

Office of the Correctional Investigator

Risky Business:

An Investigation of the Treatment and Management
of Chronic Self-Injury Among Federally Sentenced
Women

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Final Report

Office of the Correctional Investigator

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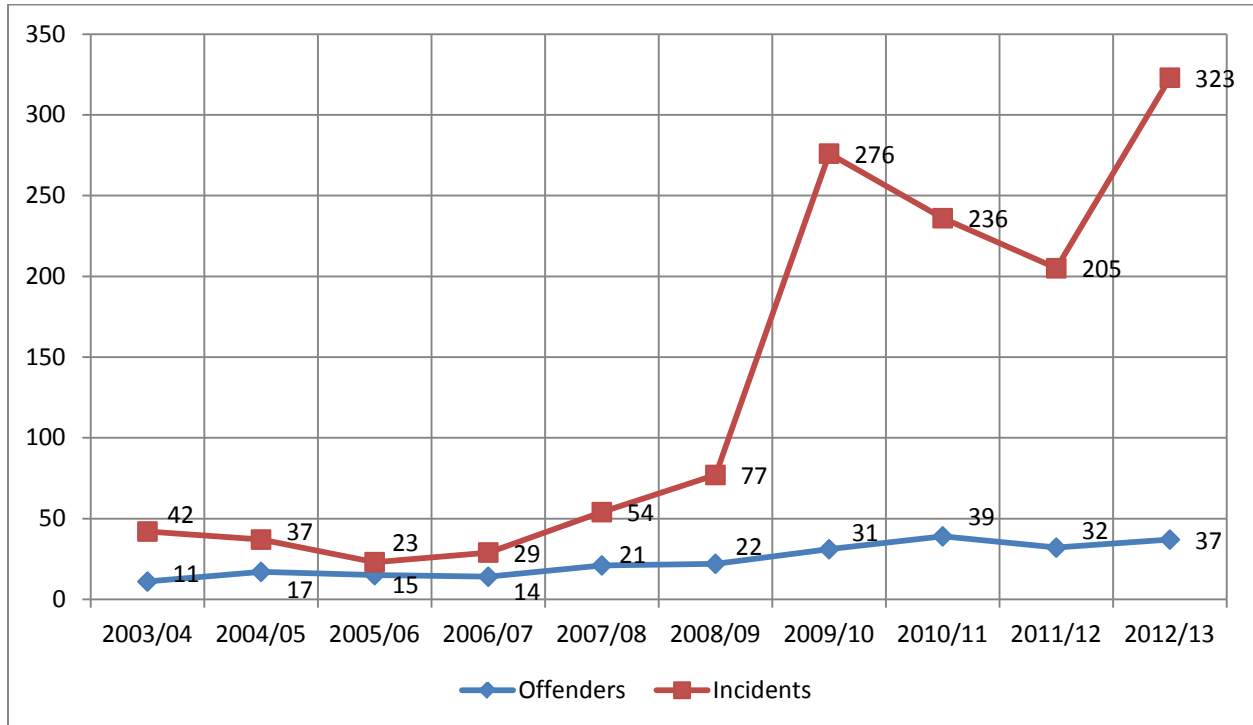
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INTRODUCTION

- Over the last five years the number of self-injury incidents in federal correctional facilities has more than tripled. In 2012–13, there were 901 incidents of recorded prison self-injury, involving 264 offenders. A relatively small number of federally sentenced women offenders (37 of 264 total) disproportionately accounted for almost 36% of all reported self-injury incidents. Aboriginal offenders were involved in more than 35% of all self-harming incidents. Aboriginal women accounted for nearly 45% of all self-injury incidents involving the federally sentenced women offender population. Of the 264 federal offenders who self-injured in 2012–13, seventeen individuals engaged in chronic (or repetitive) self-injurious behaviour (i.e., 10 or more incidents). These 17 individuals accounted for 40% of all recorded incidents. Nine were of Aboriginal descent. Nine were women (6 of whom were Aboriginal offenders).

Number of Incidents of Self-Injury Involving Federally Sentenced Women Inmates



2. In a series of Annual Reports, the Office has repeatedly raised concerns regarding the capacity of the Correctional Service of Canada (CSC) to appropriately manage chronic self-injury in federal penitentiaries:
 - over-reliance on use of force and control measures, such as physical restraints, and restrictions on movement and association to manage self-injurious offenders;
 - non-compliance with voluntary and informed consent to treatment protocols;
 - limited access to services for federally sentenced women offenders with complex mental health needs;
 - inadequate physical infrastructure, staffing complements, resources and capacity to meet complex mental health needs; and
 - inappropriate monitoring and inadequate oversight in the use of physical restraints.

There is little doubt that management of self-injurious offenders is complex and demanding work. The Office continues to believe that a handful of the most prolific self-injurious offenders simply do not belong in a federal penitentiary. These offenders should be transferred to external psychiatric facilities that are better equipped to accommodate and care for acute and complex mental health needs underlying their self-injurious behaviours.

3. The death in October 2007 of 19-year-old Ashley Smith, a young woman with an extensive history of self-injury who died as a result self-asphyxiation in the presence of CSC staff, underscored the importance of developing effective, evidence-based management and treatment strategies for complex self-injury cases. The Office's investigation into Ms. Smith's death revealed a number of individual and systemic failures that contributed to her tragic death.¹ During 11.5 months of federal incarceration, Ashley's self-injurious behaviours were routinely met with control and security-focused interventions, which included the near-perpetual use of segregation, involuntary treatment (forced medical injections), numerous inter-regional transfers and over 150 documented use of force interventions. CSC's management of Ashley's behaviour served to intensify the frequency and severity of her self-injury.
4. This investigation provides an opportunity to review CSC's capacity to balance the operational and treatment requirements of high-need, mentally ill federally sentenced women who engage in chronic self-injurious behaviour. Six years after Ashley Smith's preventable death, it serves to document how CSC responds to the mental health

¹ Office of the Correctional Investigator, *A Preventable Death* (June 2008), accessible at <http://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20080620-eng.aspx>.

needs of these women and assesses the use and impact of disciplinary measures and security controls in the management and prevention of prison self-injury.

METHODOLOGY

5. Eight federally sentenced women were selected for this investigation because they were deemed to be the most high risk and chronic self-injurious women in the federally sentenced women population. The Office identified these women through analysis of the CSC Situation Reports (SITREP), a daily report which contains information on significant incidents across the country, including incidents of self-injury. The SITREP was then cross-referenced with lists compiled by CSC National Headquarters (NHQ) and regional reports that identify and monitor offenders who chronically self-injure. In addition, at the national level, the Office regularly meets with CSC Health Care and Women Offender sectors to discuss concerns and monitor progress in acute cases of repetitive self-injury. Some of the women selected for this investigation were identified through this bilateral consultative process. A review of use of force packages² that involved self-injurious behaviour also assisted in identifying the women for this investigation.

6. The Office conducted site visits at three federal regional women's institutions—Grand Valley Institution (ON), Joliette Institution (QC) and Edmonton Institution for Women—as well as the Regional Psychiatric Centre (Saskatoon) to conduct offender and staff interviews and to review case files. The investigation employed a research strategy involving five elements:
 - i. review of relevant research and policy regarding self-injury and administrative segregation; this included academic literature and CSC research on self-injury as well as a review of the Service's staff training on mental health, suicide awareness and self-injury prevention;
 - ii. analysis of quantitative data from CSC's Offender Management System (OMS) including offence and sentence information for each woman, incident reports, segregation placements, disciplinary and institutional charges;
 - iii. review of use of force packages provided to this Office by CSC as per policy;

² CSC is required to provide all relevant use of force documentation to the Office for review. This documentation typically includes: Use of Force Report; copy of incident-related video recording; Checklist for Health Services Review of Use of Force; Post-incident Checklist; Officer's Statement/Observation Report; and Action Plan to address deficiencies.

- iv. review of respective Psychology, Discipline and Dissociation and Security records; and
 - v. qualitative interviews with the eight women; interviews were also conducted with CSC personnel at the four institutions visited, including security/operations, management, psychologists and other mental health practitioners as well as National Headquarters staff, and Aboriginal inmate committee representatives.
7. The investigation reviewed data over a 30-month period (January 1, 2010, to June 30, 2012). This window provided insight into the recorded incidents of self-injury for these women and how they were managed by CSC over time. It allowed the Office to assess the impact and effectiveness of Commissioner’s Directive 843 – *Management of Inmate Self Injurious and Suicidal Behaviour*, which was promulgated on July 21, 2011.
8. Finally, the Office conducted visits at two provincial forensic psychiatric facilities—Institute Philippe-Pinel (Montréal, QC) and the Brockville Mental Health Centre (ON)—in order to observe best practices and community standards in the clinical treatment of self-injurious behaviour. The Office also consulted staff at the Chronic Needs Program (CNP), a pilot program for self-injurious male offenders in the Pacific Region, regarding best practices for self-injury interventions.³ The Canadian Association of Elizabeth Fry Societies (CAEFS) and other community partners and stakeholder groups were also consulted.

LEGISLATIVE AND POLICY FRAMEWORK

9. Pursuant to section 86 of the *Corrections and Conditional Release Act* (CCRA), CSC is mandated by law to provide essential health services to federally sentenced offenders in conformity with professionally accepted standards of care. The Service is further obligated, under section 87 of the *Act*, to consider an offender’s state of health and health care needs in “all decisions affecting the offender, including decisions relating to placement, transfer, administrative segregation and disciplinary matters.” Section 88 of the *CCRA* provides for informed and voluntary consent to treatment, and includes an inmate’s right to refuse or withdraw from treatment at any time.⁴

³ The Complex Needs Program was a 10-bed pilot project for male inmates who chronically self injure. It operated at the Regional Treatment Centre (Pacific) from November 2010 until the pilot was terminated in March 2013.

⁴ Informed consent to medical treatment is a legally established concept that involves: i) respecting a patient’s freedom of choice (including the right to refuse or withdraw from treatment at any time); ii) providing adequate disclosure of information (e.g., diagnosis, nature and purpose of treatment, risks of treatment and treatment alternatives); and; iii) professional assessment of a patient’s capacity and competency for decision-making.

10. Significantly, though designated psychiatric facilities, CSC's five treatment centres (including the Regional Psychiatric Centre in Saskatoon where some of the women in this investigation reside) in fact operate as "hybrid" facilities, designated as both "hospitals" and "penitentiaries" under the *CCRA*. As a hospital, these centres are subject to provisions of the relevant provincial mental health legislation that prescribes standards of care and practice in matters such as legal certification, involuntary treatment and mental competency. As penitentiaries, CSC's treatment centres operate under federal statute. Taken together, this complex statutory environment imposes important legal obligations on the CSC as it manages the treatment of self-injurious offenders.
11. CSC policy defines self-injury as "the intentional, direct injuring of body tissue without suicidal intent."⁵ Self-injury may include cutting, head banging (which in rare cases can lead to permanent disfigurement or brain damage), self-strangulation, burning, ingesting harmful objects and other forms of self-mutilation. The most common form of self-inflicted injury in prison is slashing or cutting.
12. The legal and policy framework guiding Aboriginal corrections is another important consideration in this investigation, given that seven of the eight women are of Aboriginal ancestry and that the frequency of self-injury among this group is particularly concerning. Aboriginal women comprise 33% of the federally sentenced women inmate population, but accounted for over 70% of all incidents of self-injury among women offenders in 2011–12. As this investigation finds, a few Aboriginal women offenders continue to account for a disproportionate number of total self-injury incidents in CSC facilities.
13. The *CCRA* includes specific legislated provisions that govern care and treatment of Aboriginal offenders under federal sentence. For example, it directs the CSC to provide culturally appropriate programs and access to ceremonies to address the unique needs of Aboriginal offenders. Commissioner's Directive 702 – *Aboriginal Offenders* directs correctional decision-makers to consider *Gladue* factors when the interests (including health care needs) of an Aboriginal offender are at stake.⁶ As the investigation finds, a *Gladue*-informed analysis of the unique circumstances affecting the lives of most Aboriginal people could yield some important insights into the underlying causes, treatment of and response to prison self-harming behaviour among federally sentenced Aboriginal women.

⁵ Commissioner's Directive 843 – *Management of Inmate Self-Injurious and Suicidal Behaviour*.

⁶ *Gladue* factors include, but are not limited to, effects of the residential school system; family or community history of suicide, substance abuse and/or victimization; experience in the child welfare or adoption system; experiences with poverty; level or lack of formal education; loss of or struggle with cultural/spiritual identity.

14. The specific authorities and procedures for managing self-injurious inmates are outlined in Commissioner's Directive 843 – *Management of Inmate Self-Injurious and Suicidal Behaviour*. The objectives of this policy are twofold:

- i. to ensure the safety of inmates who are self-injurious or suicidal using the least restrictive measures for the purpose of preserving life and preventing serious bodily injury while maintaining the dignity of the inmate in a safe and secure environment;
- ii. to encourage and support an interdisciplinary approach so that the inmate can resume regular activities as soon as possible.

15. CD-843 also outlines the clinical treatment protocols for managing prison self-injury and includes direction on the use and monitoring of the Pinel Restraint System, or PRS.⁷ CD-843 directs that, "Where use of the Pinel Restraint System is part of a treatment plan and the inmate consents (or requests its application), it is neither a reportable incident nor a reportable use of force." As this investigation finds, there is considerable confusion (and contradiction) in the interpretation and application of this policy direction at the operational level. On the one hand, policy directs that the PRS is neither a medical nor a clinical measure, and yet on the other it allows for the "consensual" use of restraints as part of a treatment plan. The Office's position on these matters is clear: in a correctional environment, the use of restraint equipment to gain control of or manage a self-injurious offender cannot be considered "consensual" or "compliant" as this type of intervention lacks the express elements required for informed and voluntary consent.

OFFENDER PROFILE

16. The average age of the eight federally sentenced women interviewed for this investigation is 25, with the youngest being 19 years of age and the oldest, 40 years of age. Seven of the eight women are Aboriginal.

⁷The Pinel Restraint System (PRS) is an approved device listed in the Security Equipment Manual intended to temporarily restrict or limit free movement. The PRS is identified in the Manual as a "medical restraining device." It is a system of restraining belts or straps that attach to a bed, chair, or stretcher that allows for incremental restraint. The seven-point Pinel Restraint System consists of up to seven different belts and/or straps (i.e., 4 limb belts, waist belt, pelvic belt and shoulder belt). According to CSC policy, the use of the PRS "is an intervention to preserve life and is not a medical treatment."

17. All of the women were convicted of at least one violent offence; their index offences include common assault, robbery and murder. Two women are serving indeterminate sentences; the remainder are serving sentences that range from 2 to 15 years, the average length of sentence being five years. Six women are serving their first federal sentence. Consistent with the literature on prison self-injury,⁸ minimum security women are underrepresented and maximum security women overrepresented in the sample (all but one was classified as maximum security).
18. Since most of the women are of Aboriginal heritage, the social histories of these women are particularly relevant and provide important contextual information about their individual circumstances. Most of the women under this review are estranged from their families. Most spent their childhood in group homes or foster care. All have been the victim of physical abuse; seven have been sexually abused. Although four of the women are mothers, there is no evidence that they have current or long-term relationships with their children. Many have little if any existing social support.
19. The Office reviewed visitor logs and found that most of these women had no history of any prison visits. For example, one woman had not had a visitor in 13 years and another has not had a visitor in 6 years. Two of the women had a few occasional visits—one woman had five visits over a six-year period and the other had one visitor over the course of 2011.
20. These women have demonstrated difficulty in integrating with others, which is likely a function of their pre-existing mental health concerns. Six women spent time in a mental health or psychiatric institution prior to federal custody. All were previously diagnosed with a significant mental disorder and all had a psychiatric assessment on file (although one assessment was over six years old). Six of the women have identified cognitive deficiencies. Three have been diagnosed with Fetal Alcohol Syndrome. Three others cognitively function below average level (which means that they have difficulty with basic problem-solving).
21. All self-injure by way of slashing and/or cutting their body. Most also use ligatures to self-strangulate and some have inserted foreign objects into their body. All have self-injured by banging their head. All have a previous history of suicide attempt(s).

⁸ CSC 2010b; CSC 2011c.

INSTITUTIONAL PROFILE

22. During the period under review, there were a total of 22 recorded transfers involving these women between CSC federal institutions, the Regional Psychiatric Centre (RPC Prairies, Saskatoon) and/or provincial psychiatric hospitals. Some were transferred as many as six times between the RPC and other federal women's institutions. All transfers from the home institution were prompted by continuous escalation of deregulating and/or maladaptive behaviours associated with mental health problems. During the review period, one woman who was housed in long-term care at the RPC was released on parole and then transferred to a community forensic psychiatric hospital.⁹
23. Seven women incurred a considerable number of institutional charges (ranging from 19 to over 100 reported charges, which include behaviours and responses to staff during self-injury incidents). Routinely, these women are institutionally charged with issues such as refusing to stand for count, swearing at staff, and/or being involved in physical altercations with other offenders. Institutional charges often result in a fine or extra work within the institution. The Office identified a few charges directly related to self-injurious behaviour, including possession of an unauthorized item and destruction of institutional property.
24. Six women were convicted of additional offences during the course of their federal incarceration, resulting in time added to their sentences. Three women received additional convictions for criminal offences (i.e., assault) that occurred during intervention related to self-injury incidents. Two had time added to their sentence for these offences. One received an additional four months to be served consecutive to her index sentence; the other received two separate convictions resulting in a total of 75 days added to her original sentence.
25. When the Office reviewed one of these incidents in particular, it was discovered that the woman had been in her cell strangling herself. Staff did not enter her cell immediately; they initially verbally directed her to cease her behaviour. Staff subsequently determined that physical handling was required to prevent further self-injury. The offender refused to be placed in a gown to prevent suicide and self-injury, and she proceeded to self-injure. At that time, staff involuntarily placed her in Pinel restraints and she spat at the officers, resulting in formal charges and additional time added to her sentence.

⁹ Due to this woman's release, the Office extended the review period for her case by eight months to encompass the full two years before her release as well as time under community supervision.

26. CSC's Offender Management System (OMS) reported a total of 802 security incidents for these eight women. Just over half of the incidents (435) were identified as self-injurious or suicidal. However, the Office found that CSC coding overlooks a number of incidents that involve self-injury, or threats and/or ideations thereof, which are sorted into categories other than self-inflicted injury incidents (e.g., disciplinary problems, assaults on staff, cell extractions, and other incidents). The Office systematically reviewed all 802 incidents and identified an additional 47 incidents involving either ideations or threats of self-injury and/or suicide, or self-injurious behaviours (including the construction of items intended for self-injury).
27. A file review indicates that all but one of these women served time while under some form of "clinical" seclusion. It was routine for five of the women to be placed in administrative segregation due to various behavioural problems or self-injury. Seven confirmed that the use of segregation exacerbated their self-injurious ideations or behaviour.
28. There is no stand-alone specialized facility to treat chronic self-injurious women offenders in federal corrections. Some of the most challenging and complex cases are managed in the Churchill Unit, a recently expanded 20-bed female wing co-located at the otherwise male Regional Psychiatric Centre (RPC Prairies) in Saskatoon.¹⁰ It has been common for the women housed at RPC to be kept in clinical seclusion, otherwise known as Intensive Psychiatric Care (IPC) or Restrictive Psychiatric (RPI) status (the latter affording women restricted movement and privileges out of their cell). A CSC National Board of Investigation from 2009 noted the following physical infrastructure concerns:

The physical structure of Churchill Unit and especially the IPC area was not conducive to meaningful therapeutic interventions. There were three cells and a shower along a narrow hallway. The cells had no windows to outside light ...[T]here was little privacy, as there were no interview room capabilities in the IPC, and conversation and interviews, at times, had to take place through the hatch on the cell door.¹¹

¹⁰ The Churchill Unit is physically segregated from the other RPC units, which house male patients. In the Office's view, since its opening in August 1996, the Unit has never been viewed as an optimal place to treat women patients needing predominantly psychiatric interventions. The fact that the Unit is housed within a male facility compromises access to other off-unit venues. All movement of male patients is stopped and the windows into the male units are covered whenever the women are moving from Churchill Unit to an RPC facility or activity. CSC, *Review of the Regional Psychiatric Centre Churchill Women's Unit Existing Treatment Model*, November 2010.

¹¹ National Board of Investigation, 1410-2-09-39, p. 119.

29. Two women spent over 18 months in clinical seclusion at this facility under IPC status during the review period. One of these women has since been released on parole and was able to spend some months at a community psychiatric hospital where seclusion was not used as a response to her self-injurious behaviour or ideations. She described her time incarcerated in IPC in these words:

I was always in a baby doll, locked away, 24/7 either with a staff (member) sitting at my door, a nurse or a guard sitting at my door. With no mattress, with just a thin blanket on my –on...concrete...with a slab of concrete and then the floor is concrete and I would get out for an hour a day for yard and a shower.

During her time at the community psychiatric hospital, the frequency and severity her self-injurious behaviours diminished dramatically.

30. Two women were managed on the Management Protocol until it was rescinded by the CSC in May 2011 consistent with a recommendation by this Office.¹² Under the Protocol, these women were housed in segregation for extensive periods of time. Following the rescinding of the Management Protocol, these women continued to spend a significant amount of time in both voluntary and involuntary segregation.

ANALYSIS: MANAGEMENT OF SELF-INJURIOUS BEHAVIOUR

31. Within a prison milieu, security staff are almost always the first responders to self-injury incidents. Their response to self-injurious behaviour must be consistent with CD 567 – *Management of Security Incidents*. Policy directs that all interventions to manage or control security incidents must be consistent with the Situation Management Model (SMM) and the CAPRA (client, acquiring and analyzing, partnership, response, and assessment) problem-solving model. The SMM is a graduated model / graphic representation to assist staff in determining the appropriate response option in managing security situations. The CAPRA model details a range of responses from dynamic security and verbal negotiations to the use of restraints. To comply with the SMM and CAPRA model, staff are required to continually assess and re-assess a situation and formulate a response based on situational information.

“While she knows that banging her head will get her restrained or segregated, she does not think about the consequences in the moment before banging her head.”

Psychological Activity Note

¹² The Management Protocol, first introduced in 2003, was a very severe regime for women offenders considered “unmanageable” within the regular maximum security population. It was used almost exclusively to manage high needs / high risk Aboriginal women offenders.

32. Compliance with the SMM and CAPRA models should yield different responses when intervening with mentally disordered offenders in comparison to non-mentally ill offenders. Clinically driven intervention is based on the understanding that mentally ill persons should not be punished for the behaviours associated with their mental illness. At times of extreme emotional deregulation, female offenders, many of whom have significant cognitive deficiencies, often have difficulty responding to control orders.
33. The investigation found that, in most incidents, staff response to the self-injurious behaviour was not consistent with the objectives of CD 567 – *Management of Security Incidents* or with CD 843 – *Management of Inmate Self-Injurious and Suicidal Behaviour*. This finding is consistent with findings from previous CSC National Board of Investigation (NBOI) reports with regard to repeat self-injurious incidents. A number of internal investigations emphasize the importance of managing self-injurious behaviour through an ongoing dynamic risk assessment process involving four key principles: least restrictive intervention(s); humane treatment; clinical management; and collaborative planning.

A. The Least Restrictive Principle

34. Since the death of Ashley Smith in October 2007, there have been clear indications that a security-driven culture among correctional staff has resulted in a risk-averse reflex to control and/or contain self-injurious incidents. A security response is one in which incidents are characterized and treated as compliance issues—i.e., ordering women to comply with an order to cease their self-injury. If the inmate does not comply with verbal negotiations or with orders to stop self-injuring, then staff typically respond with Oleoresin Capsicum spray (commonly referred to as OC or pepper spray) and/or physical handling to control the woman (which may not be the least restrictive intervention available).

“Swift intervention and zero tolerance continues to be the plan for XXX with instances of head banging.”
Excerpt from Interdisciplinary Management Plan

35. Most correctional officers interviewed referred to the “zero tolerance” approach towards prison self-injury and acknowledged that their risk-averse response may not be consistent with the least restrictive measure. When responding to self-injurious behaviour, staff are

“...beliefs that suggested that risk must be eradicated are unattainable and unsupported. The cyclical nature of self-injury as a coping strategy requires dynamic intervention strategies.”
CSC, National Board of Investigation

required to assess the individual risk and needs of the offender and formulate a response. Compliance with the least restrictive principle requires balancing the interests (or needs) of the offender with the correctional purpose of the intervention. In all cases, the principle requires minimal impairment; the correctional response must be necessary and proportionate to the level of risk presented by the self-injurious behaviour. These are important considerations as in most cases the offender's immediate engagement in self-injury presents a risk almost exclusively to her own self, not others. Resistive or assaultive behaviour most often occurs only after correctional staff intervene and is most frequently observed in the context of mandatory strip searching as part of a segregation or observation cell placement following a self-injury incident.

36. Numerous staff (mental health, security, and medical) admitted that their response often runs counter to their instincts or awareness as to how to better handle a highly charged emotional situation. The majority of staff attribute the security-driven response to self-injury to their accountability for keeping the institution in control at all times. Some officers disclosed that they did not feel qualified to intervene with mentally ill offenders despite the mandatory training on suicide prevention and the basic mental health awareness training that they had received.
37. The investigation found that security or control interventions are generally disproportionate to the risk presented and often inappropriate from a mental health needs perspective. In most cases, these measures simply contain or reduce the immediate risk of self-injury; they are not intended to deal with the underlying reasons or symptoms of mental illness manifested in self-injurious behaviour.
38. Based on Office interviews, as well as documentation from the incidents, the Pinel Restraint System (PRS) appears to be a primary intervention measure to manage self-injurious behaviour, particularly at the RPC. Pinel restraints were used in over half of the incidents to manage self-injurious behaviours. RPC staff informed the Office that the Pinel restraint table is prepared immediately when a self-injury incident occurs. Two women were responsible for a disproportionate number of the incidents in which the Pinel restraints were applied; one of these women spent a period of some months restrained either in a Pinel bed or a Broda chair¹³ for up to 23 hours a day. When these two cases are controlled for, slightly more than 16% of cases involved the use of restraints. The PRS was often applied after the behaviour escalated or deteriorated and following other interventions (e.g., physical handling, pepper spray, and movements to observation cells).

¹³ A Broda chair is a specialized repositioning wheelchair equipped with safety pads and restraint belts.

39. The Office has previously noted its concern with regard to the confusion that exists between “reportable” use of force and a clinical intervention with respect to the use of physical restraints in managing prison self-injury. If the interpretation of the incident is that the use of restraints is for “clinical” (or treatment) purposes, it is not considered a “reportable” use of force and therefore there is no systematic coding by CSC. However, since security staff are routinely the first responders to self-injury incidents, there is some confusion as to how and when the intervention is deemed a “clinical” measure (i.e., part of an offender’s treatment plan) given that this type of intervention is intended as a preservation-of-life measure and is not medical treatment *per se*. The Office reviewed a number of Officer Statement/Observation Reports (OSORs) respecting incidents in which security staff used the threat (implied or explicit) of Pinel restraints to force compliance with an order to cease self-injurious behaviour. In the Office’s view, many of these situations did not warrant that level of risk or response. Policy is also clear that physical restraints should not be used as a form of punishment or retaliation (or coerced inducement) and should be used only as the least restrictive alternative available.
40. The Office also noticed a pattern of women requesting Pinel restraints after protracted negotiations with security staff often involving resistance to a strip search or a segregation placement. In some of these cases, staff intervention had escalated to the point at which the women could no longer cope with the situation at hand. The offender “requested” (or acquiesced to) placement in Pinel restraints and agreed to stop her self-injurious behaviour. In such cases, the interventions are considered “non-reportable” use of force.
41. As this Office has stated elsewhere, placements in Pinel and other physical restraints (such as the Broda chair) are exceptional interventions that should be used as a last resort and only when an offender presents an immediate and extreme risk of self-injury or harm to others. Consistent with the least restrictive principle, these placements should be used for the shortest time possible and should be subject to the most rigorous accountability and monitoring framework possible. To protect both staff and offenders, any use of restraints in a correctional context should be considered a “reportable” use of force, subject to applicable policy and procedural safeguards, including video and audio recording during the entire period that restraints are used.
42. Based on a review of OMS data, pepper spray was deployed in 8% of self-injury incidents. In many cases, the documentation stated that pepper spray was required to stop an offender engaged in self-injurious behaviour. However, the investigation found little supporting evidence to back up the assertion that pepper spray was the least restrictive/intrusive option available to manage the situation.

43. From the Office’s perspective, the tendency to use segregation as a management response to self-injurious behaviour often appears arbitrary and unrelated to the actual dynamic risk presented by the women who engage in self-injury. Security personnel consistently informed the Office that segregation was necessary to respond to self-injury incidents in order to prevent further harm, or to “preserve life.” While segregation is not supposed to be used to manage this kind of behaviour or as a punishment, CSC often relies on this measure to ensure personal safety and maintain the security of the institution. This is concerning, particularly given that a disproportionate number of prison self-injury incidents occur in segregation or observation cells.

During an institutional visit for the systemic investigation, one of the women identified for this investigation self harmed by placing a bag over her head to suffocate herself. A nurse was a first responder in that incident and de-escalated the situation after a few minutes. When the nurse was de-escalating the situation, our Office observed one of the correctional officers clear out one of the segregation cells. The Officer confirmed the cell was for the self-injurious woman. When asked why she was being moved to segregation, the Correctional Officer responded that it was necessary to prevent further self-harming. When the Office asked the Officer what would happen to the woman if she was moved to segregation, she responded that it would likely inflame the situation but didn’t want “any issues” on her shift.

44. Nearly a third of documented self-injury incidents involved use of force either to cease the self-injurious behaviours and/or to move the women to observation cells. Use of force was often met with resistive or combative behaviours on the women’s part, and often involved an escalation in their self-injurious behaviour. As a consequence of their behaviour, resistive women were often placed in more restrictive conditions of confinement.

45. In the spring of 2012, the Service completed construction of a padded cell at the RPC. It is Canada’s first padded cell in a correctional setting, intended as a short-term measure to manage the immediate risk presented by one mentally disordered woman.¹⁴ Prior to this, the RPC also requested and received an exemption to use a specially fitted helmet

¹⁴ The walls and floor of this cell are padded to prevent the offender from hurting herself by hitting her head (or other body parts) on hard surfaces. Following the introduction of psychotropic drugs in the 1950s, the use of padded cells in psychiatric facilities fell dramatically and their presence and use is now rare in modern mental health care facilities in most of the industrialized world.

on the same woman, to manage her chronic head-banging. The padded cell has only been added to the women's (Churchill) unit of RPC. The concern is that such an extreme measure may be used to manage other cases. It is an expensive, extraordinary and ultimately inappropriate measure. This woman requires acute care and treatment that could be more safely and efficiently provided in an external mental health facility.

B. Humane Treatment

46. The principle of humane treatment requires that management strategies for self-injury not be meant as punishment but focus on the individual needs and risk of the inmate.

47. Clinical seclusion remains a controversial intervention even in psychiatric settings.¹⁵ This practice is in place at Brockville Mental Health Centre, Institut Philippe-Pinel in Montréal, the CSC Regional Psychiatric Centre and as a management tool at the former Complex Needs Program, RTC Pacific. The Associate Chief for the Forensic Royal Ottawa Hospital told the investigation the following:

Just like an electric shock is sometimes used as emergency treatment if a patient suddenly becomes very ill, with a trial fibrillation, restraint and seclusion is sometimes used for brief period as part of a continuum of intensive psychiatric care for acutely disturbed and extremely violent patients to ensure patient's safety and/or prevent serious harm to others.

48. However, staff at both community psychiatric facilities stressed that the use of clinical seclusion as an intervention strategy for self-injurious behaviour is based on an assessment of the individualized needs of each patient; it is not relied upon as a blanket response to all self-injury incidents. In addition, decisions regarding a patient's placement in seclusion are made exclusively by mental health staff following an assessment of the patient. For example, one of the women who spent considerable time segregated at EIFW due to her self-injurious behaviour was not segregated for the same behaviours at Institut Pinel, which believed that isolating her was counterproductive to clinical aims. Moreover, the psychologist treating this woman at EIFW noted that managing her in segregation likely had a considerable negative effect, escalating the resistive and maladaptive responses and likely increasing her self-injurious behaviours. Best practices that identify seclusion as a tool in the management

¹⁵ Clinical seclusion is the involuntary confinement alone in a cell/room of a seriously disordered inmate/patient who presents an imminent risk of physical harm to self or others. The expert consensus is that seclusion should be used as a last resort and discontinued at the earliest time possible. See, for example, Kenneth Appelbaum, "Commentary: The Use of Restraint and Seclusion in Correctional Mental Health," *Journal of the American Academy of Psychiatry Law*, 2007.

of self-injurious behaviour require that the process be ordered and implemented and managed by medical staff. Clinical seclusion must also be used sparingly and be based on acute risk of self-injurious behaviour.

49. The investigation revealed considerable confusion among staff regarding the use of clinical seclusion¹⁶ and administrative segregation.¹⁷ In some cases, security staff admitted to relying on administrative segregation and clinical seclusion (CD 843) to manage self-injurious behaviours despite clear direction by CSC in a Bulletin issued to staff that offenders who are self-injuring are not to be placed in segregation.¹⁸ In some cases, contextual factors led to more restrictive placements. For example, if the woman resisted the placement for clinical seclusion (CD 843) and began engaging in self-injury or refused orders to stop self-injuring, security staff may have decided to admit her to administrative segregation for jeopardizing the security of the penitentiary under *CCRA* 31(3)(a).

“XXX tried to bite herself on the hand/arm. Physical handling by way of a rear lock was utilized to prevent her injuring herself and the handcuffs were reapplied. The decision was then made to admit her to Segregation rather than just observation.”

Incident Report

50. Staff confusion with regard to the intent of the different policies was also mirrored among self-injuring women. The investigation found considerable confusion among the women with respect to the differences between segregation and clinical seclusion (CD 843). All of the women indicated that the immediate response when they self-injured was placement in segregation. None of them were aware of the actual difference(s) between segregation and clinical seclusion (CD 843). For example, one woman told us that she was in segregation for two years. A review of her file indicated that she had never been placed in administrative segregation during the review period; however, she was under a

¹⁶ CD 843 provides for three levels of observation: “high suicide watch” (imminent risk for suicidal or self-injurious behaviour); “modified suicide watch” (elevated risk) and “mental health monitoring” (at risk, but typically following removal from high or modified suicide watch). These observation levels are forms of clinical seclusion. It is perhaps instructive that staff simply refer to them as “843” in reference to the number of this policy directive.

¹⁷ There are important distinctions in the policy related to administrative segregation and the policy with regard to the management of self-injurious behaviour. Segregation is not a medical or clinical term. According to the *CCRA*, “the purpose of administrative segregation is to maintain the security of the penitentiary or the safety of any person by not allowing an inmate to associate with other inmates.” Administrative segregation is subject to legal and procedural safeguards, and includes mandated hearings and reviews at specified periods. There is no formal mechanism in place for an inmate to challenge being kept under CD 843, though they are subject to further assessment and intervention strategies per the discretion of the interdisciplinary team in order to manage their self-injurious behaviour.

¹⁸ The Bulletin was released on 2012-06-12, during the latter stages of our data analysis.

clinical seclusion regime. When explained to her, she indicated that she had not been aware of the difference.

51. All of the other women associated clinical seclusion with segregation and most indicated that they felt they were being punished—or “consequenced” as one woman referred to it—for engaging in self-injury. It should also be noted that one woman who spent considerable time in the Intensive Psychiatric Care (IPC) unit of RPC Prairies informed the Office that although it is intended as a therapeutic environment, she did not perceive any difference between the IPC unit and the segregation range at any of the other institutions where she had been housed.

Kinew James:¹⁹ ... If I could change anything I would try to offer more, like, more tools, like, to help—like if I was to look at someone younger than me, like half-like maybe eighteen-nineteen years old and that’s into self-harming, I would try to find ways, ways that they may help them more.

Investigator: And what are those tools?

Kinew James: So that they don’t end up with all— ... a whole bunch of scars and...

Investigator: What are those tools though?

Kinew James: Like more counselling, like more intervention, and like more— (Pauses) like more stuff from DBT,²⁰ like self-soothing stuff, like, like—I don’t know ... Like the thing with the ice cream, with the girl who gave me an ice cream, the inmate? ... Maybe they should have stuff for these young girls that if they self harm , oh you know you can have a treat if you don’t do this—that’s what they used to do in-in RPC years ago when I first started doing my time. They used to give the girls—they used to give the girls a chocolate bar a day. If they didn’t self-harm, at the end of the day they would get a chocolate bar.

Investigator: Because what you’re saying is if you, at the end of the day, perhaps they work through in a positive way instead of self-harming then you’re—there’s an incentive for you.

Kinew James: Yeah, and it doesn’t even have to be just a chocolate bar...

52. Promulgation of Commissioner’s Directive 843 in July 2011 sought to standardize and clarify the placement and observation levels of inmates at risk of suicide or self-injury.

¹⁹ This excerpt was taken from an interview with Kinew James, who agreed to be interviewed under the condition that the Office publicly acknowledged her name. Ms. James died while incarcerated at the Intensive Psychiatric Care unit, RPC Prairies, on January 20, 2013, six months after this interview was conducted. Her death was unrelated to self-injurious behaviour.

²⁰ DBT or dialectical behaviour therapy is a form of psychotherapy that is used in treating self-injurious behaviour.

CD 843 allows the Correctional Manager to designate a placement under CD 843 if there are no other mental health professionals available. The Office noticed a pattern regarding CD 843 placements: decisions were often made by security personnel rather than mental health staff, even when the latter were present within the institution. Despite CD 843 guidelines, the practice of isolating women (seclusion) who self-injure remains a significant management strategy, and correctional managers are often the principal decision-makers.

53. Consistent with the literature, the Office found that CSC’s response of isolating or segregating female offenders often exacerbated the women’s distress, leading to an increase in self-injury or to resistive and combative behaviours.²¹ Research has found that these practices, even when used solely for monitoring purposes, are often perceived as punitive measures, which increases negative emotions and heightens the risk for further self-injury.²² The Office noticed a disturbing trend whereby female offenders resisted strip searches that are required for an administrative segregation or CD 843 placement, subsequent to self-injuring. The resistance to strip searching is somewhat predictable and understandable from the point of view that most of these women have reported histories of physical and/or sexual assaults.

54. As part of the file reviews, hundreds of Officer Statement Observation Reports (OSORs) completed by correctional officers were reviewed. The OSOR details information such as who, why, where, what and how an incident occurred within the institution. Every correctional officer present at an incident must complete this report independently prior to end of the officer’s shift. The Office identified many instances when an officer described processing a woman for administrative segregation or CD 843 due to self-injury ideations or behaviours and, in resisting the segregation placement, the women engaged in self-injurious behaviours during the move to an observation cell. Moreover, the women who were already engaging in self-

“...initially refused to comply with a strip search and began banging her head against the concrete wall.”

“...at approximately 1400hrs, a strip search was attempted to be completed on XXX however she would not comply with officer’s orders...crisis negotiators began to negotiate with XXX...stated that she would start biting chunks out of her skin if staff would not move her ...”

“This writer [Correctional Officer] gave directions to stop banging and to sit on the stool where she could be seen by CX staff. XXX was advised that if she continued banging she would be placed in restraints on a Pinel Board.”

Excerpts from different OSORs

²¹ Heney 1990, 2010c, Howells, Hall & Day 1999, Fillmore & Dell 2001, 2005, Borrill *et al.* 2005.

²² Heney 1990; CSC 2010e; Howells, Hall & Day 1999.

injury often escalated their self-injurious behaviour (e.g., a woman who had been engaging in superficial cutting or scratching would begin to head-bang once in an observation cell).

55. Of particular concern, the process of strip searching women for placement in administrative segregation or CD 843 often sets up a new form of negotiation between security staff and the women. The Office identified tensions that exist between staff and the female offenders when asked to strip search prior to being segregated for behaviours associated with mental health issues. Control-based strategies become clear aggravating factors in the escalation of the incident.
56. One particularly distressing incident illustrates the tensions involving a self-injurious woman being forced to move to an observation cell. The woman became combative when informed of this move. In order to be placed in the observation cell, she was required to complete a strip search. This request escalated her resistive behaviours and she begged not to be moved to segregation. Staff spent considerable time “negotiating” with her to remove her clothing. She informed the Office that she removed her clothes but refused to remove her underwear because she was menstruating. Physical handling was used to finally remove her underwear by way of holding her down and cutting them off. She was walked to the observation cell down the range with another officer holding up a blanket to cover her. She had refused to cooperate after being denied the dignity of wearing her undergarments.
57. During the interview, the woman explained her recollection of the experience: “they tied me to the Pinel board, even after I changed, but they didn’t—they didn’t offer me a tampon or anything, and I was laying there for about four or five hours just bloody and disgusting, naked.” Upon review, the Office notes that only one of the many OSORs that documented this specific incident referred to her objection to the strip search because she was menstruating.
58. In community forensic hospitals, seclusion is part of a continuum of intensive psychiatric care that is used when there is a need to increase the observation of the patient. Community mental health practitioners emphasize the importance of using seclusion only when necessary based on the individualized needs of the patient and only for brief periods of time. Staff at Brockville Mental Health Centre similarly noted that seclusion placements are made very rarely and always after a psychiatric assessment has been completed. They further stressed the importance of engaging with the patient while waiting for a psychiatrist to arrive and during the seclusion placement.

59. It is clear that there are significant differences between CSC and external health providers' management of self-injury incidents. In community psychiatric care settings, the staff that deal with the identification, assessment and management of self-injurious behaviour are nearly always health care professionals. During the review period, four women received some treatment at community psychiatric hospitals at different times. While in CSC facilities, these women spent long periods of time in either clinical seclusion or segregation due to their self-injurious behaviour. In contrast, while at the community psychiatric hospitals, the women often attended work, program or therapy as part of their daily routines; staff treated them as "patients" in a program-enriched environment.
60. At one of the community hospitals, staff actively prevented one of the women from spending too much time in her room because the risk for self-injury was higher when she was alone. However, the hospital did have to restrain this woman for a two-day period by way of a fixed chair and handcuffs to prevent her from self-injuring. During the time she was restrained, staff escorted her to the common room or programming room and then handcuffed her to a chair to minimize risk in an effort to keep her connected to other staff and patients. This woman spoke about the secure rooms²³ at Institut Philippe-Pinel de Montréal, and explained that when she is placed in one of these rooms she feels as though she is taking a "break" rather than being segregated. She also indicated that federally sentenced women receive more staff attention at the Pinel institute, noting it was a "safe" environment; she used words such as "trust" in describing staff at the hospital.
61. It is particularly noteworthy that the woman, who was on parole while she was at the community psychiatric hospital, engaged in self-injury on only fifteen occasions during her 14 months following release from RPC (this included incidents during her hospitalization)—and the majority of such incidents did not include violence towards staff. In the two years preceding her release, she was involved in 127 incidents in CSC facilities that included self-injurious behaviours. In a number of those incidents, she was combative with staff and use of force was used to gain "control" of her. When interviewed at Brockville Forensic Psychiatric Hospital, she painted a very different picture of the interventions used to respond to her self-injurious behaviour.

²³ A secure room at this facility is not considered a seclusion cell. It is located in the same area as the patients' usual rooms but, much like a CSC observation cell, has fewer fixtures that can be used to self-injure or attempt suicide.

Inmate: They would put me on a one-to-one.

Investigator: What's a one-to-one?

Inmate: It's just a—a staff that would ... sit with you or—or not—not even they wouldn't put you on a one-to-one, sometimes I would just take my medication or use my buddy bag.

Investigator: And what's a buddy bag?

Inmate: It's a bag that has like ... Disney movies in it ... relaxing CDs, some tea, some play-doh, a hugging bear... (trails off)

C. Clinical Management

62. The Office has repeatedly made recommendations to CSC to treat incidents of self-injury as mental health rather than security or behavioural issues. This approach requires that interventions result from individualized, comprehensive psychological assessments and follow an integrated treatment plan.
63. Commissioner's Directive 843 – *Management of Inmate Self-Injurious and Suicidal Behaviour* outlines a short-term two-prong response to self-injury incidents: a Critical Response and Incident Management Plan (CRIMP). The CRIMP is a document that reviews the specific circumstances of the self-injury incident, its triggers and the observation level assigned, and includes a plan to decrease the inmate's risk for self-injury should it become elevated again. It is to be completed by a mental health professional following every self-injury incident, usually within a 24-hour period.
64. Consistent with management self-audits of CD 843 conducted by CSC, file reviews indicate that the majority of CRIMPs were completed within 24 hours or, if the incident occurred on a weekend, on the next business day, when mental health staff arrived at work. In a handful of cases, however, there were considerable delays noted between the date of the incident and the completion of the CRIMP. There were also a number of incidents for which CRIMPs were not anywhere on file. The policy stresses the importance of assessing each incident separately, as reasons for individual acts of self-injury may vary. Failure to complete a CRIMP for each occurrence of self-injurious behaviour compromises the effectiveness of the treatment and intervention strategy to address the underlying behaviour.

65. In addition to the lack of consistency with regards to the completion of the CRIMPs, mental health staff often reported to the Office that they had not received any training on how to complete the CRIMPs. Some expressed confusion over whether it was a mental health tool or a security tool. The Office often heard from those responsible for completing the CRIMPs that they were uncertain of what was expected of them and found the wording of some of the questions confusing. A file review of the content of these plans reflects this confusion. For example, in the section that asks clinical staff to complete a plan to decrease the inmate's risk for self-injury should it become escalated, some of the plans listed responses such as "If [inmate] engages in self-injury, she will be monitored in segregation," or "n/a."
66. The CRIMP is intended as a tool to assist the interdisciplinary mental health team (IMHT) in coordinating self-injury interventions; however, the written responses often reflected the automatic security-driven reflex to place the women under observation to preserve or protect life with little or no clinical content. In some cases, the Office did see that the CRIMP referred to the management plan on file so that there was a direct link with the established treatment plan created by the team. Overall, however, the efficacy of this tool is undermined when there is no clear and established clinical plan to monitor, respond, prevent and treat self-injurious behaviours associated with mental disorders.
67. The investigation revealed a number of gaps in the mental health services that self-injurious women received. CD 843 requires that an inmate who engages in chronic self-injury also have an Interdisciplinary Management Plan (IMP) in place until his/her condition stabilizes and the plan is no longer needed. All of the women have at least one IMP on file, and some have several. Under CD 843 the interdisciplinary team is responsible for meeting for a formal review of the IMP every week until it is agreed that the plan can be discontinued. However, interviews with mental health staff confirmed that the IMP is often created based on the team's schedule rather than the woman's needs. For instance, one woman had an IMP on file that made no reference to future meetings of the team while those created for three other women consistently listed the following month as the date for the next meeting.
68. The investigation found shortcomings with regard to the treatment options available to self-injurious women. CSC has adapted and implemented the Dialectical Behaviour Therapy (DBT) framework for women offenders, which is part of the Structured Living Environments (SLE) and Secure Units. According to recent CSC research, DBT appears to be a promising and effective treatment for chronic self-injurious behaviour. However, for the review period examined, only one woman was consistently enrolled in a DBT program. One other was in the program for approximately one week. None of the

others were enrolled, including one woman housed in the SLE in which the DBT program operates on a 24-hour basis. RPC does not offer DBT as part of its programming. According to a representative from RPC, their population is low functioning and DBT “did not work” at that institution.

69. Some of the women interviewed noted that staff often seem too busy to engage with them. Others spoke of the quality of the therapy; for example, one specifically noted that when the psychologist attends to her after she has self-injured, “they talk to us through the door... And we don’t like talking through the door because there’s ... the vents that carry into each cell.” Another woman related that she had considerable difficulty meeting with the psychiatrist, while another said that staff on the unit were too busy with reports and other duties. She expressed the view that “they [staff] shut you off.” Staff admitted that they were often too busy completing paperwork and addressing crises to engage in therapeutic counselling sessions with inmates. Three women identified their psychologist as someone they could go to for support, but they noted that when they engaged in self-injury, it was security, not clinical staff, who responded.

D. Collaborative Planning

70. The principle of collaborative planning requires that interdisciplinary teams, including security, work together to support a consistent intervention plan. The investigation revealed considerable tension between mental health and security staff who work on the interdisciplinary team. The majority of mental health professionals interviewed indicated that self-injury incidents are mostly managed by security staff. Professional, non-security staff felt removed from the intervention process until the incident was contained and the woman was moved to segregation or an observation cell. All mental health professionals understood their role and responsibility in post-incident assessment through observation monitoring (high suicide watch, moderate suicide watch, and mental health monitoring).

71. For example, the Office heard from at least three mental health staff about being occasionally “bullied” out of the way by security staff when a self-injury incident occurred. There was evidence of a clinical staff member removing women from mental health monitoring, but correctional staff maintaining the isolation placement. The Office identified another incident of correctional officers pressuring a mental health professional to authorize the placement of a woman in the Pinel Restraint System. A mental health professional suggested that there was an “unwritten rule” at that particular institution that mental health staff are not to intervene in self-injury incidents, given these incidents are construed as security issues. She elaborated that

the only time she felt permitted to intervene immediately in a self-injurious incident was if the woman disclosed her ideations of self-injury while involved in a treatment session.

72. Many women did not associate mental health staff with the self-injury intervention process. In the words of one woman, “it’s officers that deal with you.” Even in the cases where women reported that they had positive relationships with their psychologist, social worker, behavioural counsellor or Elder, they indicated that they generally did not associate the role of these professionals as a “collaborator” in the management of their self-injurious behaviour.
73. With regard to the women’s perception of being placed in segregation as a consequence of self-injury or self-injury ideations, the Office heard from a number of women that they routinely refrain from discussing their self-injury ideations or behaviour with either mental health staff or other support staff (e.g., Elders) out of fear that these individuals will inform security staff and the women will be segregated as a result. In a meeting with a chair of an Aboriginal committee, the Office was informed of a self-injury support subculture among the women, an unauthorized peer group for women to discuss and monitor “sharps”²⁴ and other pre-self-injurious behaviour. The women covertly operate under the premise that they must refrain from informing staff of self-injurious behaviour, notably superficial cutting, to prevent being sent to segregation. The majority of the Aboriginal women interviewed said that they did not discuss their self-injurious behaviour with the assigned Elder.
74. With regard to CD 843, mental health professionals are expected to play a large role in the treatment and management of prison self-injury. The file review found that, per policy, mental health staff consistently met with offenders within 24 hours of the self-injury incident. However, in the majority of incidents reviewed, the decision to place an inmate in seclusion was made and carried out by security staff even when mental health staff were on site at the time of the incident. The majority of mental health staff indicated that they were often called only after the incident had been contained and the offender had been moved to the segregation range for observation. This is in direct contravention of the requirement that mental health professionals make all decisions regarding seclusion placements when available.

²⁴ “Sharps” is prison slang for unauthorized items that can be used for self-injury.

DISCUSSION

75. Since 2005, the CSC has invested approximately \$90M in new funding to strengthen primary institutional mental health care service delivery, implement computerized mental health screening at admission, train front-line staff in mental health awareness and enhance community partnerships and discharge planning for offenders with mental health disorders. These initiatives are part of CSC's five-point mental health strategy. Nevertheless, these initiatives have resulted in little substantive progress since the death of Ashley Smith in October 2007 with respect to the management and treatment of chronic self-injurious women in federal custody. A number of key policy, capacity, operational and infrastructure challenges remain.
76. In *R. vs. Gladue* (1999), the Supreme Court of Canada declared that the courts must take notice of the unique social, historical and cultural circumstances of Aboriginal people that have contributed to their over-representation in Canada's criminal justice system. Commissioner's Directive 702 – *Aboriginal Offenders* applies this ruling to corrections, directing that CSC will consider an Aboriginal offender's social history when his/her liberty interests are at stake (i.e., security classification, transfers, segregation placements and conditional release). However, a review of decisions related to the management of self-injurious incidents linked to the seven Aboriginal women in this investigation revealed little evidence that *Gladue* factors were considered, much less applied, pursuant to CSC policy. Moreover, CSC's policy framework on the management of self-injury does not provide specific guidance to ensure access to culturally appropriate clinical and healing approaches.
77. Recent CSC studies suggest that women offenders may be more likely than male offenders to engage in self-injurious behaviours²⁵ and have considerably higher rates of self-injury,²⁶ highlighting the need for an approach recognizing the unique needs of women. As the investigation finds, the literature suggests that punitive responses such as the use of force, segregation, transfer, restraints and the removal of personal items are counterproductive²⁷ and that women who self-injure need "ongoing, coordinated and empathetic support."²⁸ Effective clinical interventions are those that are informed by and address the underlying motivations for self-injurious behaviour (often traumatic psychological, physical or sexual abuse) rather than interventions that simply try to momentarily stop it. Community mental health practitioners support this position and

²⁵ CSC 2009; CSC 2010a; CSC 2010e.

²⁶ CSC 1990; CSC 2009; CSC 2010f.

²⁷ Fagan, Cox, Helfand and Aufderheide, 2010.

²⁸ Fillmore & Dell, 2005.

further stress the importance of engaging with a patient, particularly when waiting for clinical staff to respond or during a seclusion placement.

78. The investigation notes that pepper spray, physical handling and restraints are commonly used in an attempt to stop, interrupt or prevent prison self-injury. These interventions often simply contain or reduce the immediate risk of harm; they do not, nor are they intended to deal with the underlying reasons or symptoms of mental illness so often manifested in self-injury.
79. The Pinel Restraint System (PRS) is a routine response to self-injurious behaviour in the most complex cases. Since Pinel restraints may be part of the clinical management plan in chronic cases, their use is now often considered “consensual” or “compliant” and therefore not flagged as a use of force intervention subject to more rigorous and vigilant procedural safeguards. Although restraints are also used in a community health care facility in cases where a patient presents an imminent risk to self or others, the key difference is that this type of intervention is authorized, applied and monitored by registered health care professionals, not security personnel. In the prison context, the Office suggests that the principle of informed consent is violated at the point at which an offender who is engaged in an act of self-injury is given a “choice” by security personnel of “complying” with being placed in the Pinel Restraint System or facing other use of force measures. For these reasons, the Office is of the view that all applications of physical restraints in a correctional context should be considered “reportable” (and therefore reviewable) use of force.
80. As noted, the impact of self-injury is not limited to the women who self-injure; staff and other inmates are also negatively impacted. Since security responses to self-injurious behaviour often escalate into major incidents, other offenders who live amongst chronic self-injurers can be left on the sidelines, often locked up while security-driven interventions trump basic clinical measures. Managing these incidents often demands the attention of all staff on the floor, creating tensions in balancing operational schedules and routines with the unique and demanding mental health needs of individual chronic self-injurers.
81. The extreme deprivation and isolation that prevails in segregation, observation or clinical seclusion cells can exacerbate symptoms of mental illness. Not surprisingly, a disproportionate number of prison self-injury incidents occur in cells that are particularly austere (Secure Units in Maximum Security), lack external stimuli (clinical seclusion) or limit contact and association with others for behavioural, disciplinary or protective reasons (segregation). The irony, of course, is that the severity and frequency of self-injurious and/or resistive behaviours often intensifies as the

conditions of confinement become more isolating. In prison, placements on suicide watch, clinical seclusion or observation cells are preservation-of-life measures; in most cases, they are not clinical interventions. As the review notes, many women in this sample viewed such placements as a punitive response to their acts of self-injury.

82. Managing chronic self-injurious persons in a prison setting is demanding and challenging work. The Office does not question the integrity, commitment or professionalism of CSC's efforts. Nevertheless, there are a handful of mentally disordered women offenders whose symptoms, behaviours or severity of illness is beyond the infrastructure and human resource capacity of the CSC to safely or appropriately manage. A federal penitentiary is not the place for treating complex cases of chronic self-injury and/or acute mental illness; transfers to external treatment centres that are better equipped in terms of clinical staff, treatment interventions and facilities need to be more purposefully pursued as a matter of priority.

FINDINGS

83. Prisons are ill-equipped to safely and appropriately manage the complex mental health needs of federally sentenced women who chronically and seriously self-injure, yet CSC makes limited use of transfer of complex-needs cases to external psychiatric facilities.

84. Within CSC, the management of self-injury incidents tends to elicit a security and/or punitive response, namely containment, isolation, seclusion and/or segregation. Such responses tend to exacerbate the frequency and severity of self-injury and/or escalate the resort to other resistive/combatative behaviours.

85. Self-injurious offenders are hesitant to disclose thoughts of self-harm for fear of punishment or placement in segregation.

86. In a correctional environment, the use of restraint equipment to gain control of or manage a self-injurious offender cannot be considered "consensual" or "compliant" as this type of intervention lacks the express elements required for informed and voluntary consent.

87. There is a lack of cohesion and collaboration between mental health and security staff in responding to prison self-injury. Perceived security concerns, regardless of individual risk, tend to trump clinical interventions.

88. There is a discrepancy between staff training and their response to self injury. Nearly all staff interviewed acknowledged that isolating a self-injurious offender escalates the behaviour.
89. There is misunderstanding of the difference between segregation and clinical seclusion (CD 843) placements despite clear policy direction.
90. Prolonged clinical seclusion, isolation, observation, or segregation of chronic self-injurious offenders is counterproductive to therapeutic treatment aims and potentially unsafe.
91. Security staff are typically the first or emergency responders to incidents involving self-injurious offenders. Security decides how the “incident” and the “instigator” will be managed. Health care professionals are typically involved only when the incident has been contained or isolated by security personnel.
92. There are significant gaps in the availability of treatment options for the most complex or chronic cases of self-injury.
93. There is a lack of culturally safe or appropriate responses to the problem of self-injurious behaviour among Aboriginal women. There is little evidence to suggest that staff are aware, much less apply, a *Gladue* lens to the management of Aboriginal women who self-injure.
94. Security staff generally overlook situational factors, such as prior mental health considerations, when managing self-injury incidents.
95. The term “preservation of life” has become an all-encompassing drive in federal corrections. It permeates case management, security and clinical practice regardless of actual risk. In some extreme and rare cases, CSC efforts are reduced to simply keeping an offender alive. This is not therapeutic or good correctional practice.
96. Compliance with clinical measures in CD 834 – *Management of Inmate Self-Injurious and Suicidal Behaviour* is lacking.

RECOMMENDATIONS

1. Chronic self-injury should be treated and managed first and foremost as a mental health concern, not a security, compliance, behavioural or control issue.

2. Chronic self-injurious women offenders should have clinical management/treatment plans in place. Such plans should clearly address intervention, treatment and prevention measures. For Aboriginal women who chronically self-harm, the treatment plans should include culturally appropriate measures informed by *Gladue* principles and insights.
3. The CSC should transfer the most chronic and complex cases of self-injury to external provincial health care facilities.
4. The use of restraint equipment to control or manage self-injurious behaviour should always be considered a use of force intervention and therefore be subject to regular use of force reporting, monitoring, accountability and review procedures.
5. In cases of self-injury, physical restraints should be applied as a last resort and for the shortest time necessary to manage the period of imminent risk of self-harm. The authority to apply, monitor and discontinue use of restraint equipment should be exercised by one or more registered health care professionals, not security personnel.
6. Under no circumstances should a non-consenting or uncertified offender in a Pinel Restraint System be subject to forced medical injections.
7. Restraint equipment should not be used on a self-injurious offender for punitive, administrative or retaliatory purposes.
8. Human dignity should be maintained at all times during the period in which a self-injurious offender is physically restrained. Clothing should never be forcibly removed nor should an inmate ever be permitted to be naked while in a Pinel Restraint System.
9. CSC should appoint an independent patient advocate or a quality care coordinator at each of the five regional treatment centres, inclusive of the Churchill Unit, Regional Psychiatric Centre, Prairies.
10. The known preventive/protective factors for prison self-injury—time out of cell, purposeful and meaningful activities (including employment, education, programming, hobby craft), frequency of contacts with family, positive peer association, counselling and therapy—should be communicated widely across the Service to develop the awareness and knowledge base to better inform intervention and prevention efforts.

11. CSC should conduct a review of its use of force and health care policies to ensure better congruence and priority between the respective roles of emergency responders, decision-makers, security personnel and health care providers. Security of the institution should not automatically or necessarily trump immediate health care needs.
12. Health care staff input is required whenever a self-injurious offender is placed in a seclusion, observation or segregation cell.
13. There should be an absolute prohibition on the practice of placing self-injurious offenders in conditions of long-term clinical seclusion, isolation, observation or segregation.
14. CSC should be prohibited from constructing or using padded cells in its regional treatment centres.
15. CSC should re-evaluate the need for 24/7 health care coverage at all medium, maximum and multi-level security institutions on a site specific basis.
16. Front-line staff working with chronic self-injurious offenders should be provided with training and competencies above and beyond the basic *Fundamentals of Mental Health* awareness package currently offered by CSC to all staff. As a matter of course, CSC should implement staff respite measures in recognition of the consuming physical and emotional demands of working with complex needs offenders.

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