Chapter 13: Mentally Disabled Persons in Prisons and Jails

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I. Introduction

This chapter discusses various aspects of imprisonment and its effect on mentally disabled offenders. It examines the prevalence of mental illness in incarcerated persons and the difficulties faced by these prisoners. It also outlines various human rights issues, the right to treatment and the right to refuse treatment while incarcerated. Finally, the chapter discusses the role of the Correctional Investigator and the provincial Ombudsman in assisting mentally disabled prisoners.

II. Definition: what is mental illness?

The term "Mental Disorders", as discussed here, may include bipolar disorder or schizophrenia, Fetal Alcohol Spectrum Disorders,[1] Alzheimer's Disease, Attention Deficit Hyperactivity Disorder (ADHD), personality disorders, and problems resulting from traumatic head injuries and other disorders that influence the functioning of an individual.[2] It is estimated that up to fifty per cent of prisoners in the criminal justice system have an anti-social personality disorder referred as to psychopathy.[3]

Mental illness is a health issue rather than a criminal law matter.[4] As a result, the criminal justice system has proven ill-equipped to deal with people who suffer from mental illness. For centuries, persons with a mental illness have been systematically isolated, segregated from the mainstream of society, devalued, ridiculed, and excluded from participation in ordinary social and political processes.[5] The criminal justice system is based on a set of assumptions, such as that people act in a voluntary manner that is determined

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[1] Beverly Spencer, "A Different Kind of Justice" 20 The Canadian Bar Association: National 5 (July-August 2011). Online: <http://cbanational.rogers.dgtlpub.com/2011/2011-08-31/pdf/A_different_kind_of_justice.pdf> [Spencer]. FASD is an umbrella term referring to a complex range of brain injuries resulting from, parental exposure to alcohol. It is one of the leading causes of mental retardation, developmental and cognitive disabilities in Canada. Yukon has developed a justice training curriculum on FASD and in 2010 Canadian Bar Association passed a resolution urging the federal government to avoid criminalization of people with FASD and allocate resources to develop solutions.

[2] Correctional Service of Canada, *Let's Talk: Addressing Mental Health Needs of Offenders*, vol 32 (Ottawa: Correctional Service of Canada, 2012) [Let's Talk].

[3] *Health Canada: A Report on Mental Illness in Canada* (Ottawa: Health Canada Editorial Board, 2002) at - 9; Paul Mullen, "*Mental Health and Criminal Justice*" (Criminology Research Council, 2001). Increased rates among prisoners of wide range of mental disorders. Major mental disorders are typically found at 2-4 times the expected rates with substances abuse and personality disorders being even more dramatically represented.

[4] Paul Bentley & Larissa Ruderman, "Problem Solving and Sentencing (2007) 47 CR (6th) 212 [Problem Solving Courts].

[5] Lamer CJC, in *R v Swain*, agrees with the intervener Canadian Disability Rights Council's description of mental treatment of mentally ill cited in Katherine Brown & Erin Murphy, "Falling through the Cracks: the Quebec Mental Health System" (2002) 45 McGill LJ 1037-1079.

by free will, that are contrary to the reality faced by people with mental illness.[6] As the Right Honorable Beverley McLachlin said:

> One can see that the law has changed greatly in recent years in how it treats mentally ill offenders. Arguably it is much fairer, more effective, geared as it is to rehabilitation. It is flexible regime, designed to meet the offender's needs. Our common challenge as doctors, lawyers, and judges is to work together addressing the problems posed by mental illness. Laws cannot change people, only services and treatment provided by medical professionals can achieve that ultimate goal. But the law can create a social and regulatory environment that assists medical professionals in delivering their services in a manner that is both ethical and respectful of the rights and the needs of persons with mental illness.[7]

Today, mental illness and poor mental health have a profound impact on Canadian society. At least one in five Canadians suffers from a mental illness in a given year.[8] Among those, two out of every three adults who need mental health services or treatment do not receive it because of the stigma associated with mental illness.[9] Mental illness costs the Canadian economy $51 billion dollars annually.[10]

People with mental illnesses are less likely to be perpetrators and are more likely to be victims of violence, yet they are over-represented in the criminal justice system.[11] CSC also reports that mental health screening at admissions indicates 62% of the offenders entering a federal penitentiary are flagged as requiring follow-up mental health assessment or service.[12] Additionally, offenders who are diagnosed with mental illness are also typically afflicted by another disorder. For example, many mentally ill offenders also had a substance abuse disorder, which affected four out of five individuals in federal custody.[13]

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[6] Spencer.

[7] Beverley McLachlin, "Medicine and the Law: the Challenges of Mental Illness" (2010) 33 Dalhousie LJ 15 [Beverley McLachlin].

[8] Mental Health Commission of Canada, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (Calgary, 2012) [*Changing Directions*].

[9] *Changing Directions.*

[10] Hélène Côté, "Release of Mental Health Strategy for Canada An Historic Milestone Say Canadian Psychiatrists" (8 May 2012), online: Canada Newswire <http://www.newswire.ca/en/story/970171/release-of-mental-health-strategy-for-canada-an-historic-milestone-say-canadian-psychiatrists>.

[11] *Changing Directions*. Garry Chiamowitz, "The Criminalization of People with Mental Illness*"* (2011) 57 Canadian Journal of Psychiatry 2.

[12] The Correctional Investigator of Canada, *Annual Report of the Office of the Correctional Investigator, 2011-2012* (Ottawa, Her Majesty the Queen in Right of Canada, 2012), online: <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20112012-eng.pdf> at p – 6 -Correctional Investigator Report 2011/2012].

[13] Correctional Investigator Report 2011/2012.

III. Prison Population

A. Female Offenders

The *Corrections and Conditional Release Act* ("*CCRA*") sets out that CSC shall:

> 77(a) provide programs designed particularly to address the needs of female offenders.
> (b) consult regularly about programs for female offenders with
> (i) appropriate women's groups
> (ii) other appropriate persons and groups
> With expertise on, and experience in working with, female offenders.[14]

Women offenders make up approximately 4.9% of the federal corrections population.[15] Over the last decade, the number of female offenders in Federal corrections has increased by 29.7%.[16]

CSC reports that 94% of female offenders in a study sample experienced symptoms consistent with a psychiatric disorder, and that eight out of ten had a history of substance or alcohol abuse.[17] Another study found that 43% of female offenders have engaged in self-injurious behaviour, and that 75% of that sample had attempted suicide at some point in their lifetime.[18] In an earlier 2008 study, CSC noted that 30.1% of female offenders, compared to 14.5% of males, had previously been hospitalized for psychiatric reasons.[19] Further, 50% of federally sentenced women self-reported that they had a history of self-harm, over 50% identified a current or previous addiction to drugs, 85% reported a history of physical abuse, and 68% reported having experienced sexual abuse at some point in their lives.[20]

CSC does not have an independent psychiatric facility to house and treat female

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[14] *Corrections and Conditional Release Act*, SC 1992, c 20 [*CCRA*].
[15] Canada, Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2013-2014* (Ottawa, Her Majesty the Queen in Right of Canada, 2014) [Report 2013/2014].
[16] The Correctional Investigator of Canada, *Annual Report of the Office of the Correctional Investigator, 2016-2017* (2017) online: < www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20162017-eng.pdf > at 59 [Correctional Investigator Annual Report 2016/2017].
[17] Correctional Investigator Annual Report 2016/2017; Canada, Correctional Service Canada, *Mental health needs of federal women offenders*, by Derkzen, D, Booth, L, McConnell, A, & Taylor, K (Ottawa: Correctional Service Canada, 2012) online: <http://www.csc-scc.gc.ca/research/005008-0267-eng.shtml> [Derkzen].
[18] Canada, Correctional Service Canada, *Gender Responsive Corrections for Women in Canada: The Road to Successful Reintegration* (Ottawa, Correctional Service Canada, 2017) online: www.csc-scc.gc.ca/002/002/002002-0005-en.shtml#t1 [Gender Responsive Corrections]; Derkzen.
[19] Correctional Investigator Report 2011/2012.
[20] Correctional Investigator Report 2011/2012.

offenders requiring intensive mental health care.[21] In some regions, women requiring these services are transferred and housed in a segregated unit in male psychiatric institutions. This segregation is discriminatory and not conducive to treatment.[22] The 2002 *Mental Health Strategy for Women Offenders* provides a framework for the development of mental health services for all women offenders within CSC.[23] In April 2012, CSC implemented a modernized holistic approach to correctional programming for women offenders, entitled the Women Offender Correctional Programs (WOCP). The programs are comprehensive, gender-specific, and designed to meet the multi-faceted needs of the women offender population.

However, more needs to be done to implement these programs with a particular need of women offenders with mental illness. As of 2018, there is still a lack of infrastructure and support to respond to the needs of women with significant mental health concerns.[24]

B. Gender differences with respect to mental health

Mental health services and illnesses affect men and women differently and at different stages in life.[25] Thus, the impact of gender needs to be considered in prevention and early intervention efforts.[26] Overall, women outnumber men in all major psychiatric diagnosis, with the exception of anti-social personality disorder. Women are twice as likely as men to suffer from depression. Federally incarcerated women are three times as likely to be moderately and severely depressed compared to incarcerated men. Also, the differences exist in the behavioural manifestations of mental illness between men and women.[27] The proportion of women identified as having a current mental health diagnosis increased from 24% in 2007-08[28] to 46% after the implementation of a mental health screening tool in

[21] House of Commons, Standing Committee in Public Safety and National Security, *Mental Health and Drug and Alcohol Addiction in the Federal Correctional System* (December 2010) (Chair: Kevin Sorenson) [Mental Health, 2010].
[22] Correctional Investigator Annual Report 2016/2017 at 14.
[23] Jane Laishes, "The 2002 Mental Health Strategy For Women Offenders" Mental Health, Health Services 2002, online: Correctional Service Canada: < http://www.csc-scc.gc.ca/publications/fsw/mhealth/toc-eng.shtml>.
[24] Correctional Investigator Annual Report 2016/2017 at 14, 15, 62.
[25] *Changing Directions*.
[26] *Changing Directions*.
[27] Correctional Service of Canada, *Women Offender Programs and Issues: Community Strategy for Women Offenders* (Ottawa: 2007) .
[28] Canada, Correctional Service Canada, *The Changing Offender Profile 2007/08.*

2010.[29] By way of comparison, male offenders experienced an increase from 13% in 2007/08 to 28% after the implementation of a similar screening tool.[30] Overall, incarcerated women have been found to have a significantly higher incidence of mental disorders than women in the broader societal population, including: schizophrenia, major depression, substance abuse disorders, psychosexual dysfunction and anti-social personality disorder.

C. Indigenous peoples and the prisons

Indigenous (Aboriginal)[31] peoples represent 26.4% of the federal prison population but account for just under five percent of the general population.[32] For the last three decades, there has been an increase every single year in the federal incarceration rate for Indigenous people.[33] Indigenous rates of incarceration are now almost nine times the national incarceration rate.[34] One federal offender in four is of aboriginal origin.[35] Indigenous offenders also have a much higher incidence of mental disorders and addictions issues than non-Indigenous offenders.[36] Between 2012 and the end of 2013, 51% of Indigenous offenders received an institutional mental health service.[37]

Much of this illness occurs in the context of intergenerational trauma. In a self-reported study of 316 Indigenous offenders, half the participants "indicated that they had been in the care of the child welfare system" and "61% had family members who had spent time in prison."[38] Further, 71% reported that a family member had been a student of the residential school system, and 18% were residential school survivors.[39] There was also a significant link between criminal activity and addiction. Almost all respondents in the study

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[29] Archambault, K., Stewart, L, Wilton, G, & Cousineau, C (2010) *Initial results of the Computerized Mental Health Intake Screening System (CoMHISS) for Federally Sentenced Women*, Research Report R-230 (Ottawa, ON: Correctional Service Canada).

[30] Stewart, Wilton & Malek (2011), *Validation of the Computerised Mental Health Intake Screening System (CoMHISS) in a Federal Male Offender Population*, Research Report R-244. (Ottawa, ON: CSC).

[31] We are aware that terminology is important. Where legal provisions or reports refer to Indigenous peoples as "Aboriginal", "Native" or "Indian" we will use that terminology.

[32] Correctional Investigator Annual Report 2016/2017 at 48.

[33] Correctional Investigator Annual Report 2016/2017 at 48.

[34] Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2008-2009*, (Ottawa, June 2009) [Report 2008/2009]. Outcomes for Indigenous Offenders lag significantly behind those of Non-Indigenous. For example, they have higher risk, needs and security classifications; higher rates of recidivism, lower parole grants, a greater proportion of sentences spent in institutions before first release; higher rates of statutory release; and overrepresentation in segregation populations.

[35] Report 2008/2009. See also James Hathaway, "Native Canadians and the Criminal Justice System: A Critical Examination of the Native Court worker Program" (1984-1985) 49 Saskatchewan Law Review 201 at 233.

[36] Michelle Mann, "Good Intentions, Disappointing Result: A progress Report on Federal Aboriginal Corrections" (2009) Office of the Correctional Investigator.

[37] Report 2013/2014

[38] Report 2013/2014.

[39] Report 2013/2014.

reported that that substance abuse had played a role in their offense, and 85% were under the influence when they committed the crime.[40]

Nearly one third of study respondents were introduced to Indigenous cultural teachings during their period of incarceration.[41] Unfortunately, only a fraction of Indigenous offenders have access to culturally appropriate programs.[42] Any mental health strategy should respond to the needs of Aboriginal offenders as required by s 80 of the *CCRA*, which states that "the Service shall provide programs designed particularly to address the needs of aboriginal offenders."[43] Although CSC's policies have shifted considerably in the past decade, progress has been slow. The Correctional Investigator has highlighted the importance of "considering Aboriginal Social History factors at crucial points of the case management process."[44] Although there is considerable concern for this issue in Canadian communities, the CSC has yet to fully engage this interest.[45]

Indigenous Female Offenders

The incarcerated Indigenous (Aboriginal) women have increased by 109% between 2001-2002 and 2011-2012. Aboriginal women offenders comprise 37% of the total inmate population under federal jurisdiction.[46] Federally sentenced Indigenous women are more disadvantaged as a group than the general population of non-Indigenous women serving federal sentences.[47] CSC's existing programs for treating mental disorder and addiction issues constitute an inadequate response to the cultural and spiritual needs of Indigenous offenders.[48] A response to their needs require careful attention.[49]

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[40] Report 2013/2014.
[41] Report 2013/2014.
[42] Canadian Mental Health Association, *Keeping People with Mental Disorders Out of Trouble with the Law*, (British Columbia, 2008). The CSC is legally mandated to provide programs and services that target the specific needs of offenders, which lead to their criminal behavior and contribute to their successful transition into the community.
[43] *CCRA*, s 80.
[44] Report 2013/2014 at 44.
[45] CSC offers the following Aboriginal programs for male offenders: Basic Healing Program-Revised, In Search of Your Warrior Program, Aboriginal Offender Substance Abuse Program, High Intensity Aboriginal Family Violence Prevention Program, and the Tupiq program. These programs are not enough to meet the needs of the Aboriginal offenders and are only offered if the offender wants to participate in the programs. Aboriginal offenders who do not wish to participate can participate in the other four basic programs offered by CSC. CSC needs to have more programs tailored to mental illness for the aboriginal offenders. See Evaluation Branch.
[46] Report 2016/2017.
[47] Correctional Service Canada, *Creating Choices, The Report of the Task Force on Federally Sentenced Women* (Ottawa: Corrections Canada 2008).
[48] Mental Health, 2010.
[49] Because Aboriginal women have unique and culturally-related needs, CSC developed and implemented the Aboriginal Women Offender Correctional Programs. This gender and culturally responsive approach includes the Aboriginal Women's Engagement Program, the High Intensity Aboriginal Women Offender Programs and the Aboriginal Women Offender Self-Management Program' all of these which include Aboriginal Elder

Mental health programs for Indigenous women should be developed and delivered by Indigenous organizations or individuals with demonstrated awareness of their concerns and need while incarcerated.[50] A primary example of how this can be achieved is the Okimaw Ochi Lodge in the Prairie region for Indigenous offenders.[51] It was developed with and for the Indigenous community, and the majority of the staff are of Indigenous descent.

D. Older Offenders

Today, 21% of the federal incarcerated population is aged 50 and over.[52] The number of older offenders in federal custody continues to grow annually.[53] Further, one-quarter of the inmate population is serving an indeterminate or life sentence, meaning a substantial number of the prison population may ultimately face their final years in Federal penitentiaries.[54] More programs need to be developed to meet the particular needs of this group. According to data from a 2011 census, the population of those over the age of 65 has surged to nearly five million over the last five years, an increase of 14.1 per cent.[55]

The change in Canada's elder population, and the issues that flow from that, mirrors the concerns to address in the changing offender population . Older offenders represent a distinct group within the prison population, with unique needs and problems that require special attention and treatment.[56] The most common mental health disorders affecting elderly offenders are depression, Alzheimer's disease, anxiety and late life schizophrenia and dementia.[57] It is believed that individuals who are incarcerated advance in age faster than the general population,[58] and that the mental condition of older offenders tends to deteriorate rapidly once they are incarcerated.[59]

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involvement. Online: Correctional Service Canada < http://www.csc-scc.gc.ca/correctional-process/002001-2001-eng.shtml#s4>.

[50] Correctional Services Of Canada, *The 2002 Mental Health Strategy for Women Offenders* by Jane Laishes (Ottawa: 2002) at 15 [Women's Mental Health].

[51] Women's Mental Health at 30. Interventions are Aboriginal-based with a strong emphasis placed on Aboriginal culture and spirituality, including the provision of full-time on-site, Elder services.

[52] Public Safety Canada, "*Corrections and Conditional Release Statistical Overview: Annual Report 2012"* (Ottawa: Public Safety Canada, 2012) at 62 [Public Safety Canada Report 2012].

[53] Public Safety Canada Report 2012 at 62.

[54] Report 2013/2014 at 21.

[55]"Canada has higher proportion of seniors than ever before" (29 May 2012) online: The Canadian Press < http://www.cbc.ca/news/politics/story/2012/05/29/census-data-release.html>; [Canadian Press May 2012].

[56] Correctional Service Canada, *Managing Older Offender: Where Do We Stand?* by Julius H E Zozba (Ottawa: Correctional Service Canada, 1998) at 14 [Managing Older Offenders].

[57] Managing Older Offenders at 71.

[58] Managing Order Offenders at 5.

[59] Managing Older Offenders at 85.

IV. Federal Penitentiaries and Provincial Correctional Facilities

The overall philosophies and goals of corrections influence the attitude of prison employees and their treatment of mentally disabled prisoners. Over the years, the goal of rehabilitating prisoners has been accorded varying levels of importance. Until the late 1930s, punishment and penitence were the basis of correctional policies in both federal and provincial institutions.[60] In 1938, the Royal Commission on the Penal System in Canada (Archambault Report) raised the issue of the reformation of the offender as an objective of corrections.[61] In the 1940s and 1950s, the correctional institutions developed vocational and education programs, as well as treatment programs involving psychiatrists and psychologists.[62]

The emphasis on rehabilitation in correctional institutions subsided in 1969, after the Canadian Committee on Corrections (Ouimet) concluded that the reformation of offenders should be pursued in the community rather than in prisons, which should be utilized only as a last resort.[63] The Law Reform Commission issued a report in 1975 and the Parliamentary Sub-Committee on the Penitentiary System in Canada, 1977, concluded that penal institutions should not be utilized for rehabilitation.[64] Griffiths and Verdun-Jones conclude that these reports spawned the expansion of "probation, parole and diversion programs and the development of community-based facilities and programs, particularly during the years 1970-1978".[65]

In 1977, a Federal Government task force proposed that corrections provide programs for offenders, but that it would be the offender's responsibility to participate and benefit from them.[66] Although this represented a movement away from diagnosing and treating offenders, the report indicated that the corrections system should support offenders' efforts to participate in programs.[67] Griffiths and Verdun-Jones concluded that these developments influenced a return to punishment as a major objective of corrections.[68]

Some reports specifically addressed the needs of mentally disabled offenders. For

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[60] Curt Griffiths & Simon Verdun-Jones, *Canadian Criminal Justice* (Toronto: Butterworths, 1989) at 360-361 [Griffiths & Verdun-Jones].
[61] Griffiths & Verdun-Jones at 361.
[62] Griffiths & Verdun-Jones at 361.
[63] Griffiths & Verdun-Jones at 361.
[64] Griffiths & Verdun-Jones at 361.
[65] Griffiths & Verdun-Jones at 361.
[66] Griffiths & Verdun-Jones at 361.
[67] Griffiths & Verdun-Jones at 362.
[68] Griffiths & Verdun-Jones at 362.

example, the Ouimet Report recommended in 1969 that mentally ill offenders be treated more equitably. As a result, in 1971, the Solicitor General of Canada appointed an advisory board of psychiatric consultants to advise him on the treatment of mentally ill inmates. This report, known as the Chalke Report, is considered a milestone in the development of psychiatric services for Canada's penitentiary system.[69]

The Chalke Report estimated that approximately 750 inmates at any one time suffered from diagnosable psychiatric illnesses. The psychiatrists recommended hospital-based facilities and programs for these individuals, as well as psychiatric consulting services in penitentiaries.[70] The committee concluded that each of the five penitentiary regions of Canada (Pacific, Prairie, Ontario, Quebec and Atlantic) should develop regional psychiatric centres to provide in-house psychiatric programs and act as bases for providing psychiatric services to regional penitentiaries.[71]

In 1972, the Solicitor General of Canada instructed the Canadian penitentiary service to:

- attain a uniform psychiatric service within each geographic region of the Canadian Penitentiary Service;
- provide psychiatric resources and programs that suited regional needs;
- staff regional psychiatric centres to a level that would ensure an acceptable standard of care;
- provide adequate autonomous psychiatric facilities under the medical hospital direction of each region to accommodate inmates requiring hospital care and to serve as a professional base for the regional psychiatric services; and
- establish and maintain close ties with universities for training and research.[72]

In 1972, the Matsqui Penitentiary developed a 134-bed psychiatric facility to serve the Pacific region.[73] In 1978, the Psychiatric Centre in Saskatoon was opened to serve the Prairie region. Under a federal-provincial agreement, the Philippe Pinel Institute in Montreal

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[69] CM Green, R Menzies and L Naismith, "Psychiatry in Canadian Correctional Service" (1991) 36 Can J Psych 290 at 292 [Green, Menzies & Naismith].
[70] Green, Menzies & Naismith at 292.
[71] Green, Menzies & Naismith.
[72] Green, Menzies & Naismith.
[73] Forensic Services, Forensic Regional Services, online BC Mental Health & Substance Abuse Services < http://www.bcmhsus.ca/our-services/forensic-psychiatric-services> Forensic psychiatry needs are now met at the Forensic Services, Forensic Regional Services, B.C. In addition, there are six other clinics which are responsible for the supervision and monitoring of persons found NCR-MDs who are living in the community, and any persons who are found Unfit to Stand Trial, but have been granted a conditional discharge by British Columbia Review Board. BC Mental Health and Substance Abuse Services, "Forensic Psychiatric Services" online: http://www.bcmhsus.ca/our-services/forensic-psychiatric-services (April 11, 2018).

was used for psychiatric federal inmates in the Quebec region. The Kingston Penitentiary developed a unit, called the Regional Treatment Centre, to serve the Ontario region. The Dorchester Penitentiary in New Brunswick provided a small psychiatric treatment unit.[74]

In addition to the specialized psychiatric treatment centres, the CSC and various provincial and territorial correctional facilities conduct different programs for offenders. The programs include: inmate employment and work programs, occupational and vocational training programs, educational programs, religious services, athletic and recreational programs, medical, dental and psychiatric services and programs operated by outside agencies.[75]

The services have evolved in response to an increasing number of inmates. In 2012, Public Safety Canada stated that Canada's incarceration rate was 114 per 100,000 people.[76] The CSC administers 57 federal institutions on different security levels - six for women and 51 for men, 16 community correctional centres, 175 community residential facilities, and 74 parole offices and sub-offices.[77] Of the 57 institutions, 16 are minimum security, 20 are medium security, eight are maximum security and 13 are multi-level.[78] Four thousand seven hundred and ninety-seven people were incarcerated in federal institutions in the 2015/2016 fiscal year.[79] At any one time, CSC is responsible for approximately 23,000 offenders, of which nearly 15,000 are in institutions and approximately 8,000 in the community.[80]

In 2015/2016, there were 25,405 adult offenders admitted to provincial jails across Canada.[81] Of these, approximately 10,091 were sentenced to a period of incarceration.[82] In provincial jails, Canada has an incarceration rate of 87.90 per 100,000.[83] The total

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[74] Green, Menzies & Naismith *supra* note 44 at 292-3; Canada, Correctional Services Canada, *Report of the Task Force on Mental Health* (Ottawa: Supply and Services, 1991) at 81 [Report of the Task Force on Mental Health].

[75] Griffiths & Verdun-Jones at 410.

[76] Canada, Public Safety Canada, *2016 Corrections and Conditional Release Statistical Overview* (Ottawa: Public Safety Canada, 2017) at 5, online: http://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/2012-ccrs/#a3 [Public Safety Canada Report 2016].

[77] Mental Health, 2010 at 9.

[78] Mental Health, 2010 at 9.

[79] 2016 Corrections and Conditional Release Statistical Overview at 13.

[80] Canada, Office of the Correctional Investigator, *Under Warrant: A Review of the Implementation of the Correctional Service of Canada's Mental Health Strategy* by John Service (Ottawa: 2010) online: < http://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20100923-eng.aspx> [Under Warrant].

[81] Statistics Canada, "Adult Correctional Services, average counts of offenders, by province, territory, and federal programs", online: Statistics Canada http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/legal31b-eng.htm [Statistics Canada, Adult Correctional Services]. Total actual in counts are sums of sentenced, remand, and other statutes counts and exclude intakes temporarily not in custody at the time of the count.

[82] Statistics Canada, Adult Correctional Services.

[83] Statistics Canada, Adult Correctional Services.

community supervision count was 96,086 in 2015/2016, which includes community supervisions of the offenders on probation, conditional sentence and provincial parole.[84] The number of probation counts per 1000,000 adults was 315.42.[85]

In Alberta, the provincial adult custody population was 3,074.1 in 2012/2013.[86] In 2011, 91 per cent of adult inmates in provincial custody were male and nine per cent were female. Aboriginal offenders represented 40 per cent of the adult offender population.[87] In 2011-12, the average caseload for community supervision programs was 17, 843 adults and 3,670 youth.[88] Additionally, Alberta Corrections had 8,579 adult offenders on probation, 4,295 on Pre-Trial Supervision, 828 on Alternative Measures, 1,440 on conditional sentences and 1,271 on other programs.[89]

If prisoners are not able to function normally at regular correctional institution as a result of mental disorder, they are housed at one of the five regional treatment centres, also known as psychiatric or rehabilitation centres, operated by CSC.[90] The aim of regional treatment centres is to stabilize offenders with serious mental health problems so that they can return to the general inmate population.[91] However, most federal offenders with mental disorders do not meet the admissions criteria for regional treatment centres. Appearing before the Committee, Canada's correctional Investigator, Howard Sapers said:

> The overwhelming majority of offenders suffering from mental illness in prison do not generally meet the admission criteria that would allow them to benefit from the services provided in the regional treatment centre. They stay in general institutions, and their illnesses are often portrayed as behavioural problems or… are labelled as disciplinary as opposed to health issues. This is especially true for offenders suffering from brain injuries and for those with fetal alcohol spectrum disorder.[92]

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[84] Statistics Canada, Adult Correctional Services.
[85] Statistics Canada, Adult Correctional Services.
[86] Statistics Canada, Adult Correctional Services, Average Counts of Offenders, by Province, Territory, and Federal programs (Alberta) (Ottawa: Statistics Canada, 2014) online:< http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/legal31k-eng.htm>.
[87] Alberta, Solicitor General and Public Security, *Annual Report 2011-2012* (2012), online: <http://www.solgps.alberta.ca/Publications1/Annual%20Reports/2012/2011%20-%202012%20Solicitor%20General%20Annual%20Report.pdf>.
[88] Solicitor General and Public Security, *Annual Report 2011-2012*.
[89] Solicitor General and Public Security, *Annual Report 2011-2012*.
[90] Mental Health, 2010 at 9. Canada, Correctional Service Canada, *Audit of Regional Treatment Centres and the Regional Psychiatric Centre,* (Ottawa, Correctional Service Canada, 2011) online: <www.csc-scc.gc.ca/publications/005007-2508-eng.shtml>.
[91] Mental Health, 2010 at 10.
[92] Mental Health, 2010 at 11.

As it stands, the federal correctional system is only built to respond to and treat acute or chronic mental illness. The majority of individuals with mental health problems receive limited clinical attention or are untreated.[93] Currently, CSC offers four main programming areas: correctional, educational, social and vocational programs.[94] However, none of the programs' main focus is to treat prisoners with mental illness. Rather, the programs focus on the risk factors that contribute to criminal behaviour, and aim to reduce re-offending by helping offenders make positive change.

Not only are the sheer numbers of inmates staggering, but these individuals have numerous needs. Sixty-five percent of offenders entering the prison system test at a completion level lower than Grade 8, and 82% lower than Grade 10.[95] The functional literacy and critical thinking skills associated with the Grade 8 completion level are important; these skills are the foundation for meaningful participation in correctional programs.[96] Thus, 65% of the offenders cannot participate in correctional programs in a meaningful way without first upgrading their basic educational requirements. Additionally, many offenders have alcohol and drug dependencies, poor employment skills, learning disabilities, poor social skills and other difficulties. Consequently, the programs developed by correctional facilities and penitentiaries must meet various needs in order to rehabilitate offenders. Although the emphasis on rehabilitation has ebbed and flowed over time, the *CCRA* sets out the current purpose of the federal correctional system as follows:

> 3. 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 court 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 programs in penitentiaries and in the community.[97]

Thus, rehabilitation of offenders has become an important function of the federal

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[93] Correctional Investigator at 12.

[94] Correctional Service Canada, *Offender Rehabilitation* (Ottawa: Correctional Service Canada, 2016) online; < http://www.csc-scc.gc.ca/correctional-process/002001-2000-eng.shtml>. Educational programs provide offenders with the basic literacy, academic and personal development skills that are needed to succeed in the community. By increasing education levels, these programs can also help offenders participate in correctional and vocational programs. Social programs promote positive social, personal and recreational activities for offenders. Lastly, vocational programs provide offenders with relevant job training to increase employment opportunities.

[95] Correctional Service Canada, *Correctional Programs: Education and Employment Programs.* Online: <http://www.csc-scc.gc.ca/text/prgrm/educ-eng.shtml>.

[96] Report 2013-2014.

[97] *CCRA,* s 3.

system. The *CCRA* also mandates the provision of health care services, including mental health care.[98] Section 86(1) sets out the physical and mental health care services correctional facilities are obligated to provide for offenders:

> **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.[99]

Alberta Correctional Services states that it strives to assist and encourage offenders to avail themselves of services and programs related to their needs in order to develop the ability to conduct independent, law-abiding lives.[100] The Correctional Services Division is organized into branches, including adult centre operations, young offenders, community corrections and release programs and strategic services.[101] The Community Corrections and Release Programs offers community based programs to adults and young offenders through a network of 41 community corrections offices and two attendance centres.[102] As well, a variety of rehabilitative services delivered by agencies other than community correction are available. These services promote positive and productive behaviours, and include mental health and specialized treatment programs.[103]

A report by the Mental Health Commission of Canada found that two out of five (40%) encounters between the police and people with mental illness involve situations unrelated to criminal conduct. Alberta Mental Health Services offers a Provincial Diversion Program, which ensures that, whenever possible, adults and adolescents with mental illness who come into contact with the law as a result of committing minor, low risk offences receive appropriate care, support and treatment in the community rather than in the criminal justice system.[104] More programs like these are needed to divert people with mental illness away from the criminal justice system to receive appropriate treatment.

In 2004, an evaluation of the Calgary Diversion Pilot Project demonstrated successful

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[98] *CCRA*. Section 85 of the *CCRA* defines mental health care as:
[99] *CCRA*, s 3.
[100] Alberta Justice and Solicitor General, *Correctional Services, Programs and Services*, [Alberta Correctional Services] online: <https://www.solgps.alberta.ca/programs_and_services/correctional_services/Pages/default.aspx>.
[101] Alberta Correctional Services.
[102] Alberta Correctional Services.
[103] Alberta Correctional Services.
[104] Alberta Health Services, Forensic Services & Initiatives, *Provincial Diversion Program*, online: Alberta Health Services < https://www.albertahealthservices.ca/info/Page2767.aspx> [Forensic Services & Initiatives].

outcomes in the following areas: improvement in mental health, reduction of symptoms associated with criminal behaviour, withdrawal of charges because of the diversion program, and client satisfaction with program supports and treatment.[105] The program received funding in September 2005 from Alberta Health & Wellness to implement the Provincial Diversion Program in Lethbridge and St. Paul to sustain the current diversion services in Calgary, and provide a position in Edmonton to expand beyond the pre-charge diversion that is part of the *Police and Crisis Team (PACT)* initiative.[106]

This Calgary Diversion Program is available to adults and youth (12 to 18 years of age) that are suffering from mental illness and who have been charged with a less serious criminal offence.[107] The service offers individual assessments, identification of goals and needs, links to appropriate services and recommends the withdrawal of charges if goals are met.

V. Prevalence of Mental Disability in Prison and Jail

A. Federal Correctional Institutions

A troubling number of mentally ill persons enter into the criminal justice system each year. Some of these persons enter into the "revolving door" of the criminal justice system because of the current trend toward de-institutionalization and the more stringent requirements for admission to mental health facilities under provincial mental health statutes. Individuals awaiting bail hearings or criminal trials are held in remand facilities or jails. Once convicted, they serve out their sentences in provincial correctional facilities (for sentences under two years) or federal penitentiaries. Many of the individuals entering these institutions have mental illnesses that require treatment.

CSC has witnessed a significant increase in the number of offenders diagnosed with a mental health disorder upon admission.[108] To respond to this trend, Correctional Service Canada continues to focus on improving its capacity to assess and address the increasingly broad and multidimensional mental health needs of offenders.[109] Rates of mental illnesses such as schizophrenia and depression are between three to five times higher in offender

[105] Forensic Services & Initiatives.
[106] Forensic Services & Initiatives .
[107] Alberta Health Services, "Calgary Diversion Service, Mental Health, Programs and Services", online: Alberta Health Services<http://www.albertahealthservices.ca/services.asp?pid=service&rid=1006581>. [Calgary Diversion Service – Mental health].
[108] Let's Talk.
[109] Let's Talk.

population that those expected in the general community.[110]

According to the 2012 annual report of the Office of the Correctional Investigator, federal penitentiaries in Canada probably house the largest populations of the mentally ill in this country.[111] CSC data shows that in 2010-2011, 9,200 offenders received institutional mental health care services.[112] In 2010-2011, 20,233 male offenders moved through the federal correctional system, which means the number of mental health care interventions exceeded 45% of the total population.[113] Among female offenders, this number was 69%.[114] Moreover, the proportion of offenders identified at intake as having mental health needs doubled between 1997 and 2008.[115] According to the report, 29% of female inmates and 13% of male inmates were identified at intake as presenting mental health problems. Further, 30.1% of female offenders and 14.5% of male offenders had previously been hospitalized for psychiatric reasons.[116] Offenders who are diagnosed with mental illness often suffer from more than one disorder. For example, four out five offenders in federal custody suffer from substance abuse, which also afflicts many offenders with mental illness.[117]

The prevalence of mental illness amongst the prisoner population seems to be consistent across countries. For example, a systematic review of 62 surveys in 12 countries involving 22,790 inmates found that, among males, 26% were violent offenders, 3.7% had psychotic illnesses, 10% suffered from major depression and 65% had a personality disorders, of which 47% was antisocial disorder.[118] Among female prisoners, four percent had a psychotic illness, 12% had major depression and 42% had a personality disorder, of which 21% was antisocial disorder.[119] In Ontario, 18 percent of 8,948 inmates had a

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[110] James Ogloff, Michael Avis, George Rivers & Stuart Ross, Australian Institute of Criminology, *Trends & Issues in Crime and Criminal Justice: The Identification of Mental Disorders in the Criminal Justice System,* No 334 (Australia: Criminology Research Centre, 2007) [Australian Report]; Noni MacDonald, "The Crime of Mental Illness*"* Canadian Medical Association Journal 182 No. 13 2010 at 1399.

[111] Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2011-2012* (Ottawa, June 2012) [Correctional Investigator Report 2011-2012].

[112] Correctional Investigator Report 2011/2012 at 6.

[113] Correctional Investigator Report 2011/2012 at 6.

[114] Correctional Investigator Report 2011/2012 at 6.

[115] Correctional Investigator Report 2011/2012 at 6.

[116] Correctional Investigator Report 2011/2012 at 6.

[117] Correctional Investigator Report 2011/2012 at 6.

[118] Seena Fazel & John Danesh, "Serious Mental Disorder in 23,000 Prisoners: A Systematic Review of 62 Surveys" (2002) 359 Lancet 545-50 cited in Julio Arboleda-Florez, "Mental Patients in Prisons" (2009) Queens 8 World Psychiatry at 187-189.

[119] Seena Fazel & John Danesh.

psychiatric disorder. Thirty-one per cent of 757 female offenders were mentally ill.[120]

All inmates begin their journey through the criminal justice system as pre-trial detainees.[121] Consequently, information about the numbers of persons who are mentally ill when arrested, even if they are only incarcerated for a few days in a remand centre, is important in order to understand the extent of mental illness among inmates in the criminal justice system. Better screening of detainees at the pre-trial stage may reduce the likelihood of persons repeatedly cycling through the criminal justice, mental health and social welfare systems.[122] The increasing prevalence of mental disorders in the criminal justice system indicates that identifying such disorders is of paramount importance. It is possible to conduct a comprehensive mental health assessment of every person who comes into contact with the police, the courts or the correctional system.[123] One example of how this information can be obtained is through screening to identify those who do require a comprehensive evaluation. The aims of screening are to identify mentally disordered offenders and provide necessary treatment, prevent violent and disruptive incidents at institutions, allocate resources to those with the greatest or most immediate need, and reduce the cycle of admissions to the criminal justice system.[124]

CSC has developed a comprehensive mental health strategy that aims to enhance the capacity to address and respond to the mental health needs of offenders in institutions and in the community.[125] The components of the strategy include: mental health screening and assessment at intake for offenders entering the federal correctional system; implementation of primary health care in institutions, such as counselling, treatment, and maintenance; development of intermediate care units for male offenders with mental health issues in institutions; consistency in standards at CSC's regional treatment centres; and improved community partnerships with other correctional and mental health jurisdictions.[126]

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120 Kirk Makin, "Mentally Ill Offenders Swamping Prisons" *The Globe and Mail* (26 January 2011), online: The Globe and Mail <http://www.theglobeandmail.com/news/national/ontario/mentally-ill-offenders-swamping-prisons/article1803550/>.

121 James Ogloff, G Tien, Ronald Roesch and Richard Eaves, "A Model for the Provision of Jail Mental Health Services" (1992) 18 Journal of Mental Health Administration 2 at 5 [Ogloff, Tien, Roesch & Eaves].

122 James Ogloff, G. Tien, Ronald Roesch and Richard Eaves at 5. In British Columbia, a number of branches of the Government established a committee on the Effects of Multi-Problem Persons on the Criminal Justice System. This was struck in part to deal with more effective delivery of mental health services to those individuals who may have been neglected because the various bureaucracies did not have a coherent system for dealing with mentally disabled offenders.

123 Australian Report.

124 Australian Report.

125 Correctional Service Canada, *Mental Health Initiative Quick Facts* (January 2010), online: <http://www.csc-scc.gc.ca/publications/005007-3010-eng.shtml> [Mental Health Initiative Quick Facts].

126 Australian Report.

As part of their overall mental health strategy, CSC has also instituted the Community Mental Health Initiative (CMHI), which offers a variety of services designed to avoid gaps in care when offenders transitions from an institution to the community, as well as when the offender is on conditional release in the community.[127] The key elements of the CMHI are identified as: identifying the individual needs of offenders with mental health disorders and developing a discharge plan; supporting offenders with mental health disorders under community supervision; providing training to staff; and working with local agencies to provide specialized support for offenders with mental health disorders within the community.[128]

B. Provincial Jails

Although all offenders in Canada enter the correctional system at the provincial facilities (through remand or awaiting sentencing), there are few statistics available regarding mental health in provincial institutions.[129] British Columbia's Ministry of Justice estimates that 56% admitted in the province's correctional system have a substance abuse and/or a mental health problem. [130] An Ontario study indicates that, in 2008, 15% of provincial inmates required clinical intervention for mental illness.[131] In the remand population, mental health alerts have increased by 44% between 2005 and 2015. A study conducted in 1992 over a one year period in British Columbia of persons detained in an urban jail indicated that approximately 20 to 25 percent had mental disorders.[132] In a similar study conducted in a different British Columbia facility,[133] the range of disorders found in approximately 18 percent of the inmates included persons who were certifiable for

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[127] Mental Health Initiative Quick Facts.

[128] Mental Health Initiative Quick Facts.

[129] Public Services Foundation of Canada, *Crisis In Correctional Services: Overcrowding and Inmates with Mental Health Problems In Provincial Correctional Facilities* (April 2015) online: <https://publicservicesfoundation.ca/sites/publicservicesfoundation.ca/files/documents/crisis_in_correctional_services_april_2015.pdf> [Public Services Foundation of Canada] at 44.

[130] Public Services Foundation of Canada at 44; British Columbia, "Mental Health Services for Offenders" (accessed on March 23, 2018), online: <https://www2.gov.bc.ca/gov/content/justice/criminal-justice/corrections/reducing-reoffending/mental-health-services>.

[131] Public Services Foundation of Canada at 44; Ontario, Minister of Community Safety and Correctional Services, *A Safe Strong Secure Ontario: Strategic Plan 2008-2013, Building Awareness of the Ministry's Strategic Direction* (Ontario: Ministry of Community Safety and Correctional Services, 2008) online: <https://www.mcscs.jus.gov.on.ca/english/publications/0813_sp_full.html>.

[132] S Hart, "The Scope of the Problem: The Prevalence of Mental Disorder in Jails", *Human Rights, Mental Health, and Therapy in a Radically Changing World* (Banff, Alta: 1993) Conference Paper. See also: James Ogloff, "Delivering Mental Health Services in Urban Jails", *Human Rights, Mental Health, and Therapy in a Radically Changing World* (Banff, Alta: 1993) Conference Paper.

[133] James Ogloff, "Delivering Mental Health Services in Urban Jails", *Human Rights, Mental Health, and Therapy in a Radically Changing World* (Banff, Alta: 1993) Conference Paper.

designated facility,[134] persons who were seriously disturbed,[135] persons who were dysfunctional but not seriously mentally ill,[136] and persons who had short term or situational disorders.[137] A survey was conducted of male inmates in two Edmonton correctional centres from 1984 to 1989. These individuals were compared to a random survey of similarly aged male Edmonton residents. The study concluded that prisoners were twice as likely to have a lifetime psychiatric disorder compared with the general population.[138] Many inmates had symptoms that had developed quite recently.[139] Further, lifetime suicide attempts were seven times more frequent in prisoners than in the general population.[140] Suicide is the leading cause of death in correctional facilities across Canada.[141]

Although some mentally ill persons may be diverted from the criminal justice system before they are sentenced to the provincial correctional facilities, it is safe to assume that a significant portion of provincially incarcerated offenders are mentally ill. Indeed, in recognition of this phenomenon, the Calgary West Remand Centre contains a 32-bed assessment and treatment unit, as well as an eight-bed under-camera unit for patients with suicidal tendencies. The centre has access to the Southern Alberta Forensic Unit, which helps the centre with the treatment of certified individuals. On weekdays, either a doctor or a psychiatrist visits the patients on an individual basis, and both a psychiatric nurse and a psychologist are available to the patients on weekdays. As well, a case worker who deals with the placement both inside and outside of the centre, as well as referrals to numerous programs within the city, is available on weekdays.[142]

C. Mentally Handicapped Prisoners

It is difficult to provide accurate figures as to the numbers of mentally

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[134] Persons with a mental disorder who meet the criteria for medical certificate to be in a designated facility in British Columbia. See British Columbia's *Mental Health Act,* RSBC 1996, c 288, s 1 and s 20.
[135] These are persons who show clear signs of mental illness, but who do not present an immediate risk to themselves or others. Most of these individuals would be found fit to stand trial and competent to make informed consent decisions.
[136] These are persons who may have borderline mental illnesses with problems which aggravate their situations such as organic disorders, substance abuse, and borderline mental handicap. These individuals might present behaviour difficulties or suicide risks.
[137] These persons are not seriously disturbed but are reacting to stress. They have anxiety and depression and may present a high risk of danger to themselves.
[138] R. Bland, S. Newman, R. Dyck and H. Orn, "Prevalence of Psychiatric Disorders and Suicide Attempts in a Prison Population" (1990) 35 Can J Psychiatry 407 [Bland].
[139] Bland.
[140] Bland.
[141] Bland.
[142] Information provided by Ms. Barb Blanchette, Social Worker and Criminologist at the Calgary West Remand Centre, April 18, 2006.

handicapped,[143] brain injured or learning-disabled prisoners in federal penitentiaries or provincial correctional facilities. However, American studies have shown a disproportionately high percentage of prison inmates who are mentally handicapped.[144] While estimates of mental handicap in the general population range from one to three percent,[145] various studies in the United States place the number of mentally handicapped offenders in prisons at one to 20 percent.[146] For example, a 1989 study of adult prisoners in New York state and local correctional facilities, 18 percent had Beta I.Q's of below 80.[147] In United States, there are now more than three times more seriously mentally ill persons in jails and prisons than in hospitals. Forty percent of individuals with serious mental illnesses have been in jail or prison at some point in their lives in the U.S.[148]

These statistics do not indicate that mentally handicapped persons are more likely to engage in criminal activity. It is simply more likely that mentally handicapped persons are caught and convicted and that they will be imprisoned for longer periods of time.[149]

There are some important difficulties in determining the number of mentally handicapped offenders. First, there is a lack of clear guidelines for making estimates from facility to facility. Second, tests used to evaluate mental handicap vary. Finally, there are many difficulties with Intelligence Quotient tests that affect their accuracy (e.g., cultural bias).[150] Many suggest that a person's adaptive behaviour must also be assessed.[151]

Although there are imprecise statistics in the area of mental handicap, adult offenders are often administered standardized tests upon reception into federal institutions. These statistics do not indicate mental handicap, but they do indicate the educational level of the offenders. Approximately 65 percent of new offenders tested below

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143 Please see discussion in Chapter One: Introduction for a discussion of our choice of terminology.

144 MB Santamour and PS Watson, *The Retarded Offender* (New York: Praeger Publishers, 1982) at 8 [Santamour & Watson].

145 Santamour & Watson at 9.

146 See: J Noble Jr. and RW Conley, "Toward an Epidemiology of Attributes" in RW Conley, R Luckasson and GN Bouthilet, eds., *The Criminal Justice System and Mental Retardation* (Toronto: Paul Brookes Publ. Co., 1992) at 17 - 53 (hereinafter Noble Jr and Conley).

147 Noble Jr and Conley at 24.

148 Fuller Torry, Aaron Kennard, Don Eslinger *et al*, Treatment Advocacy Centre, *More Mentally ill Persons Are in jails and Prisons Than Hospitals: A Survey of the States*, (National Sheriffs Association: 2010). One of the key findings of this report is that the US prison system has returned to the conditions of the 1840s by putting large numbers of mentally ill persons back into jails. The prisons are filled with mentally ill (instead of hospitals). Deinstitutionalization, the emptying of state mental hospitals, has been one of the most well-meaning but poorly social planned social changes.

149 Donald Hermann, Howard Singer, & Mary Roberts, "Sentencing of the Mentally Retarded Criminal Defendant" (1988) 41 Arkansas L Rev 765 at 771.

150 Santamour & Watson.

151 See discussion in Chapter Nine, Expert Evidence.

a complete grade eight level in mathematics and language.[152] Some of these persons are probably mentally handicapped.[153] Although some difficulties exist in gathering and reporting statistics, it is likely that there are a significant number of mentally handicapped offenders in our penitentiaries and jails.

VI. Mentally Disabled Persons in Penitentiaries and Correctional Facilities

A. General—Conditions in Penitentiaries and Correctional Facilities

What difficulties do mentally disabled persons encounter in penitentiaries and correctional facilities? The effects of imprisonment vary from individual to individual. It is therefore difficult to generalize about the effects of incarceration, especially upon mentally ill prisoners. Unless all prisoners or jail inmates are screened for mental illness when they become inmates, it is difficult to assess whether they develop psychological problems as a result of incarceration, whether existing psychological problems are exacerbated by incarceration, or whether there is no change in their mental condition.[154] However, it is possible to make some general comments about the effects of incarceration and some of the unique difficulties encountered by mentally disabled offenders.

Many of the difficulties encountered by mentally disabled persons are generally experienced by all inmates. These include the social and psychological effects of incarceration. Many inmates experience a process of "mortification" when they enter institutions. This process transforms them from citizens of the community to residents of the institution[155] and requires prisoners to adopt the values, norms and culture of the prison.[156] Griffiths and Verdun-Jones opine that this process of "prisonization" will affect each prisoner differently, depending upon her/his personality, her/his pre-prison experiences and the nature of the relationships that he/she forms with other significant inmates.[157] Mentally disabled prisoners also suffer the effects of these processes.

The effects of incarceration and confinement in the prison environment are painful.

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[152] Correctional Service Canada at 44.

[153] An Access to Information request initiated in May, 1993, asking for statistics relating to mentally handicapped and brain injured inmates in the federal corrections service received a reply that no such records were available.

[154] See, for example: J Gibbs, "Symptoms of Psychopathology Among Jail Prisoners: The Effects of Exposure to the Jail Environment" (1988) 14(3) Crim Justice and Behavior 288.

[155] E. Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, New York: Doubleday Books, 1961) at 18 - 20. See also: U Bondeson, *Prisoners in Prison Society* (New Brunswick, New Jersey: Transaction Publishers, 1989).

[156] D. Clemmer, *The Prison Community* (Boston: Christopher Pub Co, 1948).

[157] Griffiths & Verdun-Jones at 402.

First, the loss of liberty is difficult to accept. Second, the prisoners experience loss of individual autonomy and personal security, as well as lack of access to goods, services and heterosexual relations.[158] Further, there is a lack of privacy that may cause prisoners a great deal of stress. The boredom and the lack of contact with the outside world also cause difficulties.

A social system among the inmates forms in all correctional institutions.[159] In order to survive, those inmates held within the general population (e.g., not in protective custody or special handling units) often become affiliated with a group or clique. Depending upon the role that he performs in the group, this involvement may have an effect on an inmate.

Griffiths and Verdun-Jones indicate that the major elements of the inmate social system include:

- a code of behaviour;
- a hierarchy of power among the inmates;
- an informal economic system for the provisions of illicit goods and services; and
- a variety of social roles assumed by the prisoners.[160]

Adjusting to this social system may cause stress, depression, anger and feelings of isolation. With all of these factors, it is very difficult, even for the average offender, to adjust to the prison routine and to survive in the prison environment.[161]

Violence is another problem that is of great concern in the Canadian prison system. Overcrowding, the age of the offender population and the transient nature of prison populations all contribute to the increasing levels of violence in Canadian prisons.[162] Violence may take the form of murder, attempted murder, assaults, inmate fights, hostage takings, major disturbances, suicide, attempted suicide, self-inflicted injury, arson and damage to government property.[163] The amount and type of violence present varies from prison to prison.[164]

Because of the realities of prison life, Griffiths and Verdun-Jones note that "life inside the total institutional world of the prison is often characterized by psychological

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[158] G Sykes, *The Society of Captives: A Study of a Maximum Security Prison* (Princeton, New Jersey: Princeton University Press, 1958).
[159] Griffiths & Verdun-Jones at 403.
[160] Griffiths & Verdun-Jones at 404.
[161] E Zamble, F Porporino and J Kalotay, *An Analysis of Coping Behaviour in Prison Inmates* (Ottawa: Solicitor General of Canada, 1984).
[162] Griffiths & Verdun-Jones at 485; Public Services Foundation of Canada.
[163] Griffiths & Verdun-Jones, quoting the Preventive Security Division of the Correctional Service of Canada.
[164] Griffiths & Verdun-Jones.

intimidation and physical violence".[165] There are many different ways that inmates may be subjected to violence in the prison setting. Inmates may be the victims of actions of other inmates, of mistreatment by staff members, or of decisions by staff members—such as being placed in solitary confinement (dissociation).[166]

Griffiths and Verdun-Jones state that, while they may suffer psychological and physical abuse by prison staff, inmates suffer far more from violence at the hands of other inmates.[167] An American study indicates that inmates may be victimized by other inmates in three ways. First, they may suffer psychological victimization. Aggressive inmates may force them to provide sexual services, to give up their possessions or to submit to other demands. Some inmates respond to this type of abuse with suicide attempts or self-injury.[168] Second, inmates may be economically victimized through loan sharking, fraudulent gambling activities, theft, robbery or protection rackets. Third, they may be socially victimized because of their racial, ethnic or religious affiliation or because they have been convicted of a particular type of offence (e.g., child molestation or sexual assault).[169]

It is more difficult to determine accurately the amount and type of abuses by correctional officers upon inmates because of the low visibility of many of the activities that occur within correctional facilities. However, the Office of the Correctional Investigator has reported cases of physical abuse and psychological harassment.[170]

Many persons *without* mental disabilities find incarceration stressful. Thus, conditions in penitentiaries and provincial correctional facilities may be very damaging to persons with mental disabilities because of their vulnerabilities.

B. Mentally Disabled Prisoners

Mentally disabled persons may be housed with the regular prison population, placed in segregation or placed in psychiatric facilities. There are special difficulties encountered by mentally disabled persons in these settings.

The Courts rely on correctional facilities to carry out the sentences given to all offenders, and that includes providing all post-sentencing services including mental health

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[165] Griffiths & Verdun-Jones at 483.
[166] Griffiths & Verdun-Jones at 484.
[167] Griffiths & Verdun-Jones.
[168] LH Bowker, *Prison Victimization* (New York: Elsevier, 1980). See also: Roger Mattews "*Doing Time [electronic resource]: An Introduction to the Sociology of Imprisonment* (New York: Macmillan Publishers, 1999) at 288 and National Crime Prevention Council, "*Incarceration in Canada"* (Ottawa: National Crime Prevention Council, 1997).
[169] L.H. Bowker, *Prison Victimization* (New York: Elsevier, 1980).
[170] Griffiths & Verdun-Jones at 487.

services for an offender.[171] In light of court recommendations, it is ultimately up to correctional authorities to decide if any realistic treatment will be given. This situation is further exacerbated by the fact that the psychiatric facilities in Canadian institutions are inadequate.[172] There may be presumed bias for offenders with mental disorders. Access to programs and mental health services is directly affected by the security level of the institutions in which the offender is placed.[173] As stated by majority in *R v Winko*, society "cannot consent itself with locking the ill offender up for a term of imprisonment and then releasing him or her into society, without having provided any opportunities for psychiatric or other treatment".[174] Thus "public safety will only be ensured by stabilizing the mental conditions".[175] Part XX.1 of the Criminal Code was designed to address the concern that offenders with mental illness must be treated with the utmost dignity and afforded the utmost liberty compatible with their situation.[176]

1. Problems Encountered in the Regular Population

(a) Mentally Handicapped Prisoners

There are many potential problems faced by mentally handicapped prisoners if they are housed with the regular prison population. For example, these prisoners are more likely to be exploited and injured than other inmates.[177] They are easily made scapegoats and often become the targets for venting hostility.[178] They may enter into same-sex relationships for protection.[179] Consequently, Wertlieb suspects that it would not be surprising to find that mentally handicapped persons leave prison more violent than when they entered.[180]

Mentally handicapped prisoners, if identified, may exhibit a tendency to be easily persuaded and manipulated by the other prisoners. They may strongly desire to be

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[171] Aman Patel, "Landing in Cuckoo's Nest: The Hospital Disposition of Guilty Mentally Ill Offenders Lessons from the United Kingdom" (2002) 39 Alta L Rev at 13.
[172] *Winko v British Columbia (Forensic Psychiatric Institute)*, 1999 2 SCR 625 at para 42 [*Winko*].
[173] *Winko* at para 42.
[174] *Winko* at para 40.
[175] *Winko* at para 40.
[176] *Winko* at para 42*; Penetanguishene Mental Health Centre v Ontario (Attorney General)*, 2004 SCC 20 at para 22 [*Penetanguishene*].
[177] *Ruiz v Estelle,* 503 F Supp 1265, 1344 (SD Tex 1980), *aff'd in part and rev'd in part on other grounds,* 679 F 2d 1115 (5th Cir 1982), *cert denied* 460 US 1042 (1983) [*Ruiz*]. See also: N Baladerian, *Disability, Abuse and Personal Rights* (California: Spectrum Institute,1994).
[178] Janet Billinghurst & Jim Hackler, "The Mentally Retarded in Prison: Justice Denied?" (1982) 24 Can J Criminology 341 [Billinghurst & Hackler].
[179] Billinghurst & Hackler at 341.
[180] Ellen Wertlieb, "Individuals with Disabilities in the Criminal Justice System" (1991) 18(3) Criminal Justice and Behaviour 332 at 343 [Wertlieb] cited in Tina Mawhorr, "Disabled Offenders and Work Release: An Exploratory Examination" (1997) 22(1) Criminal Justice Review at 34-38.

accepted by the other inmates and, therefore, will accept the values of the prison culture.[181] They are often the butt of practical jokes and sexual harassment.[182] Because mentally handicapped persons are developmentally delayed, the behaviours learned in prison are less apt to be reversed upon release.[183] The acceptance that mentally handicapped persons gain when they adopt the values of the prison society is very persuasive because they have not always been accepted by society.[184]

Mentally handicapped offenders housed with the regular population may also encounter difficulties with the prison staff and with administrative procedures (e.g., parole applications and hearings). Mentally handicapped prisoners may attempt to hide their disabilities from the administration and from other inmates in order to avoid being exploited or ridiculed. Consequently, if their difficulties are not noticed, they will not receive the type of treatment, habilitation or rehabilitation that they require.[185]

Further, mentally handicapped prisoners may require special supervision and structure. Yet staff members may not be trained or equipped to deal with their special needs.[186] Mentally handicapped prisoners require special programs that emphasize habilitation rather than rehabilitation.[187] Many cannot keep up with the rehabilitation programs offered in prisons, and consequently drop out. Sometimes, if the offender is labelled as “retarded”, he/she is assigned menial tasks or allowed to vegetate rather than being placed in appropriate programming.[188] Mentally handicapped individuals who are institutionalized without proper habilitation regress and lose important life skills they previously possessed.[189]

Mentally handicapped persons have difficulty adjusting to prison routines and in learning regulations.[190] As a result, they are involved in more rule infractions and

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[181] Santamour & Watson 9 at 29 - 30.
[182] Miles Santamour, "The Offender With Mental Retardation" (1986) 66(1) The Prison Journal 3 at 9 - 10 [Santamour, 1986].
[183] Santamour, 1986 at 30.
[184] Santamour, 1986 at 30.
[185] Santamour & Watson 9 at 21.
[186] The Calgary John Howard Society, *The Mentally Handicapped Offender: A Guide to Understanding*, 1983 at 55 [Calgary John Howard Society].
[187] While rehabilitation usually means the restoration of a former capacity, mentally handicapped persons must be trained in learning new skills, starting at the person's present developmental level. One cannot assume that mentally handicapped persons once knew the basic skills or that they have a former capacity which could be restored. See: Calgary John Howard Society at 35.
[188] Santamour & Watson 9 at 22, 26.
[189] JW. Ellis and RA Luckasson, "Mentally Retarded Criminal Defendants" (1985) 53(3-4) George Wash Law Review 414 at 482.
[190] Santamour, 1986 at 9.

experience higher rates of disciplinary action.[191] The increased numbers of infractions limits parole opportunities and may result in the serving of longer sentences.[192] A related difficulty is the inability of the mentally disabled offender to advocate properly for him/herself during parole and transfer hearings.[193] This, combined with the offender's inability to complete the requirements, may place the offender at a disadvantage when opportunities for parole and other programs (such as community living) arise. In the United States, mentally disabled offenders are denied parole more often than are other offenders. One American study found that mentally disabled offenders served, on average, two to three years longer than other prisoners for the same offence.[194]

(b) Mentally Ill Prisoners

Mentally ill prisoners also encounter difficulties with the prison society and may become the victims of violence and other abuses. There are a number of prisoners who are depressed, suicidal or who are chronically mentally ill.[195] Many of these individuals are housed in the general prison population.

As shown by the statistics, mentally ill prisoners end up in high security units and maximum-security prisons, and are segregated for months due to their illnesses. In some prisons, the environment is severe resulting in prisoners being completely isolated, confined in constantly bright or dim spaces without any meaningful human contact or programming. These conditions are proven to cause mental deterioration. The prisoners do not access any programming this way and are often released into the community despite the clear dangers of doing so.[196]

An American study of male inmates who experienced a psychiatric commitment during incarceration revealed that the vast majority of them had never been married; they

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[191] *Ruiz* at 1344. See also: Dr. M. Hamm, *Prison Discipline Study*, (Indiana State University, 1988) which indicated that in the United States, prisoners with mental disabilities were the third most frequently disciplined group of prisoners in the sample [Jailhouse Lawyers and Blacks].

[192] See *Steele* v *Mountain Institution,* [1990] 2 SCR 1385, 80 CR (3d) 257 [*Steele*] where the offender spent 37 years in prison on a conviction for attempted rape. Part of the difficulty experienced by the offender was a collection of minor disciplinary infractions which contributed to the denial of parole.

[193] It may be possible to argue that mentally disabled prisoners are being discriminated against because they are unable to properly prepare for parole or transfer hearings. Because mentally disabled prisoners are not able to advocate for themselves, they might suffer to adverse effects of the prison's system of administrative procedures. This may amount to discrimination under the *Charter of Rights* (s 15) or the various Human Rights Acts. See, generally: W Tarnopolsky and W Pentney, *Discrimination and the Law* (Scarborough, Ontario: Thomson Prof Pub, 1990, 1991).

[194] Santamour, 1986 at 10.

[195] See the figures under Prevalence of Mental Disability in Prison and Jail.

[196] John Gibbons & Nicholas Katzenbach, "Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons", (New York: Vera Institute of Justice, 2006). As per *The Basic Principles for the Treatment of Prisoners*, 14 December 1990, Doc. E/5988 No 7. Efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken or encouraged.

had limited educational background (71 percent never having completed high school) and they averaged low scores on I.Q. tests.[197] Further, the inmates had limited occupational attainment and half of them had a history of prior drug use.[198] Sixty-three percent had experienced a psychiatric hospitalization prior to incarceration with 23 percent having had three or more such admissions.[199] Sixty-nine percent of these mentally ill offenders with a previous psychiatric hospitalization had been admitted under various criminal provisions (e.g., after being found not guilty by reason of insanity).[200]

Mentally ill prisoners fall near the bottom of the prison social hierarchy.[201] While sex offenders and informants are usually held in protective custody, the mentally ill may or may not be held in the general population.[202] Studies analyzed by Hodgins and Côté indicate that only a small proportion of male penitentiary inmates who suffer from severe mental disorders (schizophrenia and major affective disorders) are transferred for care to hospitals.[203] They found that many are held within the general population and do not receive treatment.[204] If the mentally ill person is not disruptive, his/her condition may go unnoticed by correctional staff.[205] Despite many efforts and initiatives to minimize the plight of the mentally ill in prison, including deterioration, imprisonment, and re-incarceration, their numbers continue to climb.[206]

If held in the general prison population, mentally ill prisoners are more likely to be involved in assaults by other inmates, altercations with guards, generally bizarre behaviour, self-mutilations and suicide attempts.[207] Mentally ill prisoners are often victimized by other

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[197] Lynette Feder, "A Profile of Mentally Ill Offenders and Their Adjustment in the Community" (1991) 19 (1-2) Journal of Psychiatry and the Law 79 at 82 [Feder] cited in Gregg Gagliardi, David Lovell, Paul Peterson & Ron Jemika, "Forecasting Recidivism in Mentally Ill Offenders Released from Prison, (2004) 28(2) Law and Human Behavior. Prisoners with mental illness are more likely to reoffend. See A study conducted by Silver, Cohen & Spdak in 1989 reported a 5-year recidivism rate of 73.3% for 135 offenders with mental illness state prisoners.

[198] Feder at 82.

[199] Feder at 82.

[200] Feder at 83.

[201] Richard Freeman & Ronald Roesch, "Mental Disorder and the Criminal Justice System" (1989) 12 International Journal of Law and Psychiatry 105 at 110 [Freeman & Roesch].

[202] Richard Freeman & Ronald Roesch at 110.

[203] S Hodgins & G Côté, "The Mental Health of Penitentiary Inmates in Isolation" (1991) 33(2) Canadian J Criminology 175 at 175 [Hodgins & Côté, 1991].

[204] Hodgins & Côté, 1991 at 175.

[205] Hodgins & Côté, 1991 at 176; L. Teplin, "Detecting Disorder: The Treatment of Mental Illness Among Jail Detainees" (1990), 58(2) Journal of Consulting and Clinical Psychology 233 at 234.

[206] Erick Roskes & Richard Feldman, "A collaborative community-based treatment program for offenders with mental illness" (1999) 50(12) Psychiatry Serv. at 1614-9; Lamb HR, Weinberger LE, Gross BH, "Community treatment of severely mentally ill offenders under the jurisdiction of the criminal justice system: a review" (1999) 50 Psychiatric Serv. at 907-13.

[207] Freeman & Roesch at 110.

inmates because of lack of social and economic resources, dependence and the need for attention.[208] In one American study, the authors found that mentally ill inmates tended to associate with guards, which fostered suspicion and mistrust among the remaining inmates.[209] Further, because mentally ill prisoners were unable or unwilling to adhere to the informal inmate rules, they were labelled as untrustworthy.[210] Because other inmates viewed "crazy" behaviour as possibly fake, they "tested" mentally ill inmates by beating them up to observe their reactions.[211] Consequently, there was a stigma attached to mental illness that led to victimization.[212] The need for attention and dependence upon others makes mentally ill prisoners susceptible to exploitation by other inmates.[213] When the inmates need someone to take the punishment, the mentally ill inmate is easily manipulated to take the "rap" for other inmates' crimes.[214]

This study also concluded that staff-inmate relationships are affected by mental illness. First, inmates at risk of depression and suicide may not be identified and treatment not provided.[215] Second, health care professionals may not adequately assess inmates because of their suspicion and mistrust of mentally ill inmates.[216] Further, mentally disordered inmates labelled as "disturbed and disruptive" are repeatedly bussed from prison to hospital and back again because they are unwanted by both the correctional facilities and the mental health facilities.[217] Studies analyzed by Hodgins and Côté indicate that offenders with a history of psychiatric hospitalization committed more infractions of prison rules than those with no history of mental disorder.[218] Prisoners with mental illness are 1.6 times (inmate-on-inmate) and 1.2 (staff-on-inmate) more likely to be victim of physical victimization then prisoners with no reported mental illness.[219]

A British Columbia study observed that, in general, correctional officers perceived

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[208] Eileen Morrison, "Victimization in Prison: Implications for the Mentally Ill Inmate and for Mental Health Professionals" (1991) 5(1) Archives of Psychiatric Nursing 17 at 18 [Morrison].
[209] Morrison at 21.
[210] Morrison at 21.
[211] Morrison at 21.
[212] Morrison at 21.
[213] Morrison at 21.
[214] Morrison at 21.
[215] Morrison at 23.
[216] Morrison at 23.
[217] Hodgins & Côté, 1991 at 176.
[218] Hodgins & Côté, 1991 at 176; Marilyn McShane, "The Bus Stop Revisited: Discipline and Psychiatric Patients in Prison" (Fall 1989) Journal of Psychiatry and the Law 413 at 428; Feder at 85.
[219] Cynthia Blitz, Nancy Wolff & Jing Shi, "Physical Victimization in Prison: The Role of Mental Illness" (2008) 31(5) International Journal of Law and Psychiatry at 385-393.

mentally disordered inmates less favourably than other offenders.[220] They perceived mentally ill offenders as unpredictable, irrational and mysterious.[221] Mentally ill offenders were viewed as less manipulative.[222] Ninety-five percent of the correctional officers interviewed indicated that they would like more training on how to work with mentally ill offenders.[223]

The difficulties experienced by mentally ill persons has persuaded a group of mental health consumers to recommend that incarcerated mentally ill persons be provided with in-house advocates, ombudspersons or similar advocates to ensure that their rights are protected.[224]

2. Special Handling Units and Administrative Segregation

Canada has a disturbing and documented history of using Solitary Confinement, known officially as Administrative Segregation, to manage mentally ill offenders, self-injurious offenders and those at risk of suicide. While there has been an effort to reduce the use of administration segregation in recent years, there are still considerable concerns about its use generally, and particularly with regards to the mentally ill.[225]

The Correctional Investigator of Canada has argued that CSC uses segregation to manage behaviours associated with mental illness. As evidence for this position, he notes that inmates in administrative segregation are 31% more likely to have a mental health issue, and that 68% of inmates at the Regional Treatment Centres (designated psychiatric hospitals) have a history of administrative segregation.[226]

In 2010, the Correctional Investigator stated in his Annual Report that Canada must stop using administrative segregation in cases involving the mentally ill. Subsequent to 2010, there has been a series of high profile court cases and preventable inmate deaths in custody. These events, coupled with the Correctional Investigator's statements and a change in international legal standards, have pushed the Canadian government to change its approach to administrative segregation. The following section explains how

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[220] P.R. Kropp, D. Cox, Ronald Roesch and Richard Eaves, "The Perceptions of Correctional Officers Toward Mentally Disordered Offenders" (1989) 12 International Journal of Law and Psychiatry 181 at 187 [Kropp].
[221] Kropp at 187.
[222] Kropp at 187.
[223] Kropp at 187.
[224] A George, ed., *Stigma and Community Reintegration: The Perspective of Mental Health Consumers* (Canadian Mental Health Association/Alberta South Central Region) 1992 at 78.
[225] In 2015-16, the total admissions to administrative segregation decreased 18.4% from 8,319 in 2014-2015 to 6,788 in 2015-16 (See Public Safety Canada Report 2016 at 65).
[226] Canada, Office of the Correctional Investigator, *Administrative Segregation in Federal Corrections: 10 Year Trends* (Ottawa: Her Majesty the Queen in Right of Canada, 2015), online:< http://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20150528-eng.pdf>.

administrative segregation in Canada is currently structured, and how it is changing.

(a) Current Practices in Administrative Segregation

The *CCRA* provides for administrative segregation in sections 31 to 37.[227] These sections outline the grounds for segregation, review procedures and inmate rights.

According to the *CCRA,* the purpose of administrative segregation is to maintain the security of the penitentiary or the safety of any person by not allowing an inmate to associate with other inmates.[228]

Section 31(3) outlines when administrative segregation may be used. As currently drafted,[229] it provides:

> (3) The institutional head may order an inmate be confined to administrative segregation if they are satisfied there are no alternative grounds to administrative segregation and he or she believe of reasonable grounds that:
>
> (a) 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 allowing the inmate to associate with other inmates would jeopardize the security of the penitentiary or the safety of any person;
>
> (b) allowing the inmate to associate with other inmates 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) allowing the inmate to associate with other inmates would jeopardize the inmate's safety.[230]

Inmates should be released from administrative segregation at the earliest appropriate time.[231] However, administrative segregation practices have often left inmates in isolation for months, if not years.[232]

The use of indefinite isolation, and the inadequacy of existing review processes, is particularly troubling with regards to the mentally ill. Mentally disordered inmates are often

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[227] *CCRA*, s 60.

[228] *CCRA*, s 31(1).

[229] These (and other related) provisions were found unconstitutional (violating ss 7 and 15(1) of the *Charter*) by the British Columbia Supreme Court in *British Columbia Civil Liberties Association v Canada (Attorney General)*, 2018 BCSC 62 (CanLII) in so far as they permit indefinite solitary confinement. The court granted a one-year suspension of invalidity, which gives the federal government until January 2019 to amend them. See discussion below at note 241 and beyond.

[230] *CCRA*, s 31(3)

[231] *CCRA*, s 31(2).

[232] *Bacon v Surrey Pretrial Services (Warden)*, 2010 BCSC 805 [*Bacon*]. In an Ottawa case, a forty-five year-old man with mental illness, who was arrested on minor charges, apparently fell through the cracks and was held in jail for six months without being brought to court and without his lawyer being notified. See: Jake Rupert, "Mentally Ill Wait in Jail for Justice to be Done", *Ottawa Citizen*, November 10, 2004.

put in isolation because they are difficult to manage.

Whether there are any significant effects which result specifically from confinement in administrative segregation has been debated extensively in the scientific and criminological communities, and has significant implications for the management of correctional institutions as they currently operate.[233] Hodgins and Côté indicate that correctional facilities have historically held mentally disordered inmates in isolation, even though this type of confinement has been shown to make their symptoms worse.[234] Arboleda-Flórez indicated that confinement and lack of stimulation can lead to acute psychotic reactions among mentally ill persons.[235] Kaufman also indicated that solitary confinement cells are grossly inappropriate for the mentally ill inmate who may react to the sensory deprivation with psychosis.[236] In 1975, a commission launched an inquiry into the use of isolation in penitentiaries. The commission, headed by Dr. J.A. Vantour, visited 13 institutions and concluded that administrative segregation over long periods represented a serious danger for inmates.[237] A report by the UN Special Rapporteur claims that experts who have examined the impact of administrative segregation report "prison psychoses", the symptoms of which include anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia, and psychosis and self-harm.[238]

(b) Drivers of Change in Administrative Segregation Practices

The impact of administrative segregation on pre-existing mental health issues is exemplified by the case of Ashley Smith. Ms. Smith was a female inmate who, in 2007, committed suicide while placed on 24-hour supervision in administrative segregation. She had spent 11.5 months in administrative segregation—the entire duration of her federal incarceration. Ms. Smith had a history of mental health symptoms, but was never provided with a comprehensive mental health assessment or treatment plan. Attempts to obtain these assessments were thwarted in part by the fact that she was transferred 17 times during her 11-month federal incarceration. In the weeks prior to her death she had no

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[233] *Bacon*.
[234] Hodgins & Côté, 1991 at 175; Lorna A Rhodes, *Total Confinement: Madness and Reason in the Maximum Security Prison* (California: University of California Press, 2004).
[235] Julio Arboleda-Florez, "Forensic Psychiatry Services in Canada" (1981) 4 International Journal of Law and Psychiatry 391 at 397 [Arboleda-Florez].
[236] E Kaufman, "The Violation of Psychiatric Standards of Care in Prisons" (1980) 137(5) Am. J. Psychiatry 566 at 567.
[237] C Lalonde, "Les Soins de Santé en Prison, l'ère Partie" (1977) 116 Canadian Medical Journal 408.
[238] Patricia Carole Perkins & Emily Seawell, "Human Dignity and Evolving Standards of Decency: Disciplinary Segregation of Inmates in South Africa and the United States" UN Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2011) at 5.

shoes, mattress or blanket and slept on the floor of her segregation cell. She had been identified as highly suicidal by a prison psychologist. However, the staff supervising Ms. Smith were not made aware of this fact. In the hours just prior to her death, Ms. Smith spoke to a Primary Worker about her strong suicidal thoughts. She died while under twenty-four-hour observation by correctional staff.[239] A coroner's inquest ruled that Ms. Smith's death was a homicide.[240] Despite this finding, CSC refused to abandon its use of indefinite administrative segregation.

The practice of administrative segregation has been the subject of numerous court challenges over the past 40 years.[241] While certain practices were successfully challenged under the *Canadian Charter of Rights and Freedom's* predecessor,[242] many challenges failed to persuade courts that administrative segregation constituted 'cruel and unusual punishment' under s 12 of the *Canadian Charter of Rights and Freedoms*.[243]

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[239] Canada, Officer of the Correctional Investigator, "A Preventable Death" (Ottawa: Office of the Correctional Investigator, 2014) online: www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20080620info-eng.aspx [Preventable Death].

[240] Preventable Death.

[241] For example, in *Worm v Canada*, the BCCLA advanced the case of a 26-year-old Aboriginal woman who was held in solitary confinement for more than three-and-a-half years. The action was settled in May of 2013 (see: BCCLA, "Worm v Canada: Working to End Solitary Confinement" (February 12, 2014) Online: https://bccla.org/our_work/worm-v-canada/.

[242] In *McCann et al* v *The Queen et al.,* 1975, 29 CCC (2d) 337 (Fed TD) [*McCann*]. the court ruled that solitary confinement (administrative segregation) as practiced in the British Columbia Penitentiary (which is now closed) constituted cruel and unusual punishment under the *Canadian Bill of Rights.* For a detailed discussion of this case, see: M. Jackson, *Prisoners of Isolation: Solitary Confinement in Canada* (Toronto: University of Toronto Press, 1983).

[243] Part I of the *Constitution Act,* 1982, being Schedule B of the *Canada Act 1982* (UK), 1982, c 11 [*Charter*]. See *R v Olsen* (1987), 38 CCC (3d) 534 (Ont CA), appeal dismissed on other grounds (1989), 47 CCC (3d) 491 (SCC). See also: *Wu v Canada (Attorney General)* [2006] BCJ No 63 and *McArthur v Regina Correctional Centre* (1990), 56 CCC (3d) 151 (Sask QB), where the court held that segregation of an inmate because of his violence did not constitute cruel and unusual punishment under *Charter* s 12. The segregation did not meet the test of being so excessive as to outrage the standards of decency. In *Munoz v Alberta (Edmonton Remand Centre*), 2004 ABQB 769 at para 78. Nation J concluded that the treatment at Edmonton Remand Centre of the five applicants did not amount to a s12 violation. In *Munoz,* complaints included being shackled in the exercise yard, being double-bunked in administrative segregation and the loss of gymnasium privileges. In *Bacon v Surrey Pretrial Services Centre,* 2010 BCSC 805, the accused was segregated in his room from other inmates for 23 hours a day. His visits were restricted and he was subjected to numerous deprivations. The accused brought a petition for declaratory relief, and the petition was granted. The warden inappropriately relied on the police to drive the decisions on administrative segregation, resulting in a breach of s 7 of the *Charter*. The long periods of unmitigated segregation and deprivation known to cause psychological harm amounted to cruel and unusual punishment in breach of s 12 of the *Charter*. See also: *Corp. of the Canadian Civil Liberties Association v Her Majesty the Queen*, 2017 ONSC 7491, where the Ontario Superior Court held that *CCRA*, sections 31-37 were arbitrary and thus violated *Charter* s 7; however, the ONSC declined to hold that *Charter* s 12 was violated. CCLA is appealing this decision, arguing that the court too narrowly interpreted the *Charter* s 7 violation and failed to find a s 12 violation. See: Notice of appeal of CCLA to Ontario Court of Appeal: online https://ccla.org/cclanewsite/wp-content/uploads/2018/01/2018-01-17-CCLA-Solitary-Confinement-NoA.pdf https://ccla.org/legal-fight-solitary-confinement-continues/.

The situation changed in January 2018 in *British Columbia Civil Liberties Association v Canada (Attorney General*).[244] The British Columbia Civil Liberties Association and the John Howard Society successfully argued that Canada's administrative segregation practices violate ss 7, 9, 10, 12 and 15 of the *Charter* in multiple ways. The British Columbia Supreme Court declared that ss 31-33 and 37 of the *CCRA* are of no force or effect, but delayed the declaration of invalidity for one year to allow the government to draft constitutionally compliant legislation.

The Court specifically held that the administrative segregation regime violates s 15 of the *Charter* to the extent that it authorizes any period of administrative segregation for the mentally ill or disabled. In reaching its decision, the Court relied on statistics, expert witnesses, as well as lay evidence from correctional staff and prisoners who had experienced solitary confinement, to find that:

- Mentally ill persons are over-represented in administrative segregation.[245]
- Placing the mentally ill in administrative segregation exacerbates and promotes recurrence of mental disorders.[246]
- Mentally ill prisoners in administrative segregation are at higher risk of serious psychological harm, including mental pain and suffering, and increased risk of self-harm and suicide than the general prison population.[247]
- The current processes for identifying and treating inmates with mental illness are inadequate.[248]
- The administrative segregation regime is more burdensome for persons with mental illness.[249]

The federal government has appealed the ruling.[250] However, legislation has been tabled to amend the *CCRA* to create a 21-day presumptive limit (to be reduced to 15 days after 18 months) on the length of time an inmate may spend in administrative segmentation.[251] This limit aligns Canadian practice with the some of the revised United Nations Standard

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[244] *British Columbia Civil Liberties Association v Canada (Attorney General*), 2018 BCSC 62 (CanLII) [*BCCLA v Canada*]; appealed by Canada (Attorney General): *British Columbia Civil Liberties Association v Canada (Attorney General*), 2018 BCCA 282. (CanLII)
[245] *BCCLA v Canada* at para 496.
[246] *BCCLA v Canada* at para 498.
[247] *BCCLA v Canada* at para 497.
[248] *BCCLA v Canada* at para 503.
[249] *BCCLA v Canada* at para 512.
[250] *BCCLA v Canada (Attorney General),* 2018 BCCA 282 (intervenor application).
[251] See: Bill C-56 *An Act to amend the Corrections and Conditional Release Act and the Abolition of Early Parole Act* 1st Sess, 42nd, 2017; Report 2016/2017 at 42.

Minimum Rules for the Treatment of Prisoners (known as the Nelson Mandela Rules).[252] The Nelson Mandela Rules prohibit the use of "prolonged" solitary confinement (in excess of 15 days).[253] However, the Nelson Mandela Rules also prohibit the use of solitary confinement for persons who have mental or physical disabilities when their conditions would be exacerbated by such measures.[254] The proposed redrafted legislation does not address this direction.

(c) Administrative Segregation's Application to Mentally Ill

In some cases, prison administration may decide to house mentally disabled persons in hospital units, special units or in administrative segregation (solitary confinement). Sometimes, individuals who do not qualify for involuntary commitment under provincial mental health legislation, because they are not a danger to themselves or to others, nevertheless require special protection in the prison setting. The prison administration determines that they are in danger from other inmates or that they are too disruptive. These individuals may be placed in health care units, psychiatric units (where available), or in administrative segregation for varying periods.

Special handling units are also used in housing mentally disabled inmates. Hodgins and Côté conducted an evaluation of the mental health of inmates in the Special Handling Unit and the Long-Term Segregation Units in the Quebec region of the Correctional Service of Canada. The Special Handling Unit was used to house inmates who posed a serious and persistent risk to the safety of staff or inmates. Inmates were housed in administrative segregation for security reasons, for the inmate's safety, or for related reasons.[255] The Diagnostic Interview Schedule (DIS) was used to assess mental disorder. The results indicated that mentally disabled inmates were being isolated within penitentiaries.

Twenty-nine percent of the inmates held in the Special Handling Unit were found to suffer from a severe mental disorder.[256] In 86 percent of these cases, the mental disorder

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[252] UN General Assembly, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules): resolution / adopted by the General Assembly*, 8 January 2016, A/RES/70/175, available at: http://www.refworld.org/docid/5698a3a44.html [accessed 14 April 2018] [Nelson Mandela Rules] at Rule 43, 44; Report at 2016/2017.

[253] Nelson Mandela Rules, Rules 43(b), 44.

[254] Nelson Mandela Rules, Rule 45.

[255] Hodgins & Côté, 1991 at 176. See also: *Re Dennis* (1987), 78 AR 81 (Surr Ct), where on an application to rescind a compulsory care order under the *Adult Guardianship and Trusteeship (AGTA)* a psychiatrist testified that a mentally disabled person who was sexually deviant would surely come to harm in the prison system, even if he were held in a special handling unit. However, the court concluded that there was no evidence of any incidents during Dennis' previous incarceration. The *AGTA* is for adults over the age of 18 years who are unable to make personal or financial decision for themselves.

[256] Hodgins & Côté, 1991 at 176.

was present before the subject was sentenced to the penitentiary.[257] Only two out of 62 inmates had been transferred to a psychiatric hospital during a stay in a penitentiary.[258] Thirty-one percent of the inmates in the Long-Term Segregation Unit suffered from a lifetime severe mental disorder.[259] In 64 percent of these cases, the mental disorder was present before the subject was sentenced to a penitentiary.[260] Three inmates had been transferred for psychiatric care while inmates.[261]

Hodgins and Côté concluded that inmates who are disorganized, disruptive and lacking in self-control are sent to the Special Handling Unit or the Long-Term Segregation Unit.[262] Further, the proportion of inmates suffering from schizophrenia and bipolar disorder is higher in these units than in the general population. Hodgins and Côté surmised that "withdrawn mentally disordered inmates are left within the general population, while the troublesome ones are sent to isolation".[263] The proportion of inmates suffering from major depression is greater in the general inmate population than in the isolation populations.[264] Most offenders in administrative segregation are placed there involuntarily, due to danger to staff, other inmates or for the security of the institution.[265] Another concern for the mentally ill prisoners can be that they request segregation because they fear that their personal safety is in jeopardy in the general inmate population.[266] Prisoners in segregation tend to report significantly more mental health problems than non-segregated prisoners.[267] Finally, mentally disordered inmates were being isolated within the penitentiaries and were not receiving mental health care.[268]

In an Ontario study of the characteristics of offenders in protective custody in a provincial correctional centre, the authors concluded that a significant portion of the protective custody population consisted of offenders with psychiatric problems.[269] Some of the offenders were initially classified into the Protective Custody Unit and some were

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[257] Hodgins & Côté, 1991 at 176.
[258] Hodgins & Côté, 1991 at 178.
[259] Hodgins & Côté, 1991 at 178 & 179.
[260] Hodgins & Côté, 1991 at 178 & 179.
[261] Hodgins & Côté, 1991 at 178 & 179.
[262] Hodgins & Côté, 1991 at 178 & 179.
[263] Hodgins & Côté, 1991 at 178 & 179.
[264] Hodgins & Côté, 1991 at 180.
[265] Shauna Bottos, Correctional Service Canada, *Profiles of Offenders in Administrative Segregation: A Review of the Literature*, (Ottawa: Corrections Canada 2007).
[266] Cherami Wichmann & Nafekh M, "Moderating segregation as a means to reintegration" (2001) 13 Forum on corrections Research at 31-33.
[267] Bottos at 2.
[268] Bottos at 2.
[269] J.S. Wormith, M. Tellier and P. Gendreau, "Characteristics of Protective Custody Offenders in a Provincial Correctional Centre" (1988) 30(1) *Can. J. Criminology 39* at 54 [Wormith, Tellier & Gendreau].

transferred into it because of incidents in the general population.[270] Protective Custody inmates frequently had fewer recreational facilities and less access to a variety of prison programs. They often claimed to be discriminated against by prison officers.[271]

It appears that, at best, mentally disabled persons receive inconsistent treatment in correctional institutions. Their mental conditions are often not recognized by prison staff or officials. Special handling units and isolation remove those prisoners who are creating difficulties but these units might not meet the needs of the large numbers of mentally disabled persons detained therein. Indeed, in some cases, isolation and segregation exacerbate mental conditions.

C. Obligation of Prison Officials To Protect Mentally Disabled Inmates

Prison and jail authorities have a duty at common law to take reasonable care for the safety of persons in their custody.[272] This obligation is tempered somewhat by a recognition that prison officials are allowed some latitude in the amount of supervision they provide, in light of their rehabilitative efforts and in light of the risks of prisoner misbehaviour under the circumstances.[273]

In *Howley v The Queen,*[274] the plaintiff was attacked by an allegedly mentally disabled prisoner in the dormitory where they were held. The dormitory was special in that it provided greater freedom and facilities for selected prisoners. Residents were permitted to keep their tools with them in the dormitory. The prisoner utilized one of those tools to attempt to stab Howley.

Howley sued the Crown for negligence, claiming that the prison authorities should have suspected the assailant's violent propensities in light of psychiatric examinations he had undergone. On the basis of these examinations, the prisoner should not have been permitted to live in the dormitory. The Federal Court Trial Division held that while the Crown could be held vicariously liable for negligence by prison authorities, there was no evidence that the prison officials knew or ought to have known of the assailant's violent tendencies. Consequently, the plaintiff failed to show a breach of duty owed to him and was

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[270] Wormith, Tellier & Gendreau at 54.
[271] Wormith, Tellier & Gendreau at 41.
[272] *Timm v The Queen,* [1965] 1 Ex CR 174; *MacLean v The Queen* (1972), 72 DLR (3d) 365 (SCC); *Gill v Canada (Deputy Commissioner, Correctional Services)* (1988), 18 FTR 266 (TD), rev'd on other grounds (1989), 92 NR 307 (Fed CA) [*Gill*]; *Marshall v Canada* (1985), 57 NR 308 (Fed CA), varied on other grounds (1985), 13 Admin LR 195 (Fed CA); *Belliveau v Nova Scotia* (1978), 31 NSR (2d) 346 (TD); *Abbott v Canada* (1993), 64 FTR 81 (TD).
[273] *Home Office v Dorset Yacht Co Ltd.,* [1970] 2 All ER 294 (HL) at 304; *Fleishour v United States,* 244 F Supp 762 (Ill Dist Ct., 1965), *aff'd* 365 F 2d 126, *certiorari denied* 87 S Ct 597 (1965).
[274](1973), 36 DLR (3d) 261 (FCTD) [*Howley*].

unsuccessful.[275]

The common law duty to keep prisoners in safe custody is reinforced by statute. For example, subparagraph 2(c) of the Alberta *Corrections Act* provides that the Solicitor General is responsible for the safe custody and detention of inmates.[276] Additionally, section 3(a) of the federal *CCRA* provides:

> 3. 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 court through the safe and humane custody and supervision of offenders;

The statutory and common law obligations to keep prisoners safe apply to mentally disabled prisoners. It would seem that at least some of the difficulties experienced by mentally disabled prisoners should be recognized and that prison officials will have to compensate through adequate facilities, counselling and staff training.

It is possible that failing to recognize and adequately compensate for mental disability in the prison population could amount to a breach of these duties. Proving this would not, however, be an easy task. Experts have argued that it is more difficult for mentally ill inmates to prove that the hardships they suffer are caused by inadequacies with the prison health system, as compared to mentally ill patients who are not imprisoned. This is due in part to the judicial tendency to afford extreme deference to prison administrators, notwithstanding that the *Charter* places the burden of proof on the government to justify an infringement of rights. This state of affairs is exacerbated by the limited resources and means of Federal inmates.[277] This attitude likely flows from the myth of "correctional expertise", or the idea that prison administrators have access to a specialized knowledge of prison society and safety risks. While there may be some truth to this idea, it becomes problematic when deference trumps hard evidence of inadequate inmate care.

In addition to suing the Crown for a breach of its duty, mentally disabled prisoners might argue that because of the difficulties they encounter, they are subjected to cruel and unusual treatment or punishment, which is prohibited under s 12 of the *Charter*.[278] For example, if a mentally ill prisoner is exploited by other prisoners, he/she could be protected

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[275] *Howley* at 269-270.
[276] RSA 2000, c C-29.
[277] Lisa Kerr, "Contesting Expertise in Prison Law" (2014) 60 *McGill Law Journal* 1 at 43-94 [Contesting].
[278] See, for example, *Mettoudi* c *Establishment Archambault,* [1987] RJQ 1337 (CS), where an inmate was suffering from severe back problems and required physiotherapy that was not available at the high security prison where he was held. The inmate argued unsuccessfully that this was cruel and unusual punishment under s 12. However, the court was persuaded by the fact that the prison authorities were making arrangements for the prisoner to receive physiotherapy.

by removal from the situation or through effective counselling. To ignore the situation could worsen her/his mental condition.[279] Often, prisoners choose voluntary segregation, which is a temporary solution and does not resolve the underlying cause. Further, failure to alleviate the adverse conditions and special difficulties encountered by mentally disabled prisoners may violate other international human rights laws.[280] Therefore, prison officials have an obligation to maintain mentally disabled prisoners in safe custody. Failure to meet this obligation may result in harm to mentally disabled prisoners and in subsequent legal action. Such a claim will generally only succeed where there has been the deliberate or malicious imposition of cruel and unusual treatment on part of Corrections personnel.[281]

VII. Transfers of Mentally Disabled Prisoners

Sometimes it is necessary to transfer prisoners from the general prison population to mental health facilities.[282] Section 29 of the *CCRA* provides that the Commissioner may authorize the transfer of a person who is sentenced, transferred or committed to a penitentiary either to another penitentiary or to a provincial correctional facility or hospital, provided the Minister has entered into an agreement with the province under s 16 (*CCRA* s 29 and 16).

In *R v Knoblauch*, [283] the judge discussed considerations for granting mentally ill offenders transfers to treatment facilities, as well as the circumstances sentencing judges can use the *Criminal Code* to divert mentally ill offenders away from penitentiaries. The court identified that there is a distinct lack of facilities to deal with offenders who do not meet the threshold to be found not criminally responsible under s 16 of the *Criminal Code* but are nonetheless cast into the penitentiary system, as opposed to a hospital or similar

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[279] In the United States, the Eighth Amendment's ban on cruel and unusual punishment has been held by the Supreme Court to apply to deliberate indifference to prisoners' serious medical needs. See: *Estelle v Gamble,* 429 US 97 (1976); Michael Friedman, "Cruel and Unusual Punishment in the Provision of Prison Medical Care: Challenging the Deliberate Indifference Standard" (1992) 45 Vanderbilt L Rev 921.

[280] See: *Declaration on the Rights of Mentally Retarded Persons,* G.A. res. 2856, 26 UN GAOR, Supp. (No 29) 99, UN Doc. A/8429 (1971), section 6; *International Covenant on Civil and Political Rights,* (1976) 999 UNTS 171, [1976] C.T.S. 47, section 10; *Declaration on the Rights of Disabled Persons,* GA Res 3447, 30 UN GAOR, Supp. (No. 34) 92 UN Doc. A/10034 (1975), section 10; *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Official Records of the General Assembly of the United Nations, Thirty-Ninth Session,* Supplement No 51 (A/39/51), p. 197, [1986] 2 SAJHR 99; Nelson Mandela Rules.

[281] *Maljkovich v Canada,* [2005] FCJ No 1679, 143 ACWS (3d).

[282] For a discussion of the transfer cases in the United States, see M Churgin, "The Transfer of Inmates to Mental Health Facilities" cited in J Monahan & H. Steadman, *Mentally Disordered Offenders* (New York: Plenum Press, 1983) at 207.

[283] *R v Knoblauch*, 2000 SCC 58, 149 CCC (3d) 1 [*Knoblauch*].

treatment facility.[284] People who do not meet the requirements under s 16, but who are still troubled, require the same level of statutory and institutional attention as is accorded to not criminally responsible accused.[285]

The lifetime incidence of major mental disorders is considerably greater among incarcerated offenders than among the general population.[286] Prisons are not hospitals, and the conditions that prevail there are far from therapeutic or rehabilitative. Incarcerating persons with mental health problems in conditions and environments that are poorly suited to meet their needs promotes neither public safety nor rehabilitative objectives.[287] In the current correctional system, there is not enough capacity, professional experience or resources to meet the increased demands being placed on a correctional system that was not designed to house mentally ill prisoners.[288] Mentally ill prisoners are falling through the cracks. Many do not have access to intermediate care in their penitentiary, yet they also fail to meet the admission criteria of the five regional psychiatric treatment facilities.[289] Critics have declared that the deinstitutionalization of seriously mentally ill individuals has been a failed social experiment.[290] There is a need to develop partnerships and service delivery agreements between federal and provincial/territorial correctional and mental care authorities, in order to ensure that federal inmates have the same access to health care as other Canadians.[291]

The Alberta *Mental Health Act* ("*MHA*") does not clearly state how transfers can be made from federal penitentiaries.[292] Section 13(2) of the *MHA,* which provides for the

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[284] *Knoblauch*. The SCC decided that the trial judge was entitled to conclude that "serving the sentence in the community would not endanger the safety of the community and would be consistent with the fundamental purpose and principles of sentencing", in accordance with *Criminal Code* s 742.1(b). See also: *R v Prioriello,* 2012 ONCA 63, 99 WCB (2d) 542. In order for mental illness to be considered mitigating factor in sentencing, the offender must show a causal link between his illness and his criminal conduct, that is, the illness is an underlying reason for his aberrant conduct.

[285] Archibald Kasier, "*R v Knoblauch*: A Mishap at the often ambiguous crossroads between the criminal justice and the mental health care systems" (2011) 37 CR-ART 401; See also: *R v Swain*, [1991] 1 SCR 933, 63 CCC (3d) 481.

[286] RC Bland *et al*., " Psychiatric Disorders in the Population and in Prisoners" (1998) 21 Int'l JL & Psy. 273; J Brink, D Doherty, "Mental Disorder in Federal Offenders–A Canadian Prevalence Study" (2001) Int'l JL Psy. 339.

[287] A majority of the prisons in Canada were not designed to hold the prisoners with mental illness. For example, the first large prison in Canada was built in Kingston 1835 well before Confederation. Kingston Penitentiary is only set to close in the next two years.

[288] *Correctional Investigator 2010-2011* at para 53.

[289] *Under Warrant* at 55.

[290] Fuller Torry, "Jails and Prisons–America's New Mental Hospitals*"* (1995) 85:12 American Journal of Public Health at 1612 cited in Cindy Peternelj-Taylor, "Criminalization of the Mentally Ill" (2008) No 4 Journal of Forensic Nursing at 185.

[291] Mental Health, 2010.

[292] RSA 2000, c M-13, s 9 [*MHA*].

admission, treatment, examination and discharge of persons "detained for treatment" under the *Criminal Code,* does not appear to apply to mentally disabled prisoners.[293] This provision appears to apply to persons who are being detained under the unfitness provisions or perhaps those who are subject to a hospital order.[294]

However, federal prisoners may be involuntarily committed under the procedures outlined in the *MHA.* If a physician determines that a person is suffering from a mental disorder, is likely to cause harm to himself/herself or others or to suffer substantial mental or physical deterioration or serious physical impairment, and is unsuitable for admission to a facility other than as a formal patient, the physician may issue an admission certificate with respect to the person.[295] An admission certificate authorizes the facility to care for, observe, examine, assess, treat, detain and control the person named in the certificate for 24 hours from the time they arrive at the facility.[296] The period of detention may be extended if two physicians conduct separate examinations and determine that the patient is suffering from a mental disorder, likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and is unsuitable to continue at a facility other than as a formal patient.[297] There are review procedures in place to ensure that the continued detention of the person is justified.[298] Thus, there are procedural safeguards in the *MHA* intended to protect an involuntarily committed person.

Under the Alberta *MHA*, any person who is transferred from a correctional facility to a mental health facility may apply to the chair of the review panel of the facility for an order transferring him/her back to a correctional facility. The review panel may grant the transfer order, it may cancel admission or renewal certificates or it may refuse the request. If the review panel orders the transfer of the person, the board of the mental health facility must comply with the order, or, if the review panel cancels the admission certificate(s), the board must arrange to have the person returned to a correctional facility.[299]

The procedures for transferring provincially incarcerated individuals are located in provincial corrections legislation. The Alberta *Corrections Act* provides that the Chief Executive Officer may, if satisfied the inmate requires treatment in a facility pursuant to the

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[293] *MHA*, s 13(1).
[294] Arguably, this section needs to be amended to reflect the recent changes in the *Criminal Code.* Formerly, s 618 (now repealed) authorized the Lieutenant Governor to transfer mentally disabled persons from prisons to mental health facilities.
[295] *MHA,* s 2.
[296] *MHA*, s 4(b).
[297] *MHA*, s 8(1).
[298] *MHA,* s 38(1) and s 39(1).
[299] *MHA*, s 33.

MHA, direct that an inmate remain in custody while in the hospital or facility or, if advised by the person in charge of the facility that the inmate no longer requires treatment, direct transfer of the inmate to a named correctional institute.[300]

Presumably, this means that a provincial inmate may be transferred to a mental health facility if he/she agrees to be voluntarily admitted or if he/ she meets the requirements for involuntary admission under the *Act*.[301] If the prisoner does not meet the requirements for involuntary committal and does not agree to be admitted voluntarily, arguably, he/she cannot be admitted to a provincial mental health facility for treatment under the *Act.* Otherwise, s 9 of the *Corrections Act* could be used to circumvent the scheme for formal admission outlined in the *MHA.* The *MHA* has specific provisions that limit non-consensual treatment of formal patients.[302]

Although there are cases where federal prisoners have challenged the decisions of the prison administration to transfer them to other correctional facilities,[303] there are few cases where prisoners have challenged the validity of a transfer to a mental health facility. This may be because of the relative improvement in conditions between the prison and a mental health facility or because a physician is involved in obtaining an admission certificate. Consequently, prisoners may decide not to complain about a transfer because they consider the decision a medical one rather than an administrative one.

In *Teale v Canada*, the inmate sought an interlocutory injunction preventing transfer from a custodial centre to a regional psychiatric care centre.[304] The applicant`s position was that she would suffer reduced mobility and that her contact with other inmates would be reduced in the higher security setting of the psychiatric centre. The Court was unsympathetic to this viewpoint, reiterating that the primary concern was the security of the inmate and public safety. This was best served through the transfer to a facility capable of providing psychiatric assessment of the applicant.

There have been some legal decisions, however, where individuals have challenged

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[300] *MHA*, s 8 and s 9.

[301] Formerly, the Lieutenant Governor could authorize transfers of mentally disordered prisoners to mental health facilities under *Criminal Code,* s 618. This provision was repealed in 1991.

[302] See *MHA,* ss 26 - 30.

[303] See, for example: *Ericson v Canada (Deputy Director of Correction Services)* (1991), 10 CR (4th) 235 (BCSC); *Camphaug v Canada* (1990), 34 FTR 165 (TD); *R v Chester* (1984), 5 Admin LR 111 (Ont. HC); *Williams v Canada (Regional Transfer Board, Prairie Region)* (1990), [1991] 1 FC 251; *Gallant v Canada (Deputy Commissioner, Correctional Services)* (1989), 92 NR 292 (Fed CA); *Gill*; *Balain v Canada (Regional Transfer Board)* (1988), 62 CR (3d) 258 (Fed TD); *Demaria v Canada (Regional Transfer Board)* (1988), 62 CR (3d) 248 (Fed TD); *McCauley v Ferndale Institution* (1987), 15 FTR 172 (TD); *Jamieson v Canada (Commissioner of Corrections)* (1986), 51 CR (3d) 155 (FCTD); *Hay v Canada (National Parole Board)* (1985), 13 Admin LR 17 (Fed TD); *Collin v Lussier,* [1985] 1 FC 124 (CA); *Pruneau v Goulem* (1988), 23 FTR 19 (TD); *Malette v Canada (Commissioner of Corrections)* (1991), 48 FTR 238 (TD).

[304] *Teale c Canada* (Procureur général) [2000] FCJ No 1666, 104 ACWS (3d) 570.

the validity of various procedures and provisions under provincial Mental Health Acts.[305] These provisions and procedures, especially the arbitrary detention of various individuals, have been challenged as violating sections 9 and 10 of the *Charter*.

In *Khan v St Thomas Psychiatric Hospital,* a mentally ill prisoner was involuntarily admitted to a psychiatric facility after a prison physician diagnosed a condition that constituted a risk to others.[306] The attending physician completed an admission certificate that certified that Khan met the criteria for involuntary committal. Under Ontario law, involuntary commitment is authorized if a person is suffering from a mental disorder of a nature or quality that will likely result in serious bodily harm to the patient or others unless the patient remains in the custody of a psychiatric facility.[307] An *amicus curiae* (friend of the court) was appointed to represent Khan's interest as she continually discharged her lawyers.[308]

The *amicus* argued that since Khan had been detained in segregation at the prison and would likely be returned to segregation, her behaviour would not result in serious bodily harm to another person.[309] The Ontario Court of Appeal upheld the validity of the transfer from prison to hospital under what was then s. 9 of the *MHA.*[310] Further, the court held that Khan was dangerous to other inmates and prison personnel. The fact that she could be kept in isolation in prison was not dispositive of the involuntary confinement issue.[311] The possibility of treatment in the psychiatric facility justified her continued confinement there. Khan should not be denied access to treatment on the ground that the risk she posed could be adequately controlled in a jail.[312]

Under the Alberta *MHA*, any person who is transferred from a correctional facility to a mental health facility may apply to the chairman of the review panel of the facility for an order transferring him back to a correctional facility.[313] The review panel may grant the

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[305] See, for example: *Lussa v The Health Science Centre and Director of Psychiatric Services* (1983), 9 CRR 350 (Man QB); *Re Jenkins* (1984), 5 DLR (4th) 577 (PEISC) *(sub nom. Reference Re Procedures and the Mental Health Act); Thwaites v Health Sciences Centre Psychiatric Facility and Health Sciences Centre,* [1987] 1 WWR 468 (Man QB), rev'd [1988] 3 WWR 217 (CA); *C(J) v British Columbia (Forensic Psychiatric Service Commissioner)* (1992), 8 CRR (2d) 260 (SC); *Re C(J)* (1991), 2 Admin LR (2d) 92 (Penetanguishene Psychiatric Review Board), affirmed (1992), 3 Admin LR (2d) 223 (Ont Gen Div); *W(C) v Manitoba (Mental Health Review Board)* (1992), 11 CPC (3d) 11 (Man QB).
[306] (1992), 70 CCC (3d) 303, 87 D.L.R. (4th) 289. Leave to appeal to SCC dismissed October 8, 1992 [*Khan*].
[307] Note: Alberta's *Mental Health Act* does not contain the latter requirement "unless the patient remains in the custody of a psychiatric facility".
[308] *Amicus curiae* means 'Friend of the court'. Lawyer appointed by the court.
[309] *Khan* at 308.
[310] RSO 1990, c M. 7.
[311] *Khan* at 310.
[312] *Khan* at 311.
[313] *MHA*, s 33(1).

transfer order, it may cancel admission or renewal certificates or it may refuse the request.[314] If the review panel orders the transfer of the person, the board of the mental health facility must comply with the order, or, if the review panel cancels the admission certificates, the board must arrange to have the person returned to a correctional facility.[315]

In September 2010, the delivery of health services in provincial correctional facilities was transferred to Alberta Health Services.[316]. This is intended to strengthen the provision of integrated mental health and addictions services to inmates, enhance assessment and treat services within correctional centres, and strengthen transitions services in the community.[317]

VIII. Right to Treatment in Prison and Jail.[318]

A. Introduction

Mentally disabled prisoners may need psychiatric treatment while they are incarcerated. In some cases, mentally disabled prisoners may be treated within the prison or jail. In other cases, mentally disabled prisoners will be transferred to mental health facilities where they will be voluntarily or involuntarily admitted for treatment. The rights of prisoners under these circumstances are discussed below under: "Treatment in Mental Health Facilities."

Do mentally disabled prisoners have any common law or statutory right to treatment? Before this can be discussed, the meaning of "treatment" needs to be analyzed.[319] Psychiatrists and other professionals do not have a precise meaning for "treatment". However, treatment usually involves procedures intended to remedy or improve some abnormal condition.[320] Treatment may involve the administration of drugs, anger management training, life skills training and other counselling.[321] The goal of treatment is usually to alleviate the patient's suffering and to increase her adaptation to society.[322]

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[314] *MHA*, s 33(2).
[315] *MHA*, s 33(3).
[316] Alberta Health Services, *Communique – Corrections Amendment Act* (27 September 2011), online <http://www.albertahealthservices.ca/5803.asp>.
[317] *Solicitor General* at 71.
[318] With thanks to Irene MacEachern (lawyer) for her research assistance in this section.
[319] The *CCRA* unhelpfully defines treatment as "health care treatment"(*CCRA* s 85).
[320] Marnie Rice, Grant Harris, D Sutherland & J Leveque, "Principles Regarding Treatment of Patients in Psychiatric Institutions", (December 1990) Canada's Mental Health 18 at 20 [Rice, Harris, Sutherland & Leveque].
[321] Rice, Harris, Sutherland & Leveque at 20.
[322] Rice, Harris, Sutherland & Leveque at 20.

B. Corrections Legislation and the Right to Treatment

The *CCRA* mandates that every federal inmate be given access to essential mental health care, and reasonable access to non-essential mental health care.[323] In the *CCRA* "mental health care" is defined as "the care of a disorder of thought, mood, perception, orientation, or memory that significantly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life".[324] The specifics of essential mental health care in federal prisons are laid out in the National Essential Health Services Framework, and under the CSC's directive on health care, Conditional Directive 800.[325]

Under the National Health Framework, essential mental health care includes cases where an inmate has "significant mental health needs in the areas of emotion, cognition and/or behaviour indicative of a mental health disorder, and these needs are, or are likely to, create significant impairment in the individual's functioning within his or her institution or significantly impact the individual's successful reintegration into the community."[326] Inmates must pay the full cost of any non-essential health service.[327]

Essential mental health care includes mental health screening and assessment, review and follow up assessments where needed, as well as intervention, treatment and support services. It also includes discharge planning and the provision of transitional support systems, such as referrals to community resources for inmates with significant mental health needs in the areas of emotion, thinking and/or behavior.[328]

Mental health services for inmates are accessed via a triage system. Inmates can submit a confidential request for specific services, or they can be referred by any staff at the correctional facility. These requests are reviewed and prioritized according to urgency. Decisions on treatment are based on need, which is assessed by considering available mental health assessment information, clinical judgement and symptoms indicative of a mental health disorder and level of functioning.[329] In *Ennis v Canada (Attorney General)*,[330] the Federal Court afforded a wide degree of discretion to the waiting list employed by a

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[323] *CCRA*, s 86. See also: *Lavoie v Canada*, 2002 FCT 220 (CanLII) at para 4.
[324] *CCRA* s 85.
[325] Correctional Service Canada, *National Essential Health Services Framework* (Correctional Service Canada, 2015) online: <https://buyandsell.gc.ca/cds/public/2017/01/23/8921a69b8c06457ea41ee196bfb7b495/annex_f_-_national_essential_health_services_framework_-_bilingual.pdf> [National Health Framework]; Correctional Service Canada, *Commissioner's Directive 800* (Ottawa: 2015) [CD 800] online: <http://www.csc-scc.gc.ca/politiques-et-lois/800-cd-eng.shtml>
[326] National Health Framework at 36.
[327] National Health Framework at 5.
[328] National Health Framework at 2,
[329] National Health Framework at 36.
[330] 2003 FCT 461 (CanLII) [*Ennis*] at para 28.

penal institution, noting that such decisions involve the internal functioning of a penal institution that should not be interfered with lightly.[331]

The standard of care for medical services to inmates is the same as the normal medical standard applied elsewhere—that of a reasonably skilled physician.[332] Section 86(2) of the *CCRA* provides that the provision of health care must conform to "professionally accepted standards". Corrections Directive 800 indicates that health services are to be provided by health care professionals who are registered and licenced for practice in Canada, preferably in the province of practice. The Chief Psychologist at federal institutions must be registered in the province of practice. Other non-registered or unregulated health care providers can provide services under the supervision of a licenced mental health professional.[333]

Federally incarcerated prisoners receive services through the Corrections Health plan, and can be given access to external community services.[334] They would not, however, have access to provincial medical facilities unless the Solicitor General of Canada has entered into an agreement with the provincial government for the exchange of services.[335]

The provisions for treating prisoners detained in provincial jails vary from province to province. In Alberta, s 2 of the Alberta *Corrections Act* provides that the Minister is responsible for the "safe custody and detention of inmates" and for the "treatment and training of inmates with a view to their ultimate rehabilitation in society".[336] The Regulations passed under the *Corrections Act* provide that every inmate whose mental condition requires it is entitled to "adequate observation…in accordance with the recommendation…of an institution's health practitioner, on any inmate whose mental condition requires it".[337] These provisions suggest that the mentally disabled inmate has a right to some form of treatment.

The *Criminal Code* places some obligation upon prison officials to provide the necessaries of life to a person who is detained and who is unable to provide these for himself.[338] "Necessaries of life" is not defined in the legislation, but it may be argued that medical treatment may be a necessary of life. Further, ss 220 and 221 make criminal negligence causing death and criminal negligence causing bodily harm indictable offences

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331 *Ennis* at para 28.
332 *Daoust c R,* 1969 CarswellNat 335.
333 CD 800.
334 CD 800.
335 *CCRA,* s 16.
336 *Corrections Act*, RSA 2000, C-29, s 2. Section 1(e) provides that "Minister" means the Minister determined under section 16 of the Government Organization Act as the Minister responsible for this Act.
337 Correctional Institution Regulation, Alta Reg 205/2001, s 19(1).
338 *Criminal Code*, s 215(1)(c).

punishable by life imprisonment and ten years' imprisonment respectively.[339] However, "criminal negligence" is defined in s 219 as doing anything or omitting to do anything that it one's duty to do and that shows wanton or reckless disregard for the lives or safety of other persons.[340] The standard of conduct required to escape liability under these sections is quite low.[341]

Thus, while federal and provincial statutes provide a right to treatment, there is a lack of detail regarding the standard of treatment

C. Common Law Rights to Treatment

Although there are some statutory provisions that provide for a limited right to treatment (discussed above), and some general cases that deal with the right of prisoners to be kept in "safe custody",[342] there appears to be no Canadian source that creates a common law right of prisoners to treatment. However, such a right has been recognized in England and in the United States.

In England, the leading case is *Leigh v Gladstone.*[343] In this case, the King's Bench Division held that it was the duty of officials to preserve the health and lives of prisoners who were in the custody of the Crown.[344]

In the United States, one leading case is *Estelle v Gamble.*[345] The United States Supreme Court held that the public has a common law duty to provide medical care for prisoners who, because they are deprived of their liberty by incarceration, are unable to obtain such care for themselves. The Court held that "deliberate indifference to serious medical needs of prisoners constitutes unnecessary and wanton infliction of pain."[346] The 8th Amendment of the United States Constitution prohibits cruel and unusual punishment. In this case, the Supreme Court held that the 8th Amendment proscribes deliberate indifference in dealing with prisoners, whether it is doctors who are deliberately indifferent to prisoners' needs or prison guards who intentionally interfere with prisoner treatment.[347] This "deliberate indifference" standard was reaffirmed by the Supreme Court in *Wilson v*

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339 *Criminal Code*, ss 220 and 221.
340 *Criminal Code*, s 219.
341 ME Schiffer, *Psychiatry Behind Bars* (Toronto: Butterworths, 1982) at 174 [Schiffer].
342 *Timm v The Queen,* [1965] 1 Ex CR 174; *MacLean v The Queen* (1972), 72 DLR (3d) 365 (SCC); *Gill*; *Marshall v Canada* (1985), 57 NR 308 (Fed CA), varied on other grounds (1985), 13 Admin LR 195 (Fed CA); *Belliveau v Nova Scotia* (1978), 31 NSR (2d) 346 (TD).
343 [1909] 22 TLR139 [*Leigh*].
344 *Leigh* at 142.
345 429 US 97 (1976) [*Estelle*]. See also: *Helling v McKinney* 509 US 25 (1993).
346 *Estelle* at 206.
347 *Estelle* at 206.

Seiter.[348]

In *Bowring v Godwin,* the United States Court of Appeals (Fourth Circuit) held that because the failure or refusal to provide treatment could result in the deprivation of life itself, it would also violate the due process clause of the 14th Amendment to the United States Constitution.[349] This clause provides that no State shall deprive any person of life, liberty or property without due process of law. The court also held that there is no underlying distinction between the right of a prisoner to medical care for physical ailments and her right to medical care for psychological or psychiatric problems. However, the court emphasized that the treatment should be medically necessary and not merely desirable.

The United States courts have held that prisoners have a constitutional right to adequate medical diagnosis and treatment, including psychiatric care. Two cases, *Balla v Idaho State Board of Corrections*[350] and *Ruiz v Estelle*,[351] listed six elements of a constitutionally adequate prison-based mental health treatment program. These included: a systematic program to screen and evaluate prisoners to identify those who require mental health treatment; treatment that involved more than just segregating and closely supervising inmate patients; employment of trained mental health professionals who could identify and provide individualized treatment for inmates suffering from serious mental disorders; accurate, complete and confidential records of mental health treatment; a ban on the prescription and administration of behaviour-changing medications in dangerous amounts, by dangerous methods or without appropriate supervision and periodic evaluation; and a basic program to identify, treat and supervise inmates who are suicidal.[352]

The reasoning behind the recognition of prisoners' right to treatment in England and in the United States is equally applicable to Canada. Indeed, there are statutory and *Charter* rights to treatment in Canadian prisons.[353] Although there are very few legal decisions on the subject, the *Charter*, particularly ss 7, 12 and 15(1), may apply to the right of prisoners to medically necessary treatment. Inmates could argue that the failure to provide access to

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[348] 111 S Ct 2321 (1991). Cited in Micheal Friedman, "Cruel and Unusual Punishment in the Provision of Prison Medical Care: Challenging the Deliberate Indifference Standard" (1992) 45 Vanderbilt Law Review 921.
[349] 551 F 2d 44 (CA Va 1977).
[350] 595 F Supp 1558 (D Idaho 1984), rev'd in part 869 F 2d 461 (9th Cir 1989).
[351] 503 F Supp 1265 (SD Tex 1980), 650 F 2d 555 (5th Cir 1981), 666 F2d 854 (5th Cir), aff'd in part and vacated in part, 679 F 2d 1115 (5th Cir), amended in part and vacated in part, rehearing denied in part, 688 F 2d 266 (5th Cir 1982), cert denied, 460 US 1042 (1983).
[352] American Bar Association, *Criminal Justice Mental Health Standards,* Washington, DC, 1989 at 480, note 4 [*ABA Criminal Justice Mental Health Standards*]. These were supplanted by the *Criminal Justice Standards on Mental Health* on August 8, 2016, Part X: Mentally Ill and Mentally Retarded Prisoners. Online: https://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_mentalhealth_toc.html.
[353]The statutory rights are discussed above under: Corrections Legislation and the Right to Treatment.

adequate treatment violates these sections. *Charter* s 7, which provides the right to life, liberty and security of the person and the right not to be deprived of these except in accordance with the principles of fundamental justice, is similar to the 14th Amendment to the United States Constitution. Further, *Charter* s 12 deals with cruel and unusual treatment or punishment, not unlike the 8th Amendment to the United States Constitution.[354] Finally, *Charter* s 15(1) deals with treatment without discrimination of persons with mental and physical disabilities. These sections have been applied when analyzing the rights of persons committed under mental health legislation.

Human rights instruments may also imply a right to treatment. In Alberta, the *Alberta Human Rights Act* provides that no person shall deny to any person or class of persons any accommodation, services or facilities customarily available to the public on the basis of mental disability of that person or class of persons.[355] It may be argued that medical treatment is a service customarily available to the public. If prisoners are denied access to treatment because they are mentally disabled, they may be able to argue that their rights under the *Alberta Human Rights Act* are being violated.

International law also addresses the rights of mentally disabled prisoners. The United Nations provides guidelines for the rights to treatment of mentally disabled prisoners. The *Standard Minimum Rules for the Treatment of Prisoners*, were originally adopted in 1955 by the first United Nations Congress on the Prevention of Crime and the Treatment of Offenders and approved by the Economic and Social Council of the United Nations.[356] These rules were updated in 2015 and are now known as the Nelson Mandela Rules. They provide:[357]

> Rule 25 1. Every prison shall have in place a health-care service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special healthcare needs or with health issues that hamper their rehabilitation.
>
> 2. The health-care service shall consist of an interdisciplinary team with sufficient qualified personnel acting in full clinical independence

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[354] See, for example, *New Brunswick (Minister of Health and Community Services) v B(R)* (1990), 70 DLR (4th) 568 (NBQB), where the court held that the withholding of medical treatment from a severely mentally handicapped child constituted cruel and unusual treatment or punishment.

[355] *Alberta Human Rights Act,* RSA 2000, c A-25.5.

[356] Alberta Courts have relied on these rules in determining the appropriate health care to provide to incarcerated persons. See *Geary v Alberta (Edmonton Remand Centre),* 2004 ABQB 19 (CanLII) at para 38.

[357] Canada was a member of the Economic and Social Council at the time the resolution was adopted and voted in favour of its adoption. However, Canada did not incorporate this legislation into domestic law. There may be a possible argument that because these provisions have been followed by many countries over a long period of time, they have become part of customary law and are therefore morally, if not legally, binding.

> and shall encompass sufficient expertise in psychology and psychiatry. The services of a qualified dentist shall be available to every prisoner[358]

Separate (but related) international rules have been developed specifically for female inmates. The United Nations General Assembly passed the Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), provide that "Individualized, gender-sensitive, trauma-informed and comprehensive mental health care and rehabilitation programmes shall be made available for women prisoners with mental health-care needs in prison or in non-custodial settings."[359]

As per Article 14(1)(b) of the *Convention on the Rights of Persons With Disabilities*, the existence of a disability shall in no case justify a deprivation of liberty.[360]

The *Basic Principles for the Treatment of Prisoners* by the United Nations Office of the High Commissioner for Human Rights establishes prisoner's entitlement to a quality of health care comparable to that available in the outside community.[361] The *Body of Principles for the Protections* of all *Persons under Any Form of Detention Imprisonment* establishes the obligation of authorities to ensure prisoners are given medical screening upon admission and provided appropriate medical care and treatment as necessary.[362] The *Nelson Mandela Rules* provide that medical services shall seek to detect and shall treat any illnesses or defects which may hamper a prisoner's rehabilitation. All necessary psychiatric services

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[358] See also rules: Rule 78 (1) So far as possible, prison staff shall include a sufficient number of specialists such as psychiatrists, psychologists, social workers, teachers and trade instructors. Rule 109(3) Rule 109(1): Persons who are found to be not criminally responsible, or who are later diagnosed with severe mental disabilities and/or health conditions, for whom staying in prison would mean an exacerbation of their condition, shall not be detained in prisons, and arrangements shall be made to transfer them to mental health facilities as soon as possible. Rule 109(3): The health-care service shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment. Rule 110 It is desirable that steps should be taken, by arrangement with the appropriate agencies, to ensure if necessary the continuation of psychiatric treatment after release and the provision of social-psychiatric aftercare. For the perspective from the Committee Against Torture on the Revised Nelson Mandela Rules, see UN Committee Against Torture (CAT), *Observations of the Committee against Torture on the revision of the United Nations Standard Minimum Rules for the Treatment of Prisoners (SMR)*, 16 December 2013, CAT/C/51/4, available at: http://www.refworld.org/docid/53429c014.html [accessed 12 April 2018].

[359] UN General Assembly, *United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (the Bangkok Rules) by the Secretariat*, 6 October 2010, A/C.3/65/L.5, available at: http://www.refworld.org/docid/4dcbb0ae2.html [accessed 21 March 2018] at 12.

[360] Criminal reports (articles) 6th Series 2010 75 CR-ART 241 *Conway*: *A Bittersweet Victory for Not Criminally Responsible – Archibald Kasier – Thompson Reuters Canada Limited.* Despite the convention not having acted upon statutorily, Canada is obligated to consider the relevance of the Convention in some situations. For example: see *R v Conway,* 2010 SCC 22 [*R v Conway*].

[361] *The Basic Principles for the Treatment of Prisoners*, 14 December 1990, Doc E/5988 No 9 cited in *R v Rathburn*.

[362] *The Body of Principles for the Protection of all Persons under Any Form of Detention or Imprisonment*, UN Doc A/43/49 (1988) cited in *R v Rathburn.*

shall be provided to that end. The *Nelson Mandela Rules* recognize and impose a positive obligation on correctional authorities to vary the housing, supervision and care of offenders with mental disorders according to the degree of their illness. Psychiatric or acutely ill prisoners should be placed in specialized institutions under medical management. Standards of care should not be lowered because those needing medical treatment are prisoners.[363]

D. Barriers to Exercising the Right to Treatment

Even if one accepts that mentally disabled prisoners have a right to some form of treatment for their condition, there are several barriers to receiving effective treatment. First, as previously discussed, mentally disabled prisoners' need for treatment is often overlooked.[364] Because mentally disabled prisoners may deny their need for treatment, they may behave in a manner that does not draw any attention to their disability and therefore may not be treated.[365]

Second, even if a mentally disabled prisoner desires treatment, he/she may not realize that he/she has a right to treatment or may not be able to exercise or insist upon this right.

Third, prisoners who are incarcerated in federal institutions do not qualify for provincial health care coverage.[366] They are covered by CSC's health care plan.

Finally, even where prison or jail officials recognize that an inmate needs treatment and the inmate consents to the treatment, the services available in prisons and jails may not be adequate to meet the treatment needs. This inadequacy has been well documented by experts and academics for over 35 years.

In 1981, Dr. Arboleda-Flórez noted that services available to mentally disabled inmates are highly inadequate and suffer from a lack of integration and coordination.[367] Ten years later, Freeman and Roesch noted one problem is that psychological and psychiatric facilities are often located at a single centralized facility and therefore are only sporadically available to any one inmate.[368] Moreover, access to psychological or psychiatric services may require placing an inmate at an institution with more restrictive security, or one that is remote from the inmate's community.[369] Arboleda-Florez says that consent to treatment

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[363] *R v Rathburn*; Nelson Mandela Rules at para 2, 62.
[364] Freeman & Roesch at 110 - 111.
[365] Hodgins & Côté,1991 at 181.
[366] See, for example, *Alberta Health Care Insurance Act*, RSA 1980, c A-24, section 4(1)(c).
[367] Arboleda-Flórez at 393.
[368] Freeman & Roesch at 111.
[369] Freeman & Roesch at 111.

and other ethical safeguards pertaining to psychiatric treatment and research should be the same as those that apply in the community.[370]

In November 2005, the Canadian Mental Health Association published an article stating that the treatment and support of inmates who are mentally ill in Canadian prisons is sub-standard and sometimes non-existent.[371] According to the Annual Report from the Office of the Correctional Investigator of Canada, the mental health services in federal penitentiaries are woefully deficient. Across the country, prisoners are denied treatment due to a shortage of clinical staff and inadequate mental health facilities for the prison population. Penny Marrett, national CEO of the Canadian Mental Health Association (CMHA), had this to say about the treatment of the mentally ill:

> The Correctional Investigator's report highlights the seriousness of the conclusion by the Senate Committee on Social Affairs, Science and Technology that our prisons have become warehouses for the mentally ill due to funding cuts and closures in community psychiatric facilities. This is an inhumane and unsafe way to address offenders with mental illnesses, especially when they are often serving time for low-level, non-violent crimes that are the result of little to no availability of treatment or support in the community.[372]

It is estimated that up to 20 per cent of inmates have a mental illness that requires treatment. Of these, seven to nine per cent have a serious mental illness such as schizophrenia, bipolar disorder and major depression. According to Dr. Pierre Tessier of the Royal Ottawa Hospital:

> If these inmates do not receive hospital-standard psychiatric care, their chances of rehabilitation are extremely low and their risk of re-offending remains high. The mental health system needs to step forward and provide federal correctional facilities with the support they need. Allowing inmates to go untreated for their mental illness is a failure of the mental health system on many levels, from community to hospital-based care.[373]

The Annual Report of the Office of the Correctional Investigator of Canada attributed the growing rate of incarceration of the mentally ill to the lack of a national strategy for mental illness and mental health. Marrett says that this failure is due to the fact that community mental health care services are severely underfunded, disorganized and fragmented. However, according to Len Wall of the Schizophrenia Society of Canada in

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370 Julio Arboleda-Florez, "Mental Patients in Prisons" (2009) 8 World Psychiatry 187-189.

371 Canadian Mental Health Association, *Sub-Standard Treatment of Mentally Ill Inmates is Criminal: Experts Say* November, 2005 [*CMA*] online:<http://www.schizophrenia.ca/docs/SubstandardPrisonTreatmentENGLISH.pdf>.

372 *CMA* at 1.

373 *CMA* at 1.

1989, prison officials are not adequately trained to care for mentally ill inmates. "Prisons are not designated as places to provide comprehensive mental health treatment and services" says Wall. "If people with mental illness must be incarcerated, they should be in facilities designed and funded to meet their mental health needs".[374]

The aforementioned groups recommended that provincial governments establish more mental health courts. In the past 15 years, there has been significant growth in the use of mental health courts across Canada. There are presently mental health courts operating in Newfoundland, Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba, and Saskatchewan.[375] In addition, British Columbia is home to various specialized courts, including the Vancouver downtown community court, that use innovative approaches to address mental health and addiction issues in ways similar to a mental health court.[376]

Edmonton judges are working to create a mental health court in Alberta, but as of spring 2018, it is not yet in place.[377]

Mental health courts allow for prompt, specialized assessments of individuals with suspected mental illness and facilitate treatment of mental health conditions.[378]

The office of the Correctional Investigator has noted that many incarcerated offenders suffer from mental illness. In his 2014 report, the investigator noted that 61% of offenders screened for mental health problems were flagged for a follow-up. Mental illness appears to be even more prevalent among women, with 30% of federally sentenced women having been previously admitted for psychiatric care and 63% of federally sentenced women having been prescribed psychotropic medication in the previous year.[379]

E. The American Bar Association's Position on the Right to Treatment and Mentally Disabled Prisoners

The American Bar Association's revised *Criminal Justice Mental Health Standards* deal at length with treatment for mentally disordered offenders sentenced to

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[374] Kropp at 187. See also: Evan Soloman, "The mental health crisis in Canadian prisons" March 3, 2017 Maclean's Online: https://www.macleans.ca/news/canada/the-mental-health-crisis-in-canadian-prisons/.
[375] Mark Cardwell, "Mental Health Courts on the Rise In Quebec" *Canadian Lawyer* (12 February 2018) online: <http://www.canadianlawyermag.com/legalfeeds/author/mark-cardwell/mental-health-courts-on-the-rise-in-quebec-15270/>.
[376] British Columbia, "Overview of Downtown Community Court Process" (accessed on 20 March 2018) online: <https://www2.gov.bc.ca/gov/content/justice/criminal-justice/vancouver-downtown-community-court/how-the-court-works/overview>.
[377] Anna Desmarais, "Edmonton Judges to Launch Mental Health Court to Ease Backlog" *CBC News* (22 June 2017) online: <http://www.cbc.ca/news/canada/edmonton/mental-health-edmonton-provincial-court-1.4174130>.
[378] Problem Solving Courts at 3.
[379] Correctional Report 2013-2014 at 17.

imprisonment.[380] The ABA adopts the definition of mental disorder found in the current Diagnostic and Statistical Manual of the American Psychiatric Association. This encompasses mental illnesses "such as schizophrenia, bipolar disorder, and major depressive disorders; developmental disabilities that affect intellectual and adaptive functioning; and substance use disorders that develop from repeated and extensive abuse of drugs or alcohol or some combination thereof."[381]

For those offenders whose mental illness or mental disability is not severe enough to necessitate commitment to a mental health or mental handicap facility, the ABA recommends that appropriate and individualized services be provided within the correctional facility.[382] The ABA leaves the scope of the appropriate facilities and treatment or habilitation to the judiciary.[383] However, it is clear that the ABA and the United States case law recognize that prisoners have a constitutional right to adequate medical diagnosis and treatment, including psychiatric care.

Standard 7-10.1 recommends that correctional facilities provide a range of mental health and mental disability services for prisoners and should have adequately trained personnel readily available to provide such services. This standard also provides that if prisoners require mental health treatment or mental disability habilitation and it is not available in a correctional facility, they should be transferred to an appropriate facility. The ABA provides both for voluntary and involuntary transfers to mental health and mental handicap facilities.[384] The involuntary transfer procedures contain several procedural safeguards.

IX. RIGHT TO REFUSE TREATMENT IN PRISON AND JAIL

A. Introduction

Psychiatrists and physicians who work in prisons face a difficult task. Often, they are approached by corrections officials with a request to "control" a mentally disordered offender who is causing some kind of disturbance. This "control" could come in the form of medication or commitment to a mental health facility. The professional, feeling pressure

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[380] American Bar Association, *Criminal Justice Standards on Mental Health* (8 August 2016) online: <https://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/mental_health_standards_2016.authcheckdam.pdf> [ABA Mental Health Standards, 2016].

[381] ABA Mental Health Standards, 2016 at 7-1.1

[382] ABA Mental Health Standards, 2016 at 7-10.1.

[383] See discussion of United States jurisprudence under: Right to Treatment.

[384] ABA Mental Health Standards, 2016, Standard 7-10.2 and Standard 7-10.3.

from the corrections officials to act, may suggest either course of action to the prisoner.[385] What happens if the offender refuses treatment?

Canadian law governing hospitalization and consent continues to grapple with the challenges of appropriately balancing the autonomy and dignity of mentally ill persons with their right to treatment and the important objective of protecting the public from dangerous individuals.[386]

The following discussion focuses on these rights in the general context of all patients and then pinpoints some specific concerns regarding incarcerated individuals.

The right to refuse treatment involves the sub-issue of consent. The right to refuse treatment presupposes that a person must consent to any treatment that is given. There are several criteria that must be met before one has obtained a valid consent for treatment. The fact that a person is incarcerated may also affect his ability to exercise the right to refuse treatment or whether he can properly consent to treatment.

B. Consent to Treatment

1. Informed Consent[387]

Inmates in prisons or prison hospitals retain the same rights to informed consent and to refuse treatment as non-incarcerated individuals.[388] Under common law, the consent of a patient must be obtained before medical treatment is performed.[389] As stated by the Supreme Court of Canada:

> Everyone has the right to decide what is to be done to one's own body. This includes the right to be free from medical treatment to which the individual does not

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[385] See the discussion about the competing ethical dilemmas faced by psychiatrists and physicians in J. Arboleda-Florez, "The Ethics of Psychiatry in Prison Society" (1983) 25 Can J of Criminology 47 at 52-3.

[386] Beverley McLachlin at 24. According to a publication by American Bar Association: A prisoner who lacks the capacity to make decisions consenting or withholding consent to care should have surrogate decision-maker designated according to applicable law. Prisoners should be informed of the health care options available to them. Standard 23-6.15 outlines involuntary mental health treatment and transfer (a), involuntary mental health treatment if a prisoner should be permitted only if the prisoner of suffering from a serious mental illness, non-treatment poses a significant risk of serious harm to the prisoner or others, and no less intrusive alternative is reasonably available. Refer to American Bar Association, *Standards on Treatment of Prisoners*, online: <http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-6.14>.

[387] For a review of the United States law on the right to informed consent, see: James Ogloff and R Otto, "Mental Health Intervention in Jails" in PA Keller and SR Heyman, *Innovations in Clinical Practice: A Sourcebook,* (Sarasota, Florida: Professional Resource Exchange, Inc, 1989) at 357.

[388] See: *Solosky* v *The Queen* (1979), 50 CCC (2d) 495 (SCC) at 510, where Dickson J. stated that a person confined to prison retains all of his civil rights, other than those taken away from him by law. See also: *Piche* v *Canada (Solicitor General)* (1984), 17 CCC (3d) 1 (Fed TD).

[389] See generally: E. Picard, *Legal Liability of Doctors and Hospitals in Canada,* 2d ed, (Toronto: Carswell, 1984); M.A. Somerville, *Consent to Medical Care* (Law Reform Commission of Canada Study Paper, 1980); AM Linden, *Canadian Tort Law,* 5th (Toronto: Butterworths, 1993), Chapter 3 [Linden].

> consent. This concept of individual autonomy is fundamental to the common law and is the basis for the requirement that disclosure be made to a patient. [390]

Generally, if a doctor treats a person without having first obtained his/her consent, the physician could be held liable for committing the tort of battery.[391] There are some exceptions to this general rule (discussed below).

Consent can be either express or implied by conduct. Express consent can be given either orally or in writing, while non-verbal actions can also demonstrate implied consent.[392] Written consent is only evidence of consent and can be undermined if there is evidence of fraud, duress, lack of capacity or other similar circumstances.[393] Consent must be freely given by the patient.[394] The patient must not be subject to any duress, coercion, or undue influence.[395] The decision must be that of the patient, not that of the physician or hospital.

In 1980, the Supreme Court of Canada focused the issue of consent on the physician's duty to explain and disclose to his/her patient the nature of the proposed treatment, any alternative treatments (including the alternative of no treatment), to disclose the risks associated with each alternative, and to inform the patient of any inevitable adverse consequences.[396]

In *Reibl v Hughes,* the Supreme Court of Canada held that a physician would be liable in battery only if the patient had not consented at all, or if the consent had been induced by fraud or misrepresentation, or where treatment had been performed that was different

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[390] *Ciarlariello v Schacter,* [1993] 2 SCR 119 at 135. See also: *Allan v New Mount Sinai Hospital et al.* (1980), 28 OR (3d) 356, reversed on pleading issue 33 OR (2d) 603 (CA).

[391] GB Robertson, *Mental Disability and the Law in Canada* (Calgary: Carswell, 1987) at 395 [Robertson]. Battery is an actual touching, while "assault" is merely the induced fear of actual contact. However, many refer to both assault and battery when they use the term "assault".

[392] Linden at 62, 72. Valid consent can be given even if the person does not say a word. For example, if a patient enters a doctor's office and voluntary disrobes in preparation for an examination, she has given her implied consent to the physician to touch the patient and to use instruments and procedures necessary to the examination. A patient's actions may constitute legal consent, even if she did not intend to consent see *O'Brien v Cunard SS Co* (1891) 28 NE 266 (1891).

[393] Linden.

[394] *Haluska v University of Saskatchewan* (1965), 52 WWR 608 at 625 (Sask CA) [*Haluska*]. See also: *Beausoleil v Sisters of Charity* (1966), 53 DLR (2d) 65 (Que CA).

[395] C Hass, T Helgeson, and L Hume, *Do Not Go Gently: Law, Liberty and Aging in Alberta* (Alberta Civil Liberties Research Centre, 1988) at 75 [Hass, Helgeson & Hume]. See also: *Norberg* v *Wynrib,* [1992] 2 SCR 226, additional reasons [1992] 2 SCR 318, where the Supreme Court of Canada held a doctor liable in battery for giving painkilling drugs to an addicted female patient in return for sexual favours. The nature of the power relationship between the parties and the patient's dependency on the doctor placed her in a position to be exploited and therefore invalidated any consent.

[396] Hass, Helgeson, & Hume at 73-4; DS Ferguson, "Informed Consent to Medical Treatment" (1983) 5 Advocates Q 165 at 73, 169.

from or went beyond that for which consent had been given.[397] If the patient consented to treatment, the issue is whether the physician's failure to disclose relevant information caused the plaintiff to submit to treatment that he/she would have refused had he/she known all of the facts. The courts examine whether the physician has been negligent in informing the patient. It is the duty of the physician to explain the nature of the treatment, to discuss any alternative treatments (including the alternative of no treatment), to disclose the risks associated with each alternative, and to inform the patient of any inevitable adverse consequences.[398]

In *Hopp v Lepp,* the Supreme Court held that the although the physician need not disclose all of the dangers that pertain to all operations (such as the risk of infection or the possibility of death under anaesthesia), she/he must give full, frank, and honest answers to specific questions that the patient may ask about the treatment and its risks or side effects.[399] The Supreme Court recognized that there would be situations in which a physician would be justified in withholding or generalizing information, such as where a patient would be emotionally unable to cope with it. The Court also held that a patient may waive the right to be informed by the physician. However, full disclosure is essential if experimental treatment is proposed.[400] In that case, the physician must disclose all of the facts. This may include informing the patient of the "unknowns".[401]

2. Exceptions to the Rules

There are a few exceptional circumstances where a physician may be justified in treating a patient without her/his consent or in going beyond the consent of the patient. The exceptions fall into three categories:

- emergencies;
- the best interests of the patient; and
- incompetence.

(a) Emergency

If the patient is unable to consent because of a medical emergency, treatment may

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[397] [1980] 2 SCR 880 [*Reibel*].

[398] Hass, Helgeson, & Hume at 73-4; DS Ferguson, "Informed Consent to Medical Treatment" (1983) 5 Advocates Q 165 at 169.

[399] (1980), 43 NR 145 (SCC) [*Hopp*]; *Videto v Kennedy* (1981), 33 OR (2d) 497 (CA); *Haughian v Paine,* [1987] 4 WWR 97 (Sask CA), leave to appeal to SCC refused, [1987] WWR lix (SCC) ; *Poole v Morgan* (1987), 50 Alta LR (2d) 120 (QB); *Zimmer v Ringrose* (1981), 28 AR 69 (CA), leave to appeal to SCC refused (1981), 37 NR 289; *Schanczl v Singh,* [1988] 2 WWR 465 (Alta QB), *Arndt v Smith* [1997] SCJ No 65 and *Halkyard v Mathew,* [2002] CCS No 11237 See generally: G Robertson, "Informed Consent Ten Years Later: The Impact of Reibl v Hughes" (1991) 70(3) Can Bar Rev 423.

[400] *Haluska.*

[401] See more recent discussion of *Hopp* and *Reibl* in *Cuthbertson v Rasouli*, [2013] 3 SCR 341, 2013 SCC 53 (CanLII) at para 18.

be given if it is immediately necessary to save the life of the patient.[402] However, if the patient has given advance instructions (e.g., a wallet card indicating that a blood transfusion is refused under all circumstances), the doctor is not free to ignore them.[403]

The common law and the statutes do not specifically address the difficulties experienced by psychiatrists and other mental health professionals when faced with a psychiatric emergency. Unlike the situation in a physical medical emergency involving a patient who is unconscious or very seriously injured, when a psychiatric emergency arises, the patient is usually fully conscious and refuses treatment.[404] This area is fraught with difficulty and there appears to be little case law to provide assistance when a voluntary patient refuses psychiatric treatment in an emergency situation.[405]

(b) Best Interests of the Patient

In some cases, the courts have found it was in the best interests of the patient that the physician proceed without his or her consent. This situation may arise during the course of an operation if the surgeon discovers an unsuspected condition. For example, in *Marshall,* the plaintiff had consented to an operation to fix a hernia. During the operation, the physician discovered that one of the plaintiff's testicles was in a grossly diseased state. He removed the diseased testicle and was sued by his patient in negligence and assault. The Nova Scotia Supreme Court found that in view of the obvious threat to the patient's health posed by the diseased testicle, the surgeon was under a duty to remove it in his patient's best interests. However, mere convenience is not enough to permit a doctor to provide medical attention without the patient's consent.[406]

(c) Incapacity

If a patient is unable to understand the nature of a proposed medical treatment and its consequences, he/she may be unable to consent. In these cases, the state has an interest in protecting the interests of the individual.

The state has the ability to protect the interests of anyone who lacks the capacity to consent, such as a child or an incapacitated adult.[407] This is called the *parens patriae* power (literally translated, this means the state can act as a "supreme parent"). The power may be

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[402] Robertson at 396. See also: *Marshall v Curry,* [1933] 3 DLR 260 (NSTD) [*Marshall*]; *Murray v McMurchy,* [1949] 1 WWR 989 (BCSC) [*Murray*].
[403] See, for example: *Malette v Shulman et al.* (1990), 72 OR (2d) 417 (CA); *Mulloy v Sang,* [1935] 1 WWR 714 (Alta CA).
[404] C Pearson, "Consent to Psychiatric Treatment in Canada: Specific Issues" (1993) 2(2) Health Law Review 3 [Pearson].
[405] Pearson discusses this issue at length.
[406] *Murray.*
[407] Hass, Helgeson & Hume.

invoked by superior courts when the individual concerned lacks the ability to provide informed consent regarding treatment. This power is grounded in the common law, but various statutes also outline this jurisdiction.

If a person lacks the capacity to consent to treatment, interested parties must obtain authorization to provide medical treatment. This often involves making a court application. The common law *parens patriae* jurisdiction is usually only exercised where there is no person who meets the criteria to provide substitute consent under legislation, or no legislative route to obtaining a guardian duly authorized to provide the consent.[408] If the *parens patriae* jurisdiction is to be exercised, it must be done for the benefit of the mentally incompetent person and not for the benefit of others.[409] This power must also be exercised with great caution.[410]

In *Re G,* the court held that, under its *parens patriae* jurisdiction, it had the authority to order the forcible medical treatment of a mentally ill person.[411] The patient was denying the existence of her mental illness.

In *Institut Philippe Pinel de Montréal v Dion,* the court ordered that a patient in a psychiatric prison hospital be given psychotropic drug therapy, despite his refusal to consent.[412] The court concluded that the patient was "unable to give a valid consent" because of mental illness.[413] Conversely, in *Starson v* Swayze,[414] the Supreme Court of Canada permitted a patient in psychiatric care for bipolar disorder to refuse treatment, finding that the original review board failed to appropriately assess his capacity to refuse treatment.

There are several statutory provisions that incorporate the *parens patriae* jurisdiction. In Alberta, s 101 (2) of the *Adult Guardianship and Trusteeship Act* ("*AGTA*") provides that a physician may provide emergency health care to an adult without consent if the health care is necessary to preserve the adult's life, to prevent serious physical or mental harm to the adult, or to alleviate severe pain, and the physician is satisfied the adult lacks capacity to consent to or refuse the emergency health care as a result of drug or alcohol impairment, lack of consciousness, or another cause.[415] If practicable, the physician

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408 *Re Eve* (1986), 31 DLR (4th) 1 (SCC) [*Re Eve*]; *Beson* v *Newfoundland (Director of Child Welfare),* [1982] 2 SCR 716 [*Re Eve*].
409 *Re Eve.*
410 *Re Eve* at 29.
411 (1991), 96 Nfld & PEIR 236 (PEISCTD).
412 (1983), 2 DLR (4th) 234 (Que Sup Ct) [*Dion*].
413 Robertson at 397.
414 2003 SCC 32, 225 DLR (4th) 385 [*Starson*].
415 *Adult Guardianship and Trusteeship Act*, SA 2008, c A-4.2, s 101(2) [*AGTA*]. Replaces the *Dependent Adults Act*, RSA 2000, c D-11.

should obtain the written opinion of a second physician or health care provider with respect to the above matters before they provide they provide treatment.[416] If they obtain a written opinion from a second physician or health care provider, the physician should not provide the emergency health care unless the second physician is satisfied with respect to the above matters.[417]

The *AGTA* also provides for the court appointment of a substitute decision-maker,[418] called a "guardian". Any "interested person" may apply to the court to be appointed guardian of an adult person.[419] If the Public Guardian is of the opinion that an adult is in need of a guardian and no person is willing, able or suitable to make an application for appointment of a guardian, they must apply to the court for an order appointing a guardian for the adult.[420]

In making a guardianship order, the court will grant the guardian authority to act and make decisions with respect to personal matters of the adult that the court considers necessary,[421] if they are satisfied the adult does not have capacity to make decisions about the personal matters referred to in the order, less restrictive alternative measures would not meet the needs of the adult, and it is in the adult's best interests to make the order.[422] Section 33(2) of the *AGTA* contains a list of personal matters with respect to which the guardian may be granted authority to act and make decisions, including the adult's employment, participation in social activities, and living arrangements.[423] Section 33(2)(a) states that the court may grant a guardian authority to make decisions regarding the adult's health care.[424]

The Alberta *MHA* also provides broad powers to examine and treat. While these powers are partly grounded in the "best interests" aspect of the *parens patriae* jurisdiction, they are also grounded in the police power of the state.[425] The individual must be a danger to himself/herself or others before authorities can exercise jurisdiction over an individual.[426] Section 2 provides that a physician may issue an admission certificate with respect to a

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[416] *AGTA*, s 101(3)
[417] *AGTA*, s 101(3).
[418] For a discussion of substitute decision making, see: Alberta Law Reform Institute and Health Law Institute, *Advance Directives and Substitute Decision-Making in Personal Health Care* (Report No 64) 1993.
[419] *AGTA*, s 26(1).
[420] *AGTA*, s 26(2).
[421] *AGTA*, s 33(1).
[422] *AGTA*, s 26(6).
[423] *AGTA*, s 33(2).
[424] *AGTA*, s 33(2)(a).
[425] Hass, Helgeson & Hume at 79.
[426] See, for example, s 2 of the *MHA*. For an example of an application under the *MHA* to hold a patient involuntarily, see *JH v Alberta Health Services,* 2015 ABQB 316 (CanLII).

person if they have examined that person and determine the person is suffering from a mental disorder and likely to cause harm to himself/herself or to others or is likely to suffer from substantial mental or physical deterioration or serious physical impairment. [427] The admission certificate authorizes the conveyance of the person to a mental health facility and the treatment of the person for a 24-hour period from the time that he/she arrives at the facility.[428]

Once a person has been involuntarily committed to the mental health facility and a physician is of the opinion that the person is not mentally competent to make treatment decisions, that person may be subjected to treatment to which they do not consent.[429] Treatment decisions may be made on behalf of patients who are not mentally competent by the person's agent, guardian, nearest relative, or by a Public Guardian.[430]

Statutory and *parents patriae* jurisdiction applies to individuals who do not have the capacity to consent to treatment. However, mentally disabled persons (even those who are involuntary patients) are not necessarily incompetent. The tendency to conflate mental illness with incapacity is inaccurate and incorrect in law. It is important to recognize that mentally ill persons may often still have the capacity to consent to treatment.[431]

3. Capacity to Consent to Treatment

Capacity is not an all or nothing experience. It is not uncommon for a person to have the legal capacity to make some decisions, but be legally incompetent to make others.[432] For example, the fact that a person is an involuntary patient in a mental health facility does not necessarily mean that he/she is not capable of consenting to treatment.[433] Further, the fact that a person has been diagnosed as having a mental illness does not prevent him/her from having the capacity to give a valid consent.[434] Thus, a mentally disordered prisoner

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[427] *MHA*, s 2.
[428] *Mental Health Act,* s 4(1). In *Re Osinchuk* (1983), 45 AR 132 (Surr Ct), the Court held that this provision authorizes psychiatric treatment without the patient's consent.
[429] *MHA,* s 27.
[430] *Mental Health Act,* s 28(1). This issue is developed further below under Treatment in Mental Health Facilities.
[431] *Starson* at para 77.
[432] See, Robertson at Chapter 1 and Chapter 15.
[433] *Robertson* at 408. See also: Law Reform Commission of Canada, *Medical Treatment and the Criminal Law* (Working Paper No 26), 1980 at 68; Law Reform Commission of Canada, *Some Aspects of Medical Treatment and Criminal Law* (Report No 28, 1986) at 11; M. Somerville, *Consent to Medical Care* (Law Reform Commission of Canada Study Paper, 1980) at 90; EW Keyserlink, "Consent to Treatment: The Principles, the Provincial Statutes and the Charter of Rights and Freedoms" (1985) 33(3) Canada's Mental Health 7.
[434] See, for example: *Morrow v Hospital Royal Victoria* (1989), 3 CCLT (2d) 87 (Que CA), motion to appeal dismissed (1990), 111 NR 239n (SCC). For an overview of the United States situation regarding the rights of mentally ill patients and prisoners to refuse treatment, see: J Bloom, L Faulkner, V Holm, R Rawlinson, "An Empirical View of Patients Exercising Their Right to Refuse Treatment" (1984) 7 International J of Law and

may be legally competent to consent to or to refuse treatment.

All persons are presumed to be legally competent and to have the mental capacity to consent to treatment.[435] This presumption can be overcome by sufficient evidence to the contrary. Further, the presumption of competence can be removed by legislation and by judicial orders.[436]

The capacity to consent involves "an ability to appreciate the nature and consequences of the proposed treatment."[437] In *Starson*, the Supreme Court of Canada described the test for capacity as having two parts: an ability to understand the information relevant to making a treatment decision and, the reasonably foreseeable consequences of their decision regarding treatment.[438] Similarly, the Alberta *MHA,* s 26, provides that a person is mentally competent to make treatment decisions if "he is able to understand the subject-matter relating to the decisions and able to appreciate the consequences of making the decisions".

A mere refusal to accept treatment is not, in itself, proof that a patient is incapable of making rational decisions. In *Masny v Carter-Halls-Aldinger Ltd.,* a mill employee was struck on the head by a plank and suffered a cerebral hematoma. [439] He adamantly refused surgery, and at the time of the trial was slowly dying in agony. The Court found that the plaintiff fully appreciated his situation and its inevitable consequences and therefore refused to interfere with his right to refuse treatment. In *British Columbia (Attorney General) v Astaforoff,* [440] the British Columbia Court of Appeal recognized the right of a prisoner to refuse food. Even though there was medical evidence that the woman might die if she were not fed, the court held that there was no duty on the institution that would justify feeding a prisoner by force.

Psychiatry 315; EW Clayton, "From *Rogers* to *Rivers:* The Rights of the Mentally Ill to Refuse Medication" (1987-88) 13(1) American J of Law and Medicine 8; J Zito, T Craig, J Wanderling, "New York Under the *Rivers* Decision: An Epidemiologic Study of Drug Treatment Refusal" (1991) 148(7) Am J Psychiatry 904; *Washington v Harper,* 494 US 210 (1990); M Hansen, "Insane Inmate Avoids Death Penalty" (1993) 79(1) A.B.A. Journal 32; D. Olin, "Sanity by Prescription: Can Mental Patients Just Say No?" (January 1991) ABA Journal 22; B.R. Furrow, "Public Psychiatry and the Right to Refuse Treatment: Toward an Effective Damage Remedy" (1984) 19(1) Harvard Civil Rights- Civil Liberties Law Rev. 21.

[435] L.E. Rozovsky and F.A. Rozovsky, *The Canadian Law of Consent to Treatment* (Vancouver: Butterworths, 1990) at 3-5 [Rozovsky].

[436] Rozovsky at 3.

[437] Robertson at 408.

[438] *Starson* at para 78, discussed in relation to the governing Ontario legislation, but the test for capacity at common law and in Alberta statutes is the same. See, for example, s 26 of the *MHA.* See also, the *Guide for Capacity Assessors under the Alberta AGTA* at 3 online: <https://open.alberta.ca/dataset/a86649cc-b0d4-44bb-ab0a-eef8609f29f4/resource/9ff4213f-84b6-4f08-bbcf-05497b5a6017/download/opg-guardianship-publication-opg5630.pdf>.

[439] [1929] 3 WWR 741 (Sask KB).

[440] [1984] 4 WWR 385 (BCCA), affirming [1983] 6 WWR 322 (BCSC).

If a patient refuses to consent to a procedure, the court will look at whether he/she is capable of appreciating the consequences of a refusal.[441] In *Dion*, the court described Dion as a person of superior intelligence who was capable of managing his affairs. However, the court concluded that Dion was incapable of consenting to psychiatric treatment because he denied that he was mentally ill and this denial rendered him incapable of appreciating the need for treatment.

In many cases, the refusal of treatment may be rationally defensible. For example, some persons react adversely to various medications. They may feel very vulnerable if they are strongly sedated. Further, they may be concerned about the long-term risks associated with the medications. None of these reasons for refusing treatment is necessarily irrational or indicative of mental incompetence.[442]

Many studies indicate that psychiatric patients have substantial capabilities for making rational decisions about treatment in spite of their illnesses.[443] Indeed, most research indicates that there is very little difference between the competency of psychiatric patients and that of medical patients in general.[444] One study suggests that patients with schizophrenia are significantly better informed about side-effects and risks of drug treatment than are other medical patients.[445]

When considering the patient's ability to understand the consequences of his refusal to consent, it is important not to focus attention on the “reasonableness” of the decision.[446] Even if a decision appears unreasonable, it must be respected if the person making the decision has the capacity to understand the nature and consequences of his actions.[447]

4. Assessing Capacity to Consent to Treatment

One difficulty in assessing a person's ability to consent to treatment may result from the different ways that lawyers and psychiatrists look at treatment issues. Psychiatrists often say that it is their duty to make treatment decisions in the best interests of patients.[448] They are often supported in this view by family members or others who feel

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441 M. Somerville, "Refusal of Medical Treatment in 'Captive' Circumstances" (1985) 63 Can Bar Rev 59 at 62.
442 A Schafer, "The Right of Institutionalized Psychiatric Patients to Refuse Treatment" (1985) 33(3) Canada's Mental Health 12 at 14.
443 BR Furrow, "Public Psychiatry and the Right to Refuse Treatment: Toward an Effective Damage Remedy" (1984) 19(1) Harvard Civil Rights Civil Liberties Law Rev 21 at 30 [Furrow].
444 Furrow at 30.
445 DA Soskis, "Schizophrenic and Medical Inpatients as Informed Drug Consumers" (1978) 35 Arch Gen Psychiatry 645 at 646.
446 Robertson at 408.
447 Law Reform Commission of Canada, *Behaviour Alteration and the Criminal Law* (Working Paper No 43), 1985 at 19.
448 R. Gordon & Simon Verdun-Jones, "The Right to Refuse Treatment: Commonwealth Developments and Issues" (1983) 6 International J of Law and Psychiatry 57 at 57 [Gordon & Verdun-Jones].

that treatment is in the best interest of their loved one. Thus, a refusal to accept treatment may be considered unreasonable and therefore indicative of the person's inability to make the treatment decision.

At law, however, a patient's capacity to make a treatment decision does not depend on their willingness to accept treatment deemed to be in their best interests.[449] The law emphasizes the rights of competent patients to autonomy and self-determination to make their own decisions.[450] The law contemplates that clients may be incompetent for some purposes but not as it relates to making treatment decisions. Gordon and Verdun-Jones assert that this difference has created, in some cases, a "profound professional chasm".[451] It is quite difficult, at times, to resolve this difference.

The Rozovskys look at the practical aspects of determining whether a person is capable of consenting to treatment. When a person consents to treatment, he/she is agreeing to "submit to specific diagnostic, medical or surgical measures to be carried out by the care-giver."[452] The process for obtaining a valid consent depends upon whether the person is legally and mentally capable of consenting to treatment. Various authors have attempted to list the criteria necessary for obtaining a valid consent to treatment.[453] Although there are no set criteria for determining valid consent, Rozovsky and Rozovsky list the following:

> 1. The patient must be legally competent to consent to treatment.
> 2. The patient must possess the mental capacity to authorize care.
> 3. The patient must receive a proper disclosure of information from the care-giver.
> 4. The authorization should be specific to the procedure performed.
> 5. The patient should have an opportunity to ask questions and to receive understandable answers.
> 6. The authorization obtained should be free of undue influence or coercion.
> 7. The authorization should be free of misrepresentation of material

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[449] See, for example, *Starson* where the Supreme Court of Canada held that a review board wrongfully infused their capacity assessment with their views on the patient's best interests.

[450] *Starson.*

[451] *Starson.*

[452] Rozovsky at 1.

[453] See, for example, RB Edwards, ed., *Psychiatry and Ethics* (New York: Prometheus Books, 1982) at 192 - 211; Rice, Harris, Sutherland and Leveque at 20 - 23; KG Evans, "The Law of Consent" (1990) 10(4) Health Law in Canada 227; D Morrison, "Criteria Used by Physicians to Assess Competency to Consent to Treatment" (1986) Health Law In Canada 9; Dr S Kline, "The Clinical Issues of Determining Competency" (1987) 8(1) Health Law In Canada 4; T Grisso and P Appelbaum, "Mentally Ill and Non-Mentally Ill Patients' Abilities to Understand Informed Consent Disclosures for Medication" (1991) 15(4) Law and Human Behaviour 337.

information. [454]

Rozovsky and Rozovsky suggest that caregivers must assess each patient's situation in order to determine whether she is capable of consenting.[455] They provide eight suggested criteria to be used by professionals in assessing the mental capacity to consent:

> 1. Presence or absence of consciousness.
> 2. Severe pain which compromises the ability of the patient to think or to articulate.
> 3. Ingestion of alcohol and or drugs to the point that the patient cannot respond to direct questions, cannot supply pertinent information and slips in and out of a drug-alcohol stupor.
> 4. Presence or absence of lucidity.
> 5. Presence or absence of coherency.
> 6. Diagnosed mental disability such as severe organic grain syndrome, advanced stages of Alzheimer's Disease, or severe mental retardation.
> 7. Traumatic injury, illness, or episodes (including severe strokes) which have the effect of significantly modifying the individual's ability to think.
> 8. Administration of pain-killing medications which do not simply 'blunt' the effects of pain, but which actually alter the individual's thought processes.[456]

Rozovsky and Rozovsky also deal at length with the consent to treatment by mentally disabled persons.[457] They argue that there is a preconceived idea that mentally disabled individuals are incapable of making decisions relating to care and treatment.[458] The Rozovskys assert that a general rule regarding the mentally disabled person's ability to consent to treatment cannot be established, in fact or in law.[459] They state that any person who is mentally disabled may be able to consent to certain types of treatment, but not to others.[460] Further, the mentally disabled patient may be able to comprehend some types of treatment, but not others.[461] Finally, the person may be capable of understanding some

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[454] Rozovsky at 5.
[455] Rozovsky at 7.
[456] Rozovsky at 39-51. For an understanding of how the province of Alberta assesses capacity of individuals under the *Adult Guardianship and Trustee Act*, see: Alberta, Office of the Public Guardian, *Guide for Capacity Assessors,* online: <https://open.alberta.ca/dataset/a86649cc-b0d4-44bb-ab0a-eef8609f29f4/resource/9ff4213f-84b6-4f08-bbcf-05497b5a6017/download/opg-guardianship-publication-opg5630.pdf>.
[457] Rozovsky at 39.
[458] Rozovsky at 39.
[459] Rozovsky at 5.
[460] Rozovsky at 39-40.
[461] Rozovsky at 30.

information about the risks, benefits and alternatives of the proposed treatment, but not other details.[462] The Rozovskys include in their discussion persons who have been involuntarily committed and persons found unfit to stand trial and not criminally responsible on account of mental disorder.

The Rozovskys conclude that the mental ability to consent to treatment must not be assumed from the person's status within the health care system or the legal system.[463] Finally, they assert that a person's ability to consent to treatment depends upon the following factors:

> 1. The ability to understand that he has the right to either consent to or refuse treatment.
> 2. The ability to understand the information given to him and upon which the decision will be based, including the nature, risks, and benefits of treatment, and any reasonable alternatives to the proposed treatment along with the nature, risks and benefits of those alternatives.[464]

In *Starson*[465] the Supreme Court of Canada squarely addressed an involuntary mentally disordered patient's capacity to refuse treatment. The patient was involuntarily detained after being found not criminally responsible for uttering death threats. He then refused his physicians' recommended treatment. The Ontario Consent and Capacity Board found that the patient did not have capacity to reject treatment. This was overturned by the Court of Appeal, who held that the Board incorrectly infused the test for capacity with observations about the patient's best interests.

The Supreme Court was divided in its conclusion. The majority held that the patient had the capacity to refuse treatment. In reaching this decision, the majority noted that questions of capacity to consent raise fundamental values in opposition. On one hand, there is value in dignity, autonomy and personal freedom. On the other hand, there is also value in effective medical treatment and the protection of the mentally ill.[466]

The majority held that the board's conception of a patient's best interests was irrelevant to the determination of capacity. The board in *Starson* improperly allowed its own conception of the patient's best interests to influence its finding of incapacity.[467] The

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[462] Rozovsky at 39.
[463] Rozovsky at 39.
[464] Rozovsky at 39.
[465] 2003 SCC 32, 225 DLR (4th) 385 [*Starson*].
[466] *Starson* at para 7.
[467] *Starson* at para 76.

Supreme Court dismissed the physician's appeal.[468]

5. Voluntariness and Consent—The "Captive" Patient

A person's consent to medical treatment must be voluntary. Consent must be freely given by the patient.[469] The patient must not be subject to any duress, coercion, or undue influence.[470] The fact that a mentally disabled offender is incarcerated or institutionalized may affect the voluntariness of consent.[471]

An incarcerated person may be subjected to coercion. First, the inmate may wrongly view the medical staff as part of the prison personnel. Penitentiaries are coercive environments with one purpose of inducing behaviour considered appropriate by society.[472] If medical personnel are considered to be part of the prison system, true voluntariness may not be available.[473] For this reason, it is crucial to maintain a clear separation between the medical and prison staff. Medical staff must work in full clinical and professional independence from prison officials. Health care providers must not be involved in the imposition of disciplinary sanctions or other restrictive measures.[474]

Second, an inmate may feel that he/she must take treatment in order to receive certain benefits, or to obtain favourable assessments in reports that will be reviewed by officials who are considering whether to release the prisoner under statutory release provisions.[475]

The very act of institutionalizing inmates (and mentally disabled persons who are detained in facilities) may also reduce their ability to voluntarily consent to treatment. When a person is detained in an institution, many decisions are made for her/him. As Sykes said, "institutionalization tends to strip the individual of the support which permits him to maintain his sense of self-worth and the value of his own physical and mental integrity."[476]

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[468] *Starson* at para 120.
[469] *Haluska* at 625. See also: *Beausoleil v Sisters of Charity* (1966), 53 DLR (2d) 65 (Que CA).
[470] Hass, Helgeson & Hume at 75. See also: *Norberg v Wynrib,* [1992] 2 SCR 226, additional reasons at [1992] 2 SCR 318.
[471] Schiffer at 191.
[472] Schiffer at 192.
[473] Indeed, the prisoner usually does not have the right to choose which physician will treat him, a right enjoyed by persons not in prison.
[474] Nelson Mandela Rules Rule 46; Correctional Investigator Annual Report 2016/2017.
[475] Schiffer. See also: Freeman & Roesch at 111 - 112; R. Rogers and C Mitchell, *Mental Health Experts and the Criminal Courts* (Toronto: Thomson Prof Pub, 1991) at 56 - 60. For example, in *Ducap v Canada (Attorney General)*, 2017 FC 320 prisoners complained that a prison refused to transfer the inmates from isolated special handling units to a regular maximum security prison because they refused to take certain controversial and unproven medications unrelated to their original transfer.
[476] G Sykes, "The Deprivation of Autonomy" in *The Society of Captives: A Study of Maximum Security Prison* (Princeton: Princeton University Press, 1958). See also: Rozovsky at 15; A. Mewett, "The Rights of the Institutionalized" in R. MacDonald and J Humphrey eds., *The Practice of Freedom* (Toronto: Butterworths,

Persons who are institutionalized may exhibit an inability to make decisions and a dependency on authority.[477] Thus, the mere fact that a person is imprisoned may affect his ability to voluntarily consent to treatment.

Although inmates may be coerced into accepting treatment, Halleck has argued that many offenders would not seek treatment unless they were faced with the threat of continued punishment. He opines that prisoners are not unlike mentally ill persons who seek treatment to escape the psychological pain that they are experiencing.[478] Thus, it is difficult to argue that in all cases an incarcerated person cannot voluntarily consent to treatment.

However, whether a person who is in captive circumstances can truly voluntarily accept psychiatric (or other) treatment is certainly worth considering.

C. Right to Refuse Treatment, Federal Corrections Legislation and Provincial Law

In *Starson* the majority of Supreme Court judges confirmed that the presumption of capacity regarding consent to treatment continues to apply to the mentally ill and those who are involuntarily detained.[479] While the decision was made specific to s 4(2) of the *Ontario Health Care Consent Act*, the principle of presumed consent is one of general application.

The *CCRA* recognizes the right of federal prisoners to refuse treatment. Subsection 88(1) prohibits the administration of health care (including mental health care) treatment to any inmate other than those referred to in subsection 88(5), unless the inmate voluntarily gives informed consent to the treatment.[480] The subsection further provides that the inmate has the right to refuse treatment at any time or, having initially consented to the treatment, to refuse to continue with the treatment.[481]

Subsection 88(2) provides that consent is informed only if the inmate has been advised of and has the capacity to understand:

> (a) the likelihood and degree of improvement, remission, control or cure as a result of the treatment;
> (b) any significant risk, and the degree thereof, associated with the

1979) at 252 - 254; E Kluge, "Behaviour Alteration, The Law Reform Commission and the Courts: An Ethical Perspective" (1988) 11 Dalhousie L J 865 at 874.

[477] MA Somerville, *Consent to Medical Care* (Law Reform Commission of Canada Study Paper, 1980) at 101.

[478] S. Halleck, *Psychology and the Dilemma of Crime: A Study of Causes, Punishment and Treatment* (Berkeley: University of California Press, 1971) at 320.

[479] *Starson*.

[480] *CCRA*, s 88(1)(a).

[481] *CCRA*, s 88(1)(b).

> treatment;
> (c) any reasonable alternatives to the treatment;
> (d) the likely effects of refusing the treatment; and
> (e) the inmate's right to refuse the treatment or withdraw from the treatment at anytime.[482]

Subsection 88(3) provides that an inmate's consent to treatment shall not be considered involuntary merely because the treatment is a requirement for a temporary absence, work release or parole.[483] Presumably, this section addresses the concerns outlined above about voluntariness of consent in a captive situation.

The *CCRA* provides specific safeguards against treatment demonstration programs and force-feeding. Treatment under such a program is prohibited unless a duly constituted committee independent of the Corrections Service has approved the program as clinically sound and in accordance with accepted ethical programs.[484] Further, the committee must review the inmate's consent and determine that it was given in accordance with the requirements of subsection 88(2).[485]

Section 89 prohibits force-feeding if the inmate had the capacity to understand the consequences of fasting at the time that she decided to fast.[486]

Although the *CCRA* provides protection of the right to refuse treatment to inmates capable of providing informed consent, treatment for patients who do not have the capacity to consent is governed by the applicable provincial law. Subsection 88(5) provides:

> 88(5) Where an inmate does not have the capacity to understand all matters described in paragraphs [88]2(a) to (e), the giving of treatment shall be governed by the applicable provincial law.[487]

It thus appears that, with regard to the right to refuse treatment, a federal inmate who is not capable of giving informed consent to treatment will be in the same position as an inmate serving his sentence in a provincial jail within the same province.

In Alberta, the *AGTA* provides that, if an adult does not have the capacity to consent to treatment, the court can appoint a guardian who may consent on their behalf.[488] Additionally, authorization for treatment may be obtained by an application to the Court of Queen's Bench to exercise its *parens patriae* jurisdiction in granting authorization for

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[482] *CCRA*, s 88(2).
[483] *CCRA*, s 88(3).
[484] *CCRA*, s 88(4)(a).
[485] *CCRA*, s 88(4)(b).
[486] *CCRA*, s 89.
[487] *CCRA*, s 88(5).
[488] *CCRA*, ss 26 and 27.

treatment. *Parens patriae* is founded on the need to protect those who cannot care for themselves, and should only be exercised in the best interest of the protected person.[489]

Section 29 of the *CCRA* provides that the Commissioner may authorize the transfer of a person who is sentenced, transferred or committed to a penitentiary to provincial correctional facility or hospital under an exchange of service agreement and any applicable regulations.[490] The right to refuse treatment under the Alberta *MHA* for inmates transferred to a mental health facility is discussed below.

X. Treatment in Mental Health Facilities

A. The Alberta *Mental Health Act*

1. General

Mental health facilities play an important role in dealing with mentally disordered offenders. Generally, there are two types of patients in a mental health facility—voluntary (informal) and involuntary (formal). There are three circumstances where mentally disordered offenders may be admitted to a mental health facility. First, they may be transferred by prison officials who determine the offender requires treatment. This can be done voluntarily with the inmate's consent or involuntarily pursuant to provincial mental health laws.[491] Second, sometimes persons found not criminally responsible on account of mental disorder (NCR) may be detained in mental health facilities. Finally, persons found unfit to stand trial (UST) may be detained and treated in mental health facilities.

Do these persons have a right to refuse treatment? The answer depends upon the nature of their detention in the mental health facility. The Alberta *MHA* provides that involuntary patients (referred to as "formal patients") may be subjected to involuntary treatment in various circumstances, regardless of their competency. This is discussed in more detail below.

Section 19(1) of the Alberta *MHA* provides that, on admission of a patient to a facility, "the board of the facility shall provide the diagnostic and treatment services that the patient is in need of and that the staff of the facility is capable of providing and able to provide."[492] The *MHA* sets out the procedures for involuntary admission and detention of a patient in a mental health facility. This is done via the use of "Admission Certificates". One admission certificate authorizes a mental health facility to care for, observe, examine,

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[489] *Re Eve*, [1986] 2 SCR 388, 31 DLR (4th) 1 at para 73.
[490] *CCRA*, s 29.
[491] See *MHA*.
[492] *MHA*, s 19(1).

assess, treat, detain and control the person named in the certificate for up to 24 hours from the time they arrive at the facility.[493] If the patient is issued two admission certificates, that period may be extended for up to one month.[494] With the issuance of two admission certificates, the person becomes a formal patient. Admission certificates may be renewed for up to six months (on the third renewal).[495]

The *MHA* sets out the circumstances that must exist before a mental health facility may treat a formal patient without his or her consent.

First, treatment may proceed without a formal patient's consent when he or she is not competent. An individual will be considered mentally competent to make treatment decisions if he/she is "able to understand the subject‐matter relating to the decisions and able to appreciate the consequences of making the decisions."[496] Persons who are not competent may have treatment decisions made on their behalf by their agent, guardian, nearest relative or the Public Trustee.[497]

If a physician believes a formal patient is not mentally competent to make treatment decisions, before providing treatment, they must complete and file a written certificate with the board explaining why they believe the patient is not mentally competent.[498] The board must provide the certificate to the patient, their agent and/or guardian (if any), and, unless the patient objects, to the patient's nearest relative.[499] The board must also provide them with notice that the patient is entitled to have the physician's opinion reviewed by the review board.[500] If the patient decides to have the decision reviewed, neither a physician nor the board may act on the opinion until the application is decided.[501]

In the second situation, formal patients may be treated without their consent, despite the fact that they are mentally competent. Pursuant to s 29(1) of the *MHA*, if a patient who is mentally competent refuses treatment, the attending physician should not administer treatment unless a review panel makes an order under s 29(3).[502] In order to

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493 *MHA*, s 4(1)(b).
494 *MHA*, ss 7 and s. 8(3).
495 Alberta Health Services, *Guide to the Alberta Mental Health Act and Community Treatment Order Legislation,* (Edmonton: Alberta Health Services, 2010) at 41 online: <https://www.albertahealthservices.ca/assets/info/hp/mha/if-hp-mha-guide.pdf>.
496 *MHA*, s 26.
497 *MHA*, s 28(1).
498 *MHA*, ss 27(1) & (2).
499 *MHA*. s 27(3).
500 *MHA*, s 27(3).
501 *MHA*, s 27(4).
502 *MHA*, s 29(1). A review panel consists of two lawyers, a psychiatrist, a physician and a member of the general public and has the power to consider applications for review under the Act.

make an order for treatment, the review panel must be convinced, after hearing all relevant evidence, that the attending physician has examined the formal patient and that the proposed treatment is in the best interests of that patient.[503] Orders of the review panel may be appealed to the Court of Queen's Bench.[504] There is no right of appeal from the Court of Queen's Bench decision.[505]

In all cases, however, there is an exception with respect to psychosurgery. Psychosurgery may not be performed on a formal patient unless the patient consents and the review board makes an order that psychosurgery should be performed.[506]

Prisoners can be involuntarily committed into a mental health facility and, subjected to treatment they do not wish to receive. However, before an individual can become a formal patient, they must meet the standards for involuntary committal: that is, two physicians must determine that the individual is suffering from a mental disorder, that he or she is in a condition presenting or likely to present a danger to herself or others, and that he is or she is unsuitable for admission to a facility other than as a formal patient.[507] Freeman and Roesch state that in most provinces, a civilly committed mentally ill offender can be treated without his or her consent.[508]

In some circumstances, prisoners voluntarily agree to be admitted to mental health facilities.[509] Voluntary patients are presumed to have the capacity to make treatment decisions. The Alberta *MHA* does not contain provisions regarding voluntary patients who are incompetent to make treatment decisions. However, the authorities in the mental health facility may proceed to obtain involuntary committal of the person who refuses treatment. If the individual is found incompetent to make treatment decisions, they may be subject to treatment to which they do not consent.

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503 *MHA*, ss 29(3)(a) and (b). Section 29(3)(b)(i)-(iv) states: When determining whether treatment is in the patient's best interests, the review panel should have regard to: (i) whether the mental condition of the patient will be or is likely to be improved by the treatment; (ii) whether the patient's condition will deteriorate or is likely to deteriorate without the treatment; (iii) whether the anticipated benefit from the treatment outweighs the risk of harm to the patient; and whether the treatment is the least restrictive and least intrusive treatment that meets the requirements of subclauses (i), (ii) and (iii).

504 *MHA*, s 43(1).

505 *MHA*, s 43(5).

506 *MHA*, ss 28(1), 29(5).

507 For an interesting case that raises questions about the dubious standards of involuntary committal in Alberta, read *JH v Alberta Health Services*, 2017 ABQB 477 (CanLII) and accompanying commentary in Lorian Hardcastle, "Is Alberta's Mental Health Act Sufficiently Protecting Patients?" (18 September 2017) CanLII Connects (blog) online: <http://canliiconnects.org/en/commentaries/46696>.

508 Freeman & Roesch at 111.

509 Indeed, s 33(1) of the *Mental Health Act* contemplates that some prisoners sent to a mental health facility will not be subject to admission certificates. In other words, they will be there voluntarily.

2. Persons Not Criminally Responsible on Account of Mental Disorder

No person can be rightly tried, sentenced or executed while insane.[510] In other words, no person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission, or of knowing that it was wrong.[511] When a verdict of not criminally responsible on account of mental disorder (NCRMD) is rendered in respect of an accused, he/she is diverted to a separate stream that provides individualized assessment and treatment for those found to be a significant danger to the public.[512] Their future detention and risk to the public, if any, is determined by a review board rather than a court. The review board may make one of several dispositions, including discharge, discharge with conditions or detention.[513] However, almost one quarter cases involving individuals found not criminally responsible spend at least ten years in the review board systems.[514] The review board has a duty to protect public safety, and may grant absolute discharge only when not criminally responsible patients are not a significant threat to the safety of the public.

Persons who are detained in mental health facilities because they have been found not criminally responsible on account of mental disorder cannot be subjected to treatment orders by a review board under s. 672.54 of the *Criminal Code*.[515] The authority to make treatment decisions lies exclusively within the mandate of provincial health authorities in charge of the hospital where an NCR patient is detained, pursuant to various provincial laws governing the provisions of medical services.[516] The role of the review board is to ensure

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[510] *R v Les*, 1910 CarswellOnt 289.

[511] *Criminal Code*, RSC 1985, C-46 [*Criminal Code*], s 2; *R* v Chaulk (1990), 3 SCR 1303.
See: P James, "Recent Decisions: Application of Bill C-30" (1992) 1(2) Health Law Rev 29 at 30, where the author states that there needs to be a mechanism for substituted consent for treatment for individuals found not criminally responsible on account of mental disorder who do not wish to receive treatment. Ms. James further states that the provinces will have to amend their mental health legislation to include persons who fall under the provisions of Bill C-30.

[512] *Winko* at para 21; *R v Owen,* 2003 SCC 33 at para 90; *Penetanguishene* at para 21.

[513] *Criminal Code*, s 672.54; *Winko.*

[514] Jeff Latimer and Austin Lawrence, *Research Report: The Review Board Systems in Canada: Overview of Results from the Mentally Disordered Accused Data Collection Study* (Ottawa: Dept of Justice Canada, January 2006) at 39.

[515] *Criminal Code,* s 672.55. An accused is presumed fit to stand trial unless the court is satisfied on the balance of probabilities that the accused is unfit to stand trial. *Criminal Code*, RSC 1985, c-46, s 672.22. A Review Board must ensure that opportunities for medical treatment are provided for mental disorder detainees where necessary and appropriate, but cannot require hospital authorities to administer particular courses of medical treatment. It would be an inappropriate interference with provincial legislative authority for Review Boards to require hospital authorities to administer particular courses of medical treatment for the benefit of a not criminally responsible accused. See *Mazzei v British Columbia (Director of Adult Psychiatric Services),* [2006] 1 SCR 326 at para 31.

[516] *Conway*.

the opportunities for medical treatment are provided.[517]

The *Criminal Code* does not specify whether persons ordered to be detained in a mental health facility after being found not criminally responsible on account of mental disorder are voluntary or involuntary patients for the purposes of the *MHA.* Further, it does not state whether such patients can be treated without consent.[518]

In *Dion,* the Quebec Superior Court held that neither a Lieutenant Governor's warrant nor a judge's order were sufficient to confer authority on a facility to treat the patient without his consent. Robertson argues that the wording of many mental health statutes is equivocal on the issue whether compulsory treatment may be given to persons detained under a Lieutenant Governor's warrant and, therefore, not sufficiently clear to deprive such patients of their common law right to refuse treatment.[519] While the regime that issued Lieutenant Governor's warrants is no longer used, arguably Robertson's observations remain applicable to a person found not criminally responsible on account of mental disorder.[520]

3. Persons Found Unfit to Stand Trial

Section 672.58 of the *Criminal Code* provides that in cases where the accused has been found unfit to stand trial and the court has not made a disposition under s. 672.54 in respect of the accused,[521] the court may direct that treatment of the accused be carried out for a maximum period of 60 days, subject to conditions the court considers appropriate.[522] The court should not direct treatment under s 672.58 unless they are satisfied on the basis of a medical practitioner's testimony, that treatment should be administered for the purpose of making the accused fit to stand trial.[523] Further, the medical practitioner should be of the opinion that the risk of harm to the accused resulting from the specified

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[517] *Conway*.

[518] See: Schizophrenia Society of Canada, "Submission of the Schizophrenia Society of Canada on Amendments to the Criminal Code Concerning Mental Disorder" (1992) 1(2) Health Law Rev 16 at 21. The Alberta Hospital Edmonton recommended that no person should be held under the authority of a hospital without the hospital receiving the authority to administer the appropriate treatment without the consent of the patient, if necessary. See: Milliken at 26.

[519] Robertson at 402.

[520] Even if persons admitted to mental health facilities because they have been found not criminally responsible on account of mental disorder are considered to be detained as voluntary patients, the staff of the mental health facility may be able to re-admit them as involuntary patients and they too could be subjected to treatment that they do not wish to take (if they are considered incompetent to make treatment decisions).

[521] Where a court has not made a disposition under s 672.54, s 672.58 allows only a court, not a review board, to make an order directing treatment of an accused (*Evers v British Columbia (Director of Adult Forensic Services)*, 2009 BCCA 560 at para 69).

[522] *Criminal Code*, s 672.58. If the accused is not detained in custody, the court may direct the accused submit to the treatment by the person or at the hospital specified.

[523] *Criminal Code*, s 672.59(1).

treatment is not disproportionate to its anticipated benefit, and that the treatment specified is the least restrictive and intrusive treatment that could be ordered in order to make the accused fit to stand trial.[524]

The consent of the accused, or of a person authorized to consent for the accused, is not required for the court to direct treatment under s 672.58.[525] However, the court is not permitted to use that provision direct the performance of psychosurgery or electro-convulsive therapy.[526] Moreover, a court may not make an order for treatment under s 672.58 without the consent of either the person in charge of the hospital where the accused is to be treated or the person to whom the court assigns responsibility for treatment.[527] When a prosecutor files an application for an order directing the treatment of an accused under s 672.58, they must notify the accused of the application by serving a copy personally on the accused and the accused's counsel.[528]

In cases where a disposition order has been made pursuant to s 672.54, review boards cannot make specific orders regarding treatment.[529] They can only include conditions regarding treatment (for example, that the individual undergo psychiatric treatment) if the accused consents and if the review board considers the condition reasonable and necessary in the individual's best interests.

Section 13(2) of the Alberta *MHA* provides:

> A person who, pursuant to the *Criminal Code* (Canada) or the *Youth Criminal Justice Act* (Canada), is detained for treatment may be admitted to, examined, treated and detained in and discharged from a facility in accordance with the law.[530]

While this provision of the *MHA* has not been considered in any reported decisions, in *Re Osinchuck,* the Alberta Surrogate Court held that a similar provision ("authority to observe, examine, care for, treat and detain") provided the authority to provide psychiatric treatment without the patient's consent. If this decision applies to s 13(2) of the Alberta *MHA*, it is possible to treat a person found unfit to stand trial without his/her consent.[531]

Section 672.58 of the *Criminal Code* may be open to challenge.[532] Although a person

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[524] *Criminal Code*, s 672.59(2).
[525] *Criminal Code*, s 672.62(2). See also *R v Margaret Walker*, 2016 ONSC 2299 (CanLII) at para 49.
[526] *Criminal Code*, s 672.61(1).
[527] *Criminal Code*. See also: *R v Conception*, [2014] 3 SCR 82, 2014 SCC 60 (CanLII)
[528] *Notice of Application for Treatment Regulations*, SOR 92-665, s 3.
[529] *Conway*; *Mazzei; Criminal Code* s 672.55 .
[530] *MHA*, s 13(2).
[531] (1983), 45 AR 132 (Surr Ct).
[532] Generally, at common law, a person has the right to refuse treatment. However, under the *Mental Health Act*, an involuntary patient who is found incompetent to consent to treatment may be subjected to treatment after

may be found unfit to stand trial, this does not mean that he/she is incapable of making treatment decisions. Further, the treatment referred to in s. 672.58 is not necessarily for therapeutic purposes; its aim is to render the person fit to stand trial. This may or may not be in the best interests of the accused.[533]

While not squarely addressing the constitutionality of s 672.58, the Supreme Court of Canada has given indications that it could survive a challenge under s 7 of the *Charter*. In *R v Conception*, the Court emphasized that the restrictions, temporal limits and exceptional nature of s 672.58 rendered it an acceptable limit to be used in exceptional circumstances.[534] The Court upheld the constitutionality of related provisions that required a hospital's consent to treat someone under s 672.58.[535]

A direct challenge to s 672.58 could also come under *Charter* sections 12 or 15(1). The arguments would be similar to those arguments made that certain provisions of mental health legislation that permit non-consensual treatment are contrary to the *Charter.* These arguments are discussed immediately below.

B. *Charter of Rights* Implications on the Right to Refuse Treatment

The provisions in mental health laws that limit persons' right to refuse to accept treatment may provide grounds for challenges under ss 7, 12 and 15(1) of the *Charter*. There have been several *Charter* challenges to date.[536]

In *Howlett v Karunaratne,* Ontario District Court considered an appeal from a review board decision that a 79-year old voluntary psychiatric patient was not mentally competent to consent to psychiatric treatment. The appellant argued the review board erred in finding she was not mentally competent as defined in the legislation, and that provisions of the Ontario *Mental Health Act* that allowed a mentally incompetent patient to be subject to treatment without their consent violated ss 7, 12, and 15 of the *Charter*. [537]

The appellant argued the provisions of the Act that allow treatment to be administered without a patient's consent infringed her right to life, liberty and security of

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certain procedural requirements have been met. This issue is discussed above under Right to Refuse Treatment in Prison and Jail.

[533] The Louisiana Supreme Court has ruled that an insane inmate cannot be medicated over his objections to make him eligible for the death penalty. See: M Hansen, "Insane Inmate Avoids Death Penalty" (1993) 79(1) ABA Journal 32.

[534] *R v Conception*, 2014 SCC 60 (CanLII) at paras 31-35 [*Conception*].

[535] *Conception* at paras 41-43.

[536] In addition to cases described in this paper see *Mullins v Levy*, 2005 BCSC 1217 (CanLII), reversed on other grounds, *Mullins v Levy*, 2009 BCCA 6 (CanLII).

[537] (1988), 64 OR (2d) 418 (Dist Ct) [*Howlett*] at para 1. *Howlett* was followed in *T (SM) v Abouelnasr*, 2008 CarswellOnt 1915; *Nova Scotia (Minister of Community Services v Carter*), 1988 89 NSR (2nd) 275.

the person under s 7 of the *Charter*.[538] The court held that treatment administered to a patient who is not mentally competent in accordance with the patient's best interests as provided for in the *Mental Health Act* does not infringe an individual's security of the person under s 7, because the framework erected under the legislation is, in matters of both procedure and substance, in accordance with the principles of fundamental justice.[539] The Court noted that the legislation contains safeguards to protect a patient's rights at every stage of the process and that treatment is only administered after all other potential remedies under the legislation have been exhausted.[540]

The appellant also argued that imposing treatment without consent violates the right not to be subjected to cruel and unusual treatment or punishment under s 12 of the *Charter*. The Court relied upon the test set out in *R v Smith*[541] and examined whether the treatment was "so excessive as to outrage the standards of decency and whether or not it is grossly disproportionate to what would have been appropriate in the particular circumstances."[542] The Court looked at the purpose of the legislation, the safeguards in place at every stage of the process, the mechanisms for obtaining consent from a substitute consent giver, and the factors that must be considered under the *Act* when determining whether treatment is in the best interest of the patient. Based on these considerations, the court concluded that such treatment would not fall within the scope of s 12.[543]

In making its s 12 analysis, the court did not make mention of any adverse effects of the medication in question. However, in similar cases from the United States, litigants have successfully argued that compulsory medical treatment may be cruel and unusual punishment, especially where treatments induced adverse side effects.[544]

Finally, the appellant argued the impugned provisions of the legislation violated the equality provisions under s 15(1) of the *Charter* because they differentiated between

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538 *Howlett* at para 13.

539 *Howlett* at para 38.

540 See: *Rennie v Klien,* 462 F Supp 1131 (DNJ, 1978), *vacated and remanded* 653 F 2d 836 (3rd Cir 1981), 458 US 1119 (1982), 720 F 2d 266 (3rd Cir, 1983); and *Rogers v Okin,* 478 F Supp 1342 (D Mass, 1979), *rev in part* 634 F 2d 650 (1st Cir, 1980), *vacated and remanded* 457 US 291 (1982), where the courts found that the treatment of involuntary patients with anti-psychotic drugs without consent violated the due process clause of the 14th Amendment to the American Constitution. The courts also held that the treatment could be imposed without the patients' consent only after the patients were found incompetent to consent after due process.

541 [1987] 1 SCR 1045.

542 *Howlett* at para 434.

543 See also: *Re McTavish and Director, Child Welfare Act* (1986), 32 DLR (4th) 394 (Alta QB) where the court held that the provisions of medical treatment to a person who is not mentally competent does not constitute "treatment" within the meaning of "cruel and unusual treatment or punishment" in *Charter* s 12. The court in *Howlett* disagreed with this decision.

544 See, for example: *Nelson v Heyne,* 355 F Supp 451 (DC Ind), *affirmed* 491 F 2d 352, *certiorari denied* 94 SCt 3183 (1972); *Knecht v Gillman,* 488 F 2d 1136 (CA Iowa 1973).

individuals who are psychiatric patients and those who are not.[545] However, the Court concluded that "because of the importance of providing needed therapeutic psychiatric treatment for the benefit of patients who are not able to appreciate the need for such treatment and are not mentally competent to consent to such treatment, the different handling of them is not so invidious, unfair or irrational as to constitute discrimination within the meaning of s 15 of the *Charter*.[546]

The Court concluded that, even if they were wrong with respect to their finding that the impugned provisions did not violate ss 7, 12 and 15 of the *Charter*, the limits were reasonably justifiable under s 1 of the *Charter*. The legislative objective of the impugned provisions was to establish a mechanism to provide care for not mentally competent individuals who are therefore unable to make decisions regarding their care. The state has an obligation to assist with the care of mentally incompetents persons who are unable to make informed decisions about their care; thus, the legislative objective of the impugned provisions is of sufficient importance to override constitutionally protected rights.[547] Moreover, the means employed by the *MHA* are rationally connected to the stated legislative objective and are not arbitrary or based on irrational considerations.[548] Further, the protections provided in the legislation are proportionate to the means chosen, as they provide patients who are found not mentally competent with "the same panoply of rights and choices that are enjoyed by mentally competent persons through the mechanism of the substitute consent giver."[549] The Court dismissed the appeal.

If a similar s 7 challenge is brought in Alberta, the outcome may be different than in *Howlett*. This is because the procedural safeguards in Alberta's *MHA* appear to be less thorough than under Ontario's legislation. For example, the court in *Howlett* noted several procedural safeguards available that are not present in Alberta's mental health legislation, including: restrictions against "shopping for consent" among different people able to provide substitute consent; the requirement that an individual providing substitute consent do so in accordance with the patient's wishes when he/she was mentally competent, if known; the need for a belief that the treatment will *substantially* improve the mental condition of the patient (as compared to Alberta's requirement that the treatment will improve or is *likely* to improve the patient's mental condition); the requirement that the

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[545] *Charter* s 15(1) provides: Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
[546] *Howlett* at para 58.
[547] *Howlett*.
[548] *Howlett*.
[549] *Howlett* at para 60.

legal aid director be notified if a patient is found to be not mentally competent; and the patient's right to disclosure of all of evidence that will be considered by the review panel.[550]

Such a challenge is, at the time of writing,[551] working its way through the Alberta Courts. In *JH v Alberta Health Services*,[552] the Alberta Court of Queen's Bench heard an appeal from a Review Board decision from a man suffering from a neuro cognitive disorder characterized as "mild" by some experts.[553] The Court of Queen's Bench held that JH had been wrongfully characterized as a formal patient under the *MHA* and wrongfully held in a hospital against his will for a period in excess of six months. In reaching this decision, the Court held that the Review Board's decision to keep him admitted were "wholly inadequate"[554] and was critical of the methods employed by JH's consulting psychiatrist to assess capacity.[555]

JH had also challenged the constitutionality of the provisions of the *MHA* relied on to hold him involuntarily. That argument was adjourned. In late 2017, the Court denied an application by the Crown to dismiss those arguments because they were moot.[556] As such, the constitutionality arguments raised by JH will be heard in the coming months.

In *Fleming v Reid,* the Ontario Court of Appeal examined the provisions of Ontario's mental health legislation that permitted a review board to administer neuroleptic drugs to involuntary incompetent psychiatric patients who had, while still competent, expressed the wish not to be treated with such drugs.[557] The Official Guardian, appointed as a substitute decision maker, refused to consent to the proposed treatment because prior to becoming incompetent, both patients had stated that they did not wish to take neuroleptic drugs. Dr. Fleming, the attending physician, obtained orders from the review board (appointed under the Ontario *Mental Health Act*) authorizing the treatment on the basis that it was in the best interests of the patients. The patients appealed the review board's decisions to the Ontario District Court.[558] The decisions of the review board were upheld.[559]

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[550] *Howlett* at 425-35.
[551] March 2018.
[552] 2015 ABQB 316 (CanLII) [*JH 2015*].
[553] *JH 2015* at para 20.
[554] *JH 2015* at para 5
[555] *JH 2015* at paras 14, 25.
[556] *JH v Alberta Health Services*, 2017 ABQB 477 (CanLII).
[557] (1991), 4 OR (3d) 74 (Ont CA) [*Fleming*]. See also *SMT v Abouelnasr*, [2008] OJ No 1298, 171 CRR(2d) 344; *Sevels v Cameron*, [1994] OJ No 2123.
[558] *Fleming v Reid (*1990), 73 OR (2d) 169 (Dist Ct).
[559] *Dion* at 369. Where the court held that the court could substitute its decision for the refusal to accept treatment of a patient held under a Lieutenant Governor's warrant; *Re Boudreau* (1980), 43 NSR (2d) 212 (TD) and *Cooper v Stanton Yellowknife Hospital,* [1989] NWTR 265 (SC) where the courts held that the Public Trustee could consent to the medical treatment of a patient admitted to a hospital under a Lieutenant Governor's warrant.

The Ontario Court of Appeal reversed the decisions of the District Court and found that every competent adult has the right to be free from unwanted medical treatment. Further, in contemplation of circumstances where he may be incapacitated, a patient may specify in advance his refusal to consent to treatment. The common law provides that a doctor is not free to disregard these advance instructions, even in an emergency. The Ontario Court of Appeal extended these common law principles to mentally competent patients in psychiatric facilities.

The Court went on to hold that the common law right to determine what should be done with one's own body and the *Charter* s 7 right to security of the person can be treated as co-extensive. In the case of involuntary incompetent patients alone, the review board was obliged to determine what was in the patient's best interests and to ignore the patient's prior competent wishes. This legislative scheme, which permitted the competent wishes of a psychiatric patient to be overridden without a hearing as to why the substitute consent giver's refusal to consent based on the patients' wishes should not be honoured, was found to be contrary to s 7.

The Court further found that the legislative provision was not saved by s 1 of the *Charter*. While the right to be free from non-consensual psychiatric treatment is not an absolute one, the state had not demonstrated any compelling reason for eliminating the right, without a hearing or review, in order to further the best interests of involuntary incompetent patients in contravention of their competent wishes.[560] The Court did not find it necessary to consider an argument that the patient's equality rights under *Charter* s 15(1) were violated. This decision opens the door to challenging some of the provisions in mental health legislation and perhaps the *Criminal Code* provisions that permit treatment against the wishes of the patient (or accused person).

XI. ROLE OF CORRECTIONAL INVESTIGATOR AND PROVINCIAL OMBUDSMAN

In addition to the remedies available under the various human rights instruments, persons incarcerated in federal institutions may complain to the Correctional Investigator. The office of the Correctional Investigator investigates complaints from inmates housed in the federal prison system. It also reports on inmate complaints that fall within the responsibility of the Solicitor General of Canada. Part III of *CCRA* sets out the legislation regarding the Correctional Investigator.

The Correctional Investigator exercises discretion as to which complaints it will

[560] *Fleming* at 96.

investigate, based upon the nature of the complaint and when the subject matter of the complaint occurred. Generally, the Correctional Investigator does not investigate matters that ceased to exist or to be the subject of a complaint more than one year before the lodging of the complaint. However, if the decision, act or omission continues to affect or impact the offender, or if the documents containing the decision continue to be used in hearings pertaining to the offender, the Correctional Investigator may choose to investigate. The Office of the Correctional Investigator has received a number of complaints over the years about access to mental health programs in the federal penitentiaries. In the 2016/2017, 120 complaints were received related to the access or quality of prison mental health facilities, or to incidents of self-harm.[561] The Correctional Investigator has also said that mentally disabled prisoners need unbiased advocates to assist in transfer or parole proceedings. Further, they recommend that the prisons improve the identification of mental disability and increase access to community resources or programs.[562]

Similarly, a person incarcerated in a provincial facility or an interested person on her/his behalf could complain to the provincial Ombudsman about treatment in provincial jail if he/she has exhausted all other appeals and remedies.[563] The Ombudsman investigates the workings of departments and agencies of the provincial government. The Ombudsman has broad powers of investigation and can make public reports with recommendations about any injustices that he/she finds.

XII. Recidivism and Mentally Disabled Prisoners

Once mentally disabled persons are released from prison or jail, they run the risk of re-entering the revolving door of the criminal justice system. This is especially the case if they do not receive support and counselling in the community.

In some cases, mentally ill offenders do not immediately re-enter the community. If a mentally ill prisoner meets the criteria for formal admission under the Alberta *MHA,* he/she may be committed to a psychiatric facility upon release. Under s 3 of the *MHA,* if a person has been detained as unfit to stand trial, not criminally responsible on account of mental disorder or not guilty by reason of insanity, and the person's detention is about to expire, a physician is authorized to examine the person to determine if she/he meets the requirements for formal admission. A physician could also examine a person serving a

[561] Correctional Investigator Annual Report 2016/2017 at 75.
[562] Per telephone interview with E. McIsaac, Office of the Correctional Investigator, April 27, 1993.
[563] See generally: *Ombudsman Act*, RSA 2000, c O-8.

prison sentence in order to determine if she/he should be formally admitted to a mental health facility (although it is not specifically stated in the *MHA)*. The other methods of apprehension and committal apply once a person is released from jail.[564]

Alternatively, a mentally disabled person may be able to serve a portion of his/her sentence (e.g., conditional release) in one of the few halfway houses that are equipped to handle mentally disabled clients. These may assist a person who is preparing to re-enter the community.

In order to assist prisoners with mental health issues on release, Alberta Health Services offers a Corrections Transfer Team, which provides short-term case management and outreach support for soon to be or newly released provincial offenders with a history of mental health or addiction issues. This includes services regarding mental health treatment.[565]

Despite these systems and programs, many mentally disabled persons re-offend and re-enter the criminal justice system. An American study of mentally ill offenders revealed that only 56 percent were provided with support from family or friends upon release into the community.[566] Fifty-two percent of the mentally ill offenders incurred at least one arrest for a new offence during the eighteen months immediately following release.[567] A significant percentage of these were nuisance crimes (e.g., disorderly conduct, public drunkenness, loitering, etc.).[568] Almost one third was arrested for parole violations.[569] The author concluded that their post-prison performance reflected a continuation of the mentally ill offender's pattern of contact with mental health and criminal justice facilities.[570]

In Canada, several studies indicate that the recidivism rate of individuals found not criminally responsible on account of mental disorder (NCRMD) is relatively low. For example, the National Trajectory Project followed 1800 individuals who had received NCRMD dispositions for an average of 5.7 years from the date of their index offense.[571] The overall recidivism rate after three years was 16.7%, which is half the rate for the general

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564 These methods are discussed in Chapter One.

565 Alberta, Alberta Health Services, "Corrections Transitions Team" (10 March 2018), online: <https://www.albertahealthservices.ca/info/service.aspx?id=1068452>.

566 Feder at 86. The author studied male inmates who had required psychiatric hospitalization during incarceration. The statistics may be affected by her study group.

567 Feder at 86.

568 Feder at 87.

569 Feder.

570 Feder at 91.

571 Mental Health Commission of Canada, *National Trajectory Project Fact Sheet* (19 March 2015) online: <https://www.mentalhealthcommission.ca/English/document/71181/national-trajectory-project> [NTP Fact Sheet].

offender population.[572] Persons who committed severe violent index offences were less likely to reoffend than others within the group (6%). The rate for severe reoffending was 0.6%.[573]

A Justice Canada study showed that the recidivism rate for NCRMD individuals accused of committing violent offences was 10.4% over the three years following their conditional or absolute discharge.[574] In Quebec, a preliminary study of the province's NCRMD cases showed a 19.7% criminal recidivism rate for all NCRMD accused, but only a 7.7% recidivism rate for violent offences.[575] A study conducted in the early 1990's found a recidivism rate of 7.5% among the NCRMD population after they were absolutely discharged. By way of comparison, studies of all long-term offenders released from federal custody in Canada show recidivism rates of 33.5% overall and 11.6% for violent offenders.[576] The Mental Health Commission of Canada states that "more than half of the people discharged by review boards, either conditionally or absolutely, did not get re-hospitalised nor had encounters with the judicial system after a three-year observation period."[577]

Recent studies indicate that mental illness may not alone be strongly linked to recidivism. Rather, the combination of mental illness and other criminogenic factors make individuals more likely to reoffend.[578] Some people believe the apparent relationship between serious mental illness and violence is misleading due to the fact that researchers have ignored important characteristics that are related to violent behaviour and are intertwined with mental disorder.[579] For example, substance abuse, psychopathy or anti-social personality disorder, community disorganization, and victimization are factors known to be related to violence. A report by the International Centre for Criminal Law Reform and Criminal Justice Policy notes that, "[w]ith the exception of victimization, these are identical to the factors that are associated with criminality on the population without substance abuse.[580] A study of arrests of individuals with a prior arrest history and schizophrenia (or a related psychosis) found that the presence of a co-occurring disorder increased the risk of

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572 NTP Fact Sheet.
573 NTP Fact Sheet.
574 Mental Health Commission of Canada, *Fact Sheet About the NCRMD Population in Canada* (24 April 2013), online: http://www.mentalhealthcommission.ca/English/node/5926 [2013 Fact Sheet].
575 2013 Fact Sheet.
576 2013 Fact Sheet.
577 2013 Fact Sheet.
578 Alison MacPhail and Simon Verdun-Jones, "Mental Illness and the Criminal Justice System" International Centre for Criminal Law Reform and Criminal Justice Policy (January 2013) at p 5 [MacPhail].
579 MacPhail.
580 MacPhail.

arrest in all offence categories.[581]

Further, the report states that "although the number of corrections admissions is significantly higher for mentally ill offenders, when you separate out those with a mental disorder alone from those with any substance use disorder, mental disorder alone is not associated with increased risk of repeat offending relative to those people with no psychiatric diagnosis of any kind.[582] In contrast, the study found that substance abuse disorders, occurring alone or concurrently with a psychiatric disorder, were associated with significantly higher risk of recidivism.[583] Thus, it appears that recidivism is driven by the same factors, regardless of whether an individual has a mental illness or not.[584]

Additionally, mental disorder, substance abuse, and violence are more frequent in communities that are socially disorganized.[585] Individuals who reside in such communities and have severe mental illnesses learn to be violent in the same manner as non-mentally disordered individuals who reside in those communities.[586] The problem is that individuals who are diverted or released from the criminal justice system, including mentally disordered offenders, are often returned to these same communities, where they once again encounter the influences that led them to commit criminal acts in the first place.[587]

XIII. Conclusion – Recommendations and Strategies with respect to Mentally Ill offenders

It is clear that a significant portion of federally and provincially incarcerated persons suffer from mental illness or mentally disability. While all individuals may react to imprisonment, it can have a particularly negative impact on mentally disabled persons. For example, mentally disabled prisoners are more likely to be exploited by other prisoners. They may be easily manipulated by other prisoners and may be the victims of violence. Mentally disabled prisoners may also encounter difficulty with following administrative procedures and may therefore serve more time in prison than other prisoners. Mentally disabled prisoners are often isolated from the general prison population, which may exacerbate their symptoms (e.g., delusions may become more pronounced in isolation).

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[581] MacPhail at 6.
[582] MacPhail. See also Somers, J.M., Cartar, L, Russo, J, "Corrections, Health and Human Services: Evidence-Based Planning and Evaluation" Centre for Applied Research in Mental Health and Addiction at Simon Fraser University (2008).
[583] MacPhail at 6.
[584] MacPhail.
[585] MacPhail.
[586] MacPhail.
[587] MacPhail.

Mentally disabled prisoners may require treatment. Under legislation, federally incarcerated individuals have a right to treatment. This treatment must meet professionally accepted standards. Prisoners in provincial jails may have a right to treatment under common law and human rights legislation.

Mentally disabled prisoners may receive treatment in prison or be transferred to mental health facilities. Mentally disabled prisoners may be competent to refuse treatment, although they may feel that they must take treatment in order to secure early release from prison. Those who are incompetent to consent to treatment may have a substitute decision-maker appointed by the court to make the treatment decision. Alternatively, mentally ill prisoners may be involuntarily committed to a mental health facility where they may have to submit to non-consensual treatment. However, the provisions of the mental health legislation and the *Criminal Code* that permit non-consensual treatment may be open to challenge under the *Charter* and other human rights legislation.

The *Report on the Task Force on Mental Health* recognizes some of the special needs of mentally disordered prisoners and recognition of the problem is an important first step in addressing the situation. Some suggestions for reform in imprisonment and other areas dealing with mentally disabled persons may be found in Chapter Fourteen, Recommendations for Reform. Canada cannot ignore the connection between mental illness, addictions, and the criminal justice system because of the growing number of individuals with such disorders who enter the criminal justice system and end up in correctional institutions.[588]

In 2012, the Mental Health Commission of Canada released a report, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, which outlines six strategic directions designed to improve Canada's mental health system.[589] Priority 2.4 aims to "[r]educe the over-representation of people living with mental health problems and illnesses in the criminal justice system, and provide appropriate services, treatment and supports to those who are in the service."[590] Priority should be placed on providing timely access to services, treatment and supports in the community, particularly with respect to young people. Early prevention and intervention can help keep youth out of the criminal justice system, thus "recoup[ing] initial investments though saving the costs of incarceration in the future."[591]

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[588] *MHA*.
[589] Mental Health Commission of Canada, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (2012), online: <http://strategy.mentalhealthcommission.ca/pdf/strategy-text-en.pdf> [*Changing Directions*].
[590] *Changing Directions* at 46.
[591] *Changing Directions*.

The report also recommends the implementation of diversion programs, such as mental health courts and restorative justice programs.[592] These programs can be useful because they provide people who are about to enter the criminal justice system with access to needed treatment, services, and supports.[593] However, they will not work unless there are services in the community available to support the people being diverted. Furthermore, people who work in the justice system must be aware of the importance of diversion programs, and should know how to encourage and refer people to such services.[594] The report sets out the following five recommendations for action:

> 1. Increase the availability of programs to people living with mental health problems and illnesses from the corrections system, including mental health courts and other services and supports for youth and adults;
> 2. Provide appropriate mental health services, treatment and supports in the youth and adult criminal justice system, and ensure that everyone has a comprehensive discharge plan upon release into the community;
> 3. Address critical gaps in treatment programs for youth and adult offenders with serious and complex mental health needs;
> 4. Increase the role of the 'civil' mental health system in providing services, treatment, and supports to individuals in the criminal justice system; and
> 5. Provide police, court and corrections workers with knowledge about mental health problems and illnesses, training in how to respond, and information about services available in their area.[595]

In its 2011-2012 annual report, the Office of the Correctional Investigator noted that some positive measures have been made in the Service's mental health strategy since 2005. For example, there is now an institutional mental health initiative and an advanced community mental health policy. Additionally, offenders are screened for mental health problems at admission; a continuum of care model has been put in place to help assist offenders from intake through to their release; mental health awareness training has improved; and more multi-disciplinary intervention teams have been put in place to better manage complex cases.[596]

The Office of the Correctional Investigator identified seven urgent measures associated with mental health that are needed in the federal corrections system. The recommended measures are:

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592 *Changing Directions*.
593 *Changing Directions*.
594 *Changing Directions*.
595 *Changing Directions* at 49.
596 Office of Correctional Investigator Report 2011/2012.

- Create intermediate mental health care units;
- Recruit and retain more mental health professionals;
- Treat self-injurious behaviour as a mental health, not security, issue;
- Increase capacity at the Regional Treatment Centres;
- Prohibit the use of long-term segregation of offenders at risk of suicide or serious self-injury as well as offenders with acute mental health issues;
- Expand the range of alternative mental health service delivery partnerships with the provinces and territories; and
- Provide for 24/7 health care coverage at all maximum, medium and multi-level institutions.[597]

As of 2018, the Office of the Correctional Investigator noted that some progress had been made. There has been a significant decrease in the use of long-term segregation for all inmates, and particularly for offenders with mental health issues. In addition, there has been an increase in intermediate mental health care units. However, many challenges remain. There remains inadequate treatment space for complex mental health cases that cannot be handled within the prison itself. The problem is particularly acute for female inmates. More broadly, there is an unacceptable disparity in the mental health treatment facilities available as between male and female inmates (female inmates having less access to facilities).[598] The Report called for an increase in facilities that females could access.

The Correctional Investigator of Canada recommended directions for reform for mental health issues in federal penitentiaries. Those directions for reform are:

- Alternatives to incarceration for seriously mentally ill;
- Prohibit segregation for mentally ill, suicidal and self-injurious offenders;
- Patient advocates for the Regional treatment Centres;
- Adopt a 'healthy prisons' approach (WHO model);
- 24/7 health care access/ coverage; and
- Segregation reforms not renewal.[599]

[597] *Correctional Investigator Report 2011/2012*.
[598] Correctional Investigator Annual Report 2016/2017 at 58-67.
[599] Canadian Bar association Webinar Series, *Mental Health Issues in Federal Penitentiaries*, by Howard Sapers, Correctional Investigator of Canada (Ottawa: August 6, 2015).

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