Mental Health, Violence, and Corrections Canada: A Critical Discourse Analysis of 2 Reports Published by CSC on Mental Health in Federal Corrections

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A Critical Discourse Analysis of 2 Reports Published by CSC on Mental Health in Federal

Corrections

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Abstract

This critical discourse analysis aims to explore the construction of discourses on mental health inside of Canadian federal corrections through analysis of two reports published by the Correctional Service of Canada (CSC). Simultaneously utilizing Mad and Critical Disability studies as a theoretical framework, I engage with the material to examine the ways that individuals with mental health concerns are constructed in the texts. Results indicate that CSC relies on medical and individual understandings of mental health and (re)produce discourses of violence and risk as well as individual deficiency or otherness within their texts. Ways in which CSC operationalizes these discourses are explored and include violent treatments for those with mental health concerns such as segregation, forced medication, labelling, and restraint or use of force. An analysis of the ways in which CSC maintains their power and domination over discourse regarding mental health concerns in Canadian corrections is examined, including critiques of the ways they ensure erasure and silencing of mental health consumers as well as their lack of attention to historical, political and social implications in their texts. This research reveals how CSC uses negative discourses, namely discourses of violence or risk and medical or individual deficiency, to authorize various violences on those with mental health concerns within federal corrections.

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Chapter 1 - Introduction

Currently, research on federally incarcerated individuals is primarily conducted by The Correctional Service of Canada (CSC), their affiliates, and those granted access by CSC to conduct research for them. In current literature CSC has been identified repeatedly as an insular organization which can be "hostile" to researchers from outside organizations, censoring information and creating a barrier to producing research on corrections (Watson, 2015; Long, 2020; Piché, 2011). Research that has been produced by CSC often does not include the voices or experiences of those who are mental health consumers, at least not within research which is typically deemed as valid or expert in nature (i.e. published through a reputable academic journal or written by a person with a graduate degree). Further, data is largely unavailable, lacking, or incomplete regarding treatment options for federally incarcerated individuals who identify as having a mental illness but reports have highlighted that "mental health needs typically go undetected or untreated" and "mentally ill inmates are left to decompensate psychiatrically" (Stall, 2013A).

The research produced by CSC contains gaps in exploring the historical, social, and political contexts of imprisoning mental health consumers and further, does not explore the ways these individuals are erased, silenced, and removed from the conversation and academia. Current research examines tools and methods to screen for mental illness, but research on the impact and implementation of strategies to provide care for these individuals is lacking (see Stewart, Wanamaker, Wilton & Toor, 2018; Stewart & Wilton, 2011). Gaps also exist in examining how a mental health designation

impacts a person's incarceration experience as well as gaps in exploring the heightened utilization of power and surveillance over this population in incarceration facilities and within communities.

In our current context, academics have made many indications to the vast over-representation of individuals with mental health concerns in the Canadian criminal justice system (Chaimowitz, 2012), with the Office of the Correctional Investigator (OCI) noting that between 1997 and 2008, the amount of individuals who presented with mental health needs during intake has doubled (Sapers, 2012). Currently, there are three times more individuals incarcerated with a serious mental illness than there are in the general population (Simpson, McMaster & Cohen, 2013). Former Correctional Investigator of Canada, Howard Sapers, has stated that "Canadian penitentiaries are becoming the largest psychiatric facilities in the country" (Vogel, 2010, p.E819). This raises questions on mental health care provided to individuals held in correctional facilities in Canada.

The provision of "essential health care and reasonable access to non-essential health care" inside of Correctional Services Canada is mandated by the Corrections and Conditional Release Act (CCRA) (Corrections and Conditional Release Act [CCRA], 1992). The CCRA defines *health care* as "medical care, dental care and mental health care, provided by a registered health care professional or by persons acting under the supervision of registered health care professionals" (CCRA, 1992, p.57). However, Canada's adherence to neoliberal practices has created policies which favour risk-thinking, which allows for regulation and surveillance of marginalized communities who are viewed as incapable of appropriate levels of self-governance and unwilling or unable

to control their own levels of risk (Pollack, 2010; Rose, 2000). Many policies of CSC utilize this form of risk-thinking or risk-discourse to justify punitive decisions over health care. Through these forms of thinking and the application of various risk related discourses, the problem becomes the ways in which violence can and has been utilized against this population by CSC through various methods such as forced medication, segregation or isolation, and use of force. My research question then, is how are discourses of mental health wielded or operationalized within Canadian Corrections to authorize violence on inmates?

Context

In a CSC publication regarding correctional outcomes for federal offenders with "mental disorders", it was noted that understanding the risk posed by offenders who had mental health concerns was an important aspect in supervision, and that "having a diagnosis for some types of serious mental disorder does indeed increase the risk for violence" (Stewart, Wilton & Cousineau, 2012, p.2). These forms of discourses that position inmates with a mental health diagnosis as those with the risk or potential for violence have lead to practices such as the recent legislation on Structured Intervention Units (SIU). SIU's permit utilization of solitary confinement if an "inmate has acted, has attempted to act or intends to act in a manner that jeopardizes the safety of any person or security of the penitentiary" or where it may jeopardize their own safety or interfere with an investigation (Correctional Service Canada, 2019A, line 33A). As many forms of mental health concerns may be exacerbated by incarceration and further make it difficult to adhere to prison rules, the violent practice of segregation is utilized under the guise of

'safety for the inmate' to mitigate risk or violence (Bradford, 2017; Peternelj-Taylor, 2008). These forms of risk-thinking discourse are present and persist in documentation published by CSC and reproduce perceptions of mental health concerns as inherently violent, risky, or unsafe without acknowledgement of the violence done to these individuals in corrections such as solitary confinement. Moreover, the Ontario Public Service Employees Union which is the union for correctional workers maintains calls for training of staff members in relation to providing care to offenders who have addiction or mental health concerns as current training is inadequate (OPSEU Corrections Division, n.d.). This concern regarding inefficient training for correctional workers has also been made visible by academics who note that correctional workers are often made to be mental health responders without ever being given the tools to respond appropriately (Bradford, 2017; Peternelj-Taylor, 2008). The provision of care for individuals with mental health concerns inside of corrections therefore is directed by individuals in power (correctional workers) who are under-trained, working in overcrowded and understaffed conditions all whilst surrounded by negative discourses of risk relational to mental health. This then further contributes to the routine violences that are enacted on individuals with mental health concerns inside of Canadian corrections. Therefore, my research will examine the ways in which these discourses, which are reproduced within CSC literature, contributes to the violent use of various discourses of mental health by correctional staff to justify certain 'treatments' such as segregation.

Additionally, individuals with mental health concerns in CSC documentation are continuously referred to as those diagnosed with "mental disorders" which individualizes

and medicalizes the issue without concern for social, historical and political factors that have impacted this (Stewart, Wilton & Cousineau, 2012, p.2; Joseph, 2015). This framing assumes that mental health concerns are always debilitating, disabling or traits of "defectiveness, lack or disorder" and further gives power and authority to individuals who wield diagnostic tools (ability to identify mental illness) to exert this power over the other (Joseph, 2015, p.17). Further, it has been noted that CSC relies on a flawed psychological screening tool to determine who may be living with a mental health concerns in incarceration facilities (Bradford, 2017). CSC is further relying on the medical model and standardized medical tools to situate mental health concerns as a problem in the individual whilst utilizing discourses of individual disorder to exert power and silence experiences.

Finally, neoliberalism and policies impacted by neoliberalism such as Harper's 'Tough on Crime' agenda have historically and violently impacted *othered* identities such as those who are Mad, indigenous, or racialized by "actively create[ing] and sustain[ing] systematic oppression, [and] blaming individuals for not making the right choices" (O'Leary & Ben-Moshe, 2019, p.116). These individuals then face the "mandate of recovery", a compulsion to 'get better' and conform to social norms or standards, in situations and societies that have removed social safety nets, programs, and supports to aid in this process, making recovery mandatory but unattainable (O'Leary & Ben-Moshe, 2019, p.116). Tough on Crime politics, originating in America through the Nixon administration (1969-1974), and reproduced by former Prime Minister of Canada Stephen Harper, demanded an increase in sentence length and an emphasis on punishment and

harsher conditions in incarceration facilities at a time when crime rates were actually down in Canada (Mallea, 2010). This movement towards tougher crime policies was critiqued as one that would see an increase in convictions which would overcrowd the criminal justice system and reduce access to rehabilitation programs within corrections (Mallea, 2010) As of 2012, prisons remained overcrowded, underfunded and unable to provide adequate access to programming for individuals in corrections, with a snapshot of core correctional program participation showing only 12.5% out of 2,594 individuals enrolled in a program and more than 35% on a waitlist (Sapers, 2012). As completion of programming is a vital consideration for an individual's conditional release (Sapers, 2012), CSC policies and the discourses surrounding the importance of treatment for the betterment of the individual work to hold individuals in corrections longer than necessary. Further, the ten years following the implementation of 'Tough on Crime' policies saw a change not in the amount of incarcerated individuals, but a rapid change in the number of othered bodies being incarcerated with Black and Indigenous peoples being further over-represented in federal corrections (Zinger, 2016). Integral to this research is an acknowledgement of the multiplicity of oppressions experienced by othered bodies whose identities simultaneously experience mental health concerns resulting in co-occurring conditions of oppression, surveillance, and prosecution both within their communities and in Canadian correctional facilities.

Through this thesis, by utilizing Mad and critical disability theories, I will explore, through a critical discourse analysis, the ways discourses utilized by CSC operate to silence and erase experiences of individuals with mental health concerns in correctional

care, and further how these discourses are wielded to exert violence on these individuals. Neoliberalism, policy changes and discourses related to risk, mental illness and treatment have contributed to the ways in which articles are written by CSC to further depict the violence *of* offenders to justify violence *on* offenders.

Chapter 2 – Literature Review

This review seeks to explore the historical and current understandings of punishment, criminalization, power, and violence in relation to Canadian Corrections and individuals with mental health concerns who are housed within corrections. It will examine the ways various discourses have been structured to allow for violence on individuals with mental health concerns. This literature review will look at the construction of those with mental health concerns as 'others' or as individuals that require fixing, as well as the structural, political and historical violences that have occurred via asylums, eugenics, and incarceration facilities. It is important to note that in this context, the term 'violence' will be utilized to refer to the literal physical expression of violence (for example; segregation), but also to 'violence' as systemic, structural, epistemic, and reproduced inequalities.

Risk, Violence, and Danger of Mental Illness

Historical Context

Historically in Europe through the 18th century, punishment was doled out in public spectacles, through physical violence whereby the body of the convicted was in someway affected (tortured, quartering, burning) as a payment for their crimes (Foucault, 1975/1977). With advancements towards more *humane* forms of punishment such as imprisonment, forced labour or confinement, torture as a public spectacle was displaced allowing for a much less immediately physical form of punishment (Foucault, 1975/1977). As discussed by Foucault (1975/1977) the soul, rather than the body began

receiving the punishment. Therefore, those criminalized began to be judged by their soul; by their relations with others, by one's estimations of them, by their past and their potential for future offences (Foucault, 1975/1977). The punishments were turned towards supervision, surveillance, and towards altering, changing, or otherwise forcing the individual to conform (Foucault, 1975/1977). This concept has persisted and has manifested into our current system of incarceration where people are judged not only on the crime committed, but the crimes that might be, thus allowing for further surveillance and criminalization. In the current Canadian context, this calculation of future potential for crime is conducted via a statistical measure to further control and exert power over othered identities within corrections.

Risk Assessments

Attempts to calculate and manage risk in Corrections to ascertain the likelihood of future convictions, also referred to as the rate of recidivism, is standard practice in Canada. The Correctional Service of Canada (CSC) states that risk calculation or measurement tools are not only effective at reducing recidivism but the services offered through the primary model (Risk-Need-Responsivity or RNR) are cost-effective when compared to services which do not attend to this model (Ritchie & Gobeil, 2014). These risk calculation methods, however, have been heavily critiqued for their lack of attention to both moral and political components as well as for being rooted in cultural assumptions while simultaneously assuming that risk can be calculated unbiasedly across populations (Hannah-Moffat, 1999; Maurutto & Hannah-Moffat; 2006). Additional critiques of actuarial risk assessments include that, 'risk' is a subjective interpretation whereby

different individual's calculations of risk can produce conflicting results (Burgon, Mugford, Hanson, & Coligado, 2018). Further, the tools to calculate risk have evolved since their inception when they were heavily impacted by the politics of the time and to today are still "rooted in a fundamentally protectionist perspective wherein offenders are assessed on the basis of the *danger* [emphasis added] they pose to society" (Bérard, Vacheret, & Lemire, 2013, p.268). These risk calculations then impact and inform decisions ranging from treatment options, release dates, sentencing and even security classification for individuals held in corrections (Burgon et al., 2018). The overabundant application of the subjective notion of risk in corrections and its linkage to danger or violence can have potentially devastating effects on individuals who are incarcerated, specifically those with mental health concerns. Therefore, it is vital to explore the way discourses surrounding risk are taken up in literature produced by Corrections Canada and how these discourses may further implicate individuals with mental health concerns as risky.

Despite there being critiques regarding the utilization of risk measurements in correctional settings, there are gaps that remain un-examined. Presently, there is a lack of analysis on the ways that 'risk of danger', and therefore 'violence' as discourse is used to justify punitive treatment of mental health consumers to maintain safety. Risk within the context of federal correctional institutions in Canada has been conceptualized in particular ways. For example, research reports by CSC focused on mental health use the word 'risk' either in reference to potential for self-harm or suicide, to violent or disruptive behavior, to potential to overestimate risk, to risk of being given off-label medication

(medication intended for a different use than prescribed) with adverse side-effects and more (Stewart & Wilton, 2017; Stewart, Wilton & Cousineau, 2012; Brown, 2017). This is problematic because it allows for continued use of *potential* for risk or for 'violence' to be called on to justify punitive treatment. The missing piece of these reports is how the construction of risk, and implementation of such constructions by this powerful institution (CSC) may produce violent outcomes in management and treatment for mental health consumers.

Mental Health, Risk, and Violence

Additionally, it is vital to examine the general connection made between risk, violence, and the individual with mental health concerns within the literature and discourse. The belief that those who are 'mentally ill' are in fact also violent, or at risk of being violent, is one of consistent consciousness in Canadian society, invoking a 'generalized "fear of the mentally ill'"(Anonymous Female, 2019, p.31). The Canadian Mental Health Association (CMHA) draws attention not only to the public's fear of people with mental health conditions regarding their ability to be violent, but also to the detriments that such a correlative unsubstantiated link can bring; namely, social exclusion, stigma and discrimination faced by those with mental health concerns (Canadian Mental Health Association, 2011). This generalized discourse of fear of those with mental health concerns, coupled with stigma, discrimination and social exclusion may very well then inform decisions regarding correctional attitudes and decisions, whether conscious or unconsciously, due to biases attained from societal norms.

Criminalization of Madness in Canada

The history of madness or mental illness in Western Europe and Canada is extensive and linked closely with societal notions or constructs of *appropriate* decorum and behavior. Foucault links the treatment of madness in history through the development and utilization of leprosariums in European nations such as England, France and Germany to house lepers who were "saved by the hand which is not stretched out"; as their abandonment was their salvation (Foucault, 1965, p.7). When leprosy disappeared in these locations, the structures, social practices and "formulas of exclusion" remained and were utilized to exclude other unwanted populations from the community including "poor vagabonds, criminals and 'deranged minds'" (Foucault, 1965, p.7). While this practice was linked by Foucault through Europe, Canada has adhered to Eurocentric practices and worldviews since its colonial inception, and so I would argue that this practice became the norm in Canada as well. Ultimately, these practices have persisted for hundreds of years, with some of Canada's most vulnerable populations still including mental health consumers, the homeless, and people who are incarcerated who continue to be othered, excluded, silenced, erased, and removed.

Eugenics & Asylums

The historical violence and criminalization or assumed criminality of those with mental health conditions has a long-standing place in Canadian history. In the 1800's "lunatics" were prohibited from entering the country unless their family would provide for them for fear that they may be a burden to the state (Ontario Human Rights

Commission, 2014). In the 1900's these individuals were further barred entry due to the assumption and association of mental health concerns with moral weakness and criminality until amended in 1967 (Ontario Human Rights Commission, 2014). The eugenics movement during this time (approx. 1920s-1972) also led to many forced sterilizations of people who were categorized as having mental disabilities for fear that they would "produce children prone to crime and other social problems" including those who were declared psychotic, defective or demented (Ontario Human Rights Commission, 2014, p.78).

Further, the idea was commonplace in the 19th century in Canada that those with mental health concerns were better to be removed and treated outside of their homes and communities, and inside of psychiatric institutions (St-Amand & LeBlanc, 2013). Asylums were constructed as a form of social control to house these individuals who acted outside the acceptable social norms of the time and would be warehouses for various violence against mad bodies (St-Amand & LeBlanc, 2013). Canada's first asylum opened in 1845 with many others appearing across the country until 1914 and within these institutions individuals with mental health concerns experienced seclusion or isolation, both physical and chemical restraints, overcrowding and various forms of abuse (Ontario Human Rights Commission, 2014). Among accepted forms of *treatment* within these institutions were electroconvulsive therapy (without anesthesia), lobotomies, and even insulin coma therapy which involved administering enough insulin to induce a coma (Ontario Human Rights Commission, 2014).

Through all of this, we must maintain attention to the evolving discourses around mental health and madness being formed in public consciousness and beyond psychiatric institutions. Reaume (2002) examines the terms, discourses, histories, and nomenclature applied to individuals with mental health concerns beginning in the 19th century to today with specific attention on Mad scholars and activists who reclaimed or fought against these titles. Reaume's work starts with lunacy, asylums and the historical depiction of the mentally ill as animals or violent beasts and ends with current arguments over terminology and treatment, all whilst maintaining resistance to the popular societal discourse of individuals with mental health concerns as dangerous, negative, seen as an other and as an object of fear (Reaume, 2002). This evolution (or lack of evolution) of discourse over the years contributes to longstanding notions of mental health in society. Historically, through the operation of a dominant class which is English speaking, white, male, heterosexual, sane and able bodied (among other things), those who were deemed 'defective' or otherwise undesirable or 'others' (not English speaking, white, male etc.) were positioned as a sort of non-citizen whereby access to opportunities, power, privilege and rights were restricted (Perry, 2011). This effectively limited the othered individuals from engaging in civil, social, or political activities and allowed for the further construction of negative discourses surrounding immigrants, Blacks, Indigenous populations, or anyone else that may not fit the "mythical norm" or the identity society has accepted as being 'normal' (i.e white, male, able-bodied, sane, etc.) (Perry, 2011, p.57). Through the operation of eugenics and asylums, these 'defective' individuals were removed from society as their 'flaws', in this case being Mad or disabled, trumped any

dominant traits that they possessed (Reaume, 2014). In this way eugenics and asylums further worked to instill settler-colonial ideals in Canada (see Dowbiggin, 1997; McLaren, 1990). Through this, and through various terminology and discourse, the individual with mental health concerns became someone to be feared, controlled, fixed, surveilled, or dominated and this discourse has persisted. Further, this discourse then impacted and influenced policy, policing and social norms which contributed to the over-criminalization and incarceration of individuals with mental health concerns and today further contributes to notions of risk regarding danger or inherent disfunction when working with this population in corrections.

Impact of Neoliberalism & Policy

Neoliberalism is an ideological discourse that places importance on the participation of individuals in the market and the removal of government from circumstances concerned with the individual in favor of privatization of services (Mahone, 2008; Teghtsoonian, 2009; Pollack, 2010). This mindset is prevalent in Canada today as evidenced by the decrease in both budget and staff for social services including childcare, health care, social assistance and mental health care (Teghtsoonian, 2009; Pollack, 2010). Further, neoliberal views and policies tend to favour risk-thinking, a method of thought which calculates and makes decisions with the avoidance of possibly negative outcomes as the central goal (Rose, 2000). This risk-thinking, and further, this ontological perspective allows for the regulation and surveillance of already marginalized communities who are seen as unwilling/unable to control their own level of risk and incapable of sufficient self-governance (Pollack, 2010; Rose, 2000). It is through this

regulation of communities that over-surveillance and policing of historically marginalized individuals such as those with mental health concerns can be further displaced, removed, and erased by housing them within prisons.

This form of neoliberalism and reliance on risk-thinking can be further evidenced by policies enacted by former Canadian Prime Minister Stephen Harper. Harper's 'tough on crime' policies and legislative changes promised to reduce social spending, "hold offenders accountable", "tackle crime", and "make communities safer" despite crime rates being down during this time in Canada (Comack, Fabre & Burgher, 2015, p.1; Mallea, 2010). Critics of the tough-on-crime policies argued that they would lead to overcrowding, place strain on the criminal justice system, result in a lack of access to programs within corrections and that ultimately it would increase the amount of individuals in incarceration facilities with mental health concerns (Mallea, 2010; MacDonald, Hucker, & Hébert, 2010). This has held true, with approximately one thousand more individuals being held inside of corrections, and a disproportionate amount of those individuals having mental health concerns (Stall, 2013B). The effects of former PM. Harper's policies have led to the practice of arresting, detaining and incarcerating individuals for petty offences which "skew[s] towards incarceration of the mentally ill" (Stall, 2013B). While neoliberalism and tough-on-crime politics can be linked to an increase in policing of this population, it "doesn't begin to account for the effects of deficiencies in care provided to the mentally ill who are incarcerated" whose needs inside of correctional facilities typically remain untreated or undetected (Stall, 2013A).

Current Demographics

Both currently and historically, our criminal justice system in Canada has disproportionally incarcerated othered identities through violently over-policing and surveilling their communities. For instance, in the ten years between 2005 and 2015, federal corrections experienced an increase of the incarcerated population by 10% and the majority of this growth is attributed to a yearly increase in admissions of those who are Indigenous, Black or women (Sapers, 2015). During this ten-year time period, the inmate population that identified as Black increased by an astonishing 69% (Sapers, 2015). Research has further indicated that Indigenous individuals are ten times more likely than non-indigenous folks to be sentenced to incarceration facilities and in 2015, despite Indigenous individuals only representing 4.3% of the Canadian population, represented approximately 25% of the federal male and 36% of the federal female incarcerated population (Davis, 2014; Sapers, 2015). Further, heterosexist and homophobic notions in Canada has lead to a re-inscription of LGBTQ2S folks as deviant, denying them adequate social services and provisions inside of criminal justice systems which "typically socially control, regulate, and repress" these individuals which can be facilitated through various means including detainment (Faulkner, 2011, p.231). Disability however, has often been neglected from discussion with regards to mass incarceration because of the "implicit assumption that such confinements are medically necessary" due to stereotypes situating the Mad or disabled body as a location of violence or danger (Erevelles, 2014, p.83). Despite this, evidence suggests that those with disabilities are incarcerated at alarming rates with CSC stating that those with learning disabilities constitute somewhere between

5-10% of the general population, whereas the rate of those within incarceration facilities that have a learning disability is anywhere from 7% to 77% depending on the methodology of the study drawn from (Fisher-Bloom, 1995). This is important to address as these various identities which experience violent forms of policing and intervention do not always exist in isolation of each other, and in fact can converge and co-exist in a multiplicity of ways at various points in time and may include other identities which are also over-represented inside of Canadian corrections such as those with mental health concerns.

Today, our criminal justice system in Canada has been framed as becoming the largest mental health facility in the country (Vogel, 2010). Disproportionate rates of individuals are being moved into corrections with mental health concerns, with over three times more people with serious mental health concerns being held in prison than rates that are observed in the general population (Simpson, McMaster, & Cohen, 2013). Research indicates that inmates are also more likely to self-injure as well as attempt and commit suicide while incarcerated (Simpson, McMaster & Cohen, 2013, p. 503). Further, manifestations of symptoms that are correlated to mental health concerns including aggression, disruptive behavior, and inability to follow orders or rules could be misunderstood by correctional officers as manipulation, disobedience or lack of compliance which could result in increased disciplinary action (Stall, 2013A). Currently, interventions for mental health concerns within Canada's prisons are largely decided by the correctional staff, not by clinicians and may include extremes such as the use of segregation (Webster, 2015). This creates a significant threat for inmates due to

correctional staff's lax training which does not mandate the requirement of being able to identify and support individuals with mental health concerns (Wright, 2019). The ways in which manageable mental health concerns can become exacerbated within corrections, coupled with lack of training and negative interpretations of 'symptoms' creates space for violent interventions such as segregation where "unsuitable behaviour [can become] a death sentence" (MacDonald, Hucker & Hébert, 2010). This form of treatment and the overwhelming number of individuals with mental health concerns in corrections leaves gaps regarding appropriate treatment in facilities that were not built to provide care to this population. Additionally, the lack of attention to, or care given to these individuals can be linked to the historical and current discourses surrounding the mentally ill as undeserving of care, dangerous, or acting out.

Power Over Research

Currently, most of the research conducted within Corrections Canada is the product of The Correctional Service of Canada (CSC), their affiliates and those granted access to work within the organization. With regard to attaining both access to information or research participants the organization has been critiqued as being both an insular organization and one that may be hostile to researchers from outside of the organization (Watson, 2015; Long, 2020; Piché, 2011). Because of the inability of outside researchers to access correctional facilities to conduct research within, there is criticism that CSC would reproduce only certain types of knowledge which would have larger impacts on the literature over time (for example: limited insights) (Watson, 2015). Further, it has been observed that attaining access has become increasingly difficult,

especially for researchers whose work could be seen as challenging of the hegemonic criminological assumptions, or if their work had the potential to lower the public's opinion of CSC (Watson, 2015). Because of this, the discourse of corrections, and the structuring of the discourse of mental health within corrections is at the whim of very few researchers who likely subscribe to opinions, values and methods that CSC deems appropriate and further publicizes their viewpoint. I have found that gaps within this work by CSC often include a lack of attention to historical, social and political implications, and that the work lacks research which is critical, qualitative, post-modern or post-structural, and it further produces harmful discourses of mental health within corrections. The power over research, and the production of research by CSC then, allows for violent reproductions of discourses which work to maintain CSC's power and authority over specific populations.

Individual and Medical *Disorder*

The individualization and medicalization of moments of distress, and largely all aspects of madness or mental health within our Eurocentric Western communities has been ever present since the 18th century enlightenment (Beresford, 2013). However, this inclination towards individualization of mental health concerns has been regarded by those within Mad studies as not only unhelpful, but harmful (Beresford, 2013). It has been shown that the general public in Canada prefer psycho-social explanations for general mental health concerns, but are more likely to indicate some form of bio-medical issue (problem in genetics) if the individual presents with a form of "serious mental illness" (for example: schizophrenia) (Bourget & Cheiner, 2007, p.5). This link to genetic

issues within those with mental health concerns can further "increase stigma and reduce optimism for recovery" (Bourget & Cheiner, 2007, p. 5). The individualization and medicalization of mental health further ignores the social, historical, and political factors that may have contributed to mental health concerns (Joseph, 2015). The framing of mental health as mental *disorder* within the individual also produces the assumption that mental health concerns are always disabling, traits of defectiveness, or debilitating and reaffirms authority to those in positions of power who utilize diagnostic tools to exert this power over others (Joseph, 2015). The idea that there is something inherently wrong with the individual then allows for people in these positions of power to 'treat' the person to establish normalcy.

Violence as Treatment

As stated by the previous Correctional Investigator of Canada, Howard Sapers, "The Correctional Service of Canada is responsible by law for being health care providers for federally incarcerated inmates, and they are falling short in meeting that requirement for the provision of mental health services" (Stall, 2013A, p.203). Having previously reviewed the historical violent treatment of individuals with mental health concerns in Canada, we can look at the current applications of control/care utilized by CSC through segregation, restraint or use of force, counselling, and medication. Through these, we can see the many ways violence is used to *treat* individuals with mental health concerns. Violence in this context, may be framed as treatment or risk reduction by correctional services, but from my ontological viewpoint, these tools or methods are

operationalized in a way as to reproduce harm, social injustice, exclusion, or to force conformity.

Segregation & Solitary Confinement

In June of 2019, the legislation (Bill C-83) regarding use of segregation was effectively rebranded into 'Structured Intervention Units' (Commissioner's Directive CD-711) (Correctional Services Canada, 2019). The scope of this review does not include an in depth review of these changes, but for the purposes of the following literature, it is important to note that very little other than the name and the removal of policy regarding the maximum number of days spent in segregation was changed (Kelly, 2019). As well, the wording of the bill allows for subjective interpretation which could possibly be used to further limit rights of an individual in segregation (Kelly, 2019). Due to this very recent re-wording, the literature available to review is based off the previous structuring of the bill, but I argue the implications and demographics affected would remain largely the same.

In 2014, over 800 inmates that were held within correctional facilities were placed in, or continuously held in confinement (Kelsall, 2014). The utilization of solitary confinement has been found to elicit feelings of anger, depression, confusion, psychosis, anxiety and distorted thoughts, regardless of whether the individual had co-occurring mental health conditions (Kelsall, 2014). Solitary confinement is both a risk factor for suicide and is linked to the appearance of mental health concerns even when none were present prior (Sheldon, Spector & Birdsell, 2019). For those that were placed in

segregation with pre-existing mental health concerns, as early as seven days of solitary has been shown to change a person's brain activity permanently, and drastically impact the individual's ability to rejoin their community following incarceration (Kelsall, 2014). This evidence exists, albeit medical in nature, but CSC's inattention or ambivalence to the information shows who is being erased in their policies, practices, and literature in favour of creating a less "risky" environment in incarceration facilities. Despite clearly negative outcomes directly related to the utilization of segregation, the literature suggests that this method of control is used frequently by CSC to mitigate risks posed by those with mental health concerns. This is evidenced by an independent review on segregation use in Ontario from 2017 which found that segregation was the "default tool to manage individuals with mental health needs" (Sapers, Monteiro, Neault, Deshman, & McConaghy, 2017, p.3).

Restraint & Use of Force

Regional Treatment Centres (RTC) are institutions which operate as a form of hospital for those in the criminal justice system (Kelly, 2018). These facilities are mandated to house individuals who are considered unable to function within general institutions because of their physical, mental, or cognitive concerns, and are operated by the Correctional Services of Canada (Kelly, 2018). Despite this thesis not focusing specifically on RTC institutions, they are run by CSC and I believe it is vital to include in this review an example of the ways in which CSC employees routinely treat inmates with mental health concerns, even when located within *treatment* facilities. Inappropriate use of force incidents happen in many federal institutions, however some of the most

troubling cases occur within Regional Treatment Centres with Millhaven RTC in Ontario accounting for 28% of all “inappropriate and/or unnecessary” use of force incidents (Zinger, 2019). Repeatedly, use of force and restraints are used on vulnerable individuals in these treatment facilities under the guise of *preventing risk* despite there being an overwhelming lack of evidence to indicate risk (Zinger, 2019). A case study of an incident which occurred at Millhaven RTC provided by Ivan Zinger in his 2018-2019 Annual Report highlights the horrific violence perpetrated by employees in these institutions which put further harm on incarcerated individuals with mental health concerns:

> Range video evidence shows an inmate, diagnosed with a serious mental health disorder with significant impairments, engaged in a therapeutic interview with a Behavioural Technologist (BT) in the recreation room. During the interview, he asks an officer standing nearby at the control post if he could go to the yard for recreation after the interview. The officer declines, explaining that due to ongoing maintenance work the inmate would have to wait until later.
>
> The inmate becomes agitated, directing a verbal protest towards an officer standing just outside the barrier of the recreation room. The officer's response further escalates the situation. While the BT attempts to de-escalate through verbal coaching, without warning or consultation, officers decide to discontinue the interview due to alleged "staff safety concerns". The BT's report would later state that at no point did s/he feel the inmate had put anyone's safety at risk, and that the inmate was "appropriate and polite" in all interactions.
>
> An officer opens the barrier and orders the BT "get out of here." The BT attempted to leave the area; however, a group of four other officers had already gathered at the exit. The inmate lunges toward the officers attempting to strike one of them. The officers charge, tackling him to the floor. The inmate is held down by the weight of the four officers while lying prone. A nearby health practitioner reports later that an officer was kneeling across the inmate's neck and that his face was purple. The inmate is seen gasping. One of the officers is reported to have said, "want me to jizz on your face?" The others are seen laughing on video. (Zinger, 2019, p.11).

Zinger notes in his annual review that these incidents are not isolated and that despite Correctional Service of Canada taking "swift disciplinary action" reviews post-incident are simply not enough (Zinger, 2019). Further in the 2018-2019 Annual Review, the Office of the Correctional Investigator (OCI) recorded 3,146 use of force incidents, and 51% of these required review by the OCI (Zinger, 2019). There are no documents available to ascertain how many of these use of force incidents occurred solely in "treatment" facilities on individuals with mental health concerns, further erasing and silencing their experiences.

Counselling Access & Social Conformity

Much of the (limited) literature available regarding the provision of counselling services in Canadian corrections speaks to the lack of mental health professionals working within corrections to meet the amount of interventions required (Sapers, 2010). And further, to the physical space being a barrier to providing care with little to no support provided by other mental health professionals such as psychiatric nurses or social workers (Stall, 2013A). Lack of mental health professionals within corrections means that inmates in distress are responded to by correctional officers primarily, who have little to no training and are taught to respond to security and risk before health concerns (Wright, 2019; Stall, 2013A).

A study conducted by Fayter & Payne (2017) collected stories of federally sentenced women regarding priorities for change within incarceration facilities. In the study, those with mental health concerns cited fear of attending counselling due to

psychiatrists being employees of CSC who take notes which could impact their ability to access parole, increase their security ratings, or affect their ability to have temporary absences should their case management team find out about their mental health concerns (Fayter & Payne, 2017). Further, individuals were only allotted 12 sessions of counselling or therapy even if that individual was recently involved in distressing situations such as segregation or had engaged in self-injurious behavior (Fayter & Payne, 2017). An anonymous prisoner (1417 from Riverbend Institution, 2018), discusses in his article that it took over 3 requests and 10 weeks to finally see a mental health professional, and that programs offered (like anger management) are only taken as a means to an end, not because the individuals want or think they would benefit from them. Further, with some treatment programs considered mandatory within corrections, ideas of *recovery* and "neo-liberal notions of 'personal responsibility'" are coercively utilized on inmates who are given no choice but to *get well* (O'Leary & Ben-Moshe, 2019). As previously discussed, accessing mental health supports inside of corrections is difficult. Without access to desired supports CSC crafts a situation whereby individuals that cannot 'get well' on their own via mandated conformity are left to potentially decompensate and face violent treatment within a system that was not designed to provide support to these individuals. As CSC is the only government body legislated to provide mental health care for inmates, this is alarming as those within the system have no other means of accessing care.

Medicalization

While it may fall under use of force, in 2018-2019, there were 15 incidents nationally whereby to restrain an individual they were given an injection without their

consent (Zinger, 2019). Studies on incarcerated women found that many were over-medicated with psychiatric drugs (Fayter & Payne, 2017) and that individual's access to non-medical interventions were limited, with counselling only provided within the "purview of correctional control" (Kilty, 2012, p. 162). It has been noted extensively that the trend towards over-medication of these individual's links to a desire to provide a fix which is biological in nature to the social problems that are affecting these individuals (Kilty, 2012). Historically, and currently the use of medication to control has been violently utilized on individuals with mental health concerns at the hands of the state.

Research Gaps

I have found that gaps exist in analyzing the current discourses of mental health (re)produced by CSC through their publications and further, through their utilization of these discourses on those with mental health concerns inside of Canadian federal corrections. I have found that current literature does not explore the ways in which mental health discourses produced by Corrections Canada can be operationalized to justify violence *as* treatment. A review of the sociohistorical, political, and current critiques of treatment have been provided. The many ways violence, mental health, power, and treatment have historically and contemporarily intersected has created a system which can operationalize discourses of mental health *as* violent or dangerous to justify violence *on* these individuals. Contributing factors, including neoliberalism and resulting policies have made this possible, crafting the discourse of the person with mental health concerns as an individual with a problem that cannot conform to social standards and who requires treatment or isolation until they can be made better.

CHAPTER 3 – THEORETICAL FRAMEWORK

I have chosen to utilize through this thesis the theoretical frameworks of both Critical Disability Studies and Mad Studies. While this thesis focuses on mental health, both Critical Disability Studies (CDS) and Mad Studies have inextricable ties. Beresford (2000) highlights the many ways their linkage is hard to untangle. First, while individuals who ascribe to these theories of knowledge may differentiate themselves, the state acts to assimilate and label Mad individuals as disabled vis-à-vis "externally imposed definitions, administrative categories, and statistics" (Beresford, 2000, p. 169). For example, within the Correctional Service of Canada, research relating to mental health also frequently incapsulates research on intellectual or cognitive deficits, linking both frameworks together with external assumptions regarding their prevalence and overlapping existence and characteristics (see Stewart, Wilton, Nolan, Kelly, & Talisman, 2015; Stewart, Sapers, Cousineau, Wilton, & August, 2018). Second, the individuals who identify with each framework may experience significant overlap between the 'categories' that are used to define these frameworks at various times (Beresford, 2000). Membership in either group is not exclusive, and individuals can identify with either or both Mad and Critical Disability ways of knowing at multiple times in their lives. Finally, both theoretical frameworks can be applied to acknowledge the oppression and discrimination that is faced by people who live with mental health concerns and disabilities including the denial of both civil and human rights (Beresford, 2000). However, this is not to imply that the two theoretical frameworks are the same or should be the same. Instead, I acknowledge that Mad studies emerged following the work of

Critical Disability scholars who call for "transformative revaluation" and paved the way for Mad scholars to employ this technique on their own (LeFrançois, Menzies & Reaume, 2013, p.12). As a result, these theoretical frameworks are connected by many "mutual affinities" (LeFrançois, Menzies & Reaume, 2013, p.13). It is because of these reasons; this thesis seeks to explore a critical discourse analysis through the lens of *both* Critical Disability and Mad studies.

Critical Disability Studies

Emergence

Disability studies garnered widespread acknowledgement on both academic and professional fronts in the Western world through the 1970's and into current days (Meekosha & Shuttleworth, 2009). The discipline's standing gained attention through a multiplicity of avenues including the "International Year of Disabled People in 1981" which was credited with bringing the human rights issues surrounding disability into the forefront of global discourse and onto the public stage, but also through the evolution of the disability movement (Meekosha & Shuttleworth, 2009). During the 1990's with the involvement of various scholars who leaned towards post-modern thinking, critical theorising flourished within disability studies and led to examinations which began to include the cultural, psychological and discursive impacts on disability among others, whilst moving away from the Social Model of Disability (Meekosha & Shuttleworth, 2009; Goodley, 2013). It is through these recent developments that Critical Disability Studies was rooted.

Principles and Application

Disability studies as a general field of inquiry has had an impact on various disciplines including applied and social sciences, medicine, and engineering (Meekosha & Shuttleworth, 2009). Disability scholars are simultaneously concerned with the critique of current approaches, the development of multidisciplinary approaches, and with its own further development as a rising field of scholarly exploration (Meekosha & Shuttleworth, 2009). Despite Disability Studies being regarded as a discipline of its own, during the early 2000's Critical Disability Studies (CDS) emerged, and with it a new framework which sought to re-evaluate the way disability is understood and explained, moving past traditional avenues of critique and towards more concrete potential for change on a social, political and economic scale (Meekosha & Shuttleworth, 2009). CDS scholars maintain concern for issues of human rights and have radically disengaged with the traditional acceptance of binary explanations for experiences of disability (medical vs. social, disability vs. impairment), but may employ this thinking as a tool to further conceptualize and analyze (Meekosha & Shuttleworth, 2009). While the various models of disability studies seek to push against traditional medical understandings of disability (located in the body of the individual), or embrace the disabled body *as* the location where self and society interact, CDS scholars seek to explore *how* the body is made to matter in various settings (Goodley, 2013). In this way, CDS scholars explore not what constitutes, or 'counts' as disability, but rather how value is distributed unevenly across some bodies and minds when compared to others (Minich, 2016). For example, in what ways do we set up our world, space, or community to maintain comfort or acceptance for the able bodied

and discomfort for the disabled? In what ways do we frame situations, set standards, or exert control over individuals through *expectations* set up via pre-determined able-bodied standards? Further, some have stated that CDS scholars then, are primarily concerned with "mapping networks of power" which affect individuals who are disabled at various locations and across issues such as media representation, access, employment, education, or in the matter of this thesis, through treatment inside of incarceration facilities (Meekosha & Dowse, 2007, p. 173).

Further, Critical Disability scholars are concerned with language, and the cooption of language by various social structures of power (government, education, human services) which "conceive, discuss and treat disability within a diagnostic perspective that emphasises individual deficiency" (Meekosha & Shuttleworth, 2009, p.50-51). My thesis maintains ties to critical disability studies by examining the cooption of language relating to individual deficiency within the overarching power structure of the Correctional Service of Canada, through a critical discourse analysis. In this manner, the texts I have chosen to examine were all pulled from within the government agency to be critically engaged with in order to ascertain areas whereby the government may utilize the discourse of individual deficiency to justify punitive actions. Additionally, CDS scholars are interested with the ways that disability is entangled with other various identities that experience oppression, and through this, to explore the ways in which dominance and oppression are maintained (Goodley, 2013; Shildrick, 2012). It is within this context that my thesis hopes to explore the ways in which CSC maintains dominance over various identities by perpetuating compulsory 'standards'. When these pre-established universal

oppressive ‘standards’ go unmet, CSC can operationalize this to maintain power and reproduce negative discourses regarding ‘othered’ identities.

Applying Critical Disability Studies as a theoretical orientation has a direct impact on both my data collection, and my data analysis. From a data collection standpoint, I have discussed how CDS is interested in the discourse, and cooption of language by structures of power to highlight the deficiencies at an individual level (Meekosha & Shuttleworth, 2009). This will lend not only to the very literal location of power where I am analysing documents from (Correctional Service of Canada), but also to critical discourse analysis as a methodology and the exploration of instances where the deficiency of the individual in the text is highlighted rather than systemic, structural or other deviancies that created adverse conditions for individuals. Questions might include, how is the ‘problem’ or ‘deficiency’ located within the individual throughout the text? And further, how is this individualization operationalized or wielded within corrections to maintain power or reproduce violence over ‘others’? Further, Critical Disability scholars grapple with concerns and questions about disability, calling for the re-examination of how we (as a society, group, individual) become complacent in constructing and maintaining ‘normative’ ideas of what constitutes disabled or not (Shildrick, 2012). Through this, examinations in my thesis regarding the maintenance of discourses which rely on medical, individual, or binary assumptions of identity can be utilized to rethink the ways in which complacency is established and ideas about normalcy are maintained.

Mad Studies

Emergence

During the 1960s and 1970s various movements, activists, and scholars were pushing back against psychiatrization and the evolving power of psychiatry with the goal of returning human rights to individuals who had been affected by the overutilization of diagnostic tools, medication, and the pathologizing of everyday life (LeFrançois, Menzies & Reaume, 2013). Issues surrounding chronic underfunding and systemic oppression at this time (and today) resulted in a lack, or denial of social programs during the years that deinstitutionalization occurred in Canada (LeFrançois et al., 2013). It was during this time that the Mad Movement flourished and provided a springboard for what would become Mad Studies (LeFrançois et al., 2013). The Mad Movement, and therefore Mad Studies (MS) has quickly found itself being utilized around the world with emerging critical inquiry, scholarship, and activism, with critiques and contestations, and with work that seeks to radically shift the discourse of mental health (LeFrançois et al., 2013).

Principles and Application

Mad Studies is commonly understood to value the experiences and knowledge of service users/survivors, to question and critique the primary utilization of the medical model as well as the psychiatric system, and aims to foster new understandings of mental health which may further social action and critical research (Daley, Costa & Beresford, 2019). In this way, attention to Mad studies will be maintained through my thesis with acute awareness to discourses which perpetuate the medical model and hold as authority

the voices of psy-professionals over the voices of those who identify as having mental health concerns. Mad studies scholars maintain deep links to discourse; ranging from the reclamation of the word Mad (still a point of contention with some), to using madness as a means for both critique and resistance (White & Pike, 2013; Daley et al., 2019). Further Mad scholars maintain links to discourse by examining "*how* mental health is made sense of" in order to ascertain who's opinions are reproduced and validated as well as to determine who has the power to control the narrative or *common knowledge* of mental health (White & Pike, 2013, p.239). This links not only to my methodology of choice being critical discourse analysis, but additionally to the types of questions that I will ask of the literature I examine. To be deeply explored within and throughout my thesis is the question of *how* mental health is understood, taken up and written about to maintain a duality of power and otherness to justify use of power over the other. This further links to what works I have chosen to analyze, namely documents prepared by Correctional Service of Canada on mental health, to understand and critique how their position, and the discourses that are embedded within the texts that are produced by them allows them to shape the narrative regarding mental health.

Mad Studies are considered inter-disciplinary, multi-vocal, and are utilized across various fields with strong similarities to Disability Studies (LeFrançois et al., 2013). In this manner, the joint application of Disability Studies, as well as the utilization of these theories inside of a social work thesis fits well, allowing me to explore the various concerns raised from both multi-disciplinary theoretical frameworks in one thesis. Further, Mad Studies holds paramount a historical consciousness and understanding of

madness which can link together modern struggles with struggles of the past, highlight the diversity of mad people and mad experiences, and promote an understanding that the construction of madness can be dependent on cultural and historical circumstances (LeFrançois et al., 2013). For example, if we examine the historical context of mental health and criminality, we can see that "the mad often occupied the same physical and ideological spaces as criminals" (White & Pike, 2013, p. 246). It was through this proximity (both physically and ideologically) that associations between danger, crime, and madness were constructed and reproduced (White & Pike, 2013). This led to an inferred connection even today, which reproduces discourses of those who are mad and incarcerated as those who are "the most disordered, dangerous, and unrecoverable" (White & Pike, 2013, p.246). Importantly, Mad scholars seek to explore the "structural contexts and relations of power within which Mad subjectivities, embodiments, experiences, and engagements play out" (LeFrançois et al., 2013, p. 15-16). This is very important for my research given my interest to understand the historical and structural implications that affect, remain, or shape the way discourses are taken up today in correctional facilities and how bodies of power have been able to wield these discourses.

Finally, Mad Studies is considered a broader project of social justice and revolution which aims to change and restructure the mental health service industry (LeFrançois et al., 2013). Ideally, a radical change would occur from my thesis, but that is certainly not within the scope of this project. My goal however, is to shed light on how dominant institutions and structures of power shape the language which can be wielded against those with mental health concerns within incarceration facilities, primarily

because those who experience the violence resulting from the reproduction of negative discourses are restricted access to participate in the narrative or are denied as *valid* knowledge holders and producers.

Critical Disability and Mad Studies

Mad Studies is most closely allied with Disability Studies (Gorman, 2013), so their dual utilization in this thesis, especially *Critical* Disability Studies has been an easy merger, however as with any theoretical framework, there are strengths and limitations with each. As explained above, CDS and MS are both multidisciplinary, with openness to their application across fields (LeFrancois et al., 2013 & Meekosha & Shuttleworth, 2009). Scholars who take up both theoretical frames reject dichotomous debates or explanations in favour of more nuanced understandings, taking power, history, society and culture into account (LeFrancios et al., 2013 & Meekosha & Shuttleworth, 2009). Furthermore, Critical Disability and Mad scholars are concerned with the reclamation of the terms used to define their communities, and are deeply connected to social movements and social change (White & Pike, 2013; Daley et al., 2019 & Meekosha & Shuttleworth, 2009). This similar history of theoretical development, the dedication to diverse application within multidisciplinary fields, and the desire to provoke change in a systems level are some of the things that drew me to Critical Disability and Mad Studies. The critical application of these theoretical frameworks will greatly impact my questions of the literature and my interrogation of the ways discourses have been framed; for example, how is mental health made sense of, described, depicted and whose knowledge is given authority on the subject? These questions would be important to both CDS and

Mad Studies as they both move away from dichotomous definitions and look for ways in which this structuring has influenced separation of individuals by their 'otherness'. Further, both challenge the adoption of bio-medical, individual explanations for difference and my thesis will examine how this exact individualist perspective has been wielded in discourse to other, silence and erase individuals (Meekosha & Shuttleworth, 2009 & Daley et al., 2019).

Limitations to frame

There are of course limitations to these frames, for example, Mad Studies holds above all others the voices and knowledges of those who have experienced the oppressions that come with their identity (LeFrançois et al., 2013). Acknowledging that I currently do not belong to either of these identities puts me in a position as "Mad Positive" a term coined by David Reville (2013), a Mad scholar who considers 'Mad Positive' individuals to be those who do "not identify as mad but supports the goals of those who do" (p.170). My voice is less valid and important than if this were written by a psychiatric survivor, and this must be acknowledged, but I hope to continue to be Mad Positive. I hope my thesis will show the various ways mental health identity discourses are utilized to silence the voices of those with mental health concerns, and that through this thesis we may make space and raise awareness regarding this silencing.

Further, the deconstruction of difference called for by Critical Disability Studies will "not in and of itself produce respect and equality" nor will it likely result in the radical change to a social order free from the binaries of difference (Vehmas & Watson,

2014, p.648). This has led to critique of how realistic CDS is in application outside of theorizing (Vehmas & Watson, 2014). It is within these spaces that I believe the application of Mad Studies and my method of critical discourse analysis will be able to interject and play a vital role in filling the gaps. While radical change and the exclusion of binaries may not be immediately attainable, critical discourse analysis will allow us to look at a small section of language which is certainly impactful in the painting of this binary, and hopefully start a meaningful conversation about the ways we label people and the power wielded from these labels. It is therefore the use of both frames, through their commonalities and their unique critical positions and perspectives that this thesis will be explored.

CHAPTER 4 – METHODOLGOY & RESEARCH DESIGN

Critical Discourse Analysis – Van Dijk

Critical Discourse Analysis was developed from the linguistics field and has since been undertaken as a method of inquiry in various disciplines (Wodak, 2013). The complexities of CDA are linked to the relative freedom in its methodology, as it maintains minimal to no prescribed research methods (Wodak, 2013). However, many prominent scholars offer their own analytical foundation, steps, and methods related to the completion of a critical discourse analysis including the works of Wodak, van Dijk, Fairclough, and Jäger among others (Wodak, 2001). For this thesis, I draw on the work of Teun van Dijk whose work I found lined up with my aims, goals, and values particularly well.

Critical Discourse analysis as described by Teun van Dijk is concerned with power and dominance (van Dijk, 1993). Van Dijk states that "[CDA] should deal primarily with the discourse dimensions of power abuse and the injustice and inequality that result from it" (1993, p. 252). CDA approaches questions and concerns of social inequality through an analysis of the ways that discourses are utilized or constructed to reproduce dominance (van Dijk, 1993). This dominance is then acted out as a form of social control or social power by elites, which results in the reproduction of inequality for the 'others' (van Dijk, 1993). In this context, *power* includes *control* by one group over another and is operationalized through action as well as cognition (van Dijk, 1993). This method of power and domination reproduction can be actualized by different "'modes' of

discourse-power relations" such as denial, representation, direct support, and "mitigation or concealment of dominance" within text (van Dijk, 1993, p.250). Finally, it is important to note that privileged access is vital, as those who are positioned as the 'elite' have access to far more social power than the 'other' group and greater ability to influence the discourse (van Dijk, 1993). It is within this interplay of dominance, power, reproduction, control, and access within text(s) that CDA becomes integral, to discover the methods used to maintain a desired discourse.

Socio-political Stance

Another integral aspect of Critical Discourse Analysis, as instructed by van Dijk is the importance of the researcher "taking an explicit socio-political stance: [through which] they spell out their point of view, perspective, principles and aims, both within their discipline and society at large" (1993, p.252). Van Dijk continues this discussion, stating that those who choose this method of critical inquiry hope for "change through critical understanding", and that their focus is on those who are dominated by the powerful elites who work to maintain injustice (1993, p.252). In this work there is not room for neutral positions. To be clear, I believe that the correctional service of Canada utilizes negative discourses of mental illness to maintain power, domination, and to wield violent practices over mental health consumers.

My background education is in Forensic Psychology, and Criminology and I have held positions working with individuals who have mental health concerns under correctional control that where stripped of their human rights under the justification of

their 'potential for risk'. I have seen various violences produced in these facilities including segregation, forced medication, and removal of autonomy over medical, financial and personal decisions. I have been part of case conferences where every case note on behaviour was scrutinized and plotted to determine the potential for re-offending. Because of these positions that I have held, I have seen first hand the violences that are not made common knowledge, and in fact are often hidden from the public, which are enacted on bodies of those who are *disordered, defective,* or *different.* This knowledge pushes me to ensure that critical conversations occur regarding criminality and otherness and these experiences ground me in the truth that violence is occurring, albeit often unnoticed by the public or undocumented. Because of this, this thesis works to ensure that in some way critical conversations can arise regarding the inhumane and violent treatment of those with mental health concerns under the control of Corrections Canada, sanctioned by laws and policies which reproduce harm on these individuals. Through this first hand knowledge of the ways in which mental health is discussed by those in power regarding risk, violence and potential for crime and through watching these various violences utilized by those in power I offer this thesis as my unapologetic scrutiny of a system that I worked within and which I saw operationalize violence as routine. Through this thesis my goal is to shed light on the impact of discourses of mental health and how they can be constructed by the dominant power (CSC) to reproduce negative opinions with violent results. With this, I hope that more people become critical about what the 'powerful' are saying and critically understand and explore ways that inequality can be reproduced by words.

With attention to van Dijk's form of Critical Discourse Analysis the primary concern for exploration is of the elite's power, dominance, control, and the resulting injustices experienced by others (van Dijk, 1993). With attention to who the 'elite' are in this circumstance, as CSC is the main governing body of federal inmates, documents that they publish will be examined. Throughout my examination of the texts I will actively look for discourses which can be used to justify dominance, in this case through discourses which structure the individual as Other and therefore also attend to the ability of CSC to maintain control and re-enact injustices. Further, I will look for discourses which depict CSC as the primary authority on information, or other ways in which they can reaffirm themselves as the central power who has authority to reproduce knowledge. Finally, I will examine the discourses which are used to mitigate experiences of injustice or justify use of violence or control.

Methods

Text Collection

The documents gathered for this thesis, Report-268 (R-268) titled "*Federally Sentenced Offenders with Mental Disorders: Correctional Outcomes and Correctional Response*" (Stewart, Wilton & Cousineau, 2012) and Report-379 (R-379) titled "*Comorbid Mental Disorders: Prevalence and Impact on Institutional Outcomes"* (Stewart & Wilton, 2017) are not made readily available in full from the Correctional Service of Canada. Rather, they are available in one-page summaries on The Correctional Service of Canada's Research Department website. To access these documents in full, I

was required to phone (613-995-3975) or email (research@csc-scc.gc.ca) the research branch of CSC with the corresponding title or Report Code for the documents I required. I was delivered R-268 and R-379 in full following a request to CSC via personal email. I felt that these documents were vital to this thesis as they both examined mental health concerns within corrections regarding outcomes within the institution and the documents were published five years apart which would allow for me to determine if the discourse had been impacted, furthered or if it had remained stagnant during that time. Further, as this research is produced by CSC I felt that it would reflect the organization's views, including highlighting what they felt was important information, where they drew knowledge from, and what directions they were furthering their research towards.

Text Selection

For this critical discourse analysis, documents from the Correctional Service of Canada's research branch were selected. Documents were attained under the "Health and Mental Health" subtopic, and from the category "mental health" specifically because I felt documents positioned here would be reflective of what CSC considers to be a mental health concern, and therefore would provide explicit examples of discourses constructed by CSC regarding inmates with mental health concerns in federal corrections. The two documents (R-268 and R-379) were selected via narrowing down of all reports published under CSC's mental health research category by excluding documents which were outside of the scope of this thesis (exclusion criteria below). As my research was primarily concerned with discourses related to mental health within correctional systems, I felt it was imperative to critically engage with the material that was published under this

topic by the Canadian federal branch of corrections. As stated, CSC maintains power over the participation in and publication of research within their facility (Watson, 2015; Long, 2020; Piché, 2011). Therefore, I felt that these texts would not only impact and influence but also reflect CSC's institutional and operational goals, critiques, and opinions in relation to mental health.

Exclusion / Inclusion Criteria

At the time of writing this thesis, CSC has 48 reports published under the category Mental Health on their research branch page. Due to the scope of this thesis, 48 reports would be far too many and required narrowing. The criteria I used to narrow the applicable texts were as follows. The reports had to be full research publications, thus reports coded with 'RS', 'RR', or 'RIB' were removed as they were standalone one page documents with no full reports associated with them, and those coded with 'ERR' were removed as they were emerging research which already, or would be, linked to a full report (A. Costeria, personal communication, Jan 20, 2020). This resulted in 34 possible reports. Documents outside of the scope of this thesis, pertaining to either community, reintegration, literature reviews, validation of testing instruments or measures, or those with titles that narrowed their research to one specific 'disorder', gender, or identity were removed. This was done to ensure I was gathering information on CSC's discourse on mental health from a more general perspective with a wide range of identities to decipher if they brought up or singled out any specific identities on their own. Further, if two documents were very similar in research objective, or done on the same topic but years apart, the most recent publication was utilized. From this, 5 publications remained. Next,

I removed those papers that did not explicitly state "mental health" or "mental disorder" in their title. This resulted in the removal of three papers, one regarding intellectual deficits, one discussing psychotropic medication use, and one on cognitive deficits. I was left with two papers which are as follows:

1. Stewart, L. A., Wilton, G., & Cousineau, C. (2012). *Federally Sentenced Offenders with Mental Disorders: Correctional Outcomes and Correctional Response*. Research Report, R-268. Research Branch, Correctional Service of Canada.

2. Stewart, L. A., Wilton, G. (2017). *Comorbid Mental Disorders: Prevalence and Impact on Institutional Outcomes.* Research Report, R-379. Research Branch, Correctional Service of Canada.

These two papers examine various areas of contact, treatment, response and care for those with mental health concerns inside of corrections and because of this, I felt, should provide for a well rounded interrogation of texts in regards to general discourses formed, maintained, and reproduced by CSC.

Critical Analysis Questions

Keeping the works of Van Dijk in mind, as well as my own theoretical and epistemological positioning, I have chosen to orient myself in the texts through three major questions. These questions were chosen to explore the ways that discourses of those with mental health concerns are shaped by Correctional Service of Canada and how

they are used to maintain power and dominance, specifically violent power and dominance and are as follows:

1. In what ways do CSC depict, link, describe or otherwise explain mental health, illness, or disorder within their reports? (construction of discourse)
2. In what ways is domination and power over discourse reproduced in the literature? ('us vs. them' justifications, access, definitions)
3. What information, research, findings, evaluations, and voices are made visible? Which are excluded, removed, erased, ignored or otherwise silenced? (ex. Quoting credible witnesses, experts, or sources; validation or dissemination of discourse)

I chose these questions for very specific purposes. Each question allows for attention to both linguistic and thematic aspects that would arise from Critical Discourse, Critical Disability and Mad Studies. Each separately, and together maintain attention to power, dominance, social justice, discourse, and the shaping of 'otherness' by those in power (van Dijk, 1993; LeFrançois et al., 2013; Goodley, 2013).

Following the decision to narrow these questions, I read the documents twice. The first time was completed to verify if there were other possible discourse strands that I had missed that were vital in answering my research question. The second time, I read through the articles and labeled relevant sections with 1, 2, or 3 respectively with each representing the correspondingly numbered question. Additionally, on a separate document I recorded various themes, keywords or phrases that emerged under each question, from each text. From there I was able to determine prominent themes that were

present in each of the documents that I believe were indicative of CSC's construction of discourse surrounding mental health consumers which are used to maintain power, dominance and a negative depiction of the 'other'.

CHAPTER 5 – FINDINGS AND ANALYSIS

A Note on Abbreviations:

Common abbreviations found within documents and quotes include:

- OMD – offender with a serious mental disorder
- MD – mental disorder
- DAST – drug abuse screening test
- ADS – alcohol dependency scale
- OMS – electronic files of offenders
- CRS – custody rating scale

Report 1

(R-268) *Federally Sentenced offenders with Mental Disorders: Correctional Outcomes and Correctional Response.*

The first report that I examined was written in May of 2012, and was authored by Lynn A. Stewart, Geoff Wilton, and Collette Cousineau. This report was meant to be an examination of correctional outcomes and responses for individuals with mental health concerns, as per the title. Within this context however, various opportunities to critically engage with and dissect the words written by CSC became apparent. This section will focus solely on the first report, and explore various methods, themes, terms, and opinions which are used by CSC to reproduce domination over and disseminate negative discourses of those with mental health concerns in federal corrections.

Violence & Risk

One of the prominent themes found in this report was the linkage of those with mental health concerns to being both high risk and violent. In fact, the first mention of violence or risk is found in the second paragraph of the executive summary (Stewart,

Wilton, & Cousineau, 2012, p.iii) and the third and fourth paragraphs of the introduction (Stewart et al., 2012, p.1-2). Bringing up violence and riskiness in this population at such an early stage lays the groundwork for their main arguments to be scaffolded onto. This document repeatedly makes statements such as "offenders with a mental disorder [are] more likely to be serving a current sentence for violence"(Stewart et al., 2012, p.iii), and that "understanding the risk posed by offenders with mental disorders is an important component in devising effective correctional supervision" (Stewart et al., 2012, p.1). Additionally, this document relies heavily on international studies that verify the link between violence and individuals with mental health concerns, including a study from Denmark which found that within a specified birth cohort "persons hospitalized for a major mental disorder were responsible for a disproportionate percentage of violence" (Stewart et al., 2012, p.2). If offenders with mental health concerns can be linked to *violence*[1] then this can be used to justify the actual findings of the report, which found that those with mental health concerns had poor outcomes within Canadian federal corrections (Stewart et al., 2012, p.28).

This report looks at many instances within correctional facilities where those with mental health concerns received worse treatment than individuals without diagnosed mental health concerns. The report stated that those with mental health concerns received more institutional charges (minor and major), were placed more often in segregation

[1] the words 'violent' or 'violence' are present 38 times in the document not including references or charts and the word "risk" appears 54 times not including references or charts.

(voluntary and involuntarily), that they did worse in the community, and were often reconvicted "*even* [emphasis added] when criminal history risk and criminogenic need rating, age and substance abuse were controlled" (Stewart et al., 2012, p.28-29). CSC utilizes sentences like this to bring attention to the idea that *even through* controlling for various issues that they found within the individual, their mental health status made them more likely to re-offend. This ignores not only the impact of structural, historical, social and political issues but also the institutional violence that is utilized against inmates due to CSC relying solely on measures related to personal identity and 'disorder'. They explain further that "the factors that best explained outcome on *release* were having a *mental disorder, drug abuse,* and *criminal attitudes* [emphasis added]" (Stewart et al., 2012, p.29). They did not acknowledge what may explain the poor results or conditions prior to release for these individuals further perpetuating ideas that inmates within federal corrections receive quality care, and that only on release do negative outcomes begin to emerge. Further, while there are many issues with this sentence, the previous link between mental health concerns and violence which has been established through repetition and regurgitation of various studies, allows for these poor outcomes and results to remain. If mental health is equated to violence, and violence is bad, immoral, or unjust, then the root of the argument becomes that those with mental disorders are bad, violent, immoral people, and therefore poor treatment and results inside of corrections and on release are a problem of their own condition.

What is also depicted within this document, in my interpretation, is CSC's own production of violence onto these individuals. In this sense, violence is operationalized

through the many ways that domination is maintained, and injustice is reproduced. For example, this report explained that individuals in correctional facilities that they deemed as having a mental disorder were "more likely to be pen placed in maximum security… despite having CRS results that did not differ from the comparison group of offender[s] without a mental disorder" (Stewart et al., 2012, p.30). CRS is the Custody Rating Scale and measures the level of anticipated adjustment and security risk of each inmate to determine where they should be placed regarding security level, ranging from minimum to maximum security (Stewart et al., 2012, p.10). To be "pen placed" is to have your security placement result from CRS overridden by a person of authority (Stewart et al., 2012, p.17). The violence inherent in this is the blatant prejudice, unjust, and unequal treatment of those with mental health concerns who score similarly on perceived risk to the facility, themselves, and the community. Maximum Security Facilities as described by CSC are the institutions that are most restrictive, they house inmates whom "pose the greatest risk of escape and therefore the greatest danger to society" (Correctional Service Canada [CSC], 2019B). These maximum-security facilities are monitored and surveilled by armed guards in towers, and the grounds are surrounded by barbed-wire fences (CSC, 2019B). Inside of these facilities, inmates are on strict routines and schedules (CSC, 2019B). In comparison, medium and minimum-security facilities do not have armed guards or barbed wire fences, and the rules of the facility are less restrictive (CSC, 2019B). CSC states that medium security life is very similar to maximum, but then why pen-place inmates into maximum security (CSC, 2019B)? The desire to place inmates in higher security facilities where they are constantly monitored by armed guards with easy

access to weapons, simply because they have mental health concerns is violent. The conclusion that inmates with mental health concerns are those that pose a greater danger to society is violent. The inability to attend to inmates with mental health concern's needs without placing them in severely restricted facilities is a problem inherent in the structure of CSC and not within the individual and their potential *risk* or *danger*.

Additionally, CSC admits in this report that admissions to both voluntary and involuntary segregation are more prevalent for those with mental health concerns than for the general incarcerated population (Stewart et al., 2012, p.21). As well, those with mental health concerns who were placed in involuntary segregation were placed there for longer when compared to the group who had no identified mental health concerns (Stewart et al., 2012, p.21). What these facts indicate is that CSC routinely creates adverse situations for those with mental health concerns by placing them in higher security facilities and putting them in involuntary segregation for longer than those without mental health concerns. This form of violent treatment is written about however, in such a way that allows for justification through the already established discourse of mental illness as violence. The assumption becomes that through various means, particularly through their own risk and through their "problematic behaviour while incarcerated" it becomes acceptable to be "more cautious" with this population, which is a more palatable way to reinforce surveillance, unequal treatment and oppressive measures due to future assumptions regarding risk and violence (Stewart et al., 2012, p.30).

Medical & Individual Disorder

In line with Mad Studies and Critical Disability Studies is an attention to and challenge of the bio-medical and individualist perspectives and explanations of difference (Meekosha & Shuttleworth, 2009 & Daley et al., 2019). Framing mental health concerns as individual and medical can be harmful in many ways including allowing for ignorance regarding the impact of societal, historical, and political implications on mental health. One of the ways that CSC locates the 'problem' of mental health within the individual is through the use of terms such as "mental disorder" which further perpetuates stigma of mental health and works to categorize individuals as other by way of them being *disordered*. This is further operationalized through the construction of a dichotomous or 'have vs have not' relationship regarding mental health, insinuating that you are either 'disordered' or 'normal'. Through the process of marking these individuals as 'others' via identifying and labelling them, psychiatry (as well as CSC) makes them visible only as their 'illness' (Liegghio, 2013). Through this view, individuals with mental health concerns become individuals that should be controlled, repaired, fixed, treated or made *normal*. Mental health concerns are given a specific type of visibility in this context, like a medical disease or a type of cancer that demands treatment to make the person *better.* In fact, CSC uses comparisons to cancer during the first page of this report stating "Worldwide, depression is the leading cause of years lived with disability and mental disorder contributes more to the global burden of disease than all cancers combined" (Stewart et al., 2012, p.1). The comparison to cancer blatantly locates mental health concerns as something within the individual that is harmful not only to the individual, but

also to society by the way of being a burden. It additionally allows for justification of treatment regardless of individual desire due to an assumption that there must be something further 'wrong' with the person if they do not want 'treatment' for their 'illness'.

The process of labelling individuals with mental health concerns also allows for violent productions of otherness. As articulated by Liegghio (2013), when individuals and psychiatry intersect, aspects of their lives are reinterpreted by professional formulations through diagnosis which serves to mark certain non-conforming individuals as different or other. Through this process, within CSC, the organization uses institutional standards that must be met by these individuals and conformed to. Inability to conform to CSC's standards by acting in ways that are considered negative, non-productive, disobedient, disrespectful or that violate rules are remedied by institutional charges (Stewart et al., 2012). Because of this, individuals with mental health concerns have significantly more institutional charges (Stewart et al., 2012). Institutional charges can then lead to convictions within corrections which may extend sentence length for inmates (Bromwich & Kilty, 2017). This is another way that the discourse of mental health can be utilized by CSC to authorize violence.

Finally, one specific 'disorder' that is discussed in conjunction with mental health in this report is that of schizophrenia. The attention to schizophrenia can be utilized to advance discourse around mental health in several ways. Firstly, for the public, psychiatric discourse is hegemonic, and the public is typically aware of mental illness, symptoms, and well known 'conditions' such as schizophrenia (Burstow, 2013). English-

language movie watchers are bombarded by depictions of schizophrenia in the media which are largely inaccurate, and depict schizophrenia as an illness that is characterized by delusions and by violent behaviour committed without justification which promotes an "us versus them" mentality, working to further discourse of individuals with schizophrenia as people to be avoided (Owen, 2012). To operationalize this, and to justify their treatment of inmates with mental health concerns, CSC uses statements such as "Research suggests that schizophrenia, or some subtypes of schizophrenia, is one of the mental disorders associated with criminality and particularly, with violence" (Stewart et al., 2012, p.2). On many occasions CSC references data which links schizophrenia to criminality, for example they stated that women who had been diagnosed with schizophrenia were more likely to have a criminal record, and men diagnosed with schizophrenia were twice as likely than those with other diagnosed mental health conditions to have been arrested for a crime that was violent (Stewart et al., 2012, p.3). In fact, in CSC's 5 page introduction section, schizophrenia is mentioned 15 times, despite the research question clearly stating that they are offering an "examination of the outcomes of, and the correctional response to, offenders with mental disorder (OMDs) in the federal correctional system" and not on one specific diagnosis (Stewart et al., 2012, p.5). Reliance on discourse of schizophrenia or other very specific 'disorders' in CSC literature works to play to public stigma and the perception that inmates with mental health concerns are violent, or people to be avoided, removed, or fixed, effectively using discourse *of* violence to justify various methods of their own violent treatment.

Access

"Some of the highest rates [of major mental disorder] have been found among offenders in the federal Canadian correctional system" (Stewart et al., 2012, p.1).

Having access to information and to the ability to reproduce discourses of your own desire are central to this analysis of ways through which CSC maintains discourses of mental health. In this report CSC structures themselves as the only ones able to produce these forms of reports by drawing attention to the high number of individuals with mental health concerns held in corrections. By establishing that they have the highest number of individuals with mental health concerns they demonstrate that they have the best access to the information (or research participants) that they need and therefore their research *must* be trustworthy, valid or accepted. They frame their research within other published work from the global community which they state is part of the "consensus" but each of these "large scale international studies" were conducted specifically on schizophrenia (Stewart et al., 2012, p.2-3), during a time when other research exploring more general mental health and violence found that mental health had no significant correlation or contribution to cause of violence (Langan, 2010). Further, 'consensus' indicates that all agree, but CSC draws their conclusion from articles that were published between 10 and 22 years prior to their own work (Stewart et al., 2012, p.2-3). Examining work published closer in time to their publication (2012) would have showcased various works which were less than clear about the correlation and accepted a broad spectrum of professional opinion but that held a "consensus that the magnitude of risk posed by mentally ill people has been grossly over-estimated" (Langan, 2010, p.87). The reliance

on outdated information which holds individuals in corrections with mental health concerns as violent is used to further negative discourse by CSC regarding mental heath.

Sources Used

Finally, it is important to draw attention to where CSC retrieved their information from for this report regarding their references. The types of publications they took their information from, as well as the authors, journals, and focus of the documents are all indicative of what types of sources or voices that CSC deems as knowledgeable, acceptable, or of authority as these are the works that CSC has granted visibility of in their publication. For example, this report by CSC has 31 citations, of those, 13 include the words 'violent', 'violence' or 'schizophrenia', in their title (Stewart et al., 2012, p.31-33). The heavy reliance on texts that clearly paint a specific picture for the audience is indicative of what story is trying to be told. 42% of the sources (13 out of 31) are written to explore violence and/or a very specific psychiatrically prescribed mental health concern despite only 17.9% of their sample having been diagnosed with Schizophrenia/Schizophreniform (Stewart et al., 2012, p.7). Further, these publications primarily come from journals focused on the psychiatric field including journals titled Psychological Medicine, Advances in Psychiatric Treatment, American Journal of Psychiatry, and the British Journal of Psychiatry (Stewart et al., 2017). As previously discussed, the discourse of mental health as violent, or of general mental health concerns as specific diagnosis such as 'schizophrenia' contributes to discourses which allow for the wielding of violent practices by CSC. Heavy reliance on medical journals of psychiatric nature allow for the maintenance of domination and control by the medical elites over

these individuals by means of evaluating, testing, treating, medicating, labelling, and researching *on* bodies *they* deem *disordered*. Further it is evidenced that CSC holds these results as valid and important from their description of various sources within their report, including referring to sources or findings within report as "influential", or as part of the "consensus" (Stewart et al., 2012, p.2-3).

Summary

In summary, not only did CSC perpetuate a link between mental health and violence, but they also heavily rely on the bio-medical model placing the issue of 'disorder' on the individual. This report included many different examples of ways in which this elite organization controls, dominates, and exerts power over the discourse and further, highlights the views and voices that CSC found value in.

Report 2

(R-379) *Comorbid Mental Disorders: Prevalence and Impact on Institutional Outcomes*

The second report that I examined was written in May 2017 by Lynn A. Stewart and Geoff Wilton. Both authors were also 1st and 2nd author on the first report. The goal of this report was to examine which "patterns of comorbidity" or specific "disorders would be linked to misconducts, placements in segregation, and transfers to treatment centres" (p.3). The accepted definition by CSC of comorbidity is the condition whereby an individual has two or more concurrent diagnosed mental disorders (Stewart & Wilton, 2017, p.3). Important to note is that while this document was presumed to be gender

neutral upon selection for use, the report was completed using results from CSC's national mental health survey that were based on male participants.

Violence and Risk

Like the first report, the second report serves to perpetuate discourse surrounding mental health and violence or risk. The authors repeatedly state that offenders with mental health concerns are more likely to be serving time in federal corrections for offences that are violent in nature (Stewart & Wilton, 2017). Further, they link violent behaviour inside of corrections to having had "comorbid personality and substance abuse disorders" stating that these individuals were "more likely to be involved in assault related incidents while incarcerated" (Stewart & Wilton, 2017, p.16). Statements and observations such as these are littered throughout the document and allow CSC to re-produce the discourse of an inmate who is violent on conviction, and maintains ties to violence while incarcerated, through assaulting others.

Further, they pull from studies which suggests that "comorbid disorders put people at increased risk of suicide, homelessness, family conflict, social marginalization, violent and disruptive behaviour, victimization, physical health problems, and criminal involvement" (Urbanoski et al., 2007 as cited in Stewart & Wilton, 2017, p.1). These various descriptions and predictions regarding mental health concerns can make way for violent treatment inside of corrections. For example, as stated by CSC, the ways in which an individual can be placed in segregation (now referred to as Structured Intervention Units) is if they act in a way which may jeopardize the safety of any individual or the

security of the institution, or if allowing them to remain in the general inmate population could jeopardize their own safety, or could interfere with an investigation that might lead to criminal or disciplinary charges (Kelly, 2019). As this report by CSC states, inmates with mental health concerns, or co-morbidity, are more likely to be violent and disruptive, which could be operationalized as the first way through which they can be placed in segregation; by jeopardizing the safety of others or security of the facility (Stewart & Wilton, 2017; Kelly, 2019). Further, inmates can be placed in segregation if being in the general population could cause them harm, which is directly related to the discourse that individuals with co-morbid mental health concerns are more likely to attempt suicide, be victimized and socially marginalized (Stewart & Wilton, 2017; Kelly, 2019). Finally, this report argues that individuals with co-occurring mental health concerns are also at higher risk for criminal involvement, the only other avenue through which segregation is justifiable. While segregation may be utilized for a myriad of reasons, the ways in which mental health is structured by CSC and the discourse which is disseminated in their reports pre-emptively frame those with mental health concerns as ones that could easily be placed within segregation.

Social Isolation & Productivity

Negative discourses are also constructed by CSC through the notion that individuals with mental health concerns are socially isolated and unproductive. The authors argued that "having a co-occurring disorder was strongly associated with antisocial and challenging behaviour" (Stewart & Wilton, 2017, p.24). The report states that "while experiences vary across individuals, comorbid disorders have the potential to

impede individuals' ability to perform a variety of daily tasks, develop healthy relationships, and lead productive lives" (Stewart & Wilton, 2017, p. 1). The two studies used to justify those results were Palmer, Jinks & Hatcher (2010) whose study was based out of the UK, and Urbanoski, Cairney, Adlaf & Rush (2007) whose study was based out of Ontario, Canada. Both studies then are based out of locations which would ascribe to neoliberal ideologies and therefore hold the ability to lead 'productive' lives which *contribute* to society as necessary. The discourse that presents itself here is that if you have a mental health concern, it will *impede* your ability to lead a productive life and therefore those with mental health concerns are unproductive and un-contributive within neoliberal consumerist society.

CSC further constructs the idea that this population has an inability to connect or form meaningful relationships with others, structuring the idea that those with mental health concerns are in someway different or unapproachable. The inability to form and maintain relationships could then be misconstrued as another form of disfunction and individuals that cannot form healthy relationships are further ostracized and portrayed as an 'other'. As well, it assumes that we all hold the same definition of a 'healthy' relationship, to some socially or culturally imagined standard. A 'healthy' relationship may look innumerable ways to various individuals, and saying that someone with co-occurring mental health concerns may have difficulty with establishing healthy relationships assumes to know what that relationship looks like, and whether or not it is healthy but only from the perspective of someone peering in on a relationship and observing, not participating. In this way, individuals may have very healthy relationships

with others, if all involved inside of the relationship consider it healthy and is not reliant on a psychiatrist or an institution to deem it so.

Medical / Individual

Within the context of individualizing identities of those with mental health concerns, CSC attempts to dissect diagnosis down to very specific categories. Within the DSM 5 (Diagnostic and Statistical Manual of Mental Disorders, 5th edition), which was published in 2013 well before this report by CSC was released, they specifically discuss the move away from use of a multiaxial system and the flaws within Axis 5 (the Global Assessment of Functioning) which is the GAF scale (American Psychiatric Association, 2013). Despite this, CSC utilizes both the multiaxial system, further individualizing and categorizing people based on pre-established clinical conditional thresholds, as well as relying on the GAF scale which the DSM-5 indicates is flawed due to its "conceptual lack of clarity" and "questionable psychometrics" (American Psychiatric Association, 2013, p.16). This becomes a major issue with the provision of care for those with mental health concerns in corrections due to CSC's reliance on the GAF scale to determine which inmates are placed in treatment centres (Stewart & Wilton, 2017). This report by CSC states that during their examination of individuals that were transferred to treatment centres, they assessed types of diagnosis as well as the degree of impairment (Stewart & Wilton, 2017). Their results indicated that "the diagnosis was less important as a predictor than the degree of impairment as assessed on the GAF" (Stewart & Wilton, 2017, p.26). This reliance on (outdated and flawed) diagnostic tools can then be used against individuals to bar access to treatment. Further, this allows for the continued labelling and

categorizing of individuals through measures which assume to assess the level of "impairment" the individual faces (Stewart & Wilton, 2017, p.26). This level of *impairment* is then made "essentially true" through a "performative utterance" whereby it is made real by "virtue of the right person uttering it" (Burstow, 2013, p.80). It is through this process that individuals are labelled as having 'mental disorders' through psychiatric practices or in the case of this article, by research assistants who wield an analytical tool that indicates level of disorder, disfunction or illness (Stewart & Wilton, 2017).

Despite heavily relying on the DSM to organize and label individuals, the CSC appears to pick and choose their rigidity regarding compliance with standards in various ways. The DSM-5 states "use of [the] DSM-5 to assess for the presence of a mental disorder by nonclinical, nonmedical, or otherwise insufficiently trained individuals is not advised" (American Psychological Association, 2013, p.25). However, research assistants who labelled, defined and diagnosed individuals for this research (without telling the participants their results) had only been (self-)trained for 5 days (Stewart & Wilton, 2017). This creates more violence within the ability to label. The willful ignorance of CSC regarding the mental health of individuals is persistent. Without proper training or education, how are research assistants with 5 days of self-taught diagnostic tools supposed to determine if the individual required "follow-up services" or referral? CSC's power here is re-established and reproduced through their ability to name otherness as they see fit and utilize that information for research which has impacted none for the better.

Further, CSC centres 'disorder' in the individual in this report by drawing and expanding on studies which seek to determine the genetic foundation of mental health concerns:

> Research is pointing to the likelihood that antisocial behaviours and symptoms of many mental disorders are associated with varying degrees of neurological impairment that may have similar genetic underpinnings (Baker, Bezdjian, & Raine, 2006; Blair, 2003; Cross-Disorder Group of the Psychiatric Genomics Consortium, 2013; Moffitt, 2005; Serretti, & Fabbri, 2013; Silva, 2007). Typically, these impairments involve executive processing deficits that pose serious problems for an individual's ability to self-regulate, avoid self-defeating behaviours, and attain prosocial goals (Morgan & Lilienfeld, 2000). Research that examines how biological explanations can be incorporated into the development of both medical and psychological interventions that address these issues is a promising area for future study." (Stweart & Wilton, 2017, p.27)

This quote found within the report cites six studies which utilize behavioural genetics, genome analysis and neuroscience to determine what genetic underpinnings could be indicative of "antisocial behaviours and symptoms of many mental disorders" (Wilton & Stewart, 2017, p.27). To place blame at the biological level is to ignore the historical, social, political, and everyday violence that are experienced by individuals that come into contact not only with the criminal justice system but the mental health or psychiatric system. The reproduction of such discourses allows for archaic and violent thinking to re-emerge like eugenics, whereby someone's worth or otherness is defined on a cellular level. CSC's determination to examine how biology can be incorporated into their "medical and psychological interventions" comes across as a threat through which they will apply such 'interventions' in order to ensure the individual conforms to their socially determined norms of conduct. Further the word 'intervention', whose synonyms may be interfering or intruding, reads as a forceful imposition rather than a helpful one.

Interventions as they are most portrayed, are not something the individual who is the target of the intervention typically wants or decides for themselves they require. Through this, power is reinforced and re-established within CSC as a paternal figure who 'knows what's best' for the 'mentally disordered' inmate.

Access

"Both Canadian and international studies indicate that offenders with major mental disorders constitute a significant proportion of the prison population" (Stewart & Wilton, 2017, p.1).

As discussed in the first report, CSC's power is further reproduced through their ability to access information. If offenders with mental health concerns are indeed present at an alarming rate within Canadian federal corrections, and CSC controls access to research, they also control the narrative of this population. Limiting the participation and therefore the voice of individuals with mental health concerns in incarceration facilities (in this case through positivist and statistical research) also allows for CSC to control what is said, disseminated, researched and reproduced to form the public consensus and discourse of mental health concerns in corrections. This allows for the framing of CSC as the authority on this discourse as they have access to both the participants and the means to produce and share the knowledge.

Reframed Data & Sources Used

Within this report, data is structed to deliver a specific story. Through an examination of not only the way the data is delivered, but also what outside sources or

data were drawn upon, we can determine what information, research, findings, evaluations and voices that CSC works to make visible and therefore holds as valid. For example, of their 83 citations, 42 (50.6%) come from journals of psychiatry, psychopathology, psychosomatics or psychology, including the "Canadian Journal of Psychiatry", "British Journal of Psychiatry", "International Journal of Law and Psychiatry", and the "Journal of Forensic Psychiatry and Psychology" (Stewart & Wilton, 2017, p.29-35). The remaining citations are largely from books, CSC reports, journals of specific disorders, or journals of criminal justice (Stewart & Wilton, 2017, p.29-35). This further indicates the previously established finding that CSC relies heavily on psy-sciences to inform their work regarding those with mental health concerns. None of the sources which they draw from appear to be from any Mad or Critical Disability scholars which further reproduces the knowledge that CSC holds psy-disciplines as the authority on information pertaining to mental health.

Moreover, CSC has reframed at least one source within their report to better fit their discourse. When discussing the work of Urbanoski, Cairney, Adlaf & Rush (2007), they cite it (along with one other source) within the context of co-occurring mental health concerns likelihood to "impede [an] individuals' ability to perform a variety of daily tasks, develop healthy relationships, and lead productive lives" (Stewart & Wilton, 2017, p.1). CSC further utilizes this source to state that "comorbid disorders" put individuals at risk of various social and criminal conflicts (Stewart & Wilton, 2017, p.1). The issue arises when you examine the work by Urbanoski et al., (2007) which looked specifically at substance misuse in those with mental health concerns, and not at general co-morbidity

which could include any number of 'mental health disorders'. This becomes suspect when we consider some major flaws in co-opting this information, especially since Urbanoski et al., (2007)'s study was conducted in a community setting utilizing different clinical measures for substance 'abuse' than CSC utilizes (Stewart & Wilton, 2017). Through this co-option CSC relies on the individual consuming their report to not examine the sources used, and further re-frames the discourse to meet their needs.

Finally, they frame their sources as the most valid or as the authority on the information. They persuade the reader by drawing from 'credible' witnesses such as stating that "these results are consistent with guidelines provided by one of the editors of the DSM" (Stewart & Wilton, 2017, p.27). They further persuade the reader that their work is highly validated by labelling two different clinical measurements (SCID-I and SCID-II) as the "gold standard" (Stewart & Wilton, 2017, p.4-5). CSC's production of research and ability to self-publish already structures them as one of the major distributors of discourse related to inmates with mental health concerns. CSC's position as the authority on this subject is further justified by credible academics agreeing with them, and though the utilization of tools that are 'high tier'.

Summary

In summary, like the first report which was examined, CSC uses various methods and discourses to maintain power over and justify violence on those with mental health concerns. Through linking mental health to violence, labelling, diagnosing, and categorizing individuals and relying on specific measures and sources to re-affirm their narrative, CSC works to silence the inmate with mental health concerns.

CHAPTER 6 – DISCUSSION

It has been established that through various methods CSC maintains dominance and power over discourse of mental health and utilizes this discourse to cast negative opinions of those with mental health concerns allowing for violent 'treatment' within incarceration facilities. Further attention and discussion should be brought to other various ways that CSC contributes to not only discourses of mental health, but to violently maintaining reproduction of this discourse and re-establishment of their own power in the system.

Positivist Research

Within these two documents, CSC utilizes positivist forms of research. This form of research favours data that is quantitative and utilizes tools such as experiments, statistics, and surveys to obtain their data (Neuman, 1997). In terms of social research, positivism remains the oldest and most widely utilized approach (Neuman, 1997). Since this form of data collection and dissemination is most widely used, I would suggest that it is also readily regarded as 'legitimate science' which can have devastating effects on individuals. Due to positivism's well known and established framework, I argue that instances of scientific replication and rapid publication may emerge. This, I argue can contribute to flawed 'best practices' whereby these studies can then easily equate real human suffering to percentages or statistics, which if remain below a certain threshold are deemed successful. This is easily accomplished and exemplified in the work by CSC that was examined. The linking of individuals to data contributes to a sterilization of their

personalities, traits, histories, cultures, and narratives which get washed away in the numbers which are used to represent them. In the articles by CSC we can see this washing away of individual identity or voices through the utilization of standardized tests and clinical measures to gather information. For example, in the second report (R-379) they utilized the Structured Clinical Interview for DSM Axis I Disorders (SCDI-I), the Structured Clinical Interview for DSM Axis II Personality Disorders (SCDI-II), the Modified Global Assessment of Functioning – Revised (GAF) and "extracted" data from both the Offender Management System (OMS) and the Offender Intake Assessment (OIA) (Stewart & Wilton, 2017, p.6). These clinical measures convert various aspects of human life into statistical numbers or rankings on a scale which are then interpreted rather than any form of qualitative information. Because of this, voices, and experiences of those who this research is directly affecting is erased, and their ability to participate in a meaningful way or contribute to the discourse is restricted.

Accessing Documents

One other important topic to discuss is the process of requesting the reports from CSC. As already discussed in my methodology, the full versions of the reports I utilized had to be requested via email or phone from CSC's research branch. This would suggest that CSC can prohibit someone from accessing their research, or limit access as they see fit. Their choice to only make available the summary version has direct consequences. If individuals cannot access the documents from CSC and they unknowingly retrieve the document from an academic journal, it may be harder to determine where that document is coming from. For example, Research Report R-357 "National prevalence of Mental

Disorders among Incoming Federally-Sentenced Men" by Beaudette, Power and Stewart (2015), is available via request from CSC's research branch. However, the report can also be found under the title "National Prevalence of mental Disorders among Incoming Canadian Male Offenders" by Beaudette and Stewart (2016) in the Canadian Journal of Psychiatry where they simultaneously thank CSC's research branch for the funding and resources but declare no financial support or conflicting interests despite both being employed by CSC (Beaudette & Stewart, 2016). Having previously request R-357 from the CSC's research branch, I can assure you that despite removing an author, these reports are almost carbon copies of each other, down to sentences, statistics, and sources. For example, if we examine the first few sentences from Baudette, Power & Stewart (2015) they state:

> There is now well-established evidence that the rates of mental disorder among offenders are higher than those in the general population (Gilmour, 2014). Estimates of the prevalence of psychiatric disorders in prison populations have ranged from 15% to 81% (Brinded, Simpson, Laidlaw, Fairley, & Malcolm, 2001; Brink, Doherty, & Boer, 2001; Diamond, Wang, Holzer, Thomas, & Cruser, 2001; Magaletta, Diamond, Faust, Daggett, & Camp, 2009) depending on the definition of mental disorder (MD) adopted. Studies producing the highest estimates include substance abuse disorders and antisocial personality disorders (APD) and use a lifetime timeframe. Studies uniformly find high rates of substance abuse and APD among individuals involved in the criminal justice system (Black, Gunter, Loveless, Allen, & Sieleni, 2010; Butler, Indig, Allnutt, & Mamoon, 2011). (p.1)

In the article by Beaudette & Power (2016), the paper begins:

> There is well-established evidence that the rates of mental disorder in offender populations are higher than among the general public.[1,2] Estimates of the prevalence of mental disorders in prison samples have ranged from 15% to 81%[2-9] depending on the assessment tools and the definition of mental disorder adopted. Some of the highest rates have been found in the Canadian correctional systems,[5,10-12] where researchers and advocates have urged action to address the substantial mental health needs of these offenders.[13-15] Studies uniformly find high

> rates of substance abuse disorders and antisocial personality disorder (APD) among individuals involved in the criminal justice system.[10-12] (p.625).

This form of blatant self-plagiarism is a common theme in the work by CSC, who maintains power and domination over the discourse through maintaining access to the population and authority over publication and dissemination of results. This also works to violently re-produce narrow perspectives. Despite the authors stating that their work is not necessarily reflective of the ideals of CSC, they have reproduced the same paper with the same information and ideas that they have for CSC (Baudette & Power, 2016, p.630). If anyone were to find the document in the Canadian Journal of Psychiatry, and not locate it within CSC's own documents, the consumer may be unaware that they are in fact reading something produced and published by CSC and employees of CSC. This therefore skews the available data to be reflective of CSC's mandates, ideas, and opinions regardless of them requiring the public to request their research. I argue that this is violence, as it works to covertly impact the discourse of mental health in corrections from multiple locations vis a vis government and/or peer reviewed articles which are taken up and utilized in academia, or by scholars, analysists, or the general public.

Insular Organization & Self-Plagiarism

CSC has been critiqued as being an insular organization which has a history of being dismissive or hostile to researchers from outside organizations which contributes to a barrier on the production of research regarding corrections (Watson, 2015, Long, 2020; Piché, 2011). I argue that this contributes to the production of negative discourses in several ways. First, due to relying on the same group of scholars within the same

organization and under the same mandate, it is logical to assume that their ontological, theoretical, and epistemological views remain stagnant. I argue that this is not beneficial for those with mental health concerns inside of corrections as progress for them also remains stagnant. This is because while maintaining the same viewpoints due to limiting those that can conduct and produce research within CSC, they place value on and highlight the same voices repeatedly. This is reflected through the way that CSC continues to self-plagiarize, holding the same voices, statistics and 'facts' as authority. For example, in the two articles that were examined in this thesis, the reports shared 11 citations (for reference, R-268 only contained 31 citations). This is alarming when we consider that the reports were written 5 years apart. How had the discourse not been furthered, and moreover, why copy their work word for word? In the first report I examined, for example, Stewart et al., (2012) state:

> "In the influential MacArthur Risk Assessment Study that researched the relationship between criminality, violence and mental disorders, the authors found that substance abuse and personality disorder (particularly the criminal history aspect of psychopathy) were the strongest factors contributing to risk for violence among this population (Monahan et al., 2001)" (p.3).

The above statement is almost reproduced verbatim in the second report where Stewart and Wilton (2017), state:

> **"**These results support the early findings from the influential MacArthur Risk Assessment Study that examined the relationship between criminality, violence, and mental disorders. The researchers found that substance abuse and personality disorder (particularly the criminal history aspect of psychopathy) were the strongest factors contributing to risk for violence among this population (Monahan et al., 2001)" (p.25).

Aside from the switching of a few words and strategic placement of a period to create a new sentence, the paragraph has been recycled. This occurs on at least 4 other

occasions that I found following a brief re-examination of the reports used for this thesis (available in Appendix A). This further contributes to the notion that CSC has power over what is produced within their research branch and the violence that can result from this. Without intervention, new ideas, or qualitative data CSC can recycle their work years over.

Treatment & Violence

While the two reports that have been critically examined have brought up some concerns of treatment within Canadian incarceration facilities, the information that was *not* talked about is just as valuable. Through this examination we can discuss how CSC's power to label inmates can create opportunity for injustice or violence and examine the harmful impact of things like 'treatment' or the overutilization of medication or segregation on individuals with mental health concerns inside of Canadian federal corrections.

Research has found that "extreme forms of penal control" including use of force, restraints, and solitary confinement have become normalized within the Canadian carceral context and further contributes to "the overall pains of imprisonment" (Hannah-Moffat & Klassen, 2015, p.135). These methods of control, and behavioural management have been regarded as the de-facto method to use when working with individuals with mental health concerns in corrections (Hannah-Moffat & Klassen, 2015). Through this section I will discuss how labelling, treatment programs, restraints, segregation, and medication are operationalized as violence within CSC and their texts.

Labelling as violence

As discussed by Liegghio (2013) epistemic violence is a product of the intersection of psychiatry with peoples lives, whereby they are "made out of existence" through psy discourses which not only silence and stigmatize, but also classify and diagnose (p.124). Moreover, it is the construction of mad identities, through psychiatry, which labels them as various 'types' of mad such as violent or disordered, that allows for the denial of their legitimate claims as knower (Liegghio, 2013). CSC employees this method within their work on inmates with mental health concerns. CSC uses various statistical and clinical measures to determine if individuals have mental health concerns and then assigns that label to those individuals. Through this, and through the discourse that CSC sets up of inmates with mental health concerns being violent, they mark these individuals as illegitimate knowers and bar them from contributing to research in meaningful ways. Instead, inmates are categorized, labelled, numbered, examined, and plotted on charts to determine information about their lives. Further, due to the power assigned to those that wield statistical and analytical tools, their labels and categorization of individuals becomes essentially true just because the powerful have deemed it so (Burstow, 2013). Through this process, countless individuals and identities can be censored through the labelling of them as "disordered", the perpetuation of that discourse, and the opinion that their knowledge is not something worthy of inclusion in research.

Treatment Programs

Treatment programs through CSC, I argue, are often simply a mechanism to enforce standardization or compliance in individuals. As one anonymous individual, A Writer from Mission Institution (2018), who has been incarcerated since the 90's stated, "why demand that I take programs? Is it more for their benefit (i.e. CSC) than mine? Is it to sustain the business of corrections and not rehabilitation?" (p.90). Programs, as discussed by the reports used for this thesis were explored in a positivist manner and deemed to be valid if enrollment and completion was noted (Stewart & Wilton, 2017). The reports by CSC, despite acknowledging, numerically, their programs, does not look at if the individuals that were part of them felt like they gained anything from the programming, or if the programming affected the individuals long term or not. Lack of concern for the individual that is made subject to the notion of treatment and the mandate to 'get better' through these treatments contribute to opportunities for violence for those who cannot simply *get better* in this way and are therefore not seen as successful in the program. This is additionally violent when we recall that the completion of programming is directly impactful on the determining of an individual's conditional release (Sapers, 2012). Mandated conformity, I argue, is not 'treatment' despite its use in this context.

Use of force / Restraint

Neither article by CSC that was examined within this thesis looked at the use of restraint or force on inmates in federal corrections with mental health concerns. However, there are various reports that show restraint use in federal corrections is persistently a concern with an over-reliance on various control measures, including physical restraint for mental health concerns such as self-injury (Sapers, 2012). Between 2014 and 2015,

pertaining to use of force measures in federal corrections, over 1000 incidents included the administration of restraint equipment, over 1100 included physical handling and officers fired 6 ‘warning shots’ from their firearms (Sapers, 2015). Of those and other various methods, including use of batons, shields, pepper spray etc., 593 incidents were those where the inmate had a mental health concern which was named by CSC (Sapers, 2015). The numbers continue to increase, with results from 2018-2019 indicating the most use of force incidents ever recorded within CSC facilities (Zinger, 2019). Why then does CSC not discuss use of force or restraints in their reports on correctional outcomes? To not discuss it is to further ignore, silence and erase the experiences of those with mental health concerns in corrections. By not talking about the ways in which violence is enacted on those with mental health concerns, CSC can continue to practice this violence.

Segregation

Segregation, or what is now referred to as Structured Intervention Units, is an extreme form of behaviour management which is routinely used on those with mental health concerns (Hannah-Moffat & Klassen, 2015). CSC has previously been criticized for its over reliance on this method of intervention or treatment for those with mental health concerns (Sheldon, Spector, & Birdsell, 2019). However, it should be acknowledged that there is some nuance to this form of intervention, as some individuals may seek out and request to be placed in voluntary segregation as a means to remove themselves from otherwise harmful and violent situations which may be occurring in the general prison population (Bottos, 2007). I argue however, that voluntarily segregating

oneself is only a matter of trading one violence for another, and that it is because of our broken criminal justice system that individuals must make these choices.

Concerning the two reports analyzed in this thesis, both acknowledge the use of segregation, but neither hold themselves (or CSC) accountable for the inherent violence of using segregation. The authors carefully construct the argument around segregation as something that is overly utilized and relied on 'over there' but not 'here'. For example, in the second report, the authors acknowledge that there are various harms that are brought on by segregation, including that it may exacerbate mental health concerns (Stewart & Wilton, 2017). However, the authors avoid implicating CSC by stating that "prison regimes" have been criticized for placing a disproportionate number of inmates with mental health concerns in segregation (Stewart & Wilson, 2017, p.3). And that within CSC, regarding over-reliance on segregation for individuals with mental health concerns, "a clear picture did not emerge" from their examinations of this issue (Stewart & Wilton, 2017, p.3). In this way CSC denies their own reliance on segregation as a tool utilized on those with mental health concerns despite various reports stating that within maximum security facilities up to one third of the population is held in segregation, and on any given day in federal corrections, approximately 850-900 inmates are placed in confinement (Chaimowitz, 2012; Kilty & Lehalle, 2019). Through the construction of segregation as something that happens in other locations but not within CSC, they are able to avoid discussing the alarming numbers and facts related to this form of 'treatment' within federal corrections. They further can label inmates as something other than those with mental health concerns, possibly as violent offenders, to justify use of this form of

'treatment'. From what we have seen within this thesis, I would argue that they are close to accomplishing this discourse.

Medication

Neither report by CSC addressed the over-reliance on medication for individuals with mental health concerns inside of corrections. While scholarly sources indicate that reliance on medication has been an issue in Canadian Corrections (Fayter & Payne, 2017; Kilty, 2012) and criticism has arisen regarding psy-experts routine practices of prescribing sedatives as 'treatment' (O'Leary & Ben-Moshe, 2019), similar outrage regarding this concern has been voiced by inmates themselves. Drawing from works of various incarcerated individuals available through the Journal of Prisoners on Prisons we can see the many ways medication is operationalized within CSC as violence. Anonymous Prisoner 19, incarcerated at Drumheller Institution (Alberta) states that "all the doctors seem willing to commit to in terms of care is prescribing an assortment of pills, including for mental health issues – simple zombification" (2017, p.189). Another individual held inside of corrections states that "many prisoners are being routinely given unnecessary psychiatric drugs by unscrupulous psychiatrists and doctors as a form of power and control over prisoners (i.e. babysitter drugs or 'bug juice')" (Convict, 2017, p.253). This form of violence is routinely discussed in literature disseminated by those who have been convicted and held within federal corrections but is entirely lacking from the two documents produced by CSC on mental health concerns inside of these facilities. This can contribute to violence, as un-acknowledgement allows for CSC to continue to

use this form of treatment without interruption and keeps consumers of CSC's work ignorant regarding this practice.

Summary

Through discourses attended to in the two reports from this thesis, as well as an examination of the information which has been excluded from interrogation by CSC, a clear picture appears. Pertaining to how discourses of mental health are used in corrections to authorize violence on inmates, the results are astounding. CSC (re)produces discourses which categorize the inmate with mental health concerns as someone who is 'other' and who must be fixed, treated, or made well through whatever means necessary including overt violences such as medicating, segregating, or restraining. Voices of inmates that have mental health concerns are silenced and erased through various methods, including through hegemonic psy-discipline's labelling and diagnosing, as well as through positivist research, maintaining an insular organization, and through the barring of outside researchers to work within CSC. CSC maintains dominance and power over the discourse and uses these discourses of violence, risk, and individual deficiency to depict the inmate with mental health concerns as someone who is to be surveilled, feared, and fixed. Through this, CSC violently ignores the social, historical, political, and cultural contexts of the person and their experiences. In this way, the many negative discourses of mental health perpetuated, (re)produced and relied on in these reports is utilized to justify violence on individuals in corrections.

Implications for Social Work

The construction, utilization and dissemination of these discourses have various implications for social work. The Canadian federal correctional facilities have stopped *being* the punishment and started being the location of *further* punishment. CSC treats individuals with mental health concerns as if they are committing further crimes simply by way of existing within corrections. In line with the Ontario College of Social Workers and Social Service Worker's (OCSWSSW) code of ethics is the obligation to uphold the inherent worth and dignity of the person, and to advocate for policies and changes that reflect the best interest of the client, the community, and society (OCSWSSW, 2008). In this way, we must not only expose CSC for their actions but also name it and intervene in it. Through publication, my goal is to bring attention to the overt violences that are occurring within Corrections Canada, violences which are already publicized by the media (see Maniania, 2016; Nasser, 2020; Crozier, 2019), but are not explicitly referred to as violence, and have not been located within CSC's own publications until this thesis. It is through naming these violences and bringing attention to this practice that we can advocate for change – not only in how the research is done as it has been shown that many gaps remain when relying on medically and individually focused, positivist research, but also advocating for who the research involves as researchers, and who's knowledge is held as valid. Additionally, advocacy work should focus on intervention and therefore call for an immediate end to the violent practices that are still rampant in Canadian federal incarceration facilities including segregation, forced medication and use of force, through demanding policy and research practice changes within CSC.

Further, this thesis can offer implications for social work on a broader scale. Social workers should actively pursue social justice, and this thesis serves as a call to critique and critically engage with material, discourses, information, and research that not only is handed down by the elite or powerful but which simultaneously contains no voice, recognition, or acknowledgement of those which the information is on or affects. Future social workers who learn clinical skills and are encouraged to follow 'best practices' should be critically aware of who decides what the best practices are and moreover what their clinical notes can determine for a client, especially in a field such as corrections. Those Social Workers that maintain calls to more policy and macro style social work should ensure that their work holds paramount and ensures authority of those whose voices are frequently erased. In academia, as has been discussed, the voices and knowledge of the academic is frequently given priority; in social work classrooms, in our work and in our everyday lives we need to ensure that students are taught that the validity of knowledge does not always come with a Graduate degree and more often than not the most valuable or important knowledge is that which is held by the person or community being silenced. Further, social work is a discipline that carries with it inherent power and privileges that require constant reflection. Through this thesis, and through encouraging reflection we can continue to examine the ways in which our power, and the power present through publication, case notes, and even consultations can be utilized in negative, violent ways against the population we should be serving. We must be cognizant and coherent of the ways in which our work can be used to further depict and

name otherness, but also of the power in naming things that should be named – such as the violences presented throughout this thesis.

CHAPTER 7 – CONCLUSION

This thesis aimed to explore the ways in which various discourses of mental health constructed by CSC are wielded to authorize violence on inmates. The reports by CSC depict how violence and reliance on psychiatric individualization of mental health can impact individuals, and further draws attention to CSC's ability to access, produce and publish their opinion rapidly. Additionally, implications of CSC relying on positivist research, limiting outside access to information and being an insular organization have been discussed. Various ways that violence is justified through the discourses framed by CSC, as labelling, treatment, and segregation, as well as information which was left out of CSC's reports such as use of force or restraint and reliance on medication to 'treat' has been examined through these reports. It is through these various avenues that CSC is able to construct discourse, maintain power and ensure the silence and erasure of voices and knowledges of those with mental health concerns in federal Canadian corrections.

Implications

Integral to social work practice is the pursuit of social justice. One of the reasons why I was drawn to conducting a critical discourse analysis was because "most of our research is directed at the powerless (i.e., convicts) and not at the systems of elite power which manage these members" (Yeager, 2008, p.413). Without examining the ways in which violence is authorized by the powerful, we may lose sight of how to resist this operation. Without using the language and tools which the powerful wield to maintain otherness, and to subjectify those deemed 'disordered', we may be unable to successfully

combat this discourse. Through this, I believe I have been pursuing social justice, and through disseminating my results, hopefully in academic journals, I will be able to encourage others to critically engage with discourse constructed by the powerful.

Equally as important, I believe, is the attention and ability to inquire critically. Without critically engaging with these documents, I may not have been aware of the various injustices and violences that are justified by CSC through their production of discourse. Through publication, I hope to engage others in critical discussion regarding how discourses can be operationalized to justify violence.

Limitations

Like all research, my work has limitations. Given the scope of this thesis and the number of articles by CSC, I was only able to critically engage with two reports. This is a very small sample, and because of that, should be approached as such. Additionally, there were various themes that could have potentially added more to the critical discussion, but which fell slightly outside of my scope (such as drug addiction) or which I thought I had only a weak argument for. Future research, if able, should invite and include those with lived experiences. If further discourse analysis were to be conducted, I would suggest engaging with more articles and broadening the research question.

Finally, it is important to acknowledge that my work was conducted within my own viewpoint, ontological and theoretical frame at this point in time, and therefore will hold biases that I may not be aware of. In this manner, my work and what I considered critical to engage with, dissect, and interpret of the literature is certainly up for debate.

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APPENDIX

Chart 1 – Self-Plagiarism between R-268 and R-379

Chart on Self-Plagiarism between Report 1 (R-268) Federally Sentenced Offenders with Mental Disorders: Correctional Outcomes and Correctional Response and Report 2 (R-379) Comorbid Mental Disorders: Prevalence and Impact on Institutional Outcomes. Italicized sections are identical.

Citation	Report 1 (268)	Report 2 (379)
Hodgins, S., & Janson, C. (2002). *Criminality and violence among the mentally disordered: The Stockholm Metropolitan Project.* New York, New York: Cambridge University Press.	*Adults with APD and schizophrenia, like adults with APD but without schizophrenia, begin abusing alcohol and drugs at a young age and continue to do so through adolescence and adulthood* (Hodgins & Janson, 2002). **(p. 4)**	*Adults with APD and schizophrenia, like adults with APD but without schizophrenia, begin abusing alcohol and drugs at a young age and continue to do so through adolescence and adulthood* (Hodgins & Janson, 2002). **(p. 25)**
Hodgins, S., Toupin, J., & Côté, G. (1996). Schizophrenia and antisocial personality disorder: A criminal combination. In L. B. Schlesinger (Ed.), *Explorations in criminal psychopathology* (pp. 217-237). Springfield, IL: Charles C Thomas Publisher.	Antisocial Personality Disorder *(APD)* has been *found to be 5 to 11 times more prevalent among persons with schizophrenia than among age- and gender-matched individuals in the general population* (Hodgins, Toupin, & Côté, 1996). **(p.4)**	*APD* was *found to be 5 to 11 times more prevalent among persons with schizophrenia than among age- and gender-matched individuals in the general population* (Hodgins, Toupin, & Côté, 1996). **(p.25)**
Bonta, J., Law, M., & Hanson, R. K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin*, 123(2), 123-142.	An earlier meta-analytic study by Bonta et al. (1998) also *found that key* contributions *to risk of violent reoffending among offenders with mental disorders were factors such as* antisocial personality disorder *(APD), previous criminal history and substance abuse.* **(p. 3)**	Two meta-analytic studies by Bonta and colleagues (Bonta, Blais, &Wilson, 2013; Bonta, Law, & Hanson, 1998) *found that key* factors *contributing to risk of violent reoffending among offenders with mental disorders were APD, previous criminal history, and substance abuse* **(p.26)**

Eaton, W., & Kessler, L. (1985) The NIMH Epidemiologic Catchment Area Study. *Epidemiological Field Methods in Psychiatry*. New York: Academic Press	*A large scale study that examined a sample of 10,059 adult residents from Epidemiologic Catchment Area (ECA) study sites in the US (Eaton & Kessler, 1985), found that having a diagnosis of schizophrenia increased the chance of violence from 2% for those without a diagnosis to 8% of those with a diagnosis. Comorbidity with substance abuse further increased this percentage of adults committing acts of violence to 30%.* **(p.3)**	Similarly, *a large scale study that examined a sample of 10,059 adult residents from Epidemiologic Catchment Area (ECA) study sites in the US (Eaton & Kessler, 1985), found that having a diagnosis of schizophrenia increased the chance of* future *violence from 2% for those without a diagnosis to 8% of those with a diagnosis, but comorbidity with substance abuse further increased this percentage of adults committing acts of violence to 30%.* **(p. 25)**