



Cruel, Inhuman and Degrading?

Canada's treatment of federally-sentenced women with mental health issues



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PROGRAM**

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Addressing the criminalization and warehousing in penitentiaries of those who suffer from mental illness is not simply a public health issue, it's a human rights issue.

Ivan Zinger
Executive Director and General Counsel
Office of the Correctional Investigator of Canada

I. SUMMARY OF FINDINGS

Ashley Smith was 19-years-old when she died in the segregation unit at Grand Valley Institution for Women in October 2007. She died by asphyxiation after tying a ligature around her neck. Under direct orders from management, correctional staff did not intervene to save her life. Instead, they watched her die alone in her segregation cell, far away from her family and community supports.

Since her youth, Ms. Smith had displayed difficult behaviour stemming from mental health issues. While in federal custody, Ms. Smith's mental health issues and associated behavioural issues were "treated" through excessive periods of segregation. She was also transferred between federal penitentiaries across the country 17 times during her 11 month stay.

Ms. Smith's death was a direct result of the interaction between her mental health issues and the prison environment, and the failure of the Correctional Service of Canada (CSC) to respond appropriately to her mental health needs. In his report on the incident, the federal prison ombudsperson found that: "Ms. Smith's death was the result of individual failures that occurred in combination with much larger systemic issues within ill-functioning and under-resourced correctional and mental health systems."¹

Ms. Smith's problems were extreme but not unique. Our research indicates that at least one in three FSW suffers from a mental health issue and nearly half have engaged in self-harm. As of 2009, Canada's prison ombudsperson declared that mental health is "perhaps the most pressing issue" facing federal corrections today.²

Nor has Ms. Smith's death substantively changed the way correctional authorities deal with FSW with mental health issues. Our research indicates that Canada's treatment of FSW is characterized by the following:

¹ *A Preventable Death*, *infra* note 23.

² *Annual Report of the Office of the Correctional Investigator, 2008-2009*, *infra* note 21.

- **A mental health strategy that is overly focused on assessment rather than treatment, under-resourced,** blind to FSW's past histories of abuse, and inaccessible or inappropriate for women in solitary confinement;
- **Security classification tools that over-classify FSW with mental health issues** and Aboriginal women such that they are housed in more secure environments than required to manage their risk;
- **Management of FSW with serious mental health issues through excessive periods of administrative segregation and unlimited institutional transfers** to prisons far away from family and community supports, all without mandatory judicial oversight; and
- **Staff authorization to use of force against women with serious mental health issues without regard for their underlying health issues.**

We find that Canada's treatment of FSW with mental health issues violates its obligations under international law:

- **Violation of the right to health:** The lack of available and appropriate mental health care resources for FSW is a breach of their right to health. CSC's disproportionate use of segregation and institutional transfers to deal with FSW with serious mental health issues, and associated disruptions in treatment and exacerbation of symptoms, also violate the right to health.
- **Discrimination:** CSC's approach to security classification discriminates against women with mental health issues, especially those who are Aboriginal. CSC has not created a risk assessment tool that is appropriate for women, properly distinguishes between needs and risks, and addresses the over-classification of Aboriginal women as maximum security.
- **Unlawful deprivation of liberty and security of person:** The over-reliance on administrative segregation and institutional transfers to deal with FSW who exhibit behavioral issues due to serious mental health issues is discriminatory and an unlawful deprivation of FSW's residual liberty. Canada's policies related to use of force violate the right to security of person because CSC staff are not appropriately trained to manage FSW with mental health issues without resort to force.
- **Violation of the right to access justice:** The absence of legislatively-mandated judicial review of prolonged administrative segregation and repeated institutional transfers is a violation the right to access justice.
- **Cruel, inhuman and degrading treatment:** Prolonged segregation of FSW with serious mental health issues violates the right to freedom from cruel, inhuman and degrading treatment. Use of force against FSW with serious mental health issues

without due regard to their underlying conditions may also constitute cruel, inhuman and degrading treatment.

- **Violation of the right to information:** CSC's failure to provide the IHRP with information that could be used to assess Canada's human rights compliance despite repeated requests for the same is a violation of international law. This is especially serious given that there are no other means to access this data.

II. INTRODUCTION: CANADIAN CORRECTIONS AT THE CROSSROADS³

The inquest into the 2007 death of Ashley Smith while in federal custody at Grand Valley Institution in Kitchener, Ontario has been repeatedly delayed, but the issues that Ms. Smith's death raises remain pressing. At its most basic level, Ms. Smith died due to the state's conviction that solitary confinement is a legitimate response to mental illness, coupled with systemic discrimination against federally sentenced women (FSW) who have inadequate mental health treatment and community support. Ms. Smith's death should have been a wakeup call for Canada but, instead, nearly five years and at least four major reports later, Canada has shown absolutely no willingness to address human rights violations against FSW with mental health issues. Ashley's death is a damning critique of our government and illustrates Canada's failure to protect fundamental human rights guaranteed in international law.

When Canada fails to show leadership to address the multi-layered discrimination faced by female prisoners with mental health issues, which are hardly unique to Canada, we set the bar far too low.

For years, Canada has been party to international treaties that require it to limit the use of solitary confinement and stop discrimination against women, including Aboriginal women (First Nations, Inuit and Métis) and those with disabilities. In 2006, prior to Ms. Smith's death, the UN Human Rights Committee considered Canada's human rights record and "expresse[d] concern about the situation of women prisoners, in particular Aboriginal women... and women with disabilities."⁴ In 2010, Canada ratified the UN *Convention on the Rights of Persons with Disabilities* (CRPD)⁵ and, at the time, then Foreign Affairs Minister Lawrence Cannon spoke strongly in support of Canada's commitment to the rights of the disabled: "Canada is committed to promoting and protecting the rights of persons with disabilities and enabling their full participation in society."⁶ Yet, little has changed since Ms. Smith's death or Canada's ratification of the CRPD.

This report is the culmination of a 20-month research project spearheaded by the International Human Rights Program (IHRP) at the University of Toronto Faculty of Law. It details Canada's treatment of FSW with mental health issues, and analyzes this treatment through the lens of international human rights law. Indeed, we take our queue from the

³ This introduction is a revision with permission of the following: R. Mandhane, "Prisoners with mental health issues deserve better" *Ottawa Citizen* (18 April 2011) A12.

⁴ *Concluding observations of the Human Rights Committee: Canada*, UN HRC, 85th Sess., UN Doc. CCPR/C/CAN/CO/5 (2006) at para. 18.

⁵ United Nations Treaty Collection, *Status of Treaties*, online: <http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en>.

⁶ "Canada ratifies UN treaty for disabled rights" Canadian Broadcasting Corporation (11 March 2010) online: <<http://www.cbc.ca/news/health/story/2010/03/11/disabled-treaty011.html>>.

Executive Director of the Office of the Correctional Investigator who states: “addressing the criminalization and warehousing in penitentiaries of those who suffer from mental illness is not simply a public health issue, it’s a human rights issue.”

For the purposes of this report, we have defined “mental health issues” broadly. This is consistent with the approach of correctional authorities in Canada and the approach under international law. Section 85 of the *Corrections and Conditional Release Act* (CCRA) defines mental health care as: “the care of a disorder of thought, mood, perception, orientation or memory that significantly impairs judgment, behavior, the capacity to recognize reality or the ability to meet the ordinary demands of life.”⁷ Article 1 of the CRPD defines persons with disabilities to include those who have “long-term...mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”⁸

As of August 2010, there were 512 women serving federal sentences in Canada, of these, 34% (174 women) were Aboriginal.⁹ Approximately 77% of women admitted to abusing alcohol and drugs upon admission to federal custody, while just below 50% reported engaging in self-harm. Further, 86% of FSW reported experiencing physical abuse and 68% reported experiencing sexual abuse.¹⁰ For Aboriginal women, the impacts of post-traumatic stress disorder suffered by inter-generational residential school survivors are compounded by collective cultural and historical trauma and ongoing racial discrimination.¹¹ Given these antecedents, it is not surprising that a significant proportion of FSW have mental health issues: 29% of FSW were identified at intake as having mental health problems, while 31% had a previous mental health diagnosis.¹² The latest internal CSC data suggests that 50% of FSW admitted to penitentiary require further assessment to determine if they have mental health needs.¹³ These above percentages are, in all likelihood, lower than actual figures, as mental illness is typically underreported in the prison environment, due to stigma, fear and lack of detection or diagnosis.¹⁴

Unfortunately, despite the high prevalence of mental health issues amongst FSW, our research indicates that the Correctional Service of Canada (CSC) responds to FSW with mental health issues in a discriminatory manner. CSC equates mental health issues with

⁷ *Corrections and Conditional Release Act*, SC 1992, c 20 s 85.

⁸ *Convention on the Rights of Persons with Disabilities*, 3 May 2008, 993 UNTS 3 [CRPD] at Art. 1.

⁹ Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator: 2010-2011*, (Ottawa: Office of the Correctional Investigator, 29 June 2011) [*Annual Report of the Office of the Correctional Investigator: 2010-2011*] at 50. NWAC notes that the over-incarceration of Aboriginal women could be ameliorated through protection of Aboriginal women and girls from violence, exploitation, homelessness, hunger, and other forms of discrimination [Cook, *supra* note 11].

¹⁰ *Ibid.*

¹¹ Key Informant Interview with Fiona Meyer Cook, Research and Policy Officer, Native Women’s Association of Canada, 7 May 2012 [Fiona Cook]

¹² *Ibid.* Note that there are no publicly available statistics on how many women develop mental health issues while incarcerated, or how many of the women currently incarcerated suffer from mental health issues.

¹³ *Annual Report of the Office of the Correctional Investigator: 2010-2011*, *supra* note 9 at 10.

¹⁴ Ivan Zinger, “Mental Health in Federal Corrections: Reflections and Future Directions” (2012) 20(2) Health L.R. 22 at 23 (forthcoming) [Zinger].

increased risk to the institution or public and responds with excessive use of segregation (sometimes for months at a time), repeated institutional transfers (sometimes over ten times in a year), and use of force (including restraints). This treatment is exacerbated by a lack of adequate mental health care resources for FSW and training for prison staff.

We find that CSC's treatment of FSW with mental health issues is a violation of their rights under international law. Pursuant to the CRPD, Canada's treatment of FSW with mental health issues is discriminatory; results in an unjustified deprivation of liberty without judicial oversight; violates the right to health; and, in cases where women are segregated for long periods or subject to excessive institutional transfers, constitutes cruel, inhuman or degrading treatment. Moreover, CSC's refusal to provide us with basic statistics and information about the treatment of FSW with mental health issues constitutes a further violation of the CRPD.

Canada's blatant and continued violation of the rights of FSW with mental health issues has wide-ranging implications for civil and political rights the world over. Rightly or wrongly (and there is much debate), Canada is seen as a global leader in corrections and in our treatment of the disabled. When Canada fails to show leadership to address the multi-layered discrimination faced by female prisoners with mental health issues, which are hardly unique to Canada, we set the bar far too low. We cannot allow other states to look to us to justify their similar failures. Canada should be blazing the trail and advocating for policies and programs that place the protection of human rights above political expediency, alleged financial constraints and, quite frankly, discrimination and fear-mongering. We can and must do better.

III. METHODOLOGY

This report is based on a desk review of publicly-accessible government documents, statistics, existing public reports on FSW, domestic and international law, interviews with experts and FSW, and representative cases.

A. ACCESS TO INFORMATION REQUEST

For nearly a year and a half, we have engaged in a time-consuming and resource-intensive quest to obtain relevant information from CSC. This began as a naïve effort to ground our analysis in the most current available data. In December 2010, the IHRP submitted a request for information to CSC pursuant to s. 6 of the *Access to Information Act*.¹⁵ Our request was expansive: we sought “all information within the possession or control of the Correctional Service of Canada related to federally sentenced prisoners with mental health issues.” The request also included a non-exhaustive list of the types of information we hoped to receive, including information related to discipline, segregation, transfer, treatment resources available, staff training, et cetera .

To date, CSC has provided us with a total of 15 pieces of information (eight documents and seven links to web-based materials). Of the eight documents received, one was publicly available through CSC’s website, and one was significantly redacted. A chart detailing the information requested, documents received, and a summary thereof is provided in Appendix A. In short, we received information relating to CSC’s:

- *Mental Health Strategy*;
- *National Strategy related to Inmates who Self-Injure*;
- *Internal Review of Mental Health Concerns of Inmates in Long-Term Segregation*;
- *Report on The Psychological Effects of 60 Days in Administrative Segregation*;
- Computerized Mental Health Intake Screening System, and needs assessment upon admission to prison; and
- Employment of mental health professionals at each correctional institution.

As a result of CSC’s prolonged and consistent efforts to thwart access to relevant documents, in October 2011, we filed a complaint with the Information Commissioner of Canada pursuant to s. 30 of the *Access to Information Act*. The covering letter to the complaint is attached as Appendix B.

To date, the Information Commissioner has responded to two of the IHRP’s myriad complaints. In particular, by way of letter dated February 29, 2012, the Office of the Information Commissioner found that “it is the responsibility of government institutions to make every reasonable effort to assist requesters in connection to their requests and to respond in a timely manner” and that CSC had “failed in its duty to assist obligations.” In particular, in relation to our requests for information relating to the treatment of and

¹⁵ *Access to Information Act*, R.S.C., 1985, c A-1.

resources available to prisoners with mental health issues, and regional psychiatric centres, the Information Commissioner found that CSC had “no authority” to request that the IHRP prioritize its requests and then put these requests on hold and delay response for a period of nearly six months. As of the publication of this report, our additional complaints are under investigation and remain outstanding, and we have yet to receive all of the information initially requested.

B. DESK RESEARCH

We consulted the following public reports on FSW to inform our analysis and findings:

- Correctional Service of Canada, *Creating Choices: the Report of the Task Force on Federally Sentenced Women (Creating Choices)*;¹⁶
- *Final Report of the Commission of Inquiry into Certain Events at the Prison for Women in Kingston (The Arbour Report)*;¹⁷
- Canadian Human Rights Commission, *Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women (Protecting their Rights)*;¹⁸
- Correctional Service of Canada, *Ten-Year Status Report on Women’s Corrections: 1996-2006*;¹⁹
- Correctional Service of Canada, *Task Force Report on Administrative Segregation*;²⁰
- Correctional Investigator of Canada, Annual Reports 2008-2009, 2009-2010, 2010-2011;²¹
- Correctional Investigator of Canada, *Correctional Investigator’s Response to the Canadian Human Rights Commission’s Consultation Paper for the Special Report on the Situation of Federally Sentenced Women*;²²

¹⁶ Correctional Service of Canada, *Creating Choices: The Report of the Task Force on Federally Sentenced Women*, (Ottawa: Supply and Services Canada, April 1990) [Creating Choices].

¹⁷ *Commission of Inquiry into certain events at the Prison for Women in Kingston*, (Ottawa: Public Works and Government Services Canada, 1996) [Arbour Report].

¹⁸ Canadian Human Rights Commission, *Protecting their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women*, (Ottawa: Canadian Human Rights Commission, 2003) [Protecting their Rights].

¹⁹ Correctional Service Canada, *Ten-Year Status Report on Women’s Corrections, 1996-2006*, (Ottawa: Correctional Service Canada, 2006) [Ten-Year Status Report].

²⁰ Correctional Service Canada, *Task Force Report on Administrative Segregation: Preliminary Assessment: Task Force Findings*, online: <<http://www.csc-scc.gc.ca/text/pblct/tf/05-eng.shtml>> [Task Force Report on Administrative Segregation].

²¹ Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator, 2008-2009* (Ottawa: Office of the Correctional Investigator, 2009) [Annual Report of the Office of the Correctional Investigator, 2008-2009]; Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator, 2009-2010* (Ottawa: Office of the Correctional Investigator, 2010) [Annual Report of the Office of the Correctional Investigator, 2009-2010]; *Annual Report of the Office of the Correctional Investigator, 2010-2011*, *supra* note 9.

²² Office of the Correctional Investigator, *Correctional Investigator’s Response to the Canadian Human Rights Commission’s Consultation Paper for the Special Report on the Situation of Federally Sentenced Women*, online: <<http://www.oci-bec.gc.ca/chrc-ccddp/women-femmes-eng.aspx>>.

- Correctional Investigator of Canada, *A Preventable Death* (a report on the in-custody death of Ashley Smith);²³ and
- Union of Canadian Correctional Officers, *A rush to judgment: A report on the death in custody of Ashley Smith, an inmate at Grand Valley Institution for Women*.²⁴

C. INTERVIEWS WITH EXPERTS

We conducted interviews with a number of organizations that work on issues relating to the rights of FSW, Aboriginal women, and women with disabilities including the:

- Canadian Association of Elizabeth Fry Societies (CAEFS) (an NGO that works extensively with and for women and girls who are criminalized, including hundreds of FSW);
- Disabled Women’s Network of Canada (DAWN);
- Native Women’s Association of Canada (NWAC);
- British Columbia Civil Liberties Association (BCCLA); and
- Alberta Network on Mental Health (AMMH) (a provincial organization that strives to improve the quality of life of mental health consumer survivors).

In addition, the Director of the IHRP, Renu Mandhane, practiced prison law from 2004-2008 and during that period represented a number of FSW, including those with mental health issues. She was co-counsel in a *habeas corpus* challenge to the closure of Canada’s only stand-alone minimum security prison for women, and also represented FSW subject to excessive periods of segregation under CSC’s Management Protocol (discussed below).

Once we receive the information requested from CSC via our access to information request, we look forward to re-interviewing key informants and correctional authorities.

D. REPRESENTATIVE CASES AND INTERVIEWS

Due to limited resources for travel, the fact that many FSW with mental health issues are in segregation or maximum security units, and administrative obstacles to directly engaging with FSW, we have not relied exclusively on interviews with FSW themselves. We conducted a thorough desk study and held extensive discussions with key experts who themselves have good access to FSW, such as Kim Pate, the Executive Director of CAEFS. We also grounded our analysis in three cases studies, those of:

- Ashley Smith, who died in-custody at Grand Valley Institution (GVI) in Kitchener, Ontario in 2007;
- Bobby-Lee Worm, a FSW with mental health issues currently serving a sentence in British Columbia; and

²³ Office of the Correctional Investigator, *A Preventable Death*, (Ottawa: Office of the Correctional Investigator, 2008) [*A Preventable Death*].

²⁴ *A Rush to Judgment*, *infra* note 51.

- K.J., a FSW with serious mental health issues who is currently serving her sentence at GVI and who we interviewed in April 2012.

Admittedly, most cases do not lead to such an exceptional result as that of Ashley Smith, that is, death. That said, as is often the case, the most extreme cases illustrate broader trends and the real risks that FSW with mental health issues currently face, including Ms. Worm and K.J. who remain incarcerated.

IV. CANADA'S TREATMENT OF FSW WITH MENTAL HEALTH ISSUES

In Canada, sentences of two years or more (“federal sentences”) are served in federal penitentiaries (whereas sentences of less than two years are served in provincial jails). The *Criminal Code* and the *Corrections and Conditional Release Act* (CCRA)²⁵ provide authority for the administration of federal sentences. CSC is the federal government agency responsible for administering sentences of two years or more. CSC manages prisons of every security level and supervises offenders who are under conditional release into the community (i.e. on parole).²⁶

The CCRA constitutes CSC’s legislative framework: it covers corrections, conditional release and the detention of prisoners, and also establishes the Office of the Correctional Investigator (an independent prison ombudsperson). The CCRA is the Enabling Act of the *Corrections and Conditional Release Regulations* (CCRR)²⁷ which fill in some of the important gaps left by the legislation. The CCRA, CCRR, and CSC’s written policy directives together form the legislative and policy framework of federal corrections in Canada.

The policy directives primarily take the form of *Commissioner’s Directives* (CDs). CDs provide more detailed guidance on specific issues such as fleet management, inmate clothing entitlements, searching of cells, recording and reporting of security incidents, et cetera.²⁸ Each CD is issued under the authority of the Commissioner of the Corrections, and will often cross-reference a provision from the CCRA or the CCRR. Each CD links to a Policy Bulletin that explains the reason for a policy change and the process by which the change was initiated. Further, CSC has a small number of Standard Operating Practices (SOPs) that deal with issues ranging from official languages to arts and crafts to food services.²⁹

Section 3 of the *CCRA* states:

The purpose of the federal correctional system is to contribute to the maintenance of a just, peaceful and safe society by

- (a) carrying out sentences imposed by courts through the safe and humane custody and supervision of offenders; and
- (b) assisting the rehabilitation of offenders and their reintegration into the community as law-abiding citizens through the provision of provisions in penitentiaries and in the community.

According to s. 4 of the *CCRA*, the principles that shall guide the CSC in fulfilling the goals referred to in s. 3 include:

²⁵ *Corrections and Conditional Release Act*, *supra* note 7.

²⁶ Correctional Service Canada, “Organization, Mission, Values”, online: <<http://www.csc-scc.gc.ca/text/organi-eng.shtml>>.

²⁷ *Corrections and Conditional Release Regulations*, SOR/92-620.

²⁸ Correctional Service of Canada, “Commissioner’s Directives”, online: <<http://www.csc-scc.gc.ca/text/plcy/toccd-eng.shtml>>.

²⁹ Correctional Service of Canada, “Standard Operating Practices”, online: <<http://www.csc-scc.gc.ca/text/plcy/tocsop-eng.shtml>>.

- promoting “openness” through “a timely exchange of information” with other members of the criminal justice system, and communication with offenders, victims and the public (s. 4(c));
- “us[ing] the least restrictive measures consistent with the protection of the public, staff members and offenders” (s. 4(d));
- ensuring that prisoners retain “retain the rights and privileges of all members of society, except those rights and privileges that are necessarily removed or restricted as a consequence of the sentence” (s. 4(e)); and
- carrying out sentences in accordance with the “stated reasons and recommendations of the sentencing judge” (s. 4(b)).

According to s. 5 of the CCRA, CSC is responsible for the:

- (a) the care and custody of inmates;
- (b) the provision of programs that contribute to the rehabilitation of offenders and to their successful reintegration into the community;
- (c) the preparation of inmates for release;
- (d) parole, statutory release supervision and long-term supervision of offenders; and
- (e) maintaining a program of public education about the operations of the Service.

Pursuant to s. 3(a) of the CCRR, every corrections staff member is obliged to be familiar with the CCRA, the CCRR and every policy directive that relates to his or her duties.

A. TRENDS FROM THE CASES: SEGREGATION, INSTITUTIONAL TRANSFERS, INADEQUATE HEALTH CARE, AND INSUFFICIENT STAFF TRAINING

The cases below describe the experiences of three women with mental health issues in the federal prison system. Although each case is unique, the parallels in these women’s experiences are striking. All three women have been unable to access appropriate mental health treatment which leads to difficulties adjusting to institutional life, further criminal charges incurred while in custody, and longer time spent in prison. They have experienced a vicious and self-defeating cycle of administrative segregation, transfers to institutions far away from family and community support, and uses of force against them by staff. These women are not merely outliers; the similarities in their experiences point to a problem that is systemic, rather than individual.³⁰

i. Ashley Smith

Ashley Smith was 19-years-old when she died in the segregation unit at GVI in October 2007.³¹ During adolescence, Ms. Smith had displayed challenging behaviour.³² While in youth custody, she was subject to pepper spray, taser, and the “WRAP” system of

³⁰ *A Preventable Death*, supra note 23 at para. 15.

³¹ *Ibid* at para. 5.

³² *Ibid* at para. 2.

restraint (which binds the prisoner such that they have no mobility in their limbs). While in federal custody, Ms. Smith's mental health issues were "treated" through excessive periods of segregation with inadequate clothing and coverings, and was transferred 17 times during her 11 month stay.³³

Ms. Smith died by asphyxiation after tying a ligature around her neck. Correctional staff observed her the entire time, but did not intervene to save her life.³⁴ Even though she was on constant supervision suicide watch, five guards watched Ashley die.³⁵ A Coroner's Inquest is currently underway to examine the circumstances of her in-custody death. The inquest has been repeatedly delayed and is expected to resume in the fall of 2012.³⁶

Ms. Smith's death was a direct result of the interaction between mental health issues and the prison environment, and the failure of CSC to respond appropriately to Ms. Smith's mental health needs. In his report on the incident, *A Preventable Death*, Correctional Investigator Howard Sapers found that: "Ms. Smith's death was the result of individual failures that occurred in combination with much larger systemic issues within ill-functioning and under-resourced correctional and mental health systems".³⁷

Though she had a history of behavioural problems and some encounters with the criminal justice system throughout her early teen years, Ms. Smith was not incarcerated until she was 15 years old, when she was placed in the New Brunswick Youth Centre. She had previously been diagnosed with a number of mental health issues, including a learning disorder, attention deficit hyperactivity disorder and borderline personality disorder.³⁸

During her time at the New Brunswick Youth Centre, Ms. Smith continued to resist authority, which resulted in additional charges and time being added to her sentence.³⁹ From April 2003 to October 2006, she had over 800 documented behavioural incidents, including 150 related to self-harming behaviours.⁴⁰ While at the NBYC, she spent approximately two-thirds of her sentence in segregation as a result of these incidents.⁴¹ The time Ms. Smith spent in segregation exacerbated her underlying mental health problems. In his *Ashley Smith Report*, the New Brunswick Ombudsman, Bernard Richard, commented that:

There is in fact evidence in what we have shown in this report that Ashley's mental health state was deteriorating as the months went by. I challenge anyone with a sane mind to live in conditions similar to [those in

³³ *Ibid* at paras. 5, 19.

³⁴ *Ibid* at para. 5.

³⁵ *Ibid* at 71.

³⁶ "Ashley Smith inquest shut down", *CBC News* (30 September 2011) online: CBC News <www.cbc.ca/news>.

³⁷ *Ibid* at para. 15.

³⁸ New Brunswick Ombudsman, *The Ashley Smith Report*, (Fredericton: Office of the Ombudsman & Child and Youth Advocate, 2008) [*The Ashley Smith Report*] at 11-16.

³⁹ *A Preventable Death*, *supra* note 23 at para. 3.

⁴⁰ *The Ashley Smith Report*, *supra* note 38 at 18-21.

⁴¹ *Ibid* at 41.

segregation], for half the time Ashley had to endure, and to come out having maintained a perfect mental equilibrium.⁴²

This cycle of behavioural problems, segregation and worsening mental health continued when Ms. Smith was transferred to the adult federal women's correctional system in October 2006. Though she spent only 11 and a half months in the federal correctional system, Ms. Smith had 150 security incidents, many of which were related to self-injury, and was transferred between institutions 17 times.⁴³ According to the Correctional Investigator, the entire time Ms. Smith was in federal custody she was either in administrative segregation or otherwise isolated.⁴⁴

Examples of the negative interaction between the federal prison system and Ms. Smith's mental health issues are many. Ms. Smith never had a comprehensive mental health treatment plan, in part because she was transferred between institutions so many times.⁴⁵ The "only real consistency in managing Ms. Smith's behaviour was to maintain her segregation status".⁴⁶

Additionally, her placement in segregation was never externally or independently reviewed, and regional reviews were avoided because "each institution 'lifted' Ms. Smith's segregation status whenever she was physically moved out of a CSC facility (e.g., to attend criminal court, to be temporarily admitted to a psychiatric facility, or to transfer to another correctional facility)".⁴⁷ Indeed, according to the Correctional Investigator, Ms. Smith's repeated transfers had little to do with helping her but rather seemed to serve as a response to staff fatigue and to circumvent the mandatory 60-day regional review of her detention in solitary confinement.⁴⁸ By "lifting" Ms. Smith's segregation status whenever she was moved and setting the clock to zero once she was placed in the receiving institution, CSC avoided the requirement that they conduct a regional review of her placement in segregation after 60 days.⁴⁹

Further, Ms. Smith's self-injurious behaviours were "in part...a means of drawing staff into her cell in order to alleviate the boredom, loneliness and desperation she had been experiencing as a result of her prolonged isolation."⁵⁰ CSC staff felt inadequately equipped to deal with this type of behaviour.⁵¹ According to CSC staff, leading up to her death, staff had the impression that management's policy that no one enter Ms. Smith's cell if she was still breathing was designed to reduce the number of documented incidents in which force

⁴² *Ibid.*

⁴³ *A Preventable Death*, *supra* note 23 at paras. 17-18.

⁴⁴ *Ibid* at para. 16.

⁴⁵ *Ibid* at para. 24.

⁴⁶ *Ibid* at para. 37.

⁴⁷ *Ibid* at para. 43.

⁴⁸ *Ibid* at para. 19.

⁴⁹ *Ibid* at para. 43.

⁵⁰ *Ibid* at para. 28.

⁵¹ Union of Canadian Correctional Officers, *A rush to judgment: A report on the death in custody of Ashley Smith, an inmate at Grand Valley Institution for Women*, (Montreal: Union of Canadian Correctional Officers, 2008) [*A rush to judgment*] at 12, 20.

was used against her, a number that had become too high following Ms. Smith's arrival at the institution.⁵² Not entering Ms. Smith's cell while she continued to breathe was not a policy that was designed to address Ms. Smith's mental health needs but rather to insulate the institution from oversight. The "wait and see" approach that they eventually adopted resulted in staff standing by as Ms. Smith died.⁵³

ii. Bobby-Lee Worm

On March 4, 2011, approximately 4 years after Ms. Smith's death, the British Columbia Civil Liberties Association (BCCLA) filed a lawsuit on behalf of 25-year old female prisoner Bobby-Lee Worm, the focus of which is CSC's practice of holding prisoners in administrative segregation for prolonged periods of time.⁵⁴

Ms. Worm is an Aboriginal woman originally from Saskatchewan. She is currently serving a sentence of six years and four months that began in 2006. Her sentence was increased in 2010 after a criminal conviction for uttering threats against correctional officers.⁵⁵ Ms. Worm suffered physical, emotional and sexual abuse throughout her childhood and adolescence. Many of her family members were sent to residential schools.⁵⁶ As a result of this abuse, Ms. Worm now has post-traumatic stress disorder and depression. She has also been addicted to drugs in the past, though she has been institutionally sober for four years.⁵⁷

All three women have experienced a vicious and self-defeating cycle of administrative segregation, transfers to institutions far away from family and community support, and uses of force against them by staff.

Following fights with other prisoners, Ms. Worm was placed in administrative segregation and has served the majority of her sentence in solitary confinement pursuant to the Management Protocol (discussed below), which involved extensive periods of "administrative segregation."⁵⁸ She has spent a total of over three years in solitary confinement.⁵⁹

⁵² *Ibid* at 31.

⁵³ *A Preventable Death*, *supra* note 23 at para. 71.

⁵⁴ British Columbia Civil Liberties Association, Press Release, "BCCLA launches lawsuit to challenge woman's lengthy solitary confinement in federal prison" (4 March 2011) online: <<http://www.bccla.org/pressreleases/11solitary.html>> [BCCLA].

⁵⁵ Sam Cooper, "Woman Kept in Solitary for 3 years", *Abbotsford Times*, (March 9, 2011) online: <<http://www.abbotsfordtimes.com/events/Woman+kept+solitary+years/4411242/story.html?id=441124>>.

⁵⁶ *Worm v. Canada* (Notice of Civil Claim at paras. 1, 3).

⁵⁷ *Ibid* at paras. 3-4.

⁵⁸ *Ibid* at para. 1.

⁵⁹ BCCLA, *supra*.

Like Ashley Smith, Ms. Worm's mental health issues have been worsened by segregation. In particular, "she has shown significant signs of psychological deterioration" and while in segregation was unable to access treatment for her post-traumatic stress disorder or Aboriginal spiritual services.⁶⁰

iii. Prisoner "K.J."⁶¹

K.J. is a 35 year old Aboriginal woman, currently incarcerated in the maximum-security unit at GVI in Kitchener, Ontario. Like Ashley Smith and Bobby-Lee Worm, K.J. has been subject to extensive periods of segregation and institutional transfers as a direct result of her mental health issues (and related challenges to her ability to adjust to the prison rules and environment). She has also been subject to the use of force, including pepper spray. Finally, she reported engaging in self-harm while imprisoned.

Although K.J.'s original sentence was for six years, as a result of criminal convictions occurred within prison, her sentence has more than doubled. At the time of the researchers' interview with K.J., she had served 14 years, two months and 30 days in prison and was scheduled to be paroled to a halfway house in June 2012. She has several outstanding criminal charges arising from incidents in the maximum security unit, however, so there is a risk that she may not actually be released in June.

K.J. has received various mental health diagnoses over the course of her time in prison, including borderline personality disorder, paranoid schizophrenia and schizoaffective disorder, manic type. Like Ashley Smith, the treatment CSC provides K.J. for her mental health issues has been inconsistent. For instance, when she was transferred to GVI, she was taken off her psychiatric medication and placed on new medication. The medication she had been taking, considered appropriate at her prior institution, was not approved by the physician at GVI. She noted that it was routine for her mental health treatment to be significantly changed upon transfer to a new institution.

In addition to being inconsistent, the treatment that K.J. currently receives is inadequate to meet her mental health needs. She sees a psychologist twice a week for approximately 10 minutes per session. K.J. does not trust the psychologist because the psychologist asks her questions seemingly unrelated to her mental health. For example, she asks her about other FSW in the maximum security unit which K.J. views as an attempt to gather information that will be passed on to correctional staff.

Further, as in the cases of Ashley Smith and Bobby-Lee Worm, K.J.'s mental health issues have been exacerbated through institutional transfers and segregation. K.J. has been transferred several times, spending time in the Regional Psychiatric Centre (RPC), the Edmonton Institution for Women, Fraser Valley Institution in British Columbia and, most recently, GVI. She described the transfers as "really hard". Although she felt that CSC was

⁶⁰ *Ibid* at paras. 22, 24.

⁶¹ The information in this section is taken from: Interview of K.J., Prisoner at GVI in Kitchener, Ontario (27 April 2012).

“justified in sending [her] to [the Regional Psychiatric Centre]” because she was “really mentally ill,” the experience was difficult. More difficult still was her transfer from Fraser Valley Institution in British Columbia to GVI: “I don’t even remember coming here, I was so drugged up”. K.J. is also now far from her family; her mother has only been able to visit her once through financial support from CAEFS.

K.J. has also spent a considerable portion of her sentence in segregation, a total of approximately five to six years. On one occasion, she spent 21 months in segregation without interruption. On some occasions, K.J. has requested to be placed in segregation because it is the only place where she is permitted “get alone time”. However, she also faces difficulties while in segregation, especially when she has made the request to be placed there. She states that “some of the staff really challenge you...they come in there like ‘oh I’m going to mess with her’”. Additionally, contrary to her legal entitlements under the CCRA, K.J. sometimes has her personal effects taken away while in administrative segregation and is told that she has to “earn them back” with good behaviour.

B. REGIONAL MULTI-LEVEL WOMEN’S PRISONS

Most FSW in Canada are imprisoned in six multi-level regional prisons that hold women of all security classifications:

- Fraser Valley Institution in Abbotsford, British Columbia;
- Nova Institution for Women in Truro, Nova Scotia;
- Joliette Institution in Joliette, Quebec;
- Grand Valley Institution for Women in Kitchener, Ontario;
- Edmonton Institution for Women in Edmonton, Alberta; and
- Okimaw Ochi Healing Lodge in Maple Creek, Saskatchewan (which now only accepts women classified as minimum and medium security).

CSC also has “exchange of services” agreements with provinces for the temporary detention of women in provincial health, mental health and correctional institutions.

The Prison for Women (P4W) in Kingston Ontario (the subject of the Arbour Report, discussed below) was officially closed on July 6, 2000 and, in December 2008, CSC closed the minimum-security Isabel McNeill House after a nearly two year legal battle to keep it open.

Within the multi-level regional prisons, women classified as minimum and medium security live in houses with communal living spaces and are responsible for their own daily

living needs.⁶² Women who are classified as maximum-security are imprisoned in secure units with high levels of staff supervision and significant restriction on their movement.⁶³

Structured Living Environments (SLEs) are purpose-built duplexes within the five multi-level regional prisons.⁶⁴ The SLEs are only available to minimum and medium security women with “significant cognitive limitations or behavioral mental health concerns.”⁶⁵ According to CSC, staff with specialized training provide 24-hour assistance and supervision at these facilities.⁶⁶ According to Kim Pate, the Executive Director of CAEFS, the SLEs are not available to the most difficult to manage women, such as the women profiled in our representative cases.

Canada has two national treatment and health assessment centres that are intended to accommodate FSW with mental health issues: the Regional Psychiatric Centre (RPC) in Saskatoon⁶⁷ and the Institut Phillip-Pinel of Montreal.⁶⁸ The former is operated by CSC⁶⁹ and the latter is a provincially-based psychiatric hospital operated pursuant to memorandum negotiated pursuant to an exchange of service agreement.⁷⁰ The Churchill Unit based at RPC operates a CSC-created Intensive Healing Program.⁷¹ The Churchill Unit receives FSW from CSC according to the following admission priorities: (a) emergency psychiatric care, (b) ongoing psychiatric care, (c) comprehensive assessment and specialized treatment, and (d) special requests from regional facilities.⁷² Currently, the Churchill unit only has 12 beds.⁷³

C. HISTORIC DISADVANTAGE OF FEDERALLY-SENTENCED WOMEN

Federally-sentenced women have long been discriminated against in the Canadian correctional system. Indeed, the needs and experiences of FSW have been secondary to those of men since the advent of the modern prison system.⁷⁴ Numerous studies and reports discussed below have highlighted this disadvantage including *Creating Choices*, the

⁶² Correctional Service Canada, “Implementing Choices at Regional Facilities: Program Proposals for Women Offenders with Special Needs”, online: <http://www.csc-scc.gc.ca/text/prgrm/fsw/warner/warner_e-06-eng.shtml>.

⁶³ Correctional Service Canada, Commissioner’s Directive 710-6, “Review of Offender Security Classification”, online: <http://www.csc-scc.gc.ca/text/plcy/cdshtm/710-6-cd-eng.shtml#_ISCWOMS>.

⁶⁴ Correctional Service Canada, “Structured Living Environment (SLE) Operational Plan”, online <<http://www.csc-scc.gc.ca/text/prgrm/fsw/sleop/structured-living-eng.shtml>> [SLE].

⁶⁵ *Ibid.*

⁶⁶ *Ibid.*

⁶⁷ Correctional Service Canada, “Institutional Profiles: Prairie Region Regional Psychiatric Centre Saskatoon, Saskatchewan”, online: <<http://www.csc-scc.gc.ca/text/facilit/institutprofiles/rpc-eng.shtml>> [Prairie Regional Psychiatric Centre].

⁶⁸ Institut Phillippe-Pinel, online: <<http://www.pinel.qc.ca/>>.

⁶⁹ Prairie Regional Psychiatric Centre, *supra* note 67.

⁷⁰ *Ten-Year Status Report*, *supra* note 19 at 7.

⁷¹ Correctional Service Canada, “Mental Health Strategy for Women Offenders”, online: <<http://www.csc-scc.gc.ca/text/prgrm/fsw/mhealth/toc-eng.shtml>> [Mental Health Strategy].

⁷² *Ibid.*

⁷³ *Ibid.*

⁷⁴ *Arbour Report*, *supra* note 17 at 239.

Arbour Report, CSC's *Ten-Year Status Report on Women's Corrections: 1996-2006*, and the Canadian Human Rights Commission's report, *Protecting their Rights*.⁷⁵

On the whole, women's disadvantage in the federal correctional system arises from their low numbers and a failure to recognize their particular security needs.⁷⁶ This creates issues in a variety of areas including segregation, security classification, the appropriate response to security incidents, and cross-gender staffing.⁷⁷

These problems are multi-faceted. One aspect is the "over-classification" due to their imprisonment in multi-level prisons. Since there are fewer FSW than men and fewer institutions available to house them, FSW are often imprisoned in conditions that do not correspond to their security classification, and tend not to be "cascaded" down to lower security levels as their sentence elapses.⁷⁸

A large proportion of FSW also suffer from multiple forms of discrimination; Aboriginal women and women with mental health issues face unique challenges in the prison system. This is significant because Aboriginal women are disproportionately over-represented in federal correctional institutions,⁷⁹ their numbers are increasing, and they are disproportionately classified as maximum security.⁸⁰ FSW are more likely to have mental health issues, histories of abuse, and are more likely to self-harm or attempt suicide.⁸¹

Below we summarize findings of key reports on FSW.

Creating Choices: The Report of the Task Force on Federally Sentenced Women

In March 1989, the federal government commissioned the Task Force on Federally Sentenced Women. The establishment of the Task Force was viewed by many as a major turning point in corrections: it was co-chaired by the Executive Director of CAEFS and a Deputy Commissioner of the CSC, and its members were primarily women, many of them Aboriginal. The Task Force's mandate was to examine CSC's management of FSW from sentence commencement to the date warrant expiry; and to develop a policy and plan that would be "responsive to the unique and special needs" of FSW.⁸²

The Task Force's report, *Creating Choices*, was released in April 1990 and called for the closure of Kingston's Prison for Women (P4W), establishment of regional prisons in its place, and development of a new women-centered correctional philosophy. The release of *Creating Choices* led to a wave of reforms to Canada's corrections system in 1992. New

⁷⁵ Arbour Report, *supra* note 17; *Ten-Year Status Report*, *supra* note 19; *Protecting their Rights*, *supra* note 18.

⁷⁶ Arbour Report, *supra* note 17 at 242.

⁷⁷ *Ten-Year Status Report*, *supra* note 19 at 13.

⁷⁸ *Ibid* at 246.

⁷⁹ *Protecting their Rights*, *supra* note 18 at 1.2.

⁸⁰ *Moving Forward with Women's Corrections: The Expert Committee Review of the Correctional Service of Canada's Ten-Year Status Report on Women's Corrections, 1996-2006*, (Ottawa: Correctional Service Canada, 2006) at 18.

⁸¹ *Protecting their Rights*, *supra* note 18 at 5.1.2.

⁸² *Creating Choices*, *supra* note 16 at 125-135.

legislation gave CSC the explicit mandate to ensure that programming was sensitive to the needs of FSW, Aboriginal prisoners, and other prisoners with special needs.⁸³

Creating Choices outlines five principles that all CSC programs for FSW are to follow:⁸⁴

- **Empowerment:** Empowerment is the process through which women gain insight into their situation, identify their strengths, and are supported and challenged to take positive action to gain control of their lives.
- **Meaningful and Responsible Choices:** Women need options that allow them to make responsible choices. Dependence on alcohol and/or drugs, men, and government financial assistance has denied women the opportunity and ability to make choices.
- **Respect and Dignity:** Correctional Service of Canada had often been criticized for its tendency to encourage, and therefore perpetuate, dependent and child-like behaviour among women offenders. Mutual respect is needed among offenders, among staff and between the two.
- **Supportive Environment:** The quality of the environment (both physical and emotional) can promote physical and psychological health and personal development.
- **Shared Responsibility:** There is a role to play for all levels of government, corrections, volunteer organizations, businesses, private sector services, and the community in developing support systems and continuity of service for women offenders

Commission of Inquiry into certain events at the Prison for Women in Kingston (The Arbour Report)

In April 1995, pursuant to Part II of Canada's *Inquiries Act*,⁸⁵ Canada's Solicitor General appointed Madame Justice Louise Arbour (as she then was), to investigate and report on incidents that occurred at the P4W in Kingston, Ontario in April 1994 and CSC's response.⁸⁶ These incidents involved the cell extraction and strip search of eight women in segregation by a male emergency response team. The incident came to light following the release of videotape documenting the abuse and a 1995 special report by the Correctional Investigator.⁸⁷

In her 1996 Report, entitled *Commission of Inquiry into Certain Events at the Prison for Women in Kingston* ("The Arbour Report"), Justice Arbour aimed to assist Canada's correctional system "in coming into the fold of two basic Canadian constitutional ideals, towards which the rest of the administration of justice strives: the protection of individual rights and the entitlement to equality".⁸⁸

⁸³ Arbour Report, *supra* note 17 at 1.7.

⁸⁴ *Creating Choices*, *supra* note 16 at Section C: Principles for Change.

⁸⁵ *Inquiries Act*, RSC, 1985, c I-11.

⁸⁶ Arbour Report, *supra* note 17 at ii.

⁸⁷ *Ibid* at v.

⁸⁸ *Ibid* at preface.

The Arbour Report found that nearly every action CSC took in response to the incidents that occurred at P4W in April 1994 were at odds with the intent of *Creating Choices*. Justice Arbour ultimately made 14 main recommendations and over 100 sub-recommendations on the improvement of women's corrections.

The Report highlighted numerous problems in federal women's prisons and identified segregation as a key rights issue plaguing Canadian prisons.⁸⁹ One of Madam Justice Arbour's key recommendations was that *no prisoner should spend more than 30 consecutive days in administrative segregation*, and segregation should not itself be imposed more than twice in a calendar year.⁹⁰ She also recommended that administrative segregation be subject to judicial review or independent adjudication to ensure strict compliance with the law.⁹¹

Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women

In December 2003, the CHRC released a report entitled *Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women (Protecting their Rights)*.⁹² This Report was developed by the CHRC in response to a request by CAEFS, NWAC, DAWN, the Canadian Bar Association, the Assembly of First Nations, and the National Association of Women and the Law, amongst 21 other organizations.

The Report is a broad-based review on the discriminatory treatment of FSW on the basis of gender, race (including Aboriginal status), and disability. The focus is the extent to which CSC's services relating to the custody, supervision, rehabilitation, and reintegration were not responsive to the situation of FSW.

One of Madam Justice Arbour's key recommendations was that no prisoner should spend more than 30 consecutive days in administrative segregation, and segregation should not itself be imposed more than twice in a calendar year.

The CHRC found that, while CSC has made some progress in developing a system designed for women, systemic human rights problems remain, particularly with regard to Aboriginal women, racialized women, and women with disabilities. In general, the correctional system is designed for white, male prisoners and, CSC's gender-neutral application of its policies and procedures results in a breach of women's right to substantive equality.⁹³

⁸⁹ *Ibid* at 3.3.

⁹⁰ Arbour Report, *supra* note 17 at 3.3.5 and 9.

⁹¹ *Ibid*.

⁹² *Protecting their Rights*, *supra* note 18.

⁹³ *Ibid* at 2.

The report sets out the following guiding principles to ensure that the treatment of FSW is consistent with human rights laws:

- federal women prisoners have a right not to be discriminated against and a right to correctional services as effective as those received by men;⁹⁴
- equality must be based on the real needs and identities of women prisoners, not on stereotypes or generalizations;⁹⁵ and
- the duty of CSC is to promote and protect the human rights of women means that they must take into account the fact that some of the reasons women are criminalized, their life experiences and their rehabilitation needs are unique.⁹⁶

CHRC's key recommendations relevant to this report are as follows. In relation to needs and risk assessment, the CHRC recommended that CSC:⁹⁷

- develop and implement a needs-assessment process that responds to the needs of FSW, including Aboriginal women, racialized women, and women with disabilities;
- create a security classification tool explicitly for FSW that takes into consideration the lower risk posed to public safety by most women;
- commission an independent study of the possible discriminatory impact of the existing security classification tool on FSW with disabilities;
- address the disproportionate number of Aboriginal FSW classified as maximum security by immediately reassessing the classification of all maximum-security Aboriginal women using a gender-responsive reclassification tool;
- change the blanket policy of not allowing maximum security women at the Healing Lodge to a policy that is based on individual assessment; and
- consider the needs and low risk of minimum and medium security women prisoners in the construction of additional facilities for women.

In relation to segregation, the CHRC recommended that CSC:⁹⁸

- implement independent adjudication for decisions related to involuntary segregation, with independent external assessment after two years;
- create a Segregation Advisory Committee for Women's Institutions with broad membership; and
- examine alternatives to long-term segregation for women offenders, in consultation with external stakeholders.

⁹⁴ *Ibid* at 13.

⁹⁵ *Ibid* at 21.

⁹⁶ *Ibid* at 26.

⁹⁷ Canadian Human Rights Commission, "Backgrounder 2: Recommendations of the Special Report", online: <http://www.chrc-ccdp.ca/legislation_policies/fsw2-eng.aspx>.

⁹⁸ *Ibid*.

Finally, the CHRC recommended that CSC immediately develop and implement a comprehensive accommodation policy, addressing all prohibited grounds of discrimination.⁹⁹

CSC Task Force Report on Administrative Segregation

In June 1996, in response to the findings related to segregation in the Arbour Report, Canada's Acting Commissioner of Corrections established a task force to complete a comprehensive review of the use of segregation across all Canadian institutions. The review took place in three phases and led to the release of the *Task Force Report on Administrative Segregation*.¹⁰⁰

The *Task Force Report on Administrative Segregation* outlines shortcomings in Canada's corrections system relating to compliance with policies, effectiveness, adherence to the rule of law, and misunderstanding by staff members of the purposes of administrative segregation.¹⁰¹

The Task Force identified the following issues with respect to procedural compliance:¹⁰²

- CSC staff did not sufficiently understand the purpose of administrative segregation;¹⁰³
- CSC had segregated inmates for reasons that did not meet legislative criteria;
- Administrative segregation (discussed below) had on occasion been used as punishment;
- Prisoners were not well informed of their legal rights in administrative segregation; and
- CSC failed to keep accurate records of all events concerning the administrative segregation of prisoners, and as a result often failed to demonstrate legal compliance.

It further identified the following problems with respect to effectiveness:

- institutional alternatives to the use of segregation were not fully explored; and
- options for reintegration were usually limited to transfers away from the institution—a lengthy process that was rarely successful for inter-regional transfers.

It concluded that the above findings “provided sufficient evidence of a *casual attitude toward the demands of the law* by CSC staff members” (emphasis added) and lent credibility to the Arbour Report's finding of a culture at CSC that does not respect the rule of law.

⁹⁹ *Ibid.*

¹⁰⁰ *Task Force Report on Administrative Segregation*, *supra* note 20.

¹⁰¹ *Ibid.*

¹⁰² *Ibid.*

¹⁰³ *Ibid.*

D. KEY LEGISLATION AND POLICY PROVISIONS

i. Institutional structure

At the highest level, CSC treats women's issues and mental health issues separately. Federally-sentenced women fall within the mandate of the CSC Deputy Commissioner for Women, who is responsible for policy and program development, implementation, and ongoing program development.¹⁰⁴ In contrast, mental health falls within the mandate of the Assistant Commissioner for the Health Services Sector, who is responsible for the quality of health services provided in institutional settings, including diagnosis, treatment, and harm reduction, monitoring, and surveillance.¹⁰⁵ The Assistant Commissioner for Health does not report to the Deputy Commissioner for Women, which might result in some coordination between the sectors. Instead, both Deputy Commissioners are ultimately responsible to the Commissioner of Corrections. Accountability for mental health services does not extend outside corrections to provincial health authorities.

ii. Health care and CSC's Mental Health Strategy¹⁰⁶

Sections 86 and 87 of the CCRA state:

86. (1) The Service shall provide every inmate with

- (a) essential health care; and
- (b) reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community.

(2) The provision of health care under subsection (1) shall conform to professionally accepted standards.

87. The Service shall take into consideration an offender's state of health and health care needs

- (a) in all decisions affecting the offender, including decisions relating to placement, transfer, administrative segregation and disciplinary matters; and
- (b) in the preparation of the offender for release and the supervision of the offender.

Pursuant to these obligations, in 2002, CSC launched an official *Mental Health Strategy for Women Offenders* (Strategy).¹⁰⁷ This Strategy was meant to provide a framework for the

¹⁰⁴ Correctional Service Canada, "How We Operate," online: < <http://www.csc-scc.gc.ca/text/organi/operat-eng.shtml>>.

¹⁰⁵ *Ibid.*

¹⁰⁶ All references in this section are to the Mental Health Strategy, *supra* note 71.

¹⁰⁷ *Ibid.*

development of mental health services for all FSW. It is an updated version of the 1991 *Task Force on Mental Health*, which was developed for all prisoners, male and female.¹⁰⁸

The Strategy outlines the mental health needs of FSW and the treatment, intervention, and programs required by legislation and policy to address these issues. The Strategy further describes a “continuum of mental health care” that begins at the stage of initial assessment and continues through crisis intervention, group and individual counseling, follow-up and “the interconnected nature of all programs and services in support of mental well-being for women offenders”.¹⁰⁹ The original version of the Strategy was published in 1997, and the 2002 Strategy is an updated version that accounts for developments between 1997-2002 and the feedback of numerous stakeholders who CSC consulted with in the interim.¹¹⁰

CSC’s Mental Health Strategy lays out some helpful explanations of what mental health care should look like for FSW, and states that mental health services must be integrated into each woman’s correctional plan.¹¹¹ However, it lacks explicit direction on how the Strategy is to be integrated into other CSC programs and policies such as those related to security classification.

In its Strategy, CSC recognizes an “extremely low” base rate of recidivism amongst FSW, with the “virtual non-existence” of violent recidivism.¹¹² Unfortunately, CSC’s awareness of low recidivism rates is not integrated into all aspects of its programming for FSW. For example, CSC’s security classification system does not make any mention of the low risk women pose upon release.

With respect to CSC’s approach to assessment of mental health issues upon prisoner intake, the Strategy states that all women who have mental health problems at the time of first entering an institution “should undergo a standardized comprehensive mental health assessment resulting in a written report.”¹¹³ This assessment is to be part of a comprehensive treatment plan—which includes other correctional objectives that may not be related to mental health.¹¹⁴

However, assessment is envisioned as an event that takes place at a single point in time (upon intake) and no adequate provision is made for on-going assessment, despite the fact that federal prisoners are serving sentences between two and 25 years and that imprisonment, itself, especially in segregation or upon transfer, may cause or exacerbate mental health issues. The provision for assessment demonstrates a view of mental health that is static, rather than dynamic, focused on risks rather than needs, and at odds with the policy rationales underlying *Creating Choices*.

¹⁰⁸ *Ibid.*

¹⁰⁹ *Ibid.*

¹¹⁰ *Ibid.*

¹¹¹ *Ibid* at 15.

¹¹² *Ibid* at 21.

¹¹³ *Ibid* at 20.

¹¹⁴ *Ibid.*

The Strategy states that women with “serious” mental health problems may be referred to a psychiatrist or specialist for further assessment, but does not define “serious.” It is also unclear whether this commitment is adequately resourced. Although CSC provided the IHRP with information on the number of positions for psychologists and psychiatrists at each correctional institution, it did not provide information on whether or not these positions are filled or whether the number of positions is sufficient to meet the mental health needs of the prison population.

It is also important to distinguish assessment from treatment; the prior is often done for institutional purposes (to determine suitability for release or security classification, or to justify continued segregation) whereas treatment requires an ongoing therapeutic relationship with a psychologist or psychiatrist. Even where treatment is provided, the issue is further complicated where women with serious mental illness are segregated (such as K.J., Ms. Worm, and Ms. Smith). In such situations Kim Pate from CAEFS and Carmen Cheung from BCCLA advise that assessments and treatment are sometimes conducted through a meal slot.

The Strategy indicates that women with “acute” mental health problems may require intensive care (including psychotropic medications).¹¹⁵ While the Strategy notes that treatment for acute problems is best provided in an intensive residential facility setting, yet with the exception of one ad hoc arrangement with the Brockville Hospital, no health-administered residential treatment beds exist for FSW to access. Indeed, CSC notes that: “the services and resources that can be offered to women are dependent on what is available. Further, the operation and type of programs and approaches used by these non-CSC facilities may not necessarily be consistent with the Strategy”. One of the external units the CSC mentions is The Churchill Unit in Saskatchewan which only has 12 beds for women. Given that nearly one in three FSW has mental health issues upon intake, albeit not all acute, and given the CHRC’s ruling that such approaches are discriminatory and do not meet the needs of FSW, there remain no adequate intensive residential facilities available to FSW.

The Strategy identifies four core and related CSC programs: Suicide and Self-Injury, Sex Offenders, Substance Abuse, and Peer Support. In relation to Suicide and Self-Injury, the Strategy stipulates that staff training must take “the specific needs and issues of women offenders into consideration” including with respect to appropriate intervention. However, aside from a reference to CD 843 (“Management of Inmate Self-Injurious and Suicidal Behaviour”), no further detail is provided. The Strategy states: “self-injurious behavior should not be viewed as a security issue unless there are extenuating circumstances, such as the involvement of weapons.” This statement is at odds with the rest of CSC’s policies and programs, which equate disorderly conduct by prisoners with security threats. For example, in reference to the Ashley Smith case, the Correctional Investigator states:

Senior managers who had limited mental health expertise drafted, and then redrafted management plans for Ms. Smith. These plans largely excluded the

¹¹⁵ *Ibid* at 21.

input of those who should have been best suited to provide Ms. Smith with professional assistance, namely, the mental health care staff and physical health care staff. As a result, the plans were largely security-focused, lacked mental health components, and were often devoid of explicit directions for addressing Ms. Smith's on-going self-harming behaviours.¹¹⁶

In relation to Sex Offenders, the Strategy states that, while mental disorders are seldom found to be a significant problem in this particular subset of female offenders, a specific protocol has been developed for the *Assessment and Treatment of Women Offenders who Sexually Offend*. Interestingly, there is no specific protocol in the Strategy relating to female prisoners who are survivors of sexual abuse, despite the fact that 86% of FSW reported experiencing physical abuse and 68% reported experiencing sexual abuse.¹¹⁷ For example, one might imagine that a protocol would be appropriate for male staff who intervene with survivors of gender-based violence. CSC embarked on a plan in the early 1990s to consider the needs of women offenders who had been affected by sexual abuse; however Kim Pate of CAEFS told the IHRP that such a plan is yet to be developed.¹¹⁸ As a result, while CSC has formal programming and protocol for women labeled as sex offenders, no formal program currently exists to assist women who have experienced sexual abuse such as Ms. Worm.

“Mental health services offered by the CSC to offenders with mental disorders have not kept up with dramatically increasing numbers; the level of mental health services available continues to be seriously deficient.”

At the time the Strategy was released, it stated that a Substance Abuse program was “currently being developed.” Since then, CSC has developed Women Offender Substance Abuse Programming and Community Reintegration (WOSAP).¹¹⁹ WOSAP is a multi-stage programming model that aims to respond to continued high levels of substance abuse among women offenders under federal jurisdiction (77% upon intake). WOSAP’s stated overall goal is “to empower women to make healthy lifestyle choices.”¹²⁰

Although the WOSAP report was released six years after CSC’s Mental Health Strategy, it does not mention it. That said, the WOSAP report makes some important observations about the correlation between mental health issues and substance abuse. The report states that mental health problems are of “considerable concern” in the population of women who engage in substance abuse: 82% of the 318 women who participated in the Intensive Therapeutic Treatment-WOSAP program reported having experienced depression, 76.3%

¹¹⁶ *A Preventable Death*, *supra* note 23 at para 30.

¹¹⁷ *Annual Report of the Office of the Correctional Investigator: 2010-2011*, *supra* note 9 at 50.

¹¹⁸ Key Informant Interview with Kim Pate, Executive Director of CAEFS, 2 May 2012.

¹¹⁹ Correctional Service Canada, “Women Offender Substance Abuse Programming and Community Reintegration (WOSAP)”, online: <<http://www.csc-scc.gc.ca/text/rsrch/reports/r202/r202-eng.pdf>>.

¹²⁰ *Ibid.* at ii.

reported anxiety, and 93.1% had experienced trauma.¹²¹ Among those who reported mental health issues, 80.2% used “self-medication” to cope with anxiety and 94.2% reported experiencing depression.¹²²

The Strategy includes Peer Support as one component of CSC’s mental health continuum of care. No information is provided on the scale or nature of this program, simply that national guidelines were developed in 2002 and that a module relating to “grief and loss” was recently added. According to Kim Pate of CAEFS, peer support is used by FSW both formally and informally. Under the original formulation of the Peer Support program, women self-selected to participate as peer helpers and, with the exception of information that might comprise a security risk, all information exchanged was kept confidential from CSC correctional staff. Under the current program, CSC staff are directly involved in the peer support program, and peer support workers must be approved by the administration. This has the effect of sometimes installing individuals as peer helpers who other women in the prison may not trust. As a result, there is often only one or two individuals who are trusted by the women and they therefore tend to be repeatedly called on to provide peer support in each institution, and these individuals face a high risk of burn out.¹²³

NWAC notes that there is also inadequate support for Aboriginal women with mental health issues who are released on parole. In particular, they highlight the need for “wrap around services” for FSW with mental health issues, including non-co-ed transitional housing and shelters, non co-ed substance abuse treatment programs, and better support for cultural services.¹²⁴

In a forthcoming article, Ivan Zinger, the Executive Director and General Counsel of the Office of the Correctional Investigator states that the Correctional Investigator has “repeatedly raised the issue of and reported on the care and treatment of prisoners with mental health concerns.” He summarizes some of the Correctional Investigator’s key recommendations to CSC as follows:

- Reallocate resources to fully fund intermediate mental health care units;
- Enhance efforts to recruit, retain and train professional and dedicated mental health staff;
- Treat self-harming behaviour/incidents as mental health rather than security issues;
- Increase the capacity of the five Regional Treatment Centres;
- Prohibit forced medical injections of an uncertified offender who is physically restrained for health or security purposes;
- Prohibit prolonged segregation of offenders at risk of suicide or self-injury and offenders with acute mental health issues;

¹²¹ *Ibid.* at 14

¹²² *Ibid.*

¹²³ Key Informant Interview with Kim Pate, Executive Director of CAEFS, May 2 2012.

¹²⁴ Cook, *supra* note 11.

- Provide for independent and expert chairing of national investigations involving inmate suicides and incidents of serious self-injury;
- Expand alternative mental health service delivery partnerships with the provinces and territories; and
- Provide health care coverage 24 hours per day, 7 days per week at all maximum, medium and multilevel institutions.¹²⁵

However, he concludes that “despite significant efforts and some new funding, mental health services offered by the CSC to offenders with mental disorders have not kept up with dramatically increasing numbers; the level of mental health services available continues to be seriously deficient.”¹²⁶

iii. Canadian law and its discriminatory application to FSW with mental health issues

Security classification tools that discriminate against women with mental health issues and Aboriginal women

Ashley Smith was classified as maximum security for the entirety of her time in federal custody. Bobby-Lee Worm and K.J., both Aboriginal women, are currently classified as maximum security.

Decisions regarding security classification and subsequent allocation to a particular institutional setting are issues closely related to the treatment that FSW. According to s. 17 of the CCRR, CSC takes the following factors into consideration in determining the security classification to be assigned to an inmate pursuant to section 30 of the Act:¹²⁷

- (a) the seriousness of the offence committed by the inmate;
- (b) any outstanding charges against the inmate;
- (c) the inmate's performance and behaviour while under sentence;
- (d) the inmate's social, criminal and, if available, young-offender history and any dangerous offender designation under the Criminal Code;
- (e) any physical or mental illness or disorder suffered by the inmate;
- (f) the inmate's potential for violent behaviour; and
- (g) the inmate's continued involvement in criminal activities.

¹²⁵ Zinger, supra note 14 at 24.

¹²⁶ Ibid.

¹²⁷ Section 30(2) of the CCRR states: The Service shall give each inmate reasons, in writing, for assigning a particular security classification or for changing that classification: *Corrections and Conditional Release Act*, supra note 7.

18. For the purposes of section 30 of the Act, an inmate shall be classified as
- (a) maximum security where the inmate is assessed by the Service as
 - i. presenting a high probability of escape and a high risk to the safety of the public in the event of escape, or
 - ii. requiring a high degree of supervision and control within the penitentiary;
 - (b) medium security where the inmate is assessed by the Service as
 - i. presenting a low to moderate probability of escape and a moderate risk to the safety of the public in the event of escape, or
 - ii. requiring a moderate degree of supervision and control within the penitentiary; and
 - (c) minimum security where the inmate is assessed by the Service as
 - i. presenting a low probability of escape and a low risk to the safety of the public in the event of escape, and
 - ii. requiring a low degree of supervision and control within the penitentiary.

In its submissions to the Canadian Human Rights Commission, CAEFS identified a number of problems with respect to CSC's approach to security classification.¹²⁸ First, the security classification system discriminates against women. The risk assessment tools and classification schemes impose a male-based and male-normed approach on women, with particularly deleterious effects for racialized women and women with disabilities.¹²⁹

Second, the classification system discriminates against Aboriginal FSW. The security classification system as applied to Aboriginal women results in their being disproportionately classified as maximum security. This is partly because the assessment instruments used by CSC are culturally inappropriate and "translate marginalization experienced by Aboriginal women in the community into risk."¹³⁰ Approximately 50% of Aboriginal women in prison are classified as maximum security, while only 8-10% of the non-Aboriginal FSW population is so classified.

In its submissions to the CHRC, CAEFS scrutinizes an instrument used by CSC to assess the prisoner's background of disadvantaged. The "Dynamic Factor Analysis" tool is administered by CSC staff who make a subjective determination as to whether a prisoner has "no", "some", or "considerable" need for improvement with respect to the factors included in the instrument. While some of these factors relate to disadvantage (e.g. employment, education, abuse), some do not. CAEFS submits that the latter are embedded with middle class biases, for example, assessing whether someone has a bank account, collateral, hobbies, et cetera. Many of these latter factors arguably have nothing to do with

¹²⁸ Submission of the Canadian Association of Elizabeth Fry Societies (CAEFS) to the Canadian Human Rights Commission for the Special Report on Discrimination on the Basis of Sex, Race and Disability Faced by Federally Sentenced Women (May 2003), online: <
http://www.elizabethfry.ca/chrc/CAEFS_SUBMISSION_TO_CHRC_INQUIRY_accountability.pdf> ["CAEFS submission to the CHRC"]

¹²⁹ *Ibid* at 3.

¹³⁰ *Ibid* at 20.

“needs” let alone risk to the public. This has crucial implications because some of the factors assessed under the Dynamic Factor Analysis will affect FSW’s scores on the Custody Rating Scale, thereby potentially resulting in a higher security classification than warranted.

In the end, FSW are discriminated against and disadvantaged by a security system that equates needs with risk without a demonstrated causal link between these needs and risks. FSW are effectively penalized for their social disadvantage. This approach is particularly problematic as it relates to FSW with mental health issues: many of the factors cited above could be found in someone with an untreated mental illness and could thereby result in a higher security classification than warranted by actual risk. Moreover, the fact that s. 18 classifies those that require a high degree of supervision and control within the penitentiary to a higher security classification, coupled with the relative dearth of mental health treatment options means that FSW with mental health issues are more likely to be classified as maximum security. For example, given Ms. Smith, Ms. Worm and K.J.’s difficulties accessing consistent treatment, it is not surprising that they would require a higher degree of supervision and control and would be classified as maximum security.

Indeed, in its report *Protecting their Rights*, the CHRC expressed concern over the discriminatory impact of the risk assessment tools used by CSC and recommended that CSC create a security classification tool explicitly for FSW, commission an independent study of the possible discriminatory impact of the existing security classification tool on FSW with disabilities, and address the disproportionate number of Aboriginal FSW classified as maximum security by immediately reassessing the classification of all maximum-security Aboriginal women using a gender-responsive reclassification tool.

Administrative segregation of FSW with serious mental health issues

The treatment of Ashley Smith, Bobby-Lee Worm and K.J. is defined by extensive periods of administrative segregation, often for months to over a year in duration. These long periods of segregation were authorized despite the language in s. 87(a) which that CSC must take into consideration the prisoner’s state of health and health care needs in decisions related to segregation.

According to s. 31(1) of the CCRA, the purpose of administrative segregation is to “keep an inmate from associating with the general inmate population.” Subsection 31(3) of the CCRA stipulates that the institutional head may order administrative segregation for a particular inmate if the institutional head believes on reasonable grounds:

- (a) that
 - i. the inmate has acted, has attempted to act or intends to act in a manner that jeopardizes the security of the penitentiary or the safety of any person, and
 - ii. the continued presence of the inmate in the general inmate population would jeopardize the security of the penitentiary or the safety of any person,

- (b) that the continued presence of the inmate in the general inmate population would interfere with an investigation that could lead to a criminal charge or a charge under subsection 41(2) of a serious disciplinary offence, or
- (c) that the continued presence of the inmate in the general inmate population would jeopardize the inmate's own safety, and the institutional head is satisfied that there is no reasonable alternative to administrative segregation.

Section 19 of the CCRR stipulates that any inmate involuntarily confined in administrative segregation is entitled to notice in writing of the reasons for the segregation within one working day after the her confinement and s. 20 requires the institutional head to review the order within one working day and either confirm the confinement or order that the inmate be returned to the general population. The review requirements for administrative segregation beyond 30 and 60 days are set out in the CCRR as follows.

s. 21(1) Where an inmate is involuntarily confined in administrative segregation, the institutional head shall ensure that the person or persons referred to in section 33 of the Act who have been designated by the institutional head, which person or persons shall be known as a Segregation Review Board, are informed of the involuntary confinement.

(2) A Segregation Review Board referred to in sub- section (1) shall conduct a hearing

- (a) within five working days after the inmate's confinement in administrative segregation; and
- (b) at least once every 30 days thereafter that the in- mate remains in administrative segregation.

s. 22 Where an inmate is confined in administrative segregation, the head of the region or a staff member in the regional headquarters who is designated by the head of the region shall review the inmate's case at least once every 60 days that the inmate remains in administrative segregation to determine whether, based on the considerations set out in section 31 of the Act, the administrative segregation of the inmate continues to be justified.

Despite the strong recommendations contained in the Arbour Report, notably absent from these regulations is any mention of access to a judge or judicial review mechanisms with respect to administrative segregation, regardless of how long a prisoner remains segregated. Rather, it is the institutional head of CSC who reviews the order. The Correctional Investigator has consistently challenged CSC's practices relating to segregation.¹³¹

¹³¹ *Annual Report of the Office of the Correctional Investigator, 2008-2009, supra note 21; Annual Report of the Office of the Correctional Investigator, 2009-2010, supra note 21; Annual Report of the Office of the Correctional Investigator, 2010-2011, supra note 9.*

The British Columbia Civil Liberties Association (BCCLA) states that solitary confinement (through administrative segregation) has increasingly been used in Canada as a “tool to warehouse prisoners with mental health issues.”¹³² On March 4, 2011, the BCCLA filed a lawsuit on behalf of Ms. Worm, the focus of which is CSC’s practice of holding female prisoners in solitary confinement for prolonged periods. Ms. Worm had been subjected to a program called the Management Protocol (see below) that involved extensive periods of administrative segregation. As the BCCLA’s Litigation Director notes in a press release related to the case, solitary confinement has devastating psychological and physical effects, especially for women like Ms. Worm who have a history of physical, emotional, and/or sexual abuse.¹³³ BCCLA submits that human rights bodies have “found the practice of prolonged solitary confinement to be either torture or cruel, inhuman and degrading treatment.”¹³⁴

The BCCLA explains that prisoners in Canada can be subjected to solitary confinement in two ways.¹³⁵ “Disciplinary segregation” is punitive and imposed after a prisoner is found guilty of a serious disciplinary infraction by an independent adjudicatory body.¹³⁶ This form of segregation is limited to 30 days unless there are multiple convictions—the maximum in that case is 45 days.¹³⁷ The second form, “administrative segregation,” discussed above, is imposed when a prisoner poses a security or safety risk to the rest of the prison population.¹³⁸ (Administrative segregation plays a key role in the controversial Management Protocol Program.) Because this form of segregation is viewed as a non-punitive, there is no limit on the amount of time a prisoner may be held in administrative segregation. The key concern here, as the BCCLA points out, is that the impact of solitary confinement on the prisoner is the same regardless of whether it imposed for a particular purpose by CSC.¹³⁹

Administrative segregation has increasingly been used in Canada as a “tool to warehouse prisoners with mental health issues.”

According to CSC, its Management Protocol for FSW “...comprises a series of three steps geared towards behaviour stabilization and/or management: (1) Segregation, (2) Partial Reintegration, and, (3) Transition.” As of 2010, CSC notes that: “Several women have been on the Protocol for a significant period of time,”¹⁴⁰ which our research indicates is a euphemism for extended segregation. Indeed, CSC quietly abandoned the Management

¹³² BCCLA, *supra* note 54.

¹³³ *Ibid.*

¹³⁴ *Ibid.*

¹³⁵ *Ibid.*

¹³⁶ *Corrections and Conditional Release Act, supra* note 7, s 43(1).

¹³⁷ *Ibid* at s 40(2).

¹³⁸ *Ibid* at s. 31.

¹³⁹ BCCLA, *supra* note 54.

¹⁴⁰ Correctional Service Canada, *Management of Higher-Risk Women: Results of Consultation on an Alternative to Management Protocol*, (Ottawa: Correctional Service Canada, 2010) at 5.

Protocol in the summer of 2011,¹⁴¹ however, according to Kim Pate at CAEFS, some FSW continue to spend much of their confinement in administrative segregation in substantially similar conditions as under the Management Protocol.

The Management Protocol is the subject of significant criticism. As the BCCLA notes, in each of the three stages of the Management Protocol, “the prisoner’s physical liberty and ability to associate with other inmates is extremely limited. Women assigned to the most restrictive step have no contact with other women prisoners, often for months.”¹⁴²

In an article focusing on FSW Renee Acoby *Walrus* magazine describes the Management Protocol as follows¹⁴³

The protocol permitted CSC to place troublesome female prisoners in segregation indefinitely. Offenders could work their way out in three stages — from segregation to partial reintegration to integration — but since the protocol’s inception in 2003, only two of seven women have succeeded. The rules virtually guaranteed failure; there was zero tolerance for aggressive behaviour, whether physical or emotional (Acoby was once ordered not to use profanity for thirty days). And because CSC considered the protocol an administrative rather than a punitive instrument, it could be employed without limitation, whereas purely disciplinary segregation cannot be imposed for more than forty-five days. Nor was use of the protocol subject to judicial oversight.¹⁴⁴

The lack of judicial oversight has been a key concern with respect to the Management Protocol and administrative segregation more generally. As BCCLA Counsel Carmen Cheung states: “The decision to place a woman on the Management Protocol is made without the benefit of an independent decision-maker, and there is no judicial oversight on its use, making it particularly susceptible to abuse.”¹⁴⁵ The BCCLA lawsuit seeks declarations that the Management Protocol and the sections of the CCRA providing for prolonged, indefinite solitary confinement through administrative segregation are unconstitutional under s.7 of the *Canadian Charter of Rights and Freedoms* (the right to life, liberty and security of the person). The BCCLA also draws attention to the fact that all seven of the women who have been on the Management Protocol since 2005 are Aboriginal, “suggesting that the Protocol is being applied in a discriminatory fashion”.¹⁴⁶

Despite the fact that CSC has apparently abandoned the controversial Management Protocol, it is worth noting that Ms. Worm and K.J. continue to experience long periods of

¹⁴¹ Correctional Service Canada, “Women Offender Program and Issues”, online: <<http://www.csc-scc.gc.ca/text/prgrm/fsw/secureunitop/secure-unitop-2003-eng.shtml#4-h>>.

¹⁴² BCCLA, *supra* note 54.

¹⁴³ John McFarlane, “Editor’s Note”, *The Walrus*, July 2011, online: <<http://walrusmagazine.com/articles/2011.07-editors-note-editors-note>> [John McFarlane].

¹⁴⁴ *Ibid.*

¹⁴⁵ BCCLA, *supra* note 54.

¹⁴⁶ *Ibid.*

solitary confinement through administrative segregation that CSC claims complies with the CCRA and regulations.

Finally, it is worth noting that segregation itself has negative psychological effects, especially on individuals with pre-existing mental disabilities. The cases of Ms. Smith and Ms. Worm demonstrate the harmful effects of segregation. For instance, Ms. Smith's self-injurious behaviour was, at least in part, an attempt to get the human contact she was lacking in segregation.¹⁴⁷ Ms. Worm's psychological state has also deteriorated in segregation and she is unable to access the psychological services she requires.¹⁴⁸

The experiences of these women are consistent with scientific research on the effects of segregation on mental health.¹⁴⁹ In "Psychiatric Effects of Solitary Confinement", Dr. Stuart Grassian describes the mental effects of segregation:

deprived of a sufficient level of environmental and social stimulation, individuals will soon become incapable of maintaining an adequate state of alertness and attention to the environment. Indeed, even a few days of solitary confinement will predictably shift the electroencephalogram (EEG) pattern toward an abnormal pattern characteristic of stupor and delirium... after a time, the individual becomes increasingly incapable of processing external stimuli, and often becomes "hyperresponsive" to such stimulation. For example, a sudden noise or the flashing of a light jars the individual from his stupor and becomes intensely unpleasant. Over time the very absence of stimulation causes whatever stimulation is available to become noxious and irritating. Individuals in such a stupor tend to avoid any stimulation, and withdraw progressively into themselves and their own mental fog.¹⁵⁰

This suggests that women who are segregated for long periods of time may actually develop mental health issues even if these were not pre-existing. As noted above, we were not able to obtain information from CSC as to the prevalence of the mental health issues in FSW who are segregated.

Institutional transfer of FSW with serious mental health issues

Both Ashley Smith and K.J. were transferred between institutions a number of times, often across the country, a great distance from their families and community support systems.

¹⁴⁷ *A Preventable Death*, *supra* note 23 at para. 28.

¹⁴⁸ *Worm v. Canada* (Notice of Civil Claim at paras. 22, 24).

¹⁴⁹ See e.g. Craig Haney, "Mental Health Issues in Long-Term Solitary and "Supermax" Confinement" (2003) 49:1 *Crime & Delinquency* 124; Bruce A. Arrigo and Jennifer Leslie Bullock, "The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and Recommending What Should Change" (2008) 52:6 *International Journal of Offender Therapy and Comparative Criminology* 622; Stuart Grassian, "Psychiatric Effects of Solitary Confinement" (2006) 22 *Washington University Journal of Law and Policy* 325 [Grassian].

¹⁵⁰ Grassian, *supra* note 149 at 330-331.

Once transferred, there was inadequate follow-up and little continuity with respect to their mental health needs. NWAC notes that, for Aboriginal women, transfer between institutions replicates child welfare/guardianship transfers that are common to inter-generational residential school survivors who are criminalized and may re-traumatize survivors.¹⁵¹

Section 28 of the CRRA outlines the criteria for selection of the appropriate institutional setting for a particular prisoner:

Where a person is, or is to be, confined in a penitentiary, the Service shall take all reasonable steps to ensure that the penitentiary in which the person is confined is one that provides the least restrictive environment for that person, taking into account

- (a) the degree and kind of custody and control necessary for
 - (i) the safety of the public,
 - (ii) the safety of that person and other persons in the penitentiary, and
 - (iii) the security of the penitentiary;
- (b) accessibility to
 - (i) the person's home community and family,
 - (ii) a compatible cultural environment, and
 - (iii) a compatible linguistic environment; and
- (c) the availability of appropriate programs and services and the person's willingness to participate in those programs.

Given that a significant portion of FSW are mothers and/or have significant family responsibilities,¹⁵² s. 28(b)(i) of the CRRA offers an important legal entitlement. However, given that many FSW are imprisoned in regional prisons far from their homes it is nearly impossible for CSC to adhere to these legal entitlements for FSW. This is even more the case when women are transferred between institutions. For example, Ashley Smith was originally from New Brunswick and ended up dying at GVI in Ontario, and K.J., who is originally from Saskatchewan, is currently serving her sentence in Ontario and, as a result, has little interaction with her family. Bobby-Lee Worm, who is also originally from Saskatchewan, is serving her sentence in British Columbia.

In relation to s. 28(c), as noted above, it is unclear the extent to which mental health services, including trained psychological staff and programs, are available in the regional prisons. Our request to CSC for information on this question yielded few tangible results, but consultation with experts such as Kim Pate from CAEFS and the cases above make it clear that there remains a dearth of such services.

¹⁵¹ Cook, *supra* note 11.

¹⁵² Seventy-seven percent of FSW have children: *Annual Report of the Office of the Correctional Investigator: 2010-2011*, *supra* note 9 at 50.

Finally, s.28 of the CCRA envisions confinement of FSW in “the least restrictive environment for that person.” This is a subjective standard that must be assessed from the perspective of the individual FSW. Yet, for FSW who are housed in regional multi-level prisons with little distinction between medium and minimum-security, this commitment is illusory. This is despite the fact that CSC’s own *Creating Choices* Task Force commissioned over two decades ago found that FSW have unique needs and present a relatively low security risk. The lack of appropriate institutional settings to house FSW in the “least restrictive environment” is compounded for women with mental health issues who tend to be over-classified due to the false equation of their needs as risks (see above).

Section 29 of the CCRA states that the Commissioner of Corrections may authorize the transfer of a prisoner in accordance with relevant regulations. Section 12 of the CCRR provides that prisoners are to be given written notice of the proposed transfer (including reasons therefore) (s. 12(a)), an opportunity to prepare representatives related to the transfer (s. 12(b)), and are to receive written notice of the final decision related to the transfer (s.12(d)). According to s. 13, the provisions in s. 12 do not apply where the Commissioner or a designated staff member determines “that it is necessary to immediately transfer an inmate for the security of the penitentiary or the safety of the inmate or any other person.” According to s. 16 of the CCRR and CD 701-2.26, every movement between institutions in Canada requires a transfer warrant.

The transfer of a prisoner at risk for suicide/self-injury is covered under CD 710-2.29, which stipulates that no offender who is at elevated risk for suicide/self-injury will be transferred to an institution other than a treatment facility unless the attending psychologist or psychiatrist, in consultation with the Institutional Head or delegate, and other health service professionals as required, deems that the transfer would reduce the offender’s risk for suicide or self-injury.

The transfer of prisoners to and from a CSC regional health or psychiatric centre is covered under CD 710-2.85 to 2.92. CD 710-2.89 states that, where a prisoner has been identified as being at risk for suicide or self-injury, the transfer will not be effective until: a case conference/teleconference is held between the Clinical Directors, or delegate, of the respective treatment centres, or between the Clinical Director, or delegate, and the participating psychologist or psychiatrist of the Mental Health Team at the sending/receiving facility; and the receiving facility completes an interim plan for managing the individual.

Under this regime the interim management plan for the person must be completed within seven days. However, an exception is made where the transfer is made for “urgent medical or security reasons.”¹⁵³ In all cases, within 14 days of the transfer of a person at risk of suicide or self-injury, a Mental Health Team will “make a determination regarding the need

¹⁵³ Correctional Service Canada, Commissioner’s Directive 710-2.91, “Transfer of Offenders”, online: <<http://www.csc-scc.gc.ca/text/plcy/cdshtm/710-2-cd-eng.shtm>>: An exception regarding the completion of an interim plan for the offenders referred to in paragraphs 89 and 90 will be made in the event of a transfer for urgent medical or security reasons.

for a more comprehensive plan for managing the offender, including, as appropriate, a Clinical Management Plan.”¹⁵⁴ It is important to note that the provision does not require that the Mental Health team make a management plan for anyone at-risk within 14 days, but rather that the Team determine whether there *is* a need for a (more) comprehensive plan.

There is no statutory limit on the number of transfers to which one prisoner can be subject. For example, Ms. Smith was transferred 17 times in less than one year. Moreover, there is no clear process by which FSW, especially those with mental health issues, can access a judge or third party adjudicator to assess their repeated transfer and associated disruptions in their treatment, and severing of community and family support. It is notable that these transfers were authorized despite the language in s. 87(a) which that CSC must take into consideration the prisoner’s state of health and health care needs in decisions related to transfers.

In comparison to the standard procedures for the transfer of FSW, CSC has developed a list of factors that must be identified and analyzed in the case of any transfer of an Aboriginal prisoner. Specifically, CSC staff must provide a description of the offender’s social history, and identify, analyze and consider how the following factors have impacted the prisoner’s criminal behaviour:

- effects of residential school system (offender as survivor or intergenerational effects from family’s historical experiences) and sixties scoop;
- family or community history of suicide, substance abuse, victimization, fragmentation;
- level of connectivity with family/community;
- level or lack of formal education;
- experience in child welfare system;
- experience with poverty;
- loss of or struggle with cultural/spiritual identity; and
- exposure to, or affiliation with, gangs.¹⁵⁵

Assuming that these specialized procedures are complied with, they constitute welcome progress in improving sensitivity to the unique needs of Aboriginal prisoners, albeit not addressing the particular experience of Aboriginal FSW versus that of Aboriginal men. Though we requested information from CSC regarding the institutional transfer of FSW with mental health issues, including information disaggregated by Aboriginal status, we did not receive relevant information that would allow us to assess whether CSC actually complies with these specialized procedures in practice. However, the cases of Ms. Worm and K.J. illustrate that Aboriginal women with serious mental health issues continue to be incarcerated far from their families and communities.

¹⁵⁴ *Ibid.*

¹⁵⁵ Correctional Service Canada, “Content Guidelines—Assessment for Decision for Transfers”, online: <<http://www.csc-scc.gc.ca/text/plcy/cdshtm/710-2-cd-eng.shtml>>.

Use of force against FSW with mental health issues

According to Kim Pate of CAEFS, Ashley Smith, Bobby-Lee Worm and K.J. were subject to countless numbers and types of uses of force. According to s. 96(z.5) of the CCRA the Governor in Council may make regulations “prescribing procedures to be followed after the use of force by a staff member”. CD 567-1 defines “use of force” as follows:

Any action by staff, on or off of institutional property, which is intended to obtain the cooperation and gain control of an inmate, by using one or more of the following measures:

- (a) non-routine use of physical restraint
- (b) physical handling/control
- (c) use of inflammatory and/or chemical agents...
- (d) use of batons or other intermediary weapons
- (e) use of firearms...
- (f) deployment of the Emergency Response Team in conjunction with at least one of the use of force measures identified above

Closely related to the use of force is the management of security incidents. CSC has its own Situation Management tool that it provides to staff to enable them to determine the correct response when they are faced with a particular security situation.¹⁵⁶ According to this tool, prisoner behavior can be categorized into six types, from least to most threatening:

1. cooperative,
2. verbally resistive,
3. physically uncooperative,
4. assaultive,
5. shows potential to cause grievous bodily harm or death,
6. escape

The responding CSC staff member’s characterization of an incident is of great significance in terms of the force eventually used. There is a direct correlation between more threatening behavior types by a prisoner and more invasive responses by CSC staff. For example, according to CD 567.36, restraint equipment may be used in a situation where the prisoner’s behavior is within the cooperative (#1 above) to assaultive (#4 above) range.¹⁵⁷ Once a prisoner’s behavior is identified as physically uncooperative (#3 above) or more threatening, CSC staff may respond with inflammatory sprays, chemical agents, and/or physical handling.¹⁵⁸ According to CD 567.38, these more invasive approaches can be used when a CSC staff member has attempted to de-escalate the situation using verbal

¹⁵⁶ Correctional Service Canada, Commissioner’s Directive 567, “Management of Security Incidents”, online: <<http://www.csc-scc.gc.ca/text/plcy/cdshtm/567-cd-eng.shtm>> at Annex A—Situation Management Model.

¹⁵⁷ *Ibid*: restraint equipment may be used in a situation where the prisoner’s behavior is within the cooperative to assaultive range.

¹⁵⁸ *Ibid*: inflammatory sprays, chemical agents and physical handling are most often use in combination when offender behavior is physically uncooperative.

intervention or restraint equipment, but these responses “have proven ineffective or assessed as inappropriate options for the situation.”¹⁵⁹

The language employed here merits scrutiny. As suggested by the wording of CD 567, there is significant deference to the perspective of the CSC staff member addressing events unfold in the prison context. While this may be desirable, it is crucial to consider how CSC staff are trained to respond in these types of situations, and how their performance is assessed following an incident or intervention. In particular, it is essential to understand how and whether the legal requirement to use the least restrictive means necessary is integrated into staff training and subsequent performance evaluations. Put differently, it is not the language of the policy that is most critical here, but rather the system of incentives and disincentives at an institutional level that shape how a given CSC is likely to react in a (potential) crisis situation involving an FSW. Moreover, recent changes to the CCRA occasioned by the omnibus crime bill reinforce staff impulse to use the most expedient, or appropriate rather than the least restrictive measures available.

CSC explicitly recognizes the application of the *Criminal Code* to its staff and the provisions related to use of force by police officers and prison guards are explicitly cross-referenced within various CSC regulations and policies relating to the use of force. In addition CD 567.8(h) stipulates that: “no person must ever consent to or take part in any cruel, inhuman or degrading treatment or punishment of an inmate.”¹⁶⁰ However, it is far from clear where the line between an accurate assessment of an appropriate response strategy ends, and where degrading treatment begins. For example, how hard does a CSC staff member have to try to make headway with a “physically uncooperative” prisoner using moderate means, before they are entitled to declare that such modest responses ineffective? Indeed, the provision stipulates that CSC staff may proceed directly to the more invasive and serious responses in any situation where they have “assessed as inappropriate” alternative options. On one reading, this suggests that without even attempting to de-escalate a situation using the least invasive measures possible, CSC staff may proceed straight to more serious responses in accordance with their own judgment.

The potential ramifications of this complete deference to staff discretion are immediately clear when one considers a confrontation between a CSC staff member and a FSW with mental health issues. First, without effective treatment and community support, such a woman is more likely to exhibit the type of behaviours that justify use of force (such was the case with Ms. Smith, and remains the case with Ms. Worm and K.J.). Second, according to Kim Pate from CAEFS, even those with training in mental health issues tend to default to punitive correctional approaches to deal with FSW with mental health issues: security concerns always trump mental health considerations.

These ramifications have been highlighted by the Correctional Investigator. In the case of an anonymous female prisoner profiled in the *Annual Report of the Office of the Correctional*

¹⁵⁹ *Ibid*: these would be used when verbal intervention or restraint equipment have proven ineffective or assessed as inappropriate options for the situation.

¹⁶⁰ *Ibid*.

Investigator, 2009-2010, the Investigator noted that “on almost every occasion of self-harm, her behaviour is met with overly restrictive, punitive and security-based interventions that often necessitate use of force”.¹⁶¹ In the *Annual report of the Office of the Correctional Investigator, 2010-2011*,¹⁶² he notes that “there is an inconsistent understanding of whether the use of physical restraints is a ‘reportable’ use of force or a clinical intervention....This confusion highlights the lack of alignment between security practices and health care interventions in the management of self-injurious behaviour.”

Further, the Union of Canadian Correctional Officers emphasized that inadequate training was a problem in the case of Ashley Smith. A correctional officer at the Regional Psychiatric Centre stated that “[w]e weren’t prepared at all...There was no plan to deal with her. There was no clear direction on what to do”.¹⁶³

This scenario becomes even more worrisome when one considers the provisions of CD 567.39-41 which regulate responses to more serious incidents. While firearms are to be used as a last resort,¹⁶⁴ CSC staff are entitled to respond with batons and other intermediary weapons such as canines or high pressure water where “offender behavior is assaultive or worse, and/or other responses are not available, have proven ineffective, or have been assessed as inappropriate”.¹⁶⁵ The experiences of Ashley Smith and Renee Acoby¹⁶⁶ offer but two examples of how easily these policies can lead to escalation of potential crisis situations in a manner that is extremely harmful to women in prison .

There is some attempt in the Commissioner’s Directives to include safeguards relating to the use of force. Following any use of force, for example, CSC staff are required to prepare and submit a “use of force package,” which includes a: Use of Force Report, Offender Management System Incident Report, copy of all incident-related video¹⁶⁷, action plan to address identified deficiencies or deal with violations of law and/or policy, and any other documentation relating to the use of force.

¹⁶¹ *Annual Report of the Office of the Correctional Investigator, 2009-2010*, *supra* note 21 at 18.

¹⁶² *Annual report of the Office of the Correctional Investigator, 2010-2011*, *supra* note 21 at pp. 15-16.

¹⁶³ *A Rush to Judgment*, *supra* note 51 at 22.

¹⁶⁴ *Ibid.*

¹⁶⁵ *Ibid.*

¹⁶⁶ Renee Acoby is an inmate at the Edmonton Institution for Women who was original sentenced to 3 ½ years for trafficking cocaine and assault with a weapon at the age of 21. She was subsequently charged for acts committed inside two institutions, including an attempted escape and several hostage takings, and 18 years were added to her initial sentence. While in prison, Acoby was transferred and put in isolation countless times: after being designated as “high risk” by CSC, she spent almost an entire seven years in isolation under CSC’s controversial Management Protocol penal measures, which are described elsewhere in this memo. Acoby is the third woman in Canadian history to be classified as a “dangerous offender”. See John McFarlane, *supra* note 143.

¹⁶⁷ Correctional Service Canada, Commissioner’s Directive 567.1(24), “Use of Force”, online: <<http://www.csc-scc.gc.ca/text/plcy/cdshtm/567-1-cd-eng.shtm>>: a video recording must be made from the beginning of any planned use of force, and as soon as possible once a spontaneous use of force is under way.

In theory, the above legal requirements should mean that detailed information regarding any noteworthy use of force in a Canadian prison resides with CSC; however, when we requested access to the same (with personal information redacted) we received nothing. It is also worth noting that, ironically, as a result of these safeguards and the associated worries from management that there were too many use of force incidents at the institution, correctional staff at GVI were instructed not to intervene to save Ms. Smith's life and instead watched as she suffocated to death.¹⁶⁸

Self-harm, self-injury, and suicidal behavior

According to the 2003 CHRC report, self-destructive behaviors such as slashing and cutting are more prevalent among female than male prisoners.¹⁶⁹ Ms. Smith's case is characterized by incidents of self-harm and injury, while K.J. reported harming herself in the past. Indeed, it would not be surprising to find a high correlation between serious mental health issues and self-harm. Again, we requested information from CSC that would explore this correlation, but received nothing.

A new Commissioner's Directive, CD 843, was issued in July 2011 in direct response to the widely publicized incidents surrounding Ms. Smith's death. This directive addresses the management of prisoner behavior where self-injury and suicide are at issue. According to CSC, the primary policy objective here is "to ensure the safety of prisoners who are self-injurious or suicidal using the *least restrictive measures* for the purpose of preserving life and preventing serious bodily injury, while maintaining the dignity of prisoners in a safe and secure environment"(emphasis added).¹⁷⁰ Addressing directly the staff inactions in relation to Ms. Smith's death, CD 843.6(a) stipulates that staff will *intervene immediately* when a prisoner is discovered in the act of self-injury or suicide. Interventions must be in accordance with the Situation Management Model.¹⁷¹ Annex C of CD 843 guides the process for self-injury intervention: CSC has developed a flow chart diagram to illustrating the key steps that should be followed by CSC staff when intervening in a self-injury situation.¹⁷²

CD 705-3, "Immediate Needs and Admissions Interviews," governs screening for suicide risk. Under CD 843.10 all prisoners are to be screened using the Immediate Needs Checklist-Suicide Risk. CD 843.11 provides that this screening tool is to be used: within 24 hours of arrival to a new institution, upon admission to administrative segregation, and/or where there is reason to believe that the prisoner may present some risk for suicide and a mental health professional is not immediately available. According to the screening test, an observation level will be assigned to the prisoner. There are three possible observation levels: high suicide watch, modified suicide watch, and mental health monitoring.

¹⁶⁸ *A Rush to Judgment*, *supra* note 51 at 31.

¹⁶⁹ *Protecting Their Rights*, *supra* note 18 at 8.

¹⁷⁰ Correctional Service Canada, Commissioner's Directive 843, "Management of Inmate Self-Injurious and Suicidal Behaviour", online: <<http://www.csc-scc.gc.ca/text/plcy/cdshtm/843-cd-eng.shtm>>.

¹⁷¹ The Situation Management Model is elaborated in CD 567, *supra* note 156.

¹⁷² Commissioner's Directive 843, "Management of Inmate Self-Injurious and Suicidal Behaviour", *supra* note 170 at Annex C: Self-Injury Intervention.

Depending on which level is assigned, a different set of monitoring procedures will be required.¹⁷³

CSC has a two-pronged method for intervention with prisoners who self-injure. In the short term, CSC staff are instructed to develop a Critical Response and Incident Management Plan (CRIMP). This plan is essentially a review of the prisoner's behavior following a self-injury incident and includes an interview with the prisoner. Where numerous incidents of self-injury take place, separate CRIMPs are to be initiated.

The second prong of self-injury intervention is focused on the longer term: for prisoners who engage in self-injury "repetitively and whose ongoing behavior is posing significant challenges to the institution."¹⁷⁴ This prong takes the form of an Interdisciplinary Management Plan, which is described as an integrated "case management and security intervention" plan designed to help staff effectively manage prisoners with complex self-injury needs. Under this latter approach, prisoners are required to undergo a Comprehensive Psychological Assessment and a Comprehensive Suicide/Self-Injurious Assessment (CSSIA). According to CSC, the CSSIA must be completed by a psychologist or psychiatrist who works in one of the CSC institutions or is contracted for this purpose. The CSSIA involves a detailed self-injury assessment, "focused on triggers (past, present and changes), factors affecting risk, offender goals and treatment targets;" it provides a synthesis of self-injury and suicidal behaviour over time, including "changes in mood, lethality, risk, areas of increased/decreased clinical concern".¹⁷⁵

¹⁷³ *Ibid*: prisoners on the observation level of modified suicide watch may be monitored by Closed Circuit Television (CCTV). For women prisoners, CSC stipulates that CCTV monitoring will be done in accordance with CD 577 ("Operational Requirements for Cross-Gender Staffing in Women Offender Institutions").

¹⁷⁴ *Ibid*: According to CSC, the IMP must be completed for those atypical prisoners who repeatedly exhibit behaviour that endanger their life or physical integrity, who are often the subject of special incident reports, and for whom known standard intervention practices do not seem to produce the desired results."

¹⁷⁵ Correctional Service Canada, "Comprehensive Suicide/Self-Injury Assessment", online: <<http://www.csc-scc.gc.ca/text/plcy/cdshtm/843-cde-eng.shtml>>.

V. CANADA'S TREATMENT OF FSW WITH MENTAL HEALTH ISSUES VIOLATES INTERNATIONAL LAW

In this section, we find that Canada's treatment of FSW with mental health issues violates international human rights law, particularly, under the UN *Convention on the Rights of Persons with Disabilities* (CRPD).

The CRPD entered into force on May 3, 2008. To date, 153 states have signed the Convention and agreed to be bound by its provisions. The Optional Protocol of the CRPD, which permits individuals to submit complaints regarding alleged violations of their rights under the CRPD to the Committee on the Rights of Persons with Disabilities ("CRPD Committee"), has received 90 signatures.

Canada signed the CRPD on March 30 2007 and ratified it on March 11, 2010, but is not a party to its Optional Protocol.¹⁷⁶ This means that Canadians cannot launch complaints to the CPRD Committee in relation to alleged violation of their rights. On the occasion of Canada's ratification of the CRPD, the Honourable Diane Finley, then Minister of Human Resources and Skills Development, emphasized Canada's commitment to the CRPD, stating that "[t]he ratification of this agreement is just further acknowledgement that Canada is a world leader in providing persons with disabilities the same opportunities in life as all Canadians."¹⁷⁷

An important goal of the CRPD is to shift the conception of persons with disabilities from one where these individuals are treated as "objects of medical treatment, charity and social protection", to one in which they are recognized as active subjects of human rights.¹⁷⁸ The aim of the CRPD is not to enshrine new human rights *per se*, but to clarify the application of existing human rights to persons with disabilities.¹⁷⁹

Article 1 of the CRPD explicitly includes individuals with mental health issues in the definition of persons with disabilities: "[p]ersons with disabilities include those who have long-term...mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."¹⁸⁰ This is an appropriately broad definition that does not slavishly apply medical diagnoses but rather focuses on the extent to which the mental health issues hinder participation in society.

¹⁷⁶ UN Treaty Collection, *Status of Treaties*, online:

<http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en>; UN Treaty Collection, *Status of Treaties*, online:

<http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15-a&chapter=4&lang=en>.

¹⁷⁷ Foreign Affairs and International Trade Canada, News Release, No 99, "Canada Ratifies UN Convention on the Rights of Persons with Disabilities" (11 March 2010) online: <

<http://www.international.gc.ca/media/aff/news-communiqués/2010/99.aspx?view=d>>.

¹⁷⁸Office of the High Commissioner for Human Rights, *Convention on the Rights of Persons with Disabilities: Advocacy Toolkit*, UNHCHR, 2008, HR/P/PT/15 at 7.

¹⁷⁹ *Ibid.*

¹⁸⁰ *Convention on the Rights of Persons with Disabilities*, 3 May 2008, 993 UNTS 3 [CRPD] at Art. 1.

Article 3 enumerates the principles that underlie the interpretation and implementation of the Convention as follows:

- a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
- b) Non-discrimination;
- c) Full and effective participation and inclusion in society;
- d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- e) Equality of opportunity;
- f) Accessibility;
- g) Equality between men and women;
- h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.¹⁸¹

Article 4 of the CRPD outlines the general obligations of States Parties.¹⁸² As with other human rights treaties, all States Parties have three overarching obligations. The first is to *respect*, which mandates non-interference by States in the rights of persons with disabilities. The second is to *protect*, which requires States to prevent violations of rights by third parties. The third is to *fulfill*, which entails the positive legislative, administrative and judicial actions that States must undertake to fully realize the protected rights.¹⁸³ In short, there is a continuum of duties placed on States, with negative obligations (non-interference) at one end and positive obligations (active reform) at the other. The particular level of action that is required of a State will vary according to the circumstances, including the right at issue and the current level of protection for that right in the State.¹⁸⁴

The CRPD is a relatively new human rights instrument and there very little authoritative interpretation of the rights contained therein. As of the writing of this report, the CRPD Committee had received 25 initial country reports, and had not issued any recommendations related to individual complaints. That said, other human rights instruments to which Canada is a party¹⁸⁵ provide guidance on the interpretation of the CRPD, especially since the CRPD is not intended to create new rights but rather apply existing rights in the disability context.

¹⁸¹ *Ibid* at Art. 3.

¹⁸² *Ibid* at Art. 4.

¹⁸³ Department of Economic and Social Affairs, Office of the High Commissioner for Human Rights and Inter-Parliamentary Union, *From Exclusion to Equality: Realizing the Rights of Persons with Disabilities*, 2007 at 20.

¹⁸⁴ Ida Elisabeth Koch, "Dichotomies, Trichotomies or Waves of Duties?" (2005) 5(1) *Human Rights Law Review* 81 at 85.

¹⁸⁵ Canada is a party to the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the Convention against Torture and the Convention on the Elimination of all Forms of Discrimination against Women. See: UN Treaty Collection, *Status of Treaties*, online: <<http://treaties.un.org>>.

In the following subsection, we consider various obligations under the CRPD, their proper interpretation, and whether CSC is in breach of them in light of their treatment of FSW with mental health issues.

A. LIBERTY AND SECURITY OF THE PERSON; ACCESS TO JUSTICE; AND FREEDOM FROM CRUEL, INHUMAN AND DEGRADING TREATMENT

Article 14 of the CRPD protects the liberty and security of person of persons with disabilities:

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
 - a. Enjoy the right to liberty and security of person;
 - b. Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.
2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.¹⁸⁶

The CRPD defines reasonable accommodation as “necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.”¹⁸⁷

Article 14(2), which is aimed specifically at the rights of persons with disabilities in prisons, is especially relevant to the treatment of FSW with mental health issues and, in particular, their treatment in segregation. It is under this article that the CRPD Committee inquires into prison conditions for persons with disabilities. For instance, in the List of Issues presented to Tunisia, the Committee asked, under Article 14:

To what extent are persons with disabilities represented in the criminal justice system? What special measures are provided for in the law for persons with disabilities? Please outline the training programmes established for judicial officials and for prison officials on the rights of persons with disabilities, and to what extent they are mandatory.¹⁸⁸

¹⁸⁶ CRPD, *supra* note 180 at Art. 14.

¹⁸⁷ *Ibid.* at Art. 2.

¹⁸⁸ Committee on the Rights of Persons with Disabilities, *List of issues to be taken up in connection with the consideration of the initial report of Tunisia (CRPD/C/TUN/1), concerning articles 1 to 33 of the Convention on the Rights of Persons with Disabilities*, 2010, CRPD/C/TUN/Q/1.

In its List of Issues for Spain, the CRPD Committee asked, under Article 14:

Please provide information on the general directives and norms ensuring that persons with disabilities who are deprived of their liberty following a judicial process are treated in compliance with international human rights law on an equal basis with others and are provided with reasonable accommodation if necessary.¹⁸⁹

Additionally, several initial country reports submitted to the CRPD Committee consider the treatment of persons with disabilities in prisons under this Article.¹⁹⁰ For example, in China's Initial Report, the provision of basic medical and psychological care for prisoners with disabilities is mentioned under Article 14.¹⁹¹ Similar information is provided in Azerbaijan's Initial Report.¹⁹² In its Initial Report, under Article 14, Australia details its policies and practices that relate to the detention of persons with disabilities.¹⁹³ With regards to prisoners with mental health issues, these include a special unit for prisoners with cognitive impairment, disability-specific training for corrections staff, and a pilot project that consists of special training for staff, Disability Support Workers in prisons and a partnership with an NGO to provide support for transition into the community.¹⁹⁴

The right to liberty and security of the person is also protected by Article 9 of the *International Covenant on Civil and Political Rights* (ICCPR) which provides:

1. Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.
2. Anyone who is arrested shall be informed, at the time of arrest, of the reasons for his arrest and shall be promptly informed of any charges against him.

¹⁸⁹ Committee on the Rights of Persons with Disabilities, *List of issues to be taken up in connection with the consideration of the initial report of Spain (CRPD/C/ESP/1), concerning articles 1 to 33 of the Convention on the Rights of Persons with Disabilities*, 2011, CRPD/C/ESP/Q/1.

¹⁹⁰ See e.g. *Australia's Initial Report under the Convention on the Rights of Persons with Disabilities*, 2010, CRPD/C/AUS/1; *Implementation of the Convention on the Rights of Persons with Disabilities, Initial reports submitted by States Parties under Article 35 of the Convention, China*, 2010, CRPD/C/CHN/1; *Initial Report of the Republic of Azerbaijan about the implementation of the UN Convention "On the Rights of Persons with Disabilities"*, 2011, CRPD/C/AZE/1; *UK Initial Report on the UN Convention on the Rights of Persons with Disabilities*, 2011, CRPD/C/GBR/1.

¹⁹¹ *Implementation of the Convention on the Rights of Persons with Disabilities, Initial reports submitted by States Parties under Article 35 of the Convention, China*, *supra* note 190 at para. 60.

¹⁹² *Initial Report of the Republic of Azerbaijan about the implementation of the UN Convention "On the Rights of Persons with Disabilities"*, *supra* note 190 at 17.

¹⁹³ *Australia's Initial Report under the Convention on the Rights of Persons with Disabilities*, *supra* note 190 at paras. 79-84.

¹⁹⁴ *Ibid.* at paras. 81-82.

3. Anyone arrested or detained on a criminal charge shall be brought promptly before a judge or other officer authorized by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release. It shall not be the general rule that persons awaiting trial shall be detained in custody, but release may be subject to guarantees to appear for trial, at any other stage of the judicial proceedings, and, should occasion arise, for execution of the judgement.

4. Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful.

5. Anyone who has been the victim of unlawful arrest or detention shall have an enforceable right to compensation.¹⁹⁵

Under Article 9, the Human Rights Committee (HRC), the treaty-monitoring body for the ICCPR, emphasizes the importance of recourse to a court for persons subject to detention. The HRC held that “whenever a decision depriving a person of his liberty is taken by an administrative body or authority, there is no doubt that article 9, paragraph 4, obliges the State party concerned to make available to the person detained the right of recourse to a court of law.”¹⁹⁶ The finding that recourse to a court of law is a necessary component of the right to liberty and security of the person was also made by the HRC in the context of immigration detention in *C v. Australia*¹⁹⁷ and in the context of psychiatric detention in *A v. New Zealand*.¹⁹⁸

The “Istanbul Statement on the Use and Effects of Solitary Confinement” recommends that solitary confinement be absolutely prohibited for prisoners with mental health issues.

In *Antti Vuolanne v. Finland*, the complainant was a member of the military who was subject to solitary confinement for ten days as a form of discipline for leaving his garrison without permission. The HRC found that Article 9(4) applied to this case since the discipline went

¹⁹⁵ *International Covenant on Civil and Political Rights*, 16 December 1966, 999 UNTS 171 [ICCPR] at Art. 9.

¹⁹⁶ *Ibid.* at para. 9.6.

¹⁹⁷ UN Human Rights Committee, *C v. Australia*, Communication No. 900/1999, A/58/40 (2002) [*C v. Australia*] at para. 8.3 (Review of the complainant’s detention was only a formal assessment of whether or not he was a non-citizen without an entry permit. This was not sufficient since there was no opportunity for a court to substantively review the complainant’s detention).

¹⁹⁸ UN Human Rights Committee, *A v. New Zealand*, Communication No. 754/1997, A/54/40 (1999) at para. 7.3 (Complainant’s detention under Mental Health Act was regularly reviewed by courts and thus did not constitute a violation of Article 9(4)).

“over and above the exigencies of normal military service and deviate[d] from the normal conditions of life within the armed forces of the State party concerned”.¹⁹⁹ This situation is analogous to that of prisoners, who are already subject to a deprivation of liberty, but for whom segregation goes “over and above” the normal level of that deprivation.

Closely related to protection of liberty and security of person in Article 14, is the Article 13 right to access justice when one’s liberty is subscribed. Article 13 states:

1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.
2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.

Article 13(2) specifically mentions the need for appropriate training of prison staff. A number of country reports from States Parties provide information on training for prison staff under Article 13.²⁰⁰ For instance, in its Initial Report, China states that individuals working in the prison system are required to study the CRPD.²⁰¹ Similarly, Australia mentions that training on interviewing persons with cognitive impairments is provided to custodial officers in order to assist them in identifying and communicating effectively with persons with such impairments in its Initial Report.²⁰² The United Kingdom’s Initial Report also notes that prison staff receive training on disability issues.²⁰³

Outside of the CRPD, in its *Handbook on Prisoners with Special Needs*, the United Nations Office on Drugs and Crime makes several recommendations regarding prisoners with mental health issues and access to justice. In particular, it recommends that such prisoners have “immediate and regular access to legal counsel during their whole period of arrest,

¹⁹⁹ UN Human Rights Committee, *Antti Vuolanne v. Finland*, Communication No. 265/1987, U.N. Doc. Supp. No. 40 (A/44/40) at 311 (1989) at para. 9.4.

²⁰⁰ See e.g. *Implementation of the Convention on the Rights of Persons with Disabilities, Initial reports submitted by States Parties under Article 35 of the Convention, China*, 2010, *supra* note 190; *Initial Report of the Republic of Azerbaijan about the implementation of the UN Convention “On the Rights of Persons with Disabilities”*, *supra* note 190; *UK Initial Report on the UN Convention on the Rights of Persons with Disabilities*, *supra* note 190; *Implementation of the Convention on the Rights of Persons with Disabilities, Initial reports submitted by States Parties under Article 35 of the Convention, Peru*, 2010, CRPD/C/PER/1.

²⁰¹ *Implementation of the Convention on the Rights of Persons with Disabilities, Initial reports submitted by States Parties under Article 35 of the Convention, China*, *supra* note 190 at para. 57.

²⁰² *Australia’s Initial Report under the Convention on the Rights of Persons with Disabilities*, *supra* note 190 at para. 71.

²⁰³ *UK Initial Report on the UN Convention on the Rights of Persons with Disabilities*, *supra* note 190 at para. 131.

detention and imprisonment,” and that police and prison authorities should assist prisoners with mental health issues with accessing legal aid.²⁰⁴

Finally, Article 15 of the CRPD prohibits torture and cruel, inhuman, and degrading treatment:

1. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.²⁰⁵

In the prison context, prolonged solitary confinement likely constitutes torture and/or cruel, inhuman or degrading treatment or punishment. In General Comment 20, the Human Rights Committee considered the nature and scope of Article 7 of the ICCPR, which prohibits torture and cruel, inhuman or degrading treatment or punishment,²⁰⁶ including its applicability in the prison context. The Committee notes that Article 7 is complemented by Article 10(1), which provides that: "All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person."²⁰⁷ Additionally, while it declined to stipulate any particular definition of treatment that would violate Article 7, the Committee notes that "prolonged solitary confinement of the detained or imprisoned person may amount to acts prohibited by article 7."²⁰⁸ The General Comment also provides that individuals working in the prison system should receive training regarding this prohibition²⁰⁹ and the Committee specifically requested that States Parties provide detailed information on safeguards that are in place to protect especially vulnerable populations under this Article.²¹⁰

Jurisprudence of the HRC also highlights various conditions of detention that violate Article 7, especially as they relate to persons with mental health issues (even if these develop as a result of the imprisonment). For example, in *C v. Australia*, the complainant was subject to immigration detention for two years. This prolonged detention caused him to develop a serious mental illness. The HRC took the view that "the continued detention of the author

²⁰⁴ United Nations Office on Drugs and Crime, *Handbook on Prisoners with Special Needs*, UNODOC, 2009 at 27.

²⁰⁵ CRPD, *supra* note 180 at Art. 15. In several country reports, the treatment of imprisoned persons with disabilities is considered under this Article [Initial Report of the Republic of Azerbaijan about the implementation of the UN Convention "On the Rights of Persons with Disabilities", *supra* note 190]. For example, under Article 15, Austria describes the investigation into reports of mistreatment by police or prison officers UN Disability Rights Convention: First State Report of Austria, 2010, CRPD/C/AUT/1. at 23]

²⁰⁶ ICCPR, *supra* note 195 at Art. 7: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

²⁰⁷ *CCPR General Comment No. 20*, UNHRC, 44th Sess (1992) [*General Comment No. 20*] at para. 2.

²⁰⁸ *Ibid.* at para. 6.

²⁰⁹ *Ibid.* at para. 10.

²¹⁰ *Ibid.* at para. 11.

when the State party was aware of the author's mental condition and failed to take the steps necessary to ameliorate the author's mental deterioration constituted a violation of his rights under article 7 of the Covenant".²¹¹

In *Campos v. Peru*, the complainant's husband was imprisoned and kept in solitary confinement for 23 ½ hours per day in a cell measuring 2 square metres, without electricity or water, and was not allowed to write or to speak to anyone and was only allowed out of his cell once a day, for 30 minutes. At the time of the communication, the complainant's husband had been detained under these conditions for approximately eight months. The HRC expressed "serious concern" about these conditions and found that they violated Article 7.²¹²

In a 2008 report to the UN General Assembly, the then Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak, describes the relationship between the CRPD's definition of torture and that of the *Convention against Torture* (CAT).²¹³ CAT's definition of torture²¹⁴ requires the infliction of severe pain or suffering, with intent, particular purposes and state involvement.²¹⁵ Acts that do not meet this standard can constitute cruel, inhuman or degrading treatment or punishment.²¹⁶ Further, torture presupposes a condition of powerlessness, which is met when persons with disabilities are subject to detention in prisons.²¹⁷ The Rapporteur indicates that States Parties have an obligation to ensure that prisoners with disabilities are not subject to indirect discrimination and that denial or lack of reasonable accommodations in prisons could constitute ill treatment or torture.²¹⁸

The Special Rapporteur highlights several areas of particular concern in terms of torture or ill treatment of persons with disabilities who are imprisoned. Specifically, he notes that prolonged use of restraints, prolonged solitary confinement or seclusion, and forced or non-consensual administration of psychiatric drugs may constitute ill treatment or torture.²¹⁹ The Rapporteur's position on solitary confinement is based on *The Istanbul*

²¹¹ *C v. Australia*, *supra* note 197 at para. 8.4.

²¹² UN Human Rights Committee, *Campos v Peru*, Communication No 577/1994, UN Doc CCPR/C/61/D/577/1994 (1997) at para. 8.7.

²¹³ *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UNGA, 63rd Sess, A/63/175 (2008) [*Special Rapporteur on Torture*].

²¹⁴ Article 1 of the CAT defines torture as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions": *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987).

²¹⁵ *Special Rapporteur on Torture*, *supra* note 213 at para. 46.

²¹⁶ *Ibid.*

²¹⁷ *Ibid* at para. 50.

²¹⁸ *Ibid* at para. 53.

²¹⁹ *Ibid* at paras. 55-56.

Statement on the Use and Effects of Solitary Confinement. This statement, adopted in 2007 at the International Psychological Trauma Symposium, highlights the negative impact of solitary confinement on mental health.²²⁰ Among its recommendations are that the use of solitary confinement be absolutely prohibited for prisoners with mental health issues.²²¹

Canada is in violation of Articles 13, 14, and 15 of the CRPD through its treatment of FSW with mental health issues and, in particular, through over-reliance on segregation, excessive institutional transfers, and use of force to manage these women; and the lack of judicial review of administrative segregation and institutional transfer.

The over-reliance on administrative segregation and institutional transfers to deal with FSW who exhibit behavioral issues due to serious mental health issues is a discriminatory and unlawful deprivation of their residual liberty under Article 14.

Prolonged segregation of FSW with mental health issues violates Article 15 and is, at the very least, cruel, inhuman, and degrading treatment (if not torture). This is consistent with interpretations from the HRC such as the aforementioned case of *C v. Australia* where immigration detention of two years was found to violate the ICCPR. It is also consistent with the statements of the Special Rapporteur on Torture who found that prolonged solitary confinement or seclusion would violate the CAT. Finally, this finding is consistent with the Istanbul Statement, which recommends that segregation be prohibited for individuals with mental health issues.

Though there is no related case law, it is at least arguable that repeated institutional transfer (which impacts mental health, its treatment, and community support) is also a violation of Article 15 (as cruel, inhuman, and degrading treatment). This is especially the case where transfers are used as a means of thwarting oversight of prolonged segregations, as was the case with Ms. Smith's 17 transfers in less than a year.

The absence of judicial review of administrative segregation and institutional transfer is an independent violation of Articles 13 and 14 of the CRPD. In relation to segregation, this is consistent with *Antti Vuolanne v. Finland*, *C v. Australia*, *A v. New Zealand* which found that judicial review is required to meet the guarantee of liberty and security of the person where a person's liberty is deprived in the context of immigration detention and psychiatric detention, respectively. It is arguable that the lack of judicial review for repeated institutional transfers also results in a violation of Article 13.

Finally, CSC's policies related to use of force may also violate Articles 13, 14, and 15 of the CRPD because CSC staff are authorized to use force against FSW with mental health issues without consideration of their underlying health conditions. Thus, an appropriate use of force in relation to a FSW without mental health issues may rightly be considered an unjustifiable deprivation of liberty or security of person, or cruel and inhuman treatment when applied to a woman with a pre-existing disability. This, in turn, implicates Article

²²⁰ *Ibid* at Annex, p. 23.

²²¹ *Ibid* at Annex, p. 25.

13(2) of the CRPD, which contemplates appropriate training of prison staff. In the wake of Ms. Smith's death, Correctional staff at Grand Valley Institution noted that they were not equipped to deal with her serious mental health issues.

B. EQUALITY AND NON-DISCRIMINATION

Article 5 of the CRPD provides:

1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.
2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.
3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.
4. Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.²²²

Article 6 of the CRPD provides:

1. States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.
2. States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.²²³

In its *Thematic Study on Enhancing Awareness and Understanding of the Convention on the Rights of Persons with Disabilities*, the Office of the High Commissioner for Human Rights (OHCHR) states that Article 5 of the CRPD requires States Parties to guarantee equality and prohibit discrimination on the basis of disability in legislation. Particularly relevant to the treatment of FSW with mental health issues is the requirement that legislation provide for reasonable accommodation, and anticipates the creation of positive measures that promote

²²² CRPD, *supra* note 180 at Art. 5.

²²³ *Ibid* at Art. 6.

the equality of persons with disabilities.²²⁴ Article 6 has not yet been considered by the CRPD Committee in the prison context.

Article 26 of the ICCPR also prohibits discrimination in language similar to the CRPD.²²⁵ Commentary regarding Article 26 of the ICCPR indicates that this Article is to be interpreted as requiring not just protection against discrimination, but also positive action to promote equality.²²⁶ Equality contemplates the exclusion of distinctions that are based on grounds that lack meaning, such as race or gender.²²⁷

Additionally, the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW Committee), which is responsible for monitoring the *Convention on the Elimination of Discrimination against Women*, has recognized the needs of women with respect to health-care, particularly women with mental disabilities.²²⁸ For example, in its General Recommendation No. 24, the Committee states that “special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution, *indigenous women and women with physical or mental disabilities*” (emphasis added).²²⁹ Further, “[w]omen with mental disabilities are particularly vulnerable, while there is limited understanding, in general, of the broad range of risks to mental health to which women are disproportionately susceptible as a result of gender discrimination, violence, poverty, armed conflict, dislocation and other forms of social deprivation.”²³⁰

The CEDAW Committee has also registered concern with the treatment of women in prison in various States, including Belarus, China and the United Kingdom.²³¹ With respect to Canada, the Committee has stated that “[t]he plight of Aboriginal women in prison is of urgent concern.”²³²

²²⁴ *Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities*, UNHRC, 10th Sess., A/HRC/10/48 (2009) at para. 39.

²²⁵ Article 26 states: “All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”

²²⁶ B.G. Ramcharan, “Equality and Non-discrimination” in Louis Henkin, ed, *The International Bill of Rights: The Covenant on Civil and Political Rights* (New York: Columbia University Press, 1981) 246 at 255.

²²⁷ *Ibid.* at 253.

²²⁸ CEDAW Committee, *Andrea Szijarto v. Hungary*, Communication No. 4/2004 (2006); CEDAW Committee, General Recommendation No. 24 (Twentieth session, 1999), CEDAW-12 (1999).

²²⁹ CEDAW Committee, General Recommendation No. 24, *supra* note 228 at para. 6.

²³⁰ *Ibid* at para. 25.

²³¹ Report of the Committee on the Elimination of Discrimination against Women, Twenty-second session (17 January-4 February 2000) & Twenty-third session (12-30 June 2000), UNGA 55th sess., Supplement No. 38 (A/55/38) (2000) at 38 para 370; Report of the Committee on the Elimination of Discrimination against Women, Twentieth session (19 January- 5 February 1999) & Twenty-first session (7-25 June 1999) UNGA 54th sess., Supplement No. 38 (A/54/38/Rev.1) (1999) at 75 para 312.

²³² Report of the Committee on the Elimination of Discrimination against Women, Sixteenth and seventeenth sessions, UNGA 52nd sess., Supplement No.38 (A/52/38/Rev.1 (1999) at 45 para 341.

Canada's security classification system is discriminatory and violates Articles 5 and 6 of the CRPD. Together, Articles 5 and 6 require CSC to undertake positive measures to address the multiple discrimination faced by FSW with disabilities. Yet, to date, CSC has failed to undertake such measures. CSC's approach to security classification discriminates against women, with a particularly negative impact on Aboriginal women and those with mental health issues. CSC has not created a risk assessment tool that is appropriate for women, that appropriately distinguishes between needs and risks, and that addresses the over-classification of Aboriginal women as maximum security. Moreover, despite their different risks and needs, minimum and medium-security women are effectively housed under the same conditions of confinement. This is despite CSC's stated commitment to housing FSW in the "least restrictive environment for that person."

C. RIGHT TO HEALTH

Article 25 of the CRPD provides:

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

- a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
- b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
- c) Provide these health services as close as possible to people's own communities, including in rural areas;
- d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
- e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
- f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.²³³

²³³ CRPD, *supra* note 180 at Art. 25.

Article 25 has not yet been considered by the CRPD Committee in the context of prisoners with disabilities. However, in the Lists of Issues it has so far released, the CRPD Committee has emphasized several aspects of the right to health that could apply to the treatment of FSW with mental health issues in prisons. The most relevant of these aspects is gender-sensitivity in the provision of health care. For example, in the List of Issues adopted for Peru, the Committee asked:

Please provide data on the number of hospitals or care centres accessible to persons with disabilities, offering in particular rehabilitation and mental health services, disaggregated by urban and rural areas. Please indicate how the State ensures the provision of health-care services that are as close as possible to the beneficiaries' own communities and gender sensitive, in accordance with articles 19 and 25 of the Convention.²³⁴

The CRPD Committee has also asked about: the accessibility of information relating to sexual and reproductive health;²³⁵ the accessibility of health care facilities;²³⁶ and legal measures to prevent discrimination against persons with disabilities in the provision of health care and insurance schemes.²³⁷

The Special Rapporteur on the Right to Health emphasizes the vulnerability to human rights abuses faced by persons with mental disabilities in the prison system, as well as the negative effect of prison conditions on underlying mental health issues.

The right to the highest attainable standard of physical and mental health is also enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights ("ICESCR")²³⁸ which provides:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

²³⁴ Committee on the Rights of Persons with Disabilities, *List of issues to be taken up in connection with the consideration of the initial report of Peru (CRPD/C/PER/1), concerning articles 1 to 33 of the Convention*, 2011, CRPD/C/PER/Q/1.

²³⁵ Committee on the Rights of Persons with Disabilities, *List of issues to be taken up in connection with the consideration of the initial report of Tunisia (CRPD/C/TUN/1), concerning articles 1 to 33 of the Convention on the Rights of Persons with Disabilities*, *supra* note 188.

²³⁶ Committee on the Rights of Persons with Disabilities, *List of issues to be taken up in connection with the consideration of the initial report of Spain (CRPD/C/ESP/1), concerning articles 1 to 33 of the Convention on the Rights of Persons with Disabilities*, *supra* note 189.

²³⁷ *Ibid.*

²³⁸ *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3 at Art. 12.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

In its General Comment No. 14, the Committee on Economic, Social and Cultural Rights examined the parameters of the right to the highest attainable standard of health. The Committee determined that the right to health is “an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information”.²³⁹ This right has four elements: availability of public health and health-care facilities; accessibility of health-care, which includes non-discrimination, physical accessibility and economic accessibility; acceptability of health-care facilities, which entails respect for ethics, culture and confidentiality; and quality of health-care facilities, goods and services.²⁴⁰

The Committee placed a particular emphasis on the need for non-discrimination in the provision of health-care and on the specific needs of women, indigenous peoples and people with disabilities.²⁴¹ Additionally, in his report to the sixty-first session of the Commission on Human Rights, the-then Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt, reported specifically on mental disabilities and the right to health. He emphasizes the vulnerability to human rights abuses faced by persons with mental disabilities in the prison system, as well as the negative effect of prison conditions on underlying mental health issues and the high rate of suicides in prisons.²⁴²

In particular, the Special Rapporteur on Health states that the “high rate of persons with mental disabilities, as well as the high rate of suicides, in prisons” is “alarming”.²⁴³ Further, “[p]rison conditions - such as *overcrowding, lack of privacy, enforced isolation and violence* - tend to exacerbate mental disabilities. However, there is often little access to even rudimentary mental health care and support services” [emphasis added].²⁴⁴

²³⁹ *General Comment No. 14*, UNCESCR, 22nd Sess, E/C.12/2000/4 (2000) [*General Comment No. 14*] at para. 11.

²⁴⁰ *Ibid* at para. 12.

²⁴¹ *Ibid* at paras. 18-21, 26-27.

²⁴² *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*, UNCHR, 61st Sess, E/CN.4/2005/51 (2005) at para. 11.

²⁴³ *Ibid*.

²⁴⁴ *Ibid*.

The lack of appropriate mental health care resources in Canada's women's penitentiaries is a breach of the right to health. CSC's own Mental Health Strategy is overly focused on assessment rather than treatment, and does not recognize FSW's past histories of abuse. There are currently only 12 beds available to FSW in an intensive residential setting, despite the fact that at least one-third of FSW have mental health issues. K.J., an FSW with serious mental health issues, sees a psychologist for 20 minutes per week while Ms. Worm was unable to access treatment for her post-traumatic stress disorder while in segregation.

CSC's disproportionate use of segregation and institutional transfers to deal with FSW with mental health issues and exacerbating effects of the same on mental illness also result in a violation of Article 25 of the CRPD.

D. RIGHT TO INFORMATION

Article 31 of the CRPD provides:

1. States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention. The process of collecting and maintaining this information shall:
 - a. Comply with legally established safeguards, including legislation on data protection, to ensure confidentiality and respect for the privacy of persons with disabilities;
 - b. Comply with internationally accepted norms to protect human rights and fundamental freedoms and ethical principles in the collection and use of statistics.
2. The information collected in accordance with this article shall be disaggregated, as appropriate, and used to help assess the implementation of States Parties' obligations under the present Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights.
3. States Parties shall assume responsibility for the dissemination of these statistics and ensure their accessibility to persons with disabilities and others.

This provision is unique to the CRPD and has not yet been interpreted by the CRPD Committee. Its aim is to rectify the historic underrepresentation of persons with disabilities in official statistics.²⁴⁵

²⁴⁵ *Realizing the Millennium Development Goals for persons with disabilities towards 2015 and beyond*, GA Res 65/186, UNGA, 65th Sess, UN Doc A/Res/65/186 (2011).

Article 31 of the CRPD requires Canada to collect, maintain, *disseminate and make accessible* disaggregated statistics on persons with disabilities. However, CSC's response to the IHRP's Access to Information request indicates that statistics on FSW with disabling mental health issues are either unavailable or inaccessible. This constitutes a violation of Article 31. This is especially serious when there are not other means to access this data.

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APPENDIX A: INFORMATION RECEIVED FROM CSC

Table: Information Requested and Received from CSC on prisoners with mental health issues

| | Issue | Document type and details |
|----|--|---|
| 1. | All information, both historic and current, related to the number and percentage of federally sentenced prisoners in Canada with mental health issues, including statistics broken down by region, gender, race (including Aboriginal people) and diagnoses. | <p>Document: "WOC Admissions-Men, Women, Aboriginal, Non-Aboriginal Offenders and Regional Data from FY 1996/97 to FY 2008/09, 2009 (9 pages)</p> <p>Document: "In Custody-Men, Women, Aboriginal, Non-Aboriginal Offenders and Regional Data: Snapshots from FY1997 to FY2009", 2009 (9 pages)</p> <p>Link: "Research Report: The Changing Profile of the Federal Inmate Population: 1997 and 2002" [http://www.csc-scc.gc.ca/text/rsrch/reports/r132/r132_e.pdf], Accessed October 7 2011</p> <p>Link: "Mental Health Strategy Quick Facts" [http://www.csc-scc.gc.ca/text/pblct/qf/11-eng.shtml] Accessed October 7 2011</p> |
| 2 | All information, both historic and current, related to the treatment of and resources available to prisoners with mental health issues (including psychological/psychiatric counseling, cognitive behavioural therapy, pharmacological treatments etc.), including information broken down by region, gender, race (including aboriginal people), and diagnosis. | <p>Document: "Mental Health Services for Offenders", April 2011 (6 pages)</p> <p>Document: "National Strategy to Address the Needs of Offenders Who Engage in Self-Injury", March 2011) (6 pages)</p> <p>Document: "Towards a continuum of care: Correctional Service Canada Mental Health Strategy", July 2009 (8 pages)</p> |
| 3 | All information related to the regional psychiatric centres, including information on eligibility for transfer; average duration of stay; location, physical structure | <p>Link: "Audit of Regional Treatment Centres and the Regional Psychiatric Centre" [http://www.csc-scc.gc.ca/text/pa/adt-toc-eng.shtml] Accessed 3 May 2012</p> |

| | Issue | Document type and details |
|---|--|---|
| 4 | and security; demographic of prisoners; treatment protocols; and use of segregation. | |
| | All information related to the discipline of prisoners with mental health issues, including information broken down by region, gender, race (including Aboriginal people), and diagnosis. | Link: Commissioner's Directive 580: "Discipline of Inmates" [http://www.csc-scc.gc.ca/text/plcy/cdshtm/580-cde-eng.shtml] [Accessed October 7 2011] |
| | | Link: General CSC Research Website [http://www.csc-scc.gc.ca/text/rsrch-eng.shtml] Accessed October 7 2011 |
| 5 | All information relating to the segregation of prisoners with mental health issues, including but not limited to, the total number of prisoners segregated, length of segregation, treatment while segregated, and breakdown according to region, gender, race (including Aboriginal people), and diagnoses. | Document: "Internal Review of Mental Health Concerns of Inmates in Long-Term Segregation", Correctional Service of Canada Mental Health Branch, Dec 2009 (11 pages) |
| 6 | All information relating to the transfer of prisoners with mental health issues, on both a voluntary and involuntary basis, including but not limited to, the total number of transfers, length of stay before transfer, affect on segregation status, and breakdown according to region, gender, race (including Aboriginal people), and diagnoses. | No information provided |
| 7 | All information in relating to the assessment of risk posed by prisoners with mental health issues. | Document: collection of CSC Screening Test Documents (24 pages) |

| | Issue | Document type and details |
|----|---|---|
| | | <p>Link: Commissioner's Directive 705-3 "Immediate Needs and Admission Interviews" [http://www.csc-scc.gc.ca/text/plcy/cdshtm/705-3-cd-eng.shtml], Accessed October 7 2011</p> <p>Direction to General Research Website. Recommended reports "An Initial Report on the Results of the Pilot of the Computerized Mental Health Intake Screening System (CoMHISS)" and "The Psychological Effects of 60 Days in Administrative Segregation", [http://www.csc-scc.gc.ca/text/rsrch-eng.shtml] Accessed October 7 2011</p> |
| 8 | All investigations regarding uses of force against prisoners with mental health issues. | No information provided |
| 9 | All information related to incidents of self-harm, self-injury and/or suicidal behavior by prisoners. | No information provided |
| 10 | All information related to committal proceedings against prisoners. | Link: Commissioner's Directive 803 "Consent to Health Service Assessment, Treatment and Release of Information" [http://www/csc-scc.gc.ca/text/plcy/cdshtm/803-cde-eng.shtml] Accessed October 7 2011. |
| 11 | All information related to the employment of trained professionals (i.e. psychiatrists, psychologists, etc.) by CSC, including information broken down by region, gender, race (including Aboriginal people), and expertise | Document: "PS Classification" (9 pages) |

Summary of Documents Received from CSC through Access to Information Request

Mental Health Services for Offenders

This is a CSC document containing a variety of information on prisoners with mental health issues. It provides suggested messages for the Commissioner and the Minister, as well as background information on the mental health problem in prisons, CSC's Mental Health Strategy, mental health resources and mental health service system. It also highlights current challenges faced by CSC with regards to mental health and suggests opportunities for bridging with other organizations and stakeholders.

National Strategy to Address the Needs of Offenders Who Engage in Self-Injury

This is a CSC publication from March, 2011. It outlines a national CSC strategy whose goal is to reduce the frequency and severity of self-injurious behaviour among prisoners. The publication the strategy's four priorities: (i) research; (ii) strengthened policy and tools; (iii) supporting staff; and (iv) improved interventions.

Towards a Continuum of Care: Correctional Service Canada Mental Health Strategy

This CSC publication from July 2009 details CSC's Mental Health Strategy. In particular, the Strategy has five components: (i) mental health screening upon intake; (ii) primary mental health care; (iii) intermediate mental health care (which the publication notes is currently unfunded); (iv) intensive care at regional treatment centres; and (v) transitional care for release into the community. Management practices that support the Strategy include: (i) professional development for staff; (ii) development of tools to support staff; (iii) research and performance measurement; and (iv) partnerships. This publication also identifies three priorities for the Mental Health Strategy. These are: (i) funding; (ii) recruitment and retention; and (iii) development of a pan-Canadian mental health strategy.

WOC Admissions – Men, Women, Aboriginal, Non-Aboriginal Offenders and Regional Data from FY1997 to FY2009

This document consists of graphs depicting the characteristics of warrant of committal admissions from 1997 to 2009, broken down by gender, region and Aboriginal status.

In-Custody – Men, Women, Aboriginal, Non-Aboriginal Offenders and Regional Data: Snapshots from FY1997 to FY2009

This document consists of graphs depicting the in-custody prison population from 1997 to 2009, broken down by gender, region and Aboriginal status.

The Changing Profile of the Federal Inmate Population: 1997 and 2002

This is a CSC report from January, 2003 which provides a comparison of the profile of the federal prison population at two points in time: March, 1997 and March, 2002. The profiles are separated by gender. With regards to female prisoners, among the report's findings are that the number of women in prison has increased from 1997 to 2002, there are more

women classified as maximum or minimum security and less classified as medium and there was an increase in the proportion of female prisoners with mental health issues.

Mental Health Strategy Quick Facts

This is a link to a page of the CSC website that provides basic information on CSC's Mental Health Strategy, along with a link to the main CSC website for more information.

Audit of Regional Treatment Centres and the Regional Psychiatric Centre

This is a CSC audit from January 2011. Its goal was to provide assurance that the treatment centres have the appropriate controls in place to ensure delivery of mental health services to prisoners. The audit found that a number of areas needed improvement, including a detailed plan for greater integration of physical and mental health services, a definition of essential and non-essential mental health care and tracking of programming and completion of programs.

Commissioner's Directive 580: "Discipline of Inmates"

This Directive describes the disciplinary procedures of CSC. Notably, the principles behind this procedure include taking into account the mental health of the prisoner who is subject to disciplinary action and, where applicable, consulting that prisoner's attending psychiatrist before proceeding. The Directive provides for both informal and formal disciplinary processes and enumerates the procedure for disciplinary hearings and sanctions.

Internal Review of Mental Health Concerns of Inmates in Long-Term Segregation

This December, 2009 CSC report describes an internal review of 103 prisoners in long-term segregation. This review excluded those prisoners who had previously identified mental health issues and studied the remaining individuals for signs of psychological distress. All the women originally included in the review were excluded at this stage because of pre-existing mental health issues. The review ultimately found that prisoners in long-term segregation had high rates of mental health issues, but that most of these mental health issues had been identified prior to segregation. The number of prisoners whose mental health issues had not been previously identified was redacted in the copy of the report sent to the IHRP.

CSC Screening Test Documents

These documents describe the Computerized Mental Health Intake Screening System ("CoMHISS"), used to screen prisoners upon admission. They include: a copy of the screening test; a consent form to participate in the screening process; a Mental Health Intake Assessment Summary Template (used to summarize the screening results); an example of such a Summary; the CoMHISS Administration Monthly Tracking Record Guidelines; and the National/Regional Institutional Current Tests Report.

Commissioner's Directive 705-3: "Immediate Needs and Admission Interviews"

This Directive describes the assessment process that occurs upon admission to prison. First, an Immediate Needs Interview is completed within 24 hours of admission, in which information such as security and suicide risks are evaluated. Then, an Admission Interview is undertaken within one week of admission. This interview includes, among other components, supplementing information gathered from the Immediate Needs Interview and referring the prisoner to any appropriate specialists (including for mental health assessments).

An Initial Report on the Results of the Pilot of CoMHISS

This is a CSC report from March, 2010 on the pilot of CoMHISS. It describes the CoMHISS screening process and the results of the national pilot of this process. However, the pilot only included male prisoners.

The Psychological Effects of 60 Days in Administrative Segregation

This CSC report, dated March, 1999, details the results of a study of 60 prisoners who had spent 60 days in segregation. The study found that, on the whole, these prisoners had worse mental health than other prisoners. However, it did not find that mental health significantly deteriorated as a result of segregation. This study did not include any female prisoners.

Commissioner's Directive 803: "Consent to Health Service Assessment, Treatment and Release of Information"

This Directive describes the consent that must be obtained from a prisoner prior to all medical procedures, all mental health procedures, participation in research and the sharing of health care information. Consent must be voluntary, informed and specific to the assessment, treatment or procedure. If the prisoner does not have the capacity to consent, consent is governed by the relevant provincial law. Prisoners may refuse consent. If a prisoner refuses mental health care, he or she must be advised of the consequences of that refusal and his or her case management officer must be informed in writing.

PS Classification

This chart provides the number of mental health positions at each correctional institution.

APPENDIX B: COVERING LETTER TO COMPLAINT TO INFORMATION COMMISSIONER



Suzanne Legault
The Information Commissioner of Canada
Place De Ville, Tower B
112 Kent Street, 7th Floor
Ottawa, ON K1A 1H3

Dear Ms. Legault:

Re: Complaint to the Information Commissioner of Canada re Information Requested from the Correctional Service of Canada

We are writing to submit a complaint regarding a request made pursuant to the *Access to Information Act* for information within the possession or control of the Correctional Service of Canada (“CSC”).

To assist your office in assessing our complaint, we have prepared and attached a chart that summarizes our claim, including the procedural and substantive responses provided by CSC to each of the enumerated items requested (and outlined below). We submit that the facts outlined herein establish the following grounds of complaint: incomplete search/no records response; deemed refusal; exemptions/exclusions; and the fee assessment to produce records is not justified.

The Original Request and Subsequent Correspondence

By way of letter dated December 3, 2010, we requested “all information within the possession or control of CSC relating to federally-sentenced prisoners with mental health issues.” We specifically requested the items enumerated below.

Following our initial request, we engaged in lengthy and protracted correspondence with CSC in an attempt to move the request forward. This included paying administrative fees; prioritizing, clarifying, and limiting the temporal scope of our requests; and accepting various time extensions sought by CSC.

To assist the Information Commissioner with understanding the myriad correspondence, we have included all correspondence related to each item outlined below under separate tabs.

- Tab 1: All information, both historic and current, related to the number and percentage of federally sentenced prisoners in Canada with mental health issues, including statistics broken down by region, gender, race (including aboriginal people), and diagnoses. (CSC File No: A-2010-00469)

Advisory Board

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- Tab 2: All information, both historic and current, related to the treatment of and resources available to prisoners with mental health issues (including psychological/psychiatric counseling, cognitive behavioural therapy, pharmacological treatments etc.), including information broken down by region, gender, race (including aboriginal people), and diagnosis. (CSC File No: A-2010-00470)
- Tab 3: All information related to the employment of trained professionals (i.e. psychiatrists, psychologists, etc.) by CSC, including information broken down by region, gender, race (including aboriginal people), and expertise. (CSC File No: A-2010-00471)
- Tab 4: All information related to the regional psychiatric centres, including information on eligibility for transfer; average duration of stay; location, physical structure and security; demographic of prisoners; treatment protocols; and use of segregation. (CSC File No: A-2010-00472)
- Tab 5: All information related to the discipline of prisoners with mental health issues, including information broken down by region, gender, race (including aboriginal people), and diagnosis. (CSC File No: A-2010-00473)
- Tab 6: All information relating to the segregation of prisoners with mental health issues, including but not limited to, the total number of prisoners segregated, length of segregation, treatment while segregated, and breakdown according to region, gender, race (including aboriginal people), and diagnoses. (CSC File No: A-2010-00474)
- Tab 7: All information relating to the transfer of prisoners with mental health issues, on both a voluntary and involuntary basis, including but not limited to, the total number of transfers, length of stay before transfer, affect on segregation status, and breakdown according to region, gender, race (including aboriginal people), and diagnoses. (CSC File No: A-2010-00475)
- Tab 8: All information in relating to the assessment of risk posed by prisoners with mental health issues. (CSC File No: A-2010-00476)
- Tab 9: All investigations regarding uses of force against prisoners with mental health issues. (CSC File No: A-2010-00477)
- Tab 10: All information related to incidents of self-harm, self-injury and/or suicidal behavior by prisoners. (CSC File No: A-2010-00478)
- Tab 11: All information related to committal proceedings against prisoners. (CSC File No: A-2010-00479)
- All information relating to death of Ashley Smith, including but not limited to, all segregation reports, all transfer reports, all discipline files, and all psychiatric/psychological reports (including the report prepared by Dr. Margo Rivera). (Please note that we have abandoned this request pending completion of the Coroner's Inquest.)

CSC's Substantive Response

As noted above, we have prepared and attached a chart that summarizes the procedural and substantive responses provided by CSC to each of the bulleted items requested.

Notably, despite that fact that one might expect a request of this scope to generate thousands of relevant documents, we have received almost no substantive information from CSC that was not already publicly accessible. By way of summary, we received 8 documents (some with substantial redacting), and 7 web links to publicly-available documents. In the vast majority of instances, we received no substantive information, either because CSC claimed it did not exist or because they claimed that it was exempted from disclosure under the *Act*. In two instances, we were asked to provide payment for processing; once the fee quoted was \$5356.00 and our request to waive the fee was refused (despite our status as a non-profit public institution). In two instances, we received no response at all.

Conclusion: Access to the Information Sought is in the Public Interest

The issue of mental health in prisons is one which the federal Correctional Investigator has called "perhaps the most pressing issue" facing federal corrections today. In light of this, it seems incomprehensible that CSC would have only 8 documents that might shed some light on the treatment of mentally ill prisoners who are federally incarcerated. It is these issues that are at the core of our request. Given the high profile of the ongoing Ashley Smith inquest, it is clearly in the public interest to have this issue studied and considered by third party organizations such as ourselves. Yet, despite our good faith effort to work with CSC to prioritize and narrow our requests, CSC has consistently failed to substantively respond.

Please do not hesitate to contact me directly if you require any further information or have any questions.

Sincerely,



Renu Mandhane

cc. Ginette Pilon, Correctional Service of Canada, Access to Information and Privacy Coordinator

Cruel, Inhuman and Degrading?

Canada's treatment of federally-sentenced women with mental health issues

The inquest into the 2007 death of Ashley Smith while in federal custody has been repeatedly delayed, but the issues that Ms. Smith's death raises remain pressing. At its most basic level, Ms. Smith died due to the state's conviction that solitary confinement is a legitimate response to mental illness, coupled with systemic discrimination against federally sentenced women who have inadequate mental health treatment and community support. Ms. Smith's death should have been a wakeup call for Canada but, instead, nearly five years and at least four major reports later, Canada has shown absolutely no willingness to address human rights violations against FSW with mental health issues.

This report is the culmination of a 20-month research project spearheaded by the International Human Rights Program (IHRP) at the University of Toronto Faculty of Law. It details Canada's treatment of FSW with mental health issues, and analyzes this treatment through the lens of international human rights law. Our research indicates that the Correctional Service of Canada (CSC) responds to FSW with mental health issues in a discriminatory manner. CSC equates mental health issues with increased risk and responds with excessive use of segregation (sometimes for months at a time), repeated institutional transfers (sometimes over ten times in a year), and use of force (including restraints). This treatment is exacerbated by a lack of adequate mental health care resources for FSW and training for prison staff.

We find that CSC's treatment of FSW with mental health issues is a violation of their rights under international law. Canada's treatment of FSW with mental health issues is discriminatory; results in an unjustified deprivation of liberty without judicial oversight; violates the right to health; and, in cases where women are segregated for long periods or subject to excessive institutional transfers, constitutes cruel, inhuman or degrading treatment. Moreover, CSC's refusal to provide us with basic statistics and information about the treatment of FSW with mental health issues constitutes a further violation of the CRPD.



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