

FIRST NATIONS, MÉTIS, AND INUIT PRISONERS' RIGHTS TO HEALTH WITHIN THE PRISON SYSTEM: MISSED OPPORTUNITIES

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Canadian prisons are disproportionately populated with Indigenous people who comprise 28% of the federal prison population. When First Nations, Métis, and Inuit enter the prison system, they do not relinquish their rights to health. Laws, policies, and regulations that affect health care within Canadian prisons exist and are identified in this study to assist in analyzing these rights. The authors interviewed subject matter experts, community leaders, and prison staff regarding the health of prisoners and Indigenous prisoners in particular. The research findings indicate that First Nations, Métis, and Inuit prisoners have domestic, inherent, and international rights to health while imprisoned that may be breached by the federal and provincial governments. The authors provide recommendations that include a dismantling that may entail decar-

Les personnes autochtones sont présentes de façon disproportionnée dans les prisons canadiennes où ils représentent 28% de la population. Lorsque les Premières Nations, Métis et Inuits entrent dans le système carcéral, ils ne renoncent pas à leurs droits à la santé. Ils existent des lois, politiques et règlements qui affectent les soins de santé au sein des prisons canadiennes. Ces derniers sont identifiés dans cette étude afin d'aider dans l'analyse de ces droits. Les auteurs ont interviewé des experts sur le sujet, des dirigeants des communautés et des employés de prisons au sujet de la santé des prisonniers et particulièrement, des prisonniers autochtones. Les résultats de la recherche indiquent les prisonniers issus des Premières Nations, Métis et Inuits ont des droits domestiques, inhérents et internationaux à la santé durant leur emprisonnement, et ces

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ceration or abolition of the current system in favour of approaches designed to promote a better state of health. Additional recommendations are aimed at improving prisoner health while incarcerated or allowing prisoners to serve their sentences in their communities and may entail a restructuring of health care external to the prison system.

droits pourraient être enfreints par les gouvernements fédéral et provinciaux. Les auteurs formulent des recommandations dont un démantèlement pouvant entraîner la décarcération ou l'abolition du système actuel au profit d'approches visant à promouvoir un meilleur état de santé. Des recommandations additionnelles visent à améliorer la santé des prisonniers durant l'incarcération ou à permettre aux prisonniers de purger leur sentence dans leur communauté. Cela peut aussi engendrer une restructuration des soins de santé à l'extérieur du système carcéral.

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INTRODUCTION

Most ongoing research regarding the serious challenges in First Nations, Métis, and Inuit¹ health care is concerned with those living outside of the Canadian prison system. Indigenous people make up about 4% of the Canadian population, yet 28% of federal prisoners are First Nations, Métis, or Inuit, and Indigenous women account for 38% of all admissions to provincial and territorial sentenced custody.²

The Correctional Service of Canada (CSC) is responsible for providing an estimated 23,006 federal prisoners³ with “essential health care” that “conform[s] to professionally accepted standards.”⁴ However, federal prisoners in the Canadian prison system receive substantially varied health care that does not always measure up to that of other Canadians. Howard Sapers, the (then) Correctional Investigator for Canada noted that “[t]he biggest single complaint that my office has received for the last decade has been access to equality of health care, and that’s everything from acute mental health services to dentistry.”⁵

Health care conditions are often worse within provincial and territorial prisons. Mandatory minimum sentences have resulted in prison overcapacity.⁶ From British Columbia to Newfoundland and Labrador, overcrowd-

¹ The terms “First Nations, Métis, and Inuit,” “Aboriginal,” and “Indigenous” are used in this paper. Aboriginal is used where the reference is in a legal context. Indigenous is used in a global sense. First Nation, Métis, and Inuit is used in a general sense, often interchangeably with the term Indigenous. If a specific Nation is identified, their name is used in their own language.

² See Statistics Canada, *Adult Correctional Statistics in Canada, 2015/2016*, by Julie Reitano, Catalogue No 85-002-X (Ottawa: Statistics Canada, 1 March 2017) at 5.

³ See Statistics Canada, *Adult Correctional Statistics in Canada, 2016/2017*, by Jamil Malakieh, Catalogue No 85-002-X (Ottawa: Statistics Canada, 19 June 2018) at 1 [*Correctional Statistics 2016/2017*].

⁴ *Corrections and Conditional Release Act*, SC 1992, c 20, ss 86(1)(a), 86(2) [*CCRA*].

⁵ Adam Miller, “Prison Health Care Inequality” (2013) 185:6 CMAJ 249 at 249.

⁶ See Sean Fine “Mandatory-minimum Sentencing Rules Unravelling into Patchwork”, *The Globe and Mail* (4 March 2018), online: <www.theglobeand-

ing has caused increased use of force and static security measures by staff, decreased access to programs and services, and even reduced time allotted for recreation and fresh air, all of which can lead to incidents of self-injury, feelings of hopelessness, and eventually violence against both prisoners and prison staff.⁷ Reports have indicated a direct correlation between overcrowded facilities and an increase in mental health issues.⁸ Both federal and provincial prisons have a legislated duty to use the least restrictive measures that are consistent with prisoner rehabilitation and community safety.⁹ These institutions must also provide prisoners with health care services, which includes housing them in humane conditions.¹⁰

mail.com/news/national/mandatory-minimum-sentencing-rules-unravelling-into-patchwork/article38205652/ > [perma.cc/XED9-GCR3].

- ⁷ See Public Services Foundation of Canada, “Crisis in Correctional Services: Overcrowding and Inmates with Mental Health Problems in Provincial Correctional Institutions”, (March 2015) at 19–36, online (pdf): <publicservicesfoundation.ca/sites/publicservicesfoundation.ca/files/documents/crisis_in_correctional_services_april_2015.pdf> [perma.cc/3R9B-E243].
- ⁸ See UK, House of Lords and House of Commons: Joint Committee on Human Rights, *Deaths in Custody* (Report of Session) (London: The Stationery Office, 14 December 2004); Criminal Justice Alliance, “Crowded Out? The Impact of Prison Overcrowding on Rehabilitation (March 2012) at 11, online (pdf): <criminaljusticealliance.org/wp-content/uploads/2015/02/Crowded_Out_CriminalJusticeAlliance.pdf> [perma.cc/GP5U-742G].
- ⁹ See *CCRA*, *supra* note 4, s 4(c); Ontario, Ministry of Solicitor General, *Inmate Information Guide for Adult Institutions* (last modified 17 September 2018), online: <www.mcscs.jus.gov.on.ca/english/corr_serv/PoliciesandGuidelines/CS_Inmate_guide.html> [perma.cc/MSR4-WHXE] [*Inmate Guide*]. See also *The Correctional Services Act*, 2012, SS 2012, c C-39.2, s 3 [*Correctional Services Act Saskatchewan*]; *Corrections Act*, RSNWT 1988, c C-22, s 16; *The Correctional Services Act*, SM 1998, c C230, s 2; *An Act respecting the Quebec correctional system*, CQLR c S-40.1, s 1; *Correctional Services Act*, SNL 2011, c C-37.00001, s 4.
- ¹⁰ See *CCRA*, *supra* note 4, s 86 (1)(a); *Inmate Guide*, *supra* note 9. According to the Canadian Centre for Justice Statistics, in 2016–2017, 43% of female adults in custody and 60% of female youth in custody were Aboriginal. Pursuant to the provisions of the *Youth Criminal Justice Act*, SC 2001, c 1, judges have a legislative obligation to consider the use of educational, health, and other social services rather than resorting to carceral options for youth; this requirement should be seen as particularly acute when it comes to Indigenous youth: see *Correctional Statistics 2016/2017*, *supra* note 3 at 13, 17.

This article outlines the current health status of First Nations, Métis, and Inuit prisoners with a focus primarily on the federal system and is presented in four parts. The first section provides the methodology of the study. The second section examines health issues in the prison system by analyzing the legislative framework in conjunction with interviewee experiences. The third section reviews the framework of rights for First Nations, Inuit, and Métis prisoners within Canadian domestic law, Aboriginal law, and under international instruments. The fourth section provides recommendations on how any gaps or breaches in the rights of prisoners may be filled and remedied.

The overarching goal of this work is to present evidence that Indigenous prisoners have both inherent and legislated rights to health protected by domestic and international laws. The recommendations demonstrate how Canadian correctional systems can benefit from a significant and bold reimagining. Such dismantling may entail decarceration and eventual abolition of the current system in favour of approaches designed to promote a better state of health. Further recommendations are aimed at improving prisoner health while incarcerated or allowing prisoners to serve their sentences in their communities and may involve a restructuring of health care external to the prison system.

A. Methodology

The authors reviewed the legislative framework, including relevant laws, policies and guidelines surrounding the placement and treatment of prisoners in both federal and provincial/territorial prisons. Research ethics approvals for the study was obtained by the Research Ethics Board of Brandon University, Manitoba on 16 December 2016 (see Appendix I for consent form and details).

All of the interviews were conducted with those knowledgeable about the prison systems in Canada, although no interviews were conducted in prisons. The research process included a community-engaged examination of the “lived experience” of those who have been or are currently imprisoned, which means that people who have fully served their life sentences and are living in their communities were interviewed. The researchers also canvassed people charged with enforcing prison policies, including staff, volunteers, and board members. Interviews were conducted primarily by Dr. Yvonne Boyer and with one or more of the other authors. Ten research questions were posed (see Appendix II) in a consultative semi-structured discussion format. A total of 34 participants were interviewed through face-

to-face interviews, small and large focus groups, telephone interviews, and through written interviews and correspondence. Data from these interviews were coded and grouped into three categories based on the interviewee's involvement with the prison system: Community Leaders and Stakeholders; Subject Matter Experts, and Prison Staff.

The Community Leaders and Stakeholders group consists of prison rights advocates, representatives of advocacy organizations, investigators, policymakers, lawyers, and managers of halfway houses or addictions treatment centers. Subject Matter Experts are those interviewees who are or have been imprisoned. Due to their lived experience, the authors consider these individuals as having the "PhD" of the prison system. Prison Staff include staff members who currently work in the system or formerly worked in the system and includes nurses and guards.

The researchers conducted their primary research in ten separate sessions consisting of one to two hour in-person interviews or focus groups with a total of 34 participants. The participants were comprised of 12 Community Leaders and Stakeholders, 16 Subject Matter Experts, and six Prison Staff. Some participants completed telephone interviews and written questionnaires in lieu of face-to-face interviews. In all instances, an introductory telephone call was made to discuss the process and objectives of the study, and the authors then delivered a copy of the interview questions and consent forms for participant review. Participant interviews are interspersed throughout this study and informed the entire report. Participants are quoted where applicable while respecting that some participants chose to remain anonymous. The ensuing digitally recorded interviews were transcribed by the authors and coded using a thematic analysis. Responses were coded and grouped in accordance with their responses on each topic or theme. Emerging themes structured the report.

In addition, a literature review of secondary sources, including news articles, peer-reviewed articles, and reports published by non-profit organizations, was conducted to identify potential problems with Indigenous prisoners' access to health care. Finally, the authors examined relevant international instruments and domestic jurisprudence to pinpoint sources of Indigenous prisoners' rights to health to determine whether the current legislative framework is in breach of these rights.

B. Limitations

The sample size in this study is noted to be small, with that of the prison staff category being particularly low. This impacts the generalizability of the interview data, and the conclusions drawn are thus reflective of this fact. This study also does not attempt to ascertain whether CSC policies are properly or adequately applied, nor does this study run simulations or create frameworks to ensure the proper application of recommended policies and instruments.

The lack of CSC data regarding the health of First Nations, Inuit, and Métis prisoners is another limitation. Provincial and federal prisons keep limited data regarding health statistics. It is therefore very difficult to determine the many intersectional issues that can compound health problems. It should also be noted that this study only examined people in prison and not the broader custody system, such as those on parole, probation, or serving conditional sentences.

I. HEALTH ISSUES IN THE PRISON SYSTEM

The health issues prevalent within the Indigenous prisoner population reflect the same health status outside of the prison system. Scholars have described the health status of the First Nations, Métis, and Inuit in Canada as being in crisis.¹¹ Provision of and access to health care services in prison are contingent upon overlapping and competing operational demands and priorities, such as population management and the lack of availability of external health care providers, services, and clinics.¹²

Most federal prisons lack 24/7 health care. Staffing and access to health care can be particularly challenging during the night shift and on weekends, especially in more isolated locations. People often enter the prison system with chronic health conditions. Their health needs are complex and require

¹¹ See e.g. J Reading, *The Crisis of Chronic Disease among Aboriginal Peoples: A Challenge for Public Health, Population Health and Social Policy* (Victoria: University of Victoria, Centre for Aboriginal Health Research, 2009).

¹² See Canada, Office of the Correctional Investigator, *Annual Report 2013-2014 of the Office of the Correctional Investigator*, by Howard Sapers (Ottawa: OCR) at 19, online (pdf): <www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf> [perma.cc/K92T-23XV] [2013-2014 Annual Report].

treatment for a higher than average prevalence of infectious diseases, mental illnesses, and chronic conditions. Health conditions are frequently exacerbated by histories of trauma, substance abuse, or addiction issues. From a determinants of health perspective, First Nations, Métis, and Inuit prisoners are a high-needs population that requires a variety of services and support in prison.¹³

Issues with regard to medications were raised by almost all of the interviewees, including prison staff and the subject matter experts. This study does not purport to provide a complex review of the CSC formulary. Instead, it simply reflects the views of the interviewees. For instance, a registered nurse who works in the federal corrections system shared that prisoners often arrive in a very poor state of health and that the health care they receive while imprisoned may be better than what they had access to before.¹⁴ For other prisoners, the health care realities in the prison system are inhumane. One Subject Matter Expert revealed:

I have many reflections on the lack of health, wellness, dental, [and] emotional care in CSC. This is a culture of punitive punishment that includes health care in prison – especially the culture of ‘chemically restraining’ women in prison. Especially in max – they like to keep women on so much medication, usually anti-psychotic, that they cannot carry out daily activities. Women are punished when they try to come off of medications. Methadone is pushed heavily; so much that we assume there are commissions for employees. This would seem a stretch under regular conditions, however CSC is an unregulated monster and we have no option to seek help to address these problems as our grievance system is not effective.¹⁵

All the Indigenous Subject Matter Experts said they had unpleasant experiences when attempting to access health care. One interviewee shared that “[the nurses] were very rude. Most of them said, ‘Put in a request,’ they didn’t even want to see you. ‘You gotta see the doctor,’ [they said], ‘I can’t do nothing for you, go away.’”¹⁶ Another interviewee said that withhold-

¹³ See *ibid.*

¹⁴ Interview of Prison Staff “PS1” (5 March 2017) [PS1].

¹⁵ Interview of Subject Matter Expert “SM4” (16 April 16) [SM4].

¹⁶ Interview of Subject Matter Expert “SM3” (19 May 2017) [SM3].

ing medication “is used as a form of punishment, especially if you were in segregation. If you’re in segregation forget about it.”¹⁷ Another interviewee shared:

If there is any risk the medication can be addictive, it is not prescribed. [The alternative] however is not as potent. People who are bi-polar or having anxiety, the doctors know what medication works and they can prescribe that, but if it isn’t on the list of non-insured health benefits, it is not prescribed.¹⁸

Several Indigenous prisoners interviewed said they have been reluctant to seek health care and that their health has deteriorated while imprisoned. They also recalled that they were forced to line up outside the building to receive their medications and were concerned about elderly prisoners or those in severe pain having to stand in those long lines. One interviewee shared that “[i]f you have an existing illness, one of the more difficult things is to get continuity in care. If you have a developing illness, it’s difficult to get diagnosed if you’re in corrections.”¹⁹ Another interviewee added, “[A] man went up to [the guards] and said ‘I’m having chest pains.’ They said ‘ok go back to your cell and we will have someone come.’ By the time they got there, he was passed out on the floor and gone. Other guys on the range said it was about two hours. They revitalized him, but he ended up dying.”²⁰ Another interviewee shared a similar story: “A guy in his thirties was healthy but had a heart issue. He died. By the time they realized it was serious, it’s too late. They automatically think it isn’t [serious].”²¹ One participant shared that the biggest issue for him was getting to see the doctors and said it sometimes took months.²² When asked about the biggest barrier to good health when incarcerated, one prison staff interviewee shared:

Sometimes tension[s] within prison, [such as] concerns with security versus timely access to medical care. [Additional barriers include] compliance with treatment plans, low education

¹⁷ Interview of Subject Matter Expert “SM1” (19 May 2017) [SM1].

¹⁸ Interview of Community Leader “CL1” (16 May 2017) [CLI].

¹⁹ SM1, *supra* note 17.

²⁰ *Ibid.*

²¹ Interview of Subject Matter Expert “SM2” (19 May 2017) [SM2].

²² SM3, *supra* note 16

levels, [and] trust of those in positions of authority as most of the clientele are already considered a vulnerable population. We have many with mental illness, long-term addiction issues. They are no longer connected to some family/community support. [They have suffered a] loss of their identity and, for some, loss of their mother tongue[s]. We are starting to see increasing dialects reflective of the diverse population we serve. We seem to trend in funding. One time it was all about Hep C and HIV, now it's mental health. Staffing levels and resources allocated don't always equal the demand for services.²³

Physicians are concerned about the public health risks prisoners pose to the general population when they are released in communities without having been treated for Hepatitis B and C.²⁴ Prison health expert Dr. Fiona Kouyoumdjian noted her concern about the low percentage of prisoners receiving Hepatitis C treatment under CSC's care. She notes that this lack of care raised questions about "whether health care is meeting professionally required accepted standards as required by the *Corrections and Conditional Release Act*."²⁵

The circumstances surrounding the death of Kinew James in a federal prison provide further support for the contention that health care is substandard in these institutions. Ms. James' diabetes and heart condition were largely ignored by the CSC because they considered her calls for help as components of mental health issues. Had Ms. James been in the community, both her heart and her diabetic conditions may have been treated by lifestyle and dietary adaptations. Instead, CSC placed her in segregation for mental health issues and classified her as a maximum-security prisoner. For much of the day before she died, she requested medical attention and described symptoms consistent with the heart attack that ultimately led to her death. Correctional and health records reveal that she was frequently ignored and that her call bell was ultimately disconnected. The night she died, other women in the unit tried to assist Ms. James by pressing their own call buttons when staff, including the nurse on duty, failed to respond to Ms. James' repeated calls for help. By the time the nurse attended, Ms. James was un-

²³ PS1, *supra* note 14.

²⁴ See e.g. Paul Christopher Webster, "Prison Puzzle: Treating Hepatitis C" (2012) 184:9 CMAJ 1017.

²⁵ Paul Christopher Webster, "Prisons Face Hep C-Treatment Funding Crisis" (2016) 188:3 CMAJ 178 at 179.

responsive. She was declared dead when she was finally transported to an outside hospital.²⁶

A lack of responsive access to health care exists within the prison system. Interviewees shared that they were frustrated and felt that their health suffered while they were incarcerated, citing a myriad of concerns, the most prominent being the time it took to access health care. This issue stems from a combination of the prisons system's lack of resources and its lack of trust in prisoners' abilities to identify their own health needs. These issues are especially prevalent amongst overlooked areas of health, such as dental care, geriatric care, mental health, and nutrition.

A. Dental health

Dental care is one aspect of health care delivery that appears to have fallen below the standards of care required by the *CCRA*.²⁷ The Office of the Correctional Investigator's 2016 annual report highlighted an increase in prisoner complaints about dental care. Subject Matter Experts revealed that "some of the dentists are very brutal on how they do their care," one exclaiming they would "never go back to that butcher." One community leader added that when another dentist saw what a CSC dentist had done to their teeth, he commented, "whoever had been practicing like that should not have been."²⁸ The participant added that "the standards that dentists have and doctors have for everyday Canadians have to be met in prison and that is not happening. Bad stitch here, bad work there. There is no third party to

²⁶ See Office of the Correctional Investigator, *Risky Business: An Investigation of the Treatment and Management of Chronic Self-Injury Among Federally Sentenced Women*, (Report) (Ottawa: Office of the Correctional Investigator of Canada, 2013) at 20 [*Risky*]. See also The Canadian Press, "Kinew James Inquest Hears Poorly Managed Diabetes Led to Inmates' Death", *The Toronto Star* (17 May 2017), online: <www.thestar.com/news/canada/2017/05/17/kinew-james-inquest-hears-poorly-managed-diabetes-led-to-inmates-death.html> [perma.cc/92Y2-CY9A].

²⁷ Section 85 of the *CCRA*, *supra* note 4 states "health care means medical care, dental care and mental health care, provided by registered health care professionals or by persons acting under the supervision of registered health care professionals" [emphasis added].

²⁸ CL1, *supra* note 18.

check up on the work.”²⁹ The participant further added, “I have a guy who has been waiting to see the dentist for two months. He has a broken tooth and is in severe pain. Nothing can be done.”³⁰ Another participant shared, “[T]hey go as far to think you cracked it yourself. There is always a basic assumption that the offender is trying to scam something. I was having trouble with my teeth and all they did was rip them out. It’s the cheapest alternative. I told him no, but I was in so much pain in my teeth I had to have it [done].”³¹

Between 2013 and 2015, CSC’s annual budget allocated for dental services was reduced by two million dollars, which translated into a 30% reduction in spending on dental care.³² The effect of this reduction has meant that dental care problems are prioritized and evaluated based on the level of need on a scale of “emergency,” “urgent,” or “routine” (non-essential). Non-essential services have been largely eliminated, meaning that prisoners who normally had annual oral examinations and maintenance dental services now have them every five years, if at all. Due to a reduction in funding for dental professionals, many prisons are only treating severe and urgent cases.³³

B. Geriatric care

In 2015, the proportion of the prisoner population over the age of 50 was over 24%, which was up from 20% in 2011.³⁴ There are serious issues for prisoners who require palliative care inside a CSC facility, as CSC staff often do not have the medical specialization to deal with geriatrics and palliative care. As Correctional Investigator Ivan Zinger noted, “Despite the

²⁹ *Ibid.*

³⁰ *Ibid.*

³¹ SM3, *supra* note 16.

³² See Canada, Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2015-2016* (Ottawa: Office of the Correctional Investigator, 2016) at 12 [*2015-2016 Annual Report*].

³³ See *ibid* at 12–13.

³⁴ See Canada, Office of the Correctional Investigator, *Annual Report 2014-2015 of the Office of the Correctional Investigator* (Ottawa: Office of the Correctional Investigator, 2015) at 10–11.

growing need, there is still no national strategy to address the health care concerns of the ¼ of the inmate population that is now aged 50 or older.”³⁵

C. Mental health

In the Office of the Correctional Investigator’s 2017-2018 Annual Report, it states the following figures for money that has been invested in improving mental health services in federal correctional institutions:

Budget 2017 invested \$57.8 million over five years, starting in 2017–18, and \$13.6 million per year thereafter, to expand mental health care capacity for all inmates in federal institutions. Budget 2018 invested \$20.4 million over five years (starting in 2018-19), and \$5.6 million per year ongoing, to further support the mental health needs of federal inmates, specifically women offenders in federal correctional facilities.³⁶

Yet the suicide rate in the federal corrections system is seven times higher than that of the general Canadian population.³⁷ In many cases, mental health issues are treated as security issues, with self-harming prisoners placed in segregation as a way of controlling them rather than providing them with mental health care.³⁸ The Correctional Investigator has articulated that placing prisoners in physically isolated cells increases their risk of suicide, especially those prisoners who have a prior history of mental illness.³⁹ Prison “lock downs” create additional problems. One interviewee said, “We were locked down for 14 days. One time we were locked down for 31 days. It

³⁵ 2015-2016 Annual Report, *supra* note 32 at 12.

³⁶ Canada, Office of the Correctional Investigator, *Annual Report 2017-2018 of the Office of the Correctional Investigator*, by Ivan Zinger (Ottawa: Office of the Correctional Investigator, 2018) at 4 [2017-2018 Annual Report].

³⁷ See Centre for Addiction and Mental Health, *Mental Health and Criminal Justice Policy Framework* (Toronto: Centre for Addiction and Mental Health, 2013) at 9, online (pdf): <www.camh.ca/-/media/files/pdfs---public-policy-submissions/mh_criminal_justice_policy_framework-pdf.pdf> [perma.cc/8M7K-EXT7] [CAMH].

³⁸ See *ibid* at 23.

³⁹ See *ibid* at 4.

messes with your head.”⁴⁰ The interviewee further noted, “We were locked down for 14 days with one shower. No phone calls. Clothing changed weekly, you get what you get, it could be too small, too big, they don’t care.”⁴¹

Solitary confinement places prisoners in a cell the size of the average hotel bathroom for up to 23 hours a day. Suicide and segregation are connected. Prisoners in segregation are often less able to be reintegrated into society after release, have much less access to programming while imprisoned, and are less likely to be granted release.⁴² Between April 2011 and March 2014, there were 30 recorded suicides in federal prisons, 14 of which occurred while prisoners were in solitary confinement.⁴³ Overall, one third of the prisoners who died by suicide were Indigenous.⁴⁴ Indigenous prisoners are more likely to experience segregation and they remain segregated longer than any other group.⁴⁵ According to the Office of the Correctional Investigator, “[a]s of March 31, 2017, there were 414 offenders in segregation, 151 of whom (36.5%) were Indigenous.”⁴⁶

⁴⁰ SM3, *supra* note 16.

⁴¹ *Ibid.*

⁴² See Native Women’s Association of Canada, *Indigenous Women in Solitary Confinement: Policy Backgrounder* (Policy Report) (Ottawa: Native Women’s Association of Canada, 2017) at 15, online (pdf): <www.nwac.ca/wp-content/uploads/2017/07/NWAC-Indigenous-Women-in-Solitary-Confinement-Aug-22.pdf> [perma.cc/3EUR-RYAA].

⁴³ Canada, Office of the Correctional Investigator, *A Three Year Review of Federal Inmates Suicides (2011-2014)* (Ottawa: Office of the Correctional Investigator, 2014) at 10, online (pdf): <www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20140910-eng.pdf> [perma.cc/QDF8-2QMJ] [*Three Year Review*].

⁴⁴ *Ibid.*

⁴⁵ See Canada, House of Commons, *Indigenous Peoples in the Federal Correctional System: Report of the Standing Committee on Public Safety and National Security* (June 2018) (Chair: John McKay) at 10, online (pdf): <publications.gc.ca/collections/collection_2018/parl/x76-1/X76-1-1-421-22-eng.pdf> [perma.cc/KE7P-9F37] [*Report of the Standing Committee*].

⁴⁶ Canada, Office of the Correctional Investigator, *Annual Report 2016-2017 of the Office of the Correctional Investigator* (Ottawa: Office of the Correctional Investigator, 2017) at 41, online: <www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20162017-eng.pdf> [perma.cc/59D2-VFFV].

One of the biggest mental health challenges for First Nations, Métis, and Inuit women is the federal classification system. Many Indigenous women are classified as “high risk,” often meaning they will spend more time in segregation and have less access to culturally relevant programming. Over 90% of First Nations, Métis, and Inuit women prisoners have reported a history of physical or sexual abuse. In most cases where Indigenous women are incarcerated for violent crimes, such as murder or manslaughter, they were reacting to violence perpetrated against them – often defending either themselves or their children.⁴⁷ Yet due to the violent nature of their offence, these women are considered “high risk.”

Although “Aboriginal women accounted for nearly 45% of all self-injury incidents involving the federally sentenced women offender population,”⁴⁸ the effect of the CSC classification system is to deny access to mental health programming to those who may need it the most. If a woman is self-harming in prison, the prison staff will use this as evidence that she is not adjusting well to prison life and will often place her in maximum security.⁴⁹ In 2013, guards at a CSC prison witnessed a women self-harming and responded by placing her in a segregation cell. The nurse on duty stated that she knew this would escalate the situation, but that she did not want an incident on her watch.⁵⁰ Counterintuitively, one of the most common responses by CSC when women are self-harming is to place them in solitary confinement,

⁴⁷ Before the Standing Committee on Public Safety and National Security, Senate of Canada, Dr. Ivan Zinger stated, “The rate among indigenous women with respect to self-harm and suicide attempts is off the charts, much higher than for non-indigenous women.” House of Commons, Standing Committee on Public Safety and National Security, *Evidence*, 42-1, No 82 (7 November 2017) at 9:00 (Dr. Ivan Zinger).

⁴⁸ *Risky*, *supra* note 26 at 3.

⁴⁹ See Ontario Women’s Justice Network, “Over-Represented and Over-Classified: Crisis of Aboriginal Women in Prison” (1 June 2014), online: <owjn.org/2014/06/over-represented-and-over-classified-crisis-of-aboriginal-women-in-prison/> [perma.cc/3YDQ-7TCG]; Mandy Wesley, *Marginalized: The Aboriginal Women’s experience in Federal Corrections* (Ottawa: Aboriginal Corrections Policy Unit, Public Safety Canada, 2012), online (pdf): <www.publicsafety.gc.ca/cnt/rsrscs/pblctns/mrgnlzd/mrgnlzd-eng.pdf> [perma.cc/RJG8-T74F].

⁵⁰ SM3, *supra* note 16.

which often only escalates the self-harming and exacerbates the problems.⁵¹ After conducting a review of federal inmate suicides the Office of the Correctional Investigator concluded, “A major finding of this review, one that is repeatedly supported by the literature, is that suicide rates are more prevalent in physically isolated cells (segregation, observation and mental health cells) than in general population cells. The literature is also clear that physical isolation and separation increases the risk of suicidal behaviour.”⁵²

First Nations, Métis, and Inuit prisoners have very limited access to culturally appropriate programs and services and are less likely than other prisoners to receive mental health care.⁵³ In addition, female Indigenous prisoners often do not have access to mental health supports and services that address their unique challenges.⁵⁴ Considering that 75% of imprisoned Indigenous women have children under the age of 18,⁵⁵ this is a problem as prisons are often located a long distance away from family, which may exacerbate mental health issues. The distance also makes it difficult for family members to visit and to attend court hearings, especially for those who may not be able to afford to travel. Most suicide prevention policies prohibit a prisoner from having family visits or making phone calls. For example, observation placements may include:

...among other measures, mandatory strip search, issuance of anti-suicide garments, removal of personal items, constant direct observation (via closed-circuit television, staff or both), limited association and restricted access to showers, visits and phone calls. These factors can be expected to elevate rather than reduce suicidal tendency. Behaviours driven by underlying mental illness are not modified or corrected by measures that are perceived to be punitive or depriving.⁵⁶

Despite research and community-based practices to the contrary, prison mental health officials have argued that certain stressors, including family

⁵¹ See *Risky*, *supra* note 26 at 16, 20, 30.

⁵² *Three Year Review*, *supra* note 43 at 15.

⁵³ See *CAMH*, *supra* note 37 at 10.

⁵⁴ See *ibid* at 10.

⁵⁵ See *Report of the Standing Committee*, *supra* note 45 at 24.

⁵⁶ *Three Year Review*, *supra* note 43 at 16.

visits, can increase suicide risk.⁵⁷ Based on the information gathered in the interviews and in other reports, it appears that mental health issues in the prison system are complex and varied. The factors that contribute to mental health crises are violence, overcrowding, isolation, poor health services, lack of culture and loss of identity, lack of privacy, and solitary confinement.

D. Nutrition

Cook chill technology has become the norm in federal and provincial correctional services nutrition services. The cook chill program is a process whereby meals are cooked, bagged, and rapidly chilled to extend shelf life. Large prisons prepare food and flash freeze it before shipping to smaller institutions.⁵⁸

In 2002, the Ministry of Correctional Service of Ontario entered into an agreement with the Compass Group, the world's largest food preparation company, to operate the cook chill food program at the Maplehurst Correctional Centre in Milton, Ontario.⁵⁹ Correctional Service Canada has stated that the cook chill meals served to prisoners must meet certain nutritional standards and that menus have been reviewed by a registered dietician. These "standards" are based on the minimum requirements set out by the Canada Food Guide. Cook chill food systems allow the food to be prepared in advance, chilled, and then reheated for serving.⁶⁰ The system may be compared to the highly processed dinners from the 1950s. This system

⁵⁷ See *ibid* at 26.

⁵⁸ See Kathleen Harris, "Audit flags risk of 'food-related health event' in Canadian prisons", *CBC* (8 June 2019), online: <www.cbc.ca/news/politics/prison-food-csc-audit-1.5167222> [perma.cc/EV9X-87F3].

⁵⁹ See "Ministry of Correctional Services Enters Public-Private Partnership With Compass Group", *Lexpert* (11 January 2002), online: <lexpert.ca/article-print/ministry-of-correctional-services-enters-public-private-partnership-with-compass-group/?p=14%7C119%7C210&sitecode=lex> [perma.cc/WHM8-7R9S].

⁶⁰ See Correctional Service Canada, *Communiqué to Inmates of Pacific Region: Food Service Modernization* (1 October 2014), online: *CBC News* <www.cbc.ca/news/canada/british-columbia/prison-food-after-cutbacks-called-disgusting-and-inadequate-by-b-c-inmates-1.2989657> [perma.cc/3HSC-FEKD]. See also Correctional Service Canada, *Audit of Food Services* (Ottawa: CSC, 14 January 2019) at 8, online (pdf): <www.csc-scc.gc.ca/publications/092/005007-2547-en.pdf> [perma.cc/7755-FZTQ] [*Audit of Food Services*].

may be compared to the ready-to-heat pre-packaged dishes available on the market, a higher consumption of which has been associated with increased abdominal obesity.⁶¹ Since the implementation of the cook chill food preparation system, many prisoners have complained of diarrhea, vomiting, and malnourishment. One interviewee remarked, “They make you eat it, so then you are sick and they don’t give you anything for it.”⁶² Jean-Paul Aubee, a prisoner in a British Columbia prison, described in an interview with CBC News how prisoners are getting sick from the food and that he “shakes a lot because of malnutrition.”⁶³ Another prisoner interviewed in the course of the present study shared:

So when you get your meat and all that, it’s green because it’s been in that steam thing for I don’t know how long... green roast beef or whatever it is. And all the vegetables, any good stuff that was in, it’s probably been steamed out 2 hours ago.⁶⁴

Other examples of poor nutritional food options include a report from another participant that prisoners sometimes make a soupy concoction of Doritos and ramen noodles purchased from the canteen instead of consuming the meals served by CSC.⁶⁵ A prisoner from the CBC News interview reported finding a worm in his canned peaches to which the kitchen staff responded him “it’s extra protein... just move it out...it’s fine.”⁶⁶

Nutrition and portion control came up as a pressing issue amongst participants as all prisoners are served the same type and portions of food,

⁶¹ See Ala’a Alkerwi, Georgina E Crichton & James R Hébert, “Consumption of Ready-made Meals and Increased Risk of Obesity: Findings from the Observation of Cardiovascular Risk Factors in Luxembourg (ORISCAV-LUX) Study” (2015) 113:2 Br J Nutr 270 at 273.

⁶² SM3, *supra* note 16.

⁶³ Natalie Clancy, “Prison Food After Cutbacks Called Disgusting and Inadequate by B.C. Inmates”, *CBC News British Columbia* (11 March 2015), online: <www.cbc.ca/news/canada/british-columbia/prison-food-after-cutbacks-called-disgusting-and-inadequate-by-b-c-inmates-1.2989657> [perma.cc/C3XW-JMRN] [*Prison Food Called Disgusting*].

⁶⁴ SM3, *supra* note 16.

⁶⁵ Interview of Subject Matter Expert “SM5” (13 December 2016).

⁶⁶ *Prison Food Called Disgusting*, *supra* note 63.

irrespective of their age, weight, and size.⁶⁷ There are also major issues for those with eating disorders. In the prisons for women who are not subject to the cook chill program and are allowed to make their meals in kitchens in living units, a single woman with bulimia can consume all the food in an entire living unit, which results in nutritional, emotional, and other related implications among and between women.⁶⁸ An interviewee also noted that food or withdrawal from food is used as a form of punishment by CSC. Indeed, the interviewee had weight issues and had to be placed on a weight management diet. He was found cheating on his diet, so CSC took him off his weight management diet as a form of punishment.⁶⁹

II. THE LAW

Canadian prisons are disproportionately filled with Indigenous people who comprise 28% of the federal prison population.⁷⁰ This part outlines legal principles that may establish Indigenous rights to health. Such rights, the authors argue, are encompassed in section 35 of the *Constitution Act, 1982*.⁷¹ A further examination of the *Corrections and Conditional Release Act* and the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)* illustrates the unfulfilled legal obligations that the Government of Canada, through CSC, has in relation to First Nations, Métis, and Inuit prisoners. This section also compares and analyzes current CSC policies against these rights to determine any gaps or breaches under Canadian or international law.

A. Domestic Canadian law

CSC is governed by the *CCRA* and is the administrative body tasked with implementing the *CCRA*'s purpose. The stated purpose of the *CCRA* is to “contribute to the maintenance of a just, peaceful, and safe society by carrying out sentences imposed by courts through the safe and humane

⁶⁷ See *Audit of Food Services*, *supra* note 60 at 21–22.

⁶⁸ Interview of Senator Pate (24 May 2017) [*Pate Interview*].

⁶⁹ Interview of Subject Matter Expert 6 (24 November 2016).

⁷⁰ See *2017-2018 Annual Report*, *supra* note 36 at 61.

⁷¹ s 35, being Schedule B to the *Canada Act 1982* (UK), 1982, c.11.

custody and supervision of prisoners.”⁷² CSC is responsible for supervising prisoners serving a minimum sentence of two years, either in custody or in the community.⁷³ In addition to the obligations CSC has towards all prisoners, the *CCRA* outlines additional duties CSC has towards Indigenous prisoners. Sections 79, 80, 82, and 83 of the *CCRA* require CSC to make Indigenous-specific programs and services available to Indigenous prisoners, and sections 81 and 84 provide for the direct involvement of Indigenous communities in supporting timely conditional releases.

The *CCRA* also outlines CSC’s specific health care responsibilities. Section 85 of the *CCRA* defines health care as “medical care, dental care and mental health care, provided by registered health care professionals.”⁷⁴ Section 86 states that the CSC must provide prisoners with “(a) essential health care; and (b) reasonable access to non-essential mental health care” that conforms to professionally accepted standards.⁷⁵ Non-essential mental health care is, however, limited only to that which “will contribute to the inmate’s rehabilitation and successful reintegration into the community.”⁷⁶ The *CCRA* does not define “essential” and “reasonable,” which could be interpreted as “sufficient” by CSC staff. “Sufficient” should certainly not mean anything less than the basic health care that other Canadians have access to.

The *CCRA* further outlines health care considerations. For example, section 87 provides that CSC shall consider prisoners’ health care needs and overall health status “(a) in all decisions affecting the offender, including decisions relating to placement, transfer, administrative segregation and disciplinary matters; and (b) in the preparation of the offender for release and the supervision of the offender.”⁷⁷ When CSC administers health care to prisoners, the former must get the latter’s consent before administering any treatment. Section 88(1) states, “(a) treatment shall not be given to an

⁷² *CCRA*, *supra* note 4, s 3.

⁷³ See Correctional Service Canada, “Legislation” (14 March 2017), online: *Government of Canada* <www.csc-scc.gc.ca/victims/003006-3000-eng.shtml> [perma.cc/X8QH-78TV].

⁷⁴ *CCRA*, *supra* note 4, s 85.

⁷⁵ *Ibid*, s 86.

⁷⁶ *Ibid*.

⁷⁷ *Ibid*, s 87.

inmate, or continued once started, unless the inmate voluntarily gives an informed consent thereto; and (b) an inmate has the right to refuse treatment or withdraw from treatment at any time.”⁷⁸ Despite these legal obligations, all the Subject Matter Experts confirmed the Correctional Investigator’s criticism of the poor state of health in prisons, stating that essential and basic health care needs are not being met.

Consent is clearly an issue in the correctional system that was raised in the interviews. A Subject Matter Expert shared that she was sent to administrative segregation for refusing to take a sleeping pill that was being distributed by the medical team during a 24-hour lock down. As a former nurse, she was aware of the drug they were distributing and knew they were distributing it for management purposes.⁷⁹ Another interviewee shared that “during lock down, they increased the number of drugs they give so people sleep all day long. If you wanted anything, they will give it to you. They drug everyone up.”⁸⁰

Informed consent requires the capacity to understand what the treatment is and why it is being administered, as well as the potential risks, results, side effects, and alternatives.⁸¹ It also means that a prisoner has the right to refuse any treatment or withdraw from a treatment at any time.⁸² According to the *CCRA*, the only circumstances in which consent to treatment shall be considered involuntary is when it is a requirement for a temporary absence, work release, or parole.⁸³ The issues surrounding informed consent are particularly prevalent when it comes to body cavity searches, use of psychotropic medications and other chemical restraints, as well as mental health related sedation. How many medical professionals in the community would consider a patient as giving informed consent if she arrived at their clinic in shackles and/or with armed guards present?

⁷⁸ *Ibid.*, s 88.

⁷⁹ Interview of Subject Matter Expert 7 (19 May 2017).

⁸⁰ SM3, *supra* note 16.

⁸¹ See e.g. *Hopp v Lepp*, [1980] 2 SCR 192, 112 DLR (3d) 67; *Reibl v Hughes*, [1980] 2 SCR 880, 114 DLR (3d) 1.

⁸² See *CCRA*, *supra* note 4.

⁸³ See *ibid.*

The random use of CSC discretion is another glaring issue identified by the Subject Matter Experts and seems to be supported by the *CCRA*. The *CCRA* provides ample room for the generous exercise of discretion by CSC staff, who appear to implement the legislation in such a narrow fashion that one could argue it is creating policy that effectively fetters the legislative authority of the Minister. Individual discretion is core to the management of CSC as it is mandated to develop national policies and directives particular to individual prisons.

Policy can also be amended from within CSC, not just imposed through legislation. Commissioners Directives and policy bulletins lay out the broad policy for all CSC prisons.⁸⁴ For example, effective 1 August 2017, certain prisoners are not admissible to administrative segregation, and other prisoners will only be admissible under exceptional circumstances, such as when the warden deems it operationally necessary. Prisoners with “serious mental illness with significant impairment” and prisoners “actively engaging in self-injury which is deemed likely to result in serious bodily harm or at elevated or imminent risk for suicide” are no longer admissible to administrative segregation. Yet on a monthly basis, groups like the Canadian Association of Elizabeth Fry Societies continue to document the routine and systemic flouting of these policies.⁸⁵

Criminology Professors Crichton and Ricciardelli noted a turn in federal policy direction with the change from a Conservative to Liberal government in 2015.⁸⁶ For instance, the Harper government introduced 61 bills relating to crime during its ten years in power, 20 of which became law.⁸⁷ At the same time, statistics indicate an increase in negative health indicators in

⁸⁴ See Correctional Service of Canada, *Administrative Segregation (Commissioner's Directive)*, CD 709 (Ottawa: Correctional Service of Canada, 1 August 2017), online: <www.csc-scc.gc.ca/politiques-et-lois/709-cd-eng.shtml> [perma.cc/H793-E43M] [CD 709]; Correctional Service of Canada, *Policy Bulletin 571* (Ottawa: CSC, 1 August 2017), online: <www.csc-scc.gc.ca/005/006/571-pb-eng.shtml> [perma.cc/CSG6-QZMZ]; Correctional Service of Canada, *Administrative Segregation Guidelines*, GL 709-1 (Ottawa: CSC, 1 August 2017), online: <www.csc-scc.gc.ca/politiques-et-lois/709-1-gl-eng.shtml> [perma.cc/A6TD-3TPW].

⁸⁵ See CD 709, *supra* note 84; *Pate Interview*, *supra* note 68.

⁸⁶ See Hayley Crighton & Rose Ricciardelli, “Shifting Grounds: Experiences of Canadian Provincial Correctional Officers” (2016) 41:4 *Crim J Rev* 430 at 435.

⁸⁷ For an example of a crime-related bill introduced under the Harper govern-

federal prisoners along with an annual increase in the numbers of black, female, and Indigenous prisoners.⁸⁸ In (the then) Justice Minister Wilson-Raybould's mandate letter, Prime Minister Trudeau told her to reduce the rate of incarceration amongst Indigenous Canadians, introduce more rehabilitative measures, and implement the Ashley Smith inquest recommendations, which include abolishing long-term solitary confinement.⁸⁹ On 19 June 2017, Minister Wilson-Raybould introduced Bill C-56, *An Act to amend the Corrections and Conditional Release Act (CCRA) and the Abolition of Early Parole Act (AEPA)*.⁹⁰ This Bill proposed legislating a time limit for prisoners to remain in administrative segregation and imposing independent oversight in the form of an Independent External Reviewer for any prisoner held in segregation longer than the proposed limit. The limit would be set at 21 days for the first 18 months the legislation were in force, and 15 days thereafter. The government touted this Bill as one that would put Canada's federal legislation in line with the *Mandela Rules* with regards to administrative segregation and that it would be a step towards implementing the Ashley Smith Recommendations.⁹¹ However, neither Minister Wilson-Raybould nor her successor has spoken to the Bill since its introduction in 2017, signaling that the government may have decided not to proceed with it.

ment, see Bill C-10, *Safe Streets and Communities Act*, 1st Sess, 41st Parl, 2012 (assented to 13 March 2012).

⁸⁸ See Patrick White, "Federal Prisons Have Become Less Deadly, Crowded Under Liberals, Numbers Show", *The Globe and Mail* (16 March 2017), online: <www.theglobeandmail.com/news/national/federal-prison-conditions-improve-under-liberal-rule-new-data-says/article34335089/> [perma.cc/U3MR-XXZ2].

⁸⁹ See Mandate Letter from Rgt Hon Justin Trudeau, Prime Minister of Canada to Minister of Justice and Attorney General of Canada (12 November 2015), online: *Office of the Prime Minister* <pm.gc.ca/eng/minister-justice-and-attorney-general-canada-mandate-letter> [perma.cc/B4CP-JGF8].

⁹⁰ Bill C-56, *An Act to amend the Corrections and Conditional Release Act (CCRA) and the Abolition of Early Parole Act (AEPA)*, 1st Sess, 42nd Parliament, 2017 (first reading 19 June 2017).

⁹¹ The Mandela Rules outline principles for the respectful treatment of prisoners on the basis of their value as human beings possessing inherent dignity. See *The United Nations Standard Minimum Rules for the Treatment of Prisoners (The Nelson Mandela Rules)* UNGAOR, 70th session, annex, A/RES/70/175 [*Mandela Rules*]; UN, Office on Drugs and Crime, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules): note by the Secretariat*, UN Doc A/C.3/70/L.3 (2015).

Bill C-83, *An Act to amend the Corrections and Conditional Release Act and another Act*, received Royal Assent on 21 June 2019.⁹² It is touted as ending segregation while establishing a number of measures to strengthen the federal correction system, including:

- ending administrative segregation and disciplinary segregation;
- creating “structured intervention units” and establishing a process for reviewing the decision to confine an inmate in such a unit;
- allowing the use of body scanners as a way to prevent the introduction of illegal substances into federal correctional institutions;
- setting out a series of factors that must be taken into account when making any decision affecting an Indigenous offender;
- supporting the professional autonomy and independence of health care professionals;
- establishing a network of patient advocates; and
- facilitating victims’ access to the audio recordings of certain Parole Board of Canada hearings.⁹³

Senator Kim Pate has been vocal in her opposition to this Bill:

Rather than ending segregation, Bill C-83 rebrands administrative segregation as “structured intervention units.” It allows the Commissioner of the Correctional Service of Canada to designate any unit or penitentiary as a structured intervention

⁹² See Bill C-83, *An Act to amend the Corrections and Conditional Release Act and another Act*, 1st Sess, 42nd Parl (assented to 21 June 2019), SC 2019, c 27.

⁹³ See Canada, Parliamentary Information and Research Service, *Legislative Summary of Bill C-83: An Act to amend the Corrections and Conditional Release Act and another Act*, by Lyne Casavant & Maxime Charron-Tousignant, Publication No 42-1-C83-E (Ottawa: Library of Parliament, 2019) at 1, online (pdf): <lop.parl.ca/staticfiles/PublicWebsite/Home/ResearchPublications/LegislativeSummaries/PDF/42-1/c83-e.pdf> [perma.cc/HXW7-932R].

unit without imposing restrictions on the nature or number of cells. This creates the risk that an ever-increasing number of prisoners will be segregated – an all-too-easy answer to managing mental-health issues and other needs that should be addressed through community supports rather than by restrictive confinement.⁹⁴

On 28 March 2019, the Ontario Court of Appeal held that the CSC must establish a system of review whereby no inmate will be kept in administrative segregation for more than five working days without the placement decision being reviewed and upheld by a senior official who is neither the institutional head of the institution where the inmate is incarcerated nor a person who is subordinate to that institutional head.⁹⁵ A Structured Intervention Unit Advisory Panel has also been appointed to review the changes to CSC segregation units. These changes to the Correctional facilities will be made by 30 November 2019⁹⁶. It remains to be seen whether SIUs are effective, or if they are just another name for segregation.

The will of the governing administration can have an important and profound impact on the way that prisons are run. Improvements in prison health care may be achieved more effectively via shifts in management culture than through major changes to legislation. Senator Kim Pate argues that current policy already provides the tools to improve prisoner health, and that solutions must come from the proper application of existing legislation and infrastructure.⁹⁷ A strong proponent of decarceration, Senator Pate believes that prisoner health can be improved through the consistent application of the *CCRA*. Existing exchange of service agreements between provinces and territories can be used to transfer prisoners from penitentiaries into ap-

⁹⁴ Senator Kim Pate, “Solitary by Another Name Is Just as Cruel”, *The Globe and Mail* (16 November 2018), online: <www.theglobeandmail.com/opinion/article-solitary-by-another-name-is-just-as-cruel/> [perma.cc/9XBE-B5F2].

⁹⁵ See *Corporation of the Canadian Civil Liberties Association v Canada (AG)*, 2019 ONCA 342 at para 22.

⁹⁶ See Public Safety Canada, News Release, “Government Appoints Expert Advisory Panel to Monitor New Correctional System” (6 September 2019), online: *Government of Canada* <www.canada.ca/en/public-safety-canada/news/2019/09/government-appoints-expert-advisory-panel-to-monitor-new-correctional-system.html> [perma.cc/E9HJ-GWPK].

⁹⁷ *Pate Interview*, *supra* note 68.

propriate health and mental health programs, preferably in the community where there are other supplementary housing and social assistance supports.

B. Aboriginal Law

Aboriginal and treaty rights are recognized and affirmed in Canadian law through section 35 of the *Constitution Act, 1982*. First Nations, Métis, and Inuit persons possess these important rights that are not extinguished upon incarceration. Nor do Indigenous peoples lose their section 35 constitutional Aboriginal and treaty rights while incarcerated. The fact that these rights exist in the Constitution, Canada's highest law, means they engage the principle of constitutional supremacy. Constitutional supremacy places constitutional rights above and beyond the reach of changes by ordinary legislation and "provides an added safeguard for fundamental human rights and individual freedoms that might otherwise be susceptible to government interference."⁹⁸ Placing Aboriginal and treaty rights within the Constitution situates them squarely within the power of constitutional supremacy principles and, as such, they cannot be unilaterally altered by CSC or any government body.⁹⁹ Canada therefore has a responsibility to ensure that these rights are implemented in laws and policies, including those in the correctional system. In addition, the fiduciary relationship and ensuing obligations that characterize the relationship between Canada and First Nations, Métis, and Inuit Peoples may be readily extended to the area of health and health care in the prison system.

The distinct Crown-Indigenous fiduciary relationship is reflected in the *Royal Proclamation of 1763*, where the British Crown stated that settlers were not to disturb "the several Nations or Tribes of Indians with whom We are connected, and who live under our Protection" and their lands.¹⁰⁰

⁹⁸ *Re Reference by the Governor General in Council Concerning Certain Questions Relating to the Secession of Quebec*, [1998] 2 SCR 217 at para 74, 161 DLR (4th) 385.

⁹⁹ See Peter W Hogg, *Constitutional Law of Canada*, 2018 student ed (Ontario: Thomson Reuters, 2018), s 28–34.2.

¹⁰⁰ See Aboriginal Affairs and Northern Development Canada, *Royal Proclamation of 1763: Relationships, Rights and Treaties*, Catalogue No R5-14/2013-1-PDF (Ottawa: AANDC, 2013), online (pdf): <www.publications.gc.ca/site/eng/456020/publication.html> [perma.cc/L6FN-4QUJ]; Mary C Hurley, "The

This “protective” relationship between Indigenous peoples and the Crown reflected a “guardian and ward” relationship, whereby the Crown presumed it has complete control, discretion, and decision-making abilities over Indigenous peoples.¹⁰¹

The Crown’s discretionary control over the daily lives of First Nations, Métis, and Inuit prisoners arguably establishes this fiduciary obligation. The Supreme Court of Canada (SCC) stated in *Wewaykum Indian Band v Canada* that fiduciary duties do not need to necessarily arise from section 35 rights. Rather, the nature of the relationship is determined by the amount of Crown “discretionary control...sufficient to ground a fiduciary obligation.”¹⁰² The SCC further established in *Blueberry River Indian Band v Canada* that the Crown’s fiduciary duties apply to all Indigenous interests and will arise whenever the Crown has power and control, translating into discretion, over Indigenous peoples’ interests.¹⁰³ The SCC has also noted that fiduciary obligations arise in certain contexts: “There must be a legal interest that the Crown is in a position to exercise its discretion and the Aboriginal group must be vulnerable as a result of the Crown discretion.”¹⁰⁴

The issue of a Crown-Indigenous fiduciary duty in the prison system was denied when brought before the Federal Court in 2015 in *Ewert v Canada*. In his judgment, Justice Phelan addressed the issue stating:

Despite Ewert being Aboriginal, CSC does not have an overarching fiduciary duty to him. While the government may be in a fiduciary relationship with its Aboriginal population, that does not equate with a fiduciary duty. This is especially so

Crown’s Fiduciary Relationship with Aboriginal Peoples” (2002) Parl Lib Research Pub at 1.

¹⁰¹ See Yvonne Boyer, “First Nations, Métis and Inuit Health Care: The Crown’s Fiduciary Obligation” (2004) National Aboriginal Health Organization at 20.

¹⁰² *Wewaykum Indian Band v Canada*, 2002 SCC 79 at para 83. See also Hurley, *supra* note 100 at 4.

¹⁰³ See generally *Blueberry River Indian Band v Canada (Department of Indian Affairs and Northern Development)*, [1995] 4 SCR 344, 130 DLR (4th) 193.

¹⁰⁴ *Frame v Smith*, [1987] 2 SCR 99 at para 136, 42 DLR (4th) 81. See also *Hodgkinson v Simms*, [1994] 3 SCR 377, 117 DLR (4th) 161.

given the several different obligations owed to others, including the safety of the public mandated by the legislation...¹⁰⁵

Justice Phelan's dicta at the federal court trial level may not be settled law as it is unclear how the safety of the public could completely override a Crown-Indigenous fiduciary duty. The Supreme Court in *Ewert*¹⁰⁶ did not assist in the clarification of the fiduciary argument as the case involved a *Charter* breach and a breach of statutory duty involving culturally inappropriate psychological and risk assessment tools. The fiduciary conversation was quickly dismissed. It was, however, helpful in articulating that Indigenous prisoners require unique services.

The *Ewert* case established that the Crown delegates authority through CSC, including all discretionary control over the health of Indigenous prisoners. The inclusion of sections 81 and 84 in the *CCRA* authorizes the delegation of authority to Indigenous communities;¹⁰⁷ the Commissioner's Directives that are meant to "respond to specific needs of Aboriginal offenders [sic] by providing effective interventions, through a continuum of care model,"¹⁰⁸ as well as the SCC decision that CSC violated section 24(1) among other policy and legislative directives, demonstrates that the federal government recognizes that Indigenous prisoners are vulnerable in the prison system and are entitled to specific and unique services and rights in and outside the prison system.

Unquestionably, the Crown exerts discretionary control over CSC which means that employees of CSC may be serving as agents of the Crown. As agents of the Crown, and given the amount of power and control they exert over prisoners, CSC officers may have fiduciary obligations towards Indigenous prisoners. In short, the federal government recognizes the Crown-

¹⁰⁵ *Ewert v Canada (Commissioner of the Correctional Service of Canada)*, 2015 FC 1093 at para 86.

¹⁰⁶ *Ewert v Canada*, 2018 SCC 30 [*Ewert*].

¹⁰⁷ See *CCRA*, *supra* note 4, ss 81, 84. See also Correctional Service Canada, "Aboriginal Community Development in Corrections: Enhancing the Role of Aboriginal Communities Booklet" (2015), online: <www.csc-scc.gc.ca/aboriginal/11-eng.shtml> [perma.cc/8UXC-EK9V].

¹⁰⁸ Canada, Correctional Service Canada, *Aboriginal Offenders (Commissioner's Directive)*, CD 702 (Ottawa: Correctional Service Canada, 12 November 2013), online: <www.csc-scc.gc.ca/acts-and-regulations/702-cd-eng.shtml> [perma.cc/L4KH-6VRP].

Indigenous fiduciary relationship and the ensuing fiduciary obligations.¹⁰⁹ These obligations, coupled with the meaning of Aboriginal and treaty rights that First Nations, Métis, and Inuit peoples possess, have largely been ignored by the federal and provincial prisons systems when implementing their health care policies through the *CCRA*.¹¹⁰

C. *International Law*

In addition to fiduciary responsibilities and the rights entrenched in section 35 of the *Constitution Act, 1982*, the United Nations clearly lays out a right to health that appears in a variety of instruments, declarations, and conventions within the United Nations framework of rights, to which Canada is a signatory.¹¹¹ The right to health includes the right to health care

¹⁰⁹ The Government of Canada recognizes that it must uphold the honour of the Crown, which requires the federal government and its departments, agencies, and officials to act with honour, integrity, good faith, and fairness in all of its dealings with Indigenous peoples. The honour of the Crown gives rise to different legal duties in different circumstances, including fiduciary obligations and diligence. The overarching aim is to ensure that Indigenous peoples are treated with respect and as full partners in Confederation: See e.g. Canada, Department of Justice Canada, *Principles Respecting the Governance of Canada's Relationship with Indigenous Peoples* (Ottawa: Department of Justice Canada, July 2017) at 3, online: <www.justice.gc.ca/eng/cs/sj-c/principles-principes.html> [perma.cc/U8GS-SDWU].

¹¹⁰ Modern land claims are treaties and include Inuit and Métis. Historically, the inclusiveness of Métis in the treaties has been a contentious issue. Although some say that only First Nations could sign a treaty, there are certain instances that Métis were included in the treaties, such as the adhesion to Treaty 3 as well as Métis in the Robinson Superior Treaty of 1850. While many Métis claim that the *Manitoba Act, 1870* was a treaty, many more Métis were initially included in a number of other treaties and then excluded under later amendments to the *Indian Act*: see University of Ottawa, "Prof. Larry Chartrand starts new research program entitled 'Métis Treaties in Canada: Past Present and Future' funded by the Social Sciences and Humanities Research Council", online: <cdp-hrc.uottawa.ca/en/prof-larry-chartrand-starts-new-research-program-entitled-Métis-treaties-canada-past-present-and> [perma.cc/Y2N9-KERG].

¹¹¹ See *United Nations' Universal Declaration of Human Rights*, GA Res 217A (III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810 (1948), art 25; *United Nations Declaration on the Rights of Indigenous People*, GA Res 61/295, UNGAOR, 2007, art 21.1 [UNDRIP]; *International Covenant on Economic, So-*

and may encompass the right to a culturally appropriate health care system. Health is a fundamental human right that, without other rights, may not be exercised. Such other rights include:

... the right to food; the right to adequate housing; the right to education; the right to work and rights at work; the right to life; the right to information; the right to physical integrity; the right to be free from discrimination on any ground, including gender, race, religion, sexual orientation, and disability; and the right to self-determination.¹¹²

As with other human rights, the right to health is aimed at improving conditions for the disadvantaged and vulnerable, while advancing basic standards of equality and non-discrimination. There is no evidence that these important rights are extinguished upon entry into the corrections system.

1. United Nations Declaration on the Rights of Indigenous Peoples

The *UNDRIP* remains a forceful and important instrument in directing implementation of the right to health and in defining the rights that Indigenous prisoners possess. *UNDRIP* was developed to protect the rights and interests of Indigenous peoples around the world, rights which cannot be effectively implemented through piecemeal policy changes.¹¹³ *UNDRIP*

cial and Cultural Rights, GA Res 2200A (XXI), UNGAOR, 1966, 16 December 1966, art 12.

¹¹² Yvonne Boyer, "First Nations, Métis, and Inuit Women's Health: A Right-Based Approach" (2017) 54: 3 *Alta L Rev* 611 at 622. See also Office of the High Commissioner for Human Rights, *The Right to the Highest Attainable Standard of Health*, UNCECSR, 22nd Sess, UN Doc E/C.12/2000/4 (2000) at paras 1, 30–45, 51; *The Iowa City Appeal in Advancing the Human Right to Health*, adopted 22 April 2001 by the Global Assembly on Advancing the Human Right to Health, convened at the University of Iowa, Iowa City, Iowa, 20–22 April 2001, at 3 (prior to all other treaties and conventions, the UDHR advanced the international recognition of the interdependence and indivisibility of human rights).

¹¹³ See Indigenous Bar Association, *Understanding and Implementing the UN Declaration on the Rights of Indigenous Peoples* (Winnipeg: Indigenous Bar Association, 2011) at 8, 15 online (pdf): <www.indigenousbar.ca/pdf/undrip_handbook.pdf> [perma.cc/B2JW-ALF3].

calls for a holistic approach to effecting change to systems, to governance language, and to rights and to freedoms for Indigenous peoples worldwide.

UNDRIP provides a framework for a rights-based approach to the health of Indigenous prisoners under international law. The Declaration recognizes the right to health both as a self-standing right and as a right that is joined with and interdependent with other rights. These other rights include the right to non-discrimination and the right to the improvement of economic and social conditions. Of significance is Article 21.1 which states that “Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.”¹¹⁴ Article 24.2 requires that States ensure Indigenous peoples have an equal right to the enjoyment of the highest attainable standard of physical and mental health by taking the necessary steps, with a view to achieving progressively, the full realization of this right.¹¹⁵ These provisions demonstrate that special measures must be taken to ensure that the physical, emotional, and mental health of Indigenous prisoners is protected.

In addition to specific rights under *UNDRIP*, international law has a body of prisoner protections that Canada must follow and which may be invoked when reviewing the implementation of Indigenous prisoners' rights to health.¹¹⁶ Although international law is not in itself legally binding in the domestic capacity, it is a forceful tool for setting the parameters of a rights-based approach that is inclusive of the fiduciary relationship and ensuing obligations and the articulated health principles found in *UNDRIP* and other international instruments. These instruments solidify a rights-based approach to health that is anchored in domestic and international law and further advances the goals of an equality-based health care approach within corrections in Canada.

¹¹⁴ *UNDRIP*, *supra* note 111, art 21.1.

¹¹⁵ See *ibid*, art 24.

¹¹⁶ See e.g. *The International Covenant on Civil and Political Rights*, UNGAOR, 1966, UN Treaty Series vol 999 (1966) 171; *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*, UNGAOR, 1988, GA Res 43/173 (1988); *Convention on the Rights of Persons with Disabilities*, UNGAOR, 2006, A/RES/61/106 (2006); *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UNGAOR, 1984, GA Res 39/46 (1984).

III. RECOMMENDATIONS

Prisons do not improve health care, nor do they adequately address the health care issues of prisoners. Moreover, the prison system exacerbates most health issues and many mental health and serious physical health issues are born in prison. Canadian prisons are disproportionately filled with Indigenous people who account for 28% of the federal prison population although they comprise only 4.9% of the Canadian population.¹¹⁷ Based on interviews with Community Leaders and Subject Matter Experts, two main themes developed that show the importance of implementing a health care framework that is cognizant and reflective of the constitutionally protected and international rights of First Nations, Métis, and Inuit people.

A. *Decarceration and abolition*

Some advocate for alternatives to changing policies to make prisons healthier, including the promotion of decarceration of prisoners and, possibly, the abolition of prisons altogether. Abolitionist Arthur Waskow explains:

Forget about reform; it's time to talk about abolishing jails and prisons in American society . . . Still - abolition? Where do you put the prisoners? The 'criminals'? What's the alternative? First, having no alternative at all would create less crime than the present criminal training centers do. Second, the only full alternative is building the kind of society that does not need prisons: A decent redistribution of power and income so as to put out the hidden fire of burning envy that now flames up in crimes of property both burglary by the poor and embezzlement by the affluent. And a decent sense of community that can support, reintegrate and truly rehabilitate those who suddenly become filled with fury or despair, and that can face them not as objects-'criminals'-but as people who have committed illegal acts, as have almost all of us.¹¹⁸

Prison abolition is a solution that has been brought up frequently to approach the issue of vital needs not being met inside prisons. Rather than attempting

¹¹⁷ See 2017-2018 Annual Report, *supra* note 36 at 61.

¹¹⁸ Fay Knopp & Jon Regier, *Instead of Prisons: A Handbook for Abolitionists* (Syracuse, NY: Prison Research Education Action Project, 1976) at 15–16.

to “fix” the health system that exists within, perhaps a more creative approach could be taken in addressing these issues, since health professionals are limited in what they can do under CSC’s management. CSC controls the financial resources for health care inside prisons, creating a power dynamic regarding prisoner access to the basic health care required to be healthy and functioning.¹¹⁹

Waskow argues that health should be addressed by health professionals and not “criminal training centres.” An unfortunate reality is that often prisoners who are suffering from mental health concerns are turned away or, alternatively, prison is used as a means by which these individuals in need are displaced to another system, to take “very difficult patients” off health providers’ hands. As one Subject Matter Expert explained, “They are very happy to say, ‘we don’t want you in our emergency room, we don’t want you in our hospital, we don’t want you in our clinic.’ And if you happen to be involved in the criminal justice system, they thank their lucky stars they can just call the police and get rid of you.”¹²⁰

Some argue that prison abolition would result in individuals with mental illnesses being housed in asylums, an arguably greater evil. Certainly, if prisons were abolished without developing adequate community-based supports, the rise of asylums could be a real risk. Indeed, the de-institutionalization or “normalization” movements in the 1960s and 1970s, which focused on integrating those with disabling mental illnesses and intellectual disabilities, contributed to the disproportionate incarceration of these groups. Systematic dismantling of community-based services and social safety nets results in increasing numbers of the most marginalized ending up in the streets, in jail, or dead. As such, given the cuts to social services, health care, and education over the past two decades, the concerns regarding prison abolition accompanied by a new system that is not grounded in the community, developed by the community, or sufficiently resourced, are legitimate. It is essential that any new system provides safety and support and does not strip prisoners’ fundamental health rights.¹²¹

Abolition critics have also identified potential consequences for individuals who the government considers as requiring forensic institutional care. They argue that the amount of time these individuals would spend in a

¹¹⁹ Interview of Howard Sapers (May 25 2017).

¹²⁰ *Ibid.*

¹²¹ *Ibid.*

mental health hospital is greater than the time they would spend in prison. In comparison, most non-racialized and neurotypical prisoners with six-month sentences have a good chance of being conditionally released to finish their sentence in the community at, or shortly following, the four-month or two-thirds mark of their sentence. Most prisoners with mental health issues are identified by corrections staff as being in prison primarily because of their debilitating mental health issues, but do not meet the Not Criminally Responsible criteria.¹²² That should not, however, prevent the development of a process to adequately address their health needs while simultaneously addressing any real or perceived public safety concerns. If the focus is on social, cultural, and economic determinants of good mental health, we would likely not recreate the current approaches that result in prisoners' needs being ignored, neglected, or exacerbated in prison.

Professor Angela Davis proposes that schools may be used as an alternative to prison or, rather, used as a “vehicle for decarceration.”¹²³ Additionally, other programs aimed at addressing societal issues such as colonial patriarchy, state violence, racism, homophobia, transphobia, class bias, and other forms of patriarchal dominance can serve as alternatives to incarceration.¹²⁴ Professor Davis is a proponent of using education to review typical societal standards that will help policymakers and society at large better understand and embrace differences rather than fear them, which would ultimately lead to an improved health status.

Senator Kim Pate affirms that “[t]here is no excuse for not actually looking at community-based options. There is no excuse anymore.”¹²⁵ Continuing to use resources to make prison “better” is not creating solutions. Senator Pate believes that current laws already provide the necessary tools to improve prisoner health and that solutions must come from properly applying existing legislation via policy development, financial reallocation of resources, and enhancement of community-based services and infrastructure.¹²⁶ A strong proponent of decarceration, Senator Pate argues that pris-

¹²² See *ibid.*

¹²³ See Angela Y Davis, *Are Prisons Obsolete?* (Toronto: Publishers Group Canada, 2003) at 108.

¹²⁴ See *ibid.*

¹²⁵ *Pate Interview*, *supra* note 68.

¹²⁶ *Ibid.*

oner health can be improved through the consistent application of the *CCRA* and by moving people out of the prison system and into the community.

B. Prison health services integration

In addition to planning for long-term abolition and decarceration, an immediate and positive contribution to prisoner health would be to transition the responsibility for health care away from federal and provincial corrections departments to health departments. Competing interests arise when health care is provided by the corrections system instead of the regional department responsible for health. As of November 2017, the only regions which have transferred responsibility for prisoner health to the regional public health authority are Nova Scotia, Alberta, and most recently British Columbia. British Columbia's transfer of responsibility on 1 October 2017 ended their previous reliance on an externally sourced private contractor for prisoner health services.¹²⁷ This shift is consistent with the World Health Organization's (WHO) position, outlined in the 2003 *Moscow Declaration* and other supporting documents, that "prison health services cannot be adequately provided in isolation from other health and social service."¹²⁸ The WHO recognizes that prison health must not only be integrated with public health services, but that "effective and systematic action for the improvement of health genuinely uses all available measures in all policy fields."¹²⁹

¹²⁷ See British Columbia Provincial Health Services Authority, News Release, "BC Corrections Health Care Services – from private provider to public sector" (28 April 2017), online: <www.bcmhsus.ca/about/news-stories/news/2017/bc-corrections-health-care-services-from-private-provider-to-public-sector> [perma.cc/6CEF-WFVE]. Both Alberta and Nova Scotia have already shifted health care responsibilities to provincial health departments: see Alberta Health Services, News Release, "Communique - Corrections Amendment Act" (2011), online: <www.albertahealthservices.ca/info/Page5803.aspx> [perma.cc/7VCP-744B]; The College of Family Physicians of Canada, Prison Health Program Committee, Community of Practice in Family Medicine, "Position Statement on Health Care Delivery" (14 July 2016), online (pdf): <www.cfpc.ca/uploadedFiles/Directories/Committees_List/Health%20Care%20Delivery_EN_Prison%20Health.pdf>.

¹²⁸ World Health Organization, *Prisons and Health* (Copenhagen: World Health Organization, 2014) at 2, online (pdf): <http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf> [perma.cc/6ZNM-Q5Q9].

¹²⁹ *Ibid.*

The WHO has called for the integration of health care services in prisons with regional and national systems, as well as an isolation of such services from corrections departments.¹³⁰

Transitioning prisoner health care to health departments would address many current shortcomings, such as challenges related to continuity of care, access to medication, and competing interests between security and health care. Integrating health care services would eliminate existing discrepancies, ensuring equal access for all prisoners. However, such a transition must be accompanied by an increase in funding equivalent to the increase in responsibility placed upon health agencies. Lack of access to preventative and high-quality health care practitioners was one of the top issues identified by many of those interviewed and must be addressed regardless of the department responsible. The West Coast Prison Justice Society notes that British Columbia prisons may only have a single physician on staff.¹³¹ This means that health care is not available 24/7. It also means that, should a prisoner lodge a complaint against the physician, the physician would be unable to treat the patient until the complaint had been formally resolved. This may result in a prisoner withholding valid concerns, or in a prisoner not having access to timely medical treatment.

In addition, health and health care are threaded throughout the Truth and Reconciliation Commission of Canada's (TRC) *Calls to Action*.¹³² Calls 30 and 31 specifically call upon governments to eliminate the overrepresentation of Indigenous people in custody and to provide adequate funding to alternatives to incarceration.¹³³ Reporter Nancy MacDonald compares both incarceration and residential schools in her article entitled "Canada's Prisons Are the 'New Residential Schools'" where she articulates the impact

¹³⁰ See *ibid*.

¹³¹ See Letter from Jennifer Metcalfe, Prisoners' Legal Services, to Laurie Throness, Parliamentary Secretary for Corrections, British Columbia (15 January 2014) at 18–19, online (pdf): <prisonjustice.org/wp-content/uploads/2018/12/Letter-to-Mr.-Throness.pdf> [perma.cc/9WBD-MV57].

¹³² See e.g. Truth and Reconciliation Commission of Canada, *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada*, (Final Report) (Winnipeg: Truth and Reconciliation Commission, 2015) at 143, online (pdf): <www.trc.ca/assets/pdf/Honouring_the_Truth_Reconciling_for_the_Future_July_23_2015.pdf> [perma.cc/4ZY9-J34G].

¹³³ See *ibid* at 324.

that Canadian laws have had on First Nations, Métis, and Inuit people in relation to both their overrepresentation within the prison system as well as their sub-standard mental, physical and spiritual health conditions.¹³⁴

The implementation of the TRC recommendations and the integration of prisoners' health services may improve the health status of Indigenous prisoners and provide an interim system, while the corrections is dismantling into a system that favours the overall promotion of a better state of health. At a minimum, there should be an external, oversight process to ensure there are comparable standards for health services both in and out of prison, which would be consistent with the *Nelson Mandela Rules* for the treatment for prisoners.¹³⁵

CONCLUSION

The rights in section 35 of the *Constitution Act, 1982* cannot be unilaterally amended by the federal government or by provincial or territorial governments. Any ambiguities in constitutional rights and statutory rights must be interpreted in favour of Aboriginal peoples. This type of analysis illustrates that all First Nations, Métis, and Inuit peoples have an inherent (Aboriginal) right, and possibly a treaty right, to health defined in a holistic manner, inclusive of mental, spiritual, emotional and physical health. These rights must be recognized and implemented.

The experts interviewed for this study clearly reveal that living inside correctional systems is detrimental to one's health. Participant responses regarding physical health ranged from lack of vitamins to death by neglect or apathy. Mental health responses have shown that the current system is failing miserably. Based on the research herein, CSC must shift the way in which it delivers health care services to prisoners. More specifically, CSC must change how it addresses the physical and mental health care needs of First Nations, Métis, and Inuit prisoners. Essentially, "[t]he purpose of the federal correctional system is to contribute to the maintenance of a just, peaceful, and safe society by carrying out sentences imposed by courts

¹³⁴ See Nancy MacDonald, "Canada's Prisons Are the 'New Residential Schools'", *Macleans* (18 February 2016), online: <www.macleans.ca/news/canada/canadas-prisons-are-the-new-residential-schools/> [perma.cc/B2BC-LVPT].

¹³⁵ See *Mandela Rules*, *supra* note 116, rule 24.

through the safe and humane custody and supervision of offenders.”¹³⁶ This provision affirms the need for the safe and humane treatment of all prisoners, especially vulnerable or targeted populations.

This paper posits that First Nations, Métis, and Inuit prisoners have a cause of action claiming abrogation and/or derogation of Aboriginal rights and/or treaty obligations while imprisoned. International laws and standards including the *UNDRIP* strengthen such rights. Additionally, an examination of the legal history of health care in Canada, as applied to Indigenous peoples, leads to the conclusion that Aboriginal rights and treaty rights have been effectively disregarded or ignored by CSC when implementing health policies.

This article has presented evidence showing that Indigenous prisoners have rights to health that are protected by domestic and international laws. The recommendations provide justification for a deconstruction and reconstruction process. This dismantling may entail decarceration and eventual abolition of the current system in favour of approaches designed to promote a better state of health. In addition, recommendations suggest that improvements for prisoner health status may entail a restructuring of health care external to the prison system.

It is well past time to relieve CSC of this responsibility and ensure that community-based, culturally appropriate, relevant and Indigenous law compliant supports and services are developed and resourced immediately to replace this most ineffective and expensive current reality. The human, social, and financial costs of allowing the current system to continue unchecked is a travesty.

¹³⁶ *CCRA*, *supra* note 4, s 3.

APPENDIX I

Consent of Participants

First Nations Métis and Inuit Health and the Law- a Study in Health Practices: Do First Nations, Métis and Inuit Inmates have Aboriginal and Treaty Rights to Health Within the Prison System?

The Indigenous Health Law Centre at Brandon University

A. Purpose of the Project

The goal of this project is to examine the interaction of law and health in Canada, focusing specifically on how the law impacts on health. The research objective this project is the collection of health policies that affect the health of First Nations, Métis and Inuit Inmates within the Prison System. Health is defined as physical, mental, spiritual and emotional. We are garnering information about several health related issues within the prison system including access to health care, dental care, mental health services, spiritual and cultural health services and the food quality and quantity.

Considering the health care of First Nations, Métis and Inuit is in crisis with sky rocketing diabetes, cardiovascular diseases, HIV/Aids, mental health issues and addictions, the impacts of establishing an Aboriginal and/or treaty right to health will have far reaching impacts. This project comprises a portion of the research program of the Canada Research Chair in Aboriginal Health and Wellness as well as an integral aspect of the (proposed) Indigenous Health Law Centre at Brandon University. The Director of the Centre and Chair, Dr. Yvonne Boyer is a Barrister and Solicitor and examines the interaction of law and health in Canada, focusing specifically on the legal-health interface for Aboriginal peoples. Her research evaluates existing local, regional, national and international health care policies and guidelines in the context of current and emerging Canadian and international law.

Correctional Service Canada (CSC) is responsible for providing an estimated 15,055 federal prisoners with “essential health care” that “conform[s] to professionally accepted standards,”¹³⁷ Howard Sapers, the correctional investigator for Canada notes that “[i]n fact the biggest single complaint that my office has received for the last decade has been access to equal-

¹³⁷ *CCRA*, *supra* note 4.

ity of health care, and that's everything from acute mental health services to dentistry."¹³⁸ Both federal and provincial prisons have a duty to provide health care services to inmates which includes housing them in humane conditions.¹³⁹

Considering the high statistics of Aboriginal people in the correction system, legal questions arise. The purpose of this research project is to illuminate relevant legal principles that would assist in determining if Aboriginal and treaty rights to health exist for Aboriginal people who are incarcerated and if so, is there a breach of these constitutionally protected rights through the health care they access while in prison. This project has the potential to influence policy, legislation and the laws in Canada in relation to Aboriginal health care and to improve health care status within the prison system. The overall purpose of the research is to provide a comprehensive base of knowledge that will inform further action that will lead to positive change.

This project is funded by the Law Foundation of Ontario and the term of the project is November 14, 2016 to November 14, 2017.

B. Collection

It is important to note that we are NOT seeking any information that you or your community considers confidential, sacred or protected knowledge and specifically ask that you do not share this information. We rely solely on your judgment to determine this.

C. Objectives

The following are specific objectives that help to better understand health practice information:

1. To document health practices within the correctional system in Canada. Health practices will include methods that prevent disease, treat disease and maintain good health (including mental health).
2. To document policy and policy practices within the correctional system in Canada. Policy and policy practices will include methods

¹³⁸ Miller, *supra* note 5 at E249.

¹³⁹ See *CCRA*, *supra* note 4; *Inmate Guide*, *supra* note 9.

that prevent disease, treat disease and maintain good health (including mental health).

You will be contacted by phone, email and/or in person by Dr. Yvonne Boyer or a Research Assistant, to discuss the issues directly related to your field of expertise. We will ask you to answer questions prepared in an open ended, semi-structured questionnaire and talk with you about your understanding and observations on the subject matter raised during the telephone or in person interview. The interview should not last more than one hour. The interview will be tape-recorded and transcribed for analysis. The Research Assistant will be delegated by Dr. Boyer to assist in or conduct interviews and is bound by a Confidentiality Agreement to hold in confidence any information gathered in the course of these interviews.

Follow-up availability may be necessary to clarify issues raised during the interview that may either not be clear to the researchers or need further explanation.

D. Rights of the Participant

Your participation in this research project is optional and you have the right to withdraw at any time and/or refuse to answer any questions. In the unlikely event of a harm related event occurring, you do understand that you may take legal action.

E. Confidentiality

If you indicate that you wish your identity to be confidential, you will not be personally identified in the final report or other documents. We are only seeking unclassified information that can be released to the public or for promotional purposes. If you do not wish to be identified please do not share confidential information, such as names or any identifying characteristics. If you do not wish to be identified, then anonymity will be maintained and irrevocably stripped of direct identifiers, a code is not kept to allow future re-linkage, and risk of re-identification of individuals from remaining indirect identifiers is low or very low and once that occurs you will be unable to withdraw your consent. If you wish, and it is preference of the researchers, that you be identified as an expert in your field of knowledge. You may withdraw this consent up to any time before publication of the research materials.

I do **not** want to be identified _____ (initial)

I consent to being identified _____ (initial)

F. Ownership, Control, Access and Possession (OCAP)

The Indigenous Health Law Centre implements the OCAP principles in its research with First Nation, and Métis and Inuit individuals communities and nations. This means that you as a First Nation research subject will own, in perpetuity, the material you provide to the researchers; you also have the ability to control what information you provide before and after the interview; you have the ability to access this material at any time after the interview, you will also be contacted for verification of the information that you have provided in transcription on a jump drive or CD and hard copy and you will be provided a copy.

You are:

- under no obligation to participate; are free to withdraw at any time without prejudice to pre-existing entitlements by sending the PI Dr. Boyer a written request that you wish to withdraw;
- will be given, in a timely manner throughout the course of the research project, information that is relevant to your decision to continue or withdraw from participation; and

you are given information on your right to request the withdrawal of data including any limitations on the feasibility of that withdrawal. For instance once your information is anonymized it will be impossible to withdraw your consent.

All taped data and transcribed material will be kept in a secure location, held by the Indigenous Health Law Centre at Brandon University for an indefinite period. Your information will not be sold, rented or accessed by a third party for any reason. Access to the data collected will be limited to the research team who are qualified and authorized by the Principle Investigator. Should you have any question or comments concerning your rights as a research subject, we invite you to contact Principal Investigator: Dr. Yvonne Boyer at 613-276-4362, at boyery@brandonu.ca, yboyer@gmail.com. If you have questions on ethical issues please contact Brandon University Research Ethics Office (BUREC) burec@brandonu.ca at (204) 727-9712.

I consent that I have read and understand the foregoing. I consent to be audio and/or videotaped for this interview.

Name:

Address:

Date:

Printed name

Signature

Witness

Date:

Printed name

Signature

2 original copies to be signed, one for participant and one for researcher.

APPENDIX II**Research Questions, Dr. Yvonne Boyer****Canada Research Chair in Aboriginal Health and Wellness****Director the Indigenous Health Law Centre****First Nations Métis and Inuit Health and the Law- a Study in Health Practices: Do First Nations, Métis and Inuit Inmates have Aboriginal and Treaty Rights to Health Within the Prison System?**

1. Please tell us how you came to have any knowledge of the health status of First Nation, Métis or Inuit within the correctional system in Canada? Has the health status changed to the negative or positive since incarceration?
2. Is this firsthand experience or you relaying knowledge heard from other people? If so who and what relationship are they to you? Please give details of when and where this was discussed.
3. Please tell us how you came to have any knowledge of the application of policies that affect the health status of First Nation, Métis or Inuit health status within the correctional system in Canada?
4. How do you think the policies have affected the health status of First Nation, Métis or Inuit health status within the correctional system in Canada?
5. Do you have any knowledge of how does the Non-Insured Health Benefits Policy applies given their “payor of last resort policy”?
6. Do you think the health care that Aboriginal people receive is inferior to the health care received by others in the prison system or is it that inadequate health care in the community is related to their conflict with the law and over-representation in prisons and jails?
7. What changes do you think have to be made to positively affect the health status of First Nation, Métis or Inuit health within the correctional system in Canada?
8. Would you agree to review the transcription of today’s interview for accuracy?

9. Do you have any suggestion on who we can contact for further information?
10. Where can we send the transcripts of today's interview, name, and mailing address?

