Circ., 1996).
King v. CDCR, U.S. Dist. LEXIS 51179 (E.D. Cal. July 16, 2007).
Kutrip v. City of St Louis, 329 Fed. Appx. 683 (8th Circ., 2009).
Maltby v. AG (Saskatchewan), 2 C.C.C. (3d) 153 (Sask. Q.B., Can.).
Mayzit v. Russia, App. No. 63378/00, Eur. Ct. H.R. (2005), available at: http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-68067 (last visited May 13, 2015).
Munoz v. Alberta, 2004 A.B.Q.B. 769 (Can.).
Phipps v. Sheriff of Cook County, 681 F sup 2d 899 (N.D. III, 2009).
Piche v. Solicitor General of Canada (1984), 17 C.C.C. (3d) 1 (F.C.T.D., Can.) aff'd (1989) 47 CCC (3d) 495 (F.C.A., Can.).
Purcell v. Pennsylvania Department of Corrections, U.S. Dist. LEXIS 42476 (W.D. Pa. Mar 31, 2006).
R. v. Chan, 2005 A.B.Q.B. 615 (Can.).
R v. KRP, [1994] B.C.J. No. 2405 (Prov. Ct., Can.).
R v. Miller and Cockriell, [1997] 2 S.C.R. 689 (Can.).
R. v. Munoz, 2006 A.B.Q.B. 901 (Can.).
R v. Nur, 2015 S.C.C. 15 (Can.).
R v. Oakes, [1986] 1 S.C.R. 103 (Can.).
R. v. Olson (1987), 62 O.R. (2d) 321, [1987] O.J. No. 855 (C.A., Can.), aff'd [1989] 1 SCR 296 (Can.).
R v. Smith, [1987] 1 S.C.R. 1054 (Can).
Schmidt v. Odell, 64 F. Supp. 2d 1014 (D. Kan., 1999).
Soenen v. Edmonton Remand Centre (1983), 48 A.R. 31 (Q.B., Can.).
Trang v. Alberta (Edmonton Remand Centre), 2010 A.B.Q.B. 6 (Can.).
Trang v. Alberta (Director of the Alberta Remand Centre), 2001 A.B.Q.B. 659 (Can).
Valasinas v. Lithuania, App. No. 44558/98, Eur.Ct.H.R. (July 24, 2001), available at http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-59608 (Last visited June 21, 2015).
Vincent v. France, App. No 6253/03, Eur. Ct. H.R. (24 October 2006), available at: http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-125668 (Last visited May 13, 2015.
Woods v. Goord, U.S. Dist. LEXIS 7157 (S.D. N.Y. 2002).