

# Health Law in Canada

Editor-in-Chief: Gilbert S. Sharpe, B.A., LL.B., LL.M.

Co-Editor-in-Chief: David N. Weisstub, M.A., J.D.

September 2011

VOLUME 32, NUMBER 1

Pages 1-28

## • CANADIAN PRISONERS WITH MENTAL HEALTH PROBLEMS: THE PROMISE (AND LIMITS) OF THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES •

H. Archibald Kaiser, Professor at the Schulich School of Law, Dalhousie University

### I. Prisons as Part of the Criminalization Process: Warehousing People with Mental Health Problems

Although the focus of this article is on the remedial potential of the *Convention on the Rights of Persons with Disabilities* (the “*Convention*” or the “*CRPD*”) for Canadian prisoners with mental health problems, the social dynamics that result in imprisonment for these citizens start much earlier.

At the margins of societies, vulnerable people are subject to the confluence of many destabilizing cross-currents. Increasing social inequality, coupled with the paring of social services budgets in an atmosphere of public fiscal restraint, produce more unsupported citizens living in poverty. Socio-economic deprivation provides the fertile soil for the causation, exacerbation or prolongation of mental illness and co-occurring substance abuse and creates a constellation of factors associated with criminality. The reaction by society to people who may be

agitated, troubled, disruptive and depressed, who are in crisis and come into contact with the justice system, is often punitive rather than respectful, compassionate and remedial. Many citizens experiencing mental health difficulties who become offenders are deprived of their liberty and are relegated to prisons out of fear, desperation, lack of perceived alternative responses and prejudice.

The grimly inevitable result of this cycle is that penal facilities evince an increasing overrepresentation of persons with mental health problems. The needs of these inmates frequently remain unmet. When they are released back into society, they face the double stigma of criminality and mental illness. Many become less able to meet the challenges of community life and are thereby more susceptible to re-offend. These cycles are seldom arrested and are replicated in many societies. They carry destructive effects for individuals and permit terrible societal waste and neglect. Moreover, many states, including Canada, seem determined to use the criminal law and the sanction of incarceration even more widely and repressively, despite their unproven effectiveness and deleterious effects on this segment of the population.

This article will examine the worst excrescence of the criminalization<sup>1</sup> process, the burgeoning population of offenders with mental illness who are jailed and then neglected. The distinctive, and often intensified, problems faced by young persons, women and Aboriginal people will not be explored in this introductory article, as each of these groups of

### • IN THIS ISSUE •

#### Canadian Prisoners with Mental Health Problems: The Promise (and Limits) of the *Convention* of the Rights of Persons with Disabilities

H. Archibald Kaiser.....1

#### Giving Voice — Decade Three of Protecting Mental Health Patients Rights in Alberta

Fay Orr.....24

**HEALTH LAW IN CANADA**

**Health Law in Canada** is published four times a year by LexisNexis Canada Inc., 123 Commerce Valley Drive East, Markham, Ontario L3T 7W8

© Gilbert Sharpe 1997-2011

All rights reserved. No part of this publication may be reproduced or stored in any material form (including photocopying or storing it in any medium by electronic means and whether or not transiently or incidentally to some other use of this publication) without the written permission of the copyright holder except in accordance with the provisions of the *Copyright Act*. Permissions requests should be addressed to Gilbert Sharpe, c/o LexisNexis Canada Inc.

ISBN 0-433-46756-4 ISSN 0226-88411

ISBN 0-433-46757-1 (PDF)

ISBN 0-433-46758-8 (Print & PDF)

Subscription rates: \$350 per year (Print or PDF)

\$435 per year (Print & PDF)

Please address all editorial inquiries to:

Boris Roginsky, Journals Editor

LexisNexis Canada Inc.

Tel. (905) 479-2665; Fax (905) 479-2826

E-mail: hlic@lexisnexis.ca.

**EDITORIAL BOARD**

EDITOR-IN-CHIEF:

**Gilbert S. Sharpe**, B.A., LL.B., LL.M.

CO-EDITOR-IN-CHIEF:

**David N. Weissstub**, M.A., J.D.

ASSOCIATE EDITORS:

**Julio Arboleda-Flórez**, M.D., Ph.D. • **Raisa Deber**, Ph.D. • **Barry Hoffmaster**, M.A., Ph.D. • **Hugh M. Kelly**, Q.C., B.A., LL.B. • **Mary A. Marshall**, LL.B., LL.M. • **Nyranne S. Martin**, Centre for Addiction and Mental Health • **Dr. William L. Orovan**, B.Sc., M.B.A., M.D., F.R.S.C.(C), FACS • **Madame Justice Ellen Picard**, B.Ed., LL.B., LL.M. • **Madame Justice Anne H. Russell**, B.A., LL.B. • **Ronald Stokes**, M.D., D.Psych., F.R.C.P.(C.) • **Deanna L. Williams**, B.Sc., PEBC, R.Ph., CAE

INTERNATIONAL EDITORS:

**Belinda Bennett**, University of Sydney, Australia • Prof. **John D. Blum**, Loyola University, U.S.A. • Prof. **Brian Bromberger**, University of New South Wales, Australia • Prof. **E. Deutsch**, Juristisches Seminar der Universität, Göttingen, West Germany • **Kate Diesfeld**, Auckland University of Technology, New Zealand • **Ian Freckelton**, La Trobe University, Australia • Prof. **Michael Freeman**, University College London, University of London, England • **Joseph Jacob**, LSE, England • Prof. **John Leverette**, Queen's University, Canada • Dr. **Alexander McCall Smith**, University of Edinburgh, Scotland • **Laurence R. Tancredi**, New York University, U.S.A.

**Note: The articles included in Health Law in Canada reflect the views of the individual authors. Health Law in Canada is not intended to provide legal or other professional advice and readers should not act on information contained in this**

prisoners requires separate concentration. The ubiquity of this general phenomenon will be described and its Canadian manifestation will be surveyed. The painfully slow and incomplete journey from the civil death of prisoners towards the recognition of full citizenship will be plotted. Then, the reformist potential of international human rights law will be assessed, first in its general pronouncements and later in the guise of the *Convention on the Rights of Persons with Disabilities*. After a brief overview of the paradigm shift required by the *CRPD* and its principal substantive provisions, several of its key themes which relate to the needs of prisoners with psychosocial disabilities will be developed. This *Convention* will not be portrayed as a panacea for all of the dysfunctional elements of society that crystallize into today's sad reality wherein penal institutions house too many people with mental illness. Instead, it will be concluded that the *CRPD* offers some unique legal tools and normative promises that ought to have salutary effects on an otherwise bleak situation for Canadian prisoners with mental health problems.

**II. A Ubiquitous Social Problem**

The examination of a few contemporary international sources demonstrates the ubiquity of the unwarranted and damaging use of the criminal law in reacting to people with mental health problems, which results in their being confined to penal institutions.

The United Nations Office on Drugs and Crime ("UNODC") *Handbook on Prisoners with Special Needs*<sup>2</sup> ("the Handbook") chapter on "Prisoners with mental health care needs" starts with the troubling observation that "A disproportionately large number of prisoners have mental health care needs",<sup>3</sup> noting that "several million prisoners worldwide had serious mental disabilities". Although all inmates "are at risk of developing a range of mental disabilities", the UNODC cites a wide range of causal factors, which exaggerate the effects of imprisonment, such as "overcrowding, various forms of violence, enforced solitude or lack of privacy, lack of meaningful activity, isolation from social networks, inadequate health services, especially mental health services".<sup>4</sup> The Handbook identifies broader social influences that make the resort to imprisonment more probable, including assumptions of dangerousness, societal intolerance to behavioural irregularities, poor access to community-based treatment and other supportive services and the propensity to punish as opposed to an inclination to

divert and rehabilitate.<sup>5</sup> Moreover, once imprisoned, inmates' vulnerabilities increase as they face obstacles in attaining access to justice, impoverished institutional health care services, poor physical conditions, magnification of discrimination and stigma and vastly increased risks of being victims of assaultive behavior and self-harm.<sup>6</sup>

A matching picture has been painted by the World Health Organization,<sup>7</sup> ("WHO") which establishes that of nine million prisoners worldwide, "At least half" have personality disorders, while one million live with psychosis or depression, "Nearly all prisoners experience depressed moods or stress symptoms" and "several thousand prisoners take their own lives".<sup>8</sup> The WHO list of issues within prisons that adversely affect inmates largely replicates the UNODC account and concludes that "the cumulative effect of all these factors, left unchecked, is to worsen the mental health of prisoners" and "increase the likelihood" of aggression and self-harm.<sup>9</sup>

The UNODC and WHO reports summarize data from a very wide range of national surveys, so it is useful to examine the situation in the United States and the United Kingdom, countries frequently chosen as Canadian comparators, before focusing on Canada. Early in the 21st century, American public policy analysts began recognizing this penological and human rights crisis. The Sentencing Project, while concerned about the understatement of the incidence of inmates with mental illness, reported that "jails and prisons have become the institutions most likely to house the mentally ill",<sup>10</sup> as the population shifted from hospitals, to the point where the proportion of prisoners with mental health problems was at "a vastly higher level than their proportion within the general population",<sup>11</sup> a "'revolving door' between jail and the street".<sup>12</sup> The Criminal Justice Mental Health Consensus Project recorded the recent "social experiment" of the "unprecedented increase in the number of people who are incarcerated", creating challenges where "few, if any, are more formidable than operating a comprehensive mental health service delivery system for inmates".<sup>13</sup> The Bazelon Center for Mental Health Law contended that, among the "Large numbers of individuals with mental illnesses ... in jail or prison today", "their growing numbers and the severity of their problems have recently raised concerns to new levels in criminal justice circles".<sup>14</sup> More contemporary American studies, while noting the wide variance of prevalence estimates "depending on methodology and setting"<sup>15</sup>

and that "no measure of functional impairment was used", concluded that "the volume of inmates entering jails with serious mental illnesses is substantial",<sup>16</sup> "three to six times that rate of serious mental illnesses in jails compared to the rest of the population".<sup>17</sup>

The United Kingdom is comparable, with high prevalence levels (recording "psychiatric morbidity", inmates with "two or more mental health problems", among "72% of male and 70% of female sentenced prisoners")<sup>18</sup> and an overall negative assessment: "From first contact with the police to release from prison, people with mental ill health who come into conflict with the law often find that their mental health needs are neglected ...".<sup>19</sup> One British writer, a prison official, concluded in 2009, that U.K. (and other nations') prisons "should not be a dumping ground for people with mental illness. The misuse of prison to address apparent public safety by incarcerating people with significant mental illness in prison is an abuse of power, and an infringement of human rights".<sup>20</sup>

This international data confirms the overuse of imprisonment for offenders with mental illness and the unsuitability, indeed actual harms inflicted, by a penal system which has never allocated the necessary resources nor developed the capabilities to serve inmates with mental health problems. To what extent are these verdicts replicated in Canada?

### **III. The Canadian Variant: A Similar Source of Shame**

#### **A. Poor Grades in Most Reports**

In this part, a range of sources will be used to demonstrate the depth of despair for Canadian prisoners with mental health problems. There appears to be unanimity that there are serious shortfalls in the delivery of services, despite the fact that both governments and the Correctional Service of Canada have accepted the reality of this deficiency and have started to reinvest in mental health care. The section also explains the considerable disquiet over the future, with the certainty that the current tide of criminal law "reforms" will result in more people being incarcerated, with predictable bad effects on the mental health of the inmate population.

Acquiring a comprehensive view of the mental health status of inmates in Canadian correctional institutions is an elusive goal, given that governmental responsibilities are bifurcated. The provinces operate jails under s. 92(6) of the *Constitution Act, 1867*<sup>21</sup> in which prisoners serve

sentences of less than two years. The federal government controls penitentiaries (under s. 91(28)) in which inmates are detained for terms of two years or more, under s. 743.1 of the *Criminal Code of Canada*.<sup>22</sup> The most convenient sources of data relate to the federal stream of corrections and this category comprises the bulk of the following discussion, although provincially run institutions are beset by the same problems that their federal counterparts face.<sup>23</sup>

The last decade has seen increased attention being focused upon the high proportion of inmates experiencing serious mental health problems. Although governments have acknowledged their duties at some levels, the overall state of affairs remains profoundly unsatisfactory, as summarized by Bastarache J. at paras. 106 and 115 in *R. v. Knoblauch*:<sup>24</sup>

*[U]nfortunately, the mentally ill, like aboriginals are sadly over-represented in the prison population ...*

\*\*\*\*\*

*I find it very unfortunate that there are inadequate resources to treat the mentally ill in most of Canada's correctional facilities.*

A survey of recent *Annual Reports of the Office of the Correctional Investigator* ("OCI") (prepared in accordance with s. 192 of the *Corrections and Conditional Release Act*,<sup>25</sup> [CCRA]) is entirely consistent with these comments by the Supreme Court of Canada. The *2003/2004 Report*<sup>26</sup> supported the findings of a Canadian Public Health Association study, *A Health Care Needs Assessment of Federal Inmates in Canada*,<sup>27</sup> which recorded higher inmate prevalences (especially among women) of mental disorders, substance abuse and suicide rates, confirming stakeholder input that "prisons house a disproportionate number of persons in need of mental health treatment", but that "the treatment available to inmates with mental disorders is inadequate", creating "an urgent need for action on a number of fronts".<sup>28</sup>

With little remission, these conclusions are woven throughout each subsequent Report. In 2004/2005, the OCI observed that "mental health services offered by the Correctional Service to these offenders have not kept up with the dramatic increase in numbers", such "that the level of mental health services available is now seriously deficient",<sup>29</sup> a conclusion reinforced in 2005/2006, where the OCI went further: "the Correctional Service is not fulfilling its legislative obligation to

provide every inmate with essential mental health care and reasonable access to non-essential mental health care".<sup>30</sup> The 2006/2007 Report recognized that "some progress in addressing the inadequacy of the mental health care provided to federal offenders"<sup>31</sup> had been made, but that there were still considerable funding and quality of service shortfalls. The 2007/2008 Report commented favourably upon additional fiscal commitments to mental health assessments and care, but maintained that the "situation remains problematic on several fronts", notably recruiting and retaining professionals, the physical infrastructure of Regional Treatment Facilities and shortages in intermediate, as opposed to intensive, care.<sup>32</sup>

In the 2008/2009 Report, the OCI welcomed the testimony of the Minister of Public Safety before a House of Commons Committee, who said that, having de-institutionalized "the mentally ill from provincial facilities", we "are 're-institutionalizing' them as prisoners", "criminalizing the mentally ill",<sup>33</sup> but lamented that "[t]he overall situation of offenders with mental health disorders has not significantly improved". Despite good intentions, there were problems of "priority and focus", too often concentrating on risk "rather than on treatment and intervention"<sup>34</sup> and resorting to segregation of inmates for "prolonged periods", a practice which "must end".<sup>35</sup> The 2009/2010 Report echoed previous frustrations that the "delivery and access to health care remains the number one area of offender complaint", despite some "promising initiatives"<sup>36</sup> and further complained that "mentally disordered offenders should not be held in segregation or in conditions approaching solitary confinement".<sup>37</sup> An OCI special report in 2010 reinforced the compendium of deficiencies appearing in the Annual Reports and recommended "a comprehensive plan" to address needs in "funding, implementation, accountability and evaluation",<sup>38</sup> as well as "[i]ncluding the opinions of offenders who have profited from mental health and criminogenic programming"<sup>39</sup> and confronting stigma and discrimination that exists "both inside and outside the Service", especially given the "double stigma of being labeled both 'crazy' and criminal".<sup>40</sup>

The Correctional Service of Canada Review Panel, has confirmed the basic outlook of the OCI. In *A Roadmap to Strengthening Public Safety*,<sup>41</sup> ("the Roadmap") the same portrayal of expanding prison populations with mental health problems is tendered, together with a reiteration of other concerns about deficiencies in admission screening

and follow-up in assessments and treatment planning (“this is unacceptable”)<sup>42</sup> and primary and intermediate mental health care (as opposed to crisis level interventions), limitations in professional mental health staffing, the opportunity cost to treatment services of the concentration on risk assessments and the reduction in access to treatment inherent in segregation. Somewhat more innovatively and in a realpolitik spirit, the Panel recommended that the “delivery of mental health services ... [be] identified as a critical factor in the Government’s public safety agenda”, that “Health Canada formally recognize the importance [of] addressing the mental health problems of offenders”, as well as the Mental Health Commission of Canada.<sup>43</sup>

In a highly critical study of the Roadmap, Michael Jackson and Graham Stewart<sup>44</sup> generally condemn the CSC Report “as a failed experiment in public policy”, pointing “in the wrong direction”, “through disregard of human dignity”.<sup>45</sup> Notwithstanding the stridency and thoroughness of their critique, *A Flawed Compass* goes out of its way to demonstrate that its authors are not “naysayers” by acknowledging that the Roadmap’s recommendations on mental health are the “best example” of building “upon CSC’s policy strengths” and implementing “existing good policy”.<sup>46</sup> Although sympathetic to the pathogenic nature of the prison environment from a mental health perspective (“hard to conceive of a less helpful environment for a person facing serious mental illness”),<sup>47</sup> *A Flawed Compass* endorses the Roadmap’s limited recommendations in this area as “strong and sensible”.<sup>48</sup> Where the authors do raise issues germane to this article, they regret that the Panel did not use “a human rights-based analysis”, which meant that the Roadmap lacked “principled analysis or moral urgency”.<sup>49</sup> Their verdict on the omission of human rights standards provides a clearer view of the situation in Canada for federally sentenced prisoners with mental health problems.

Some Canadian federal corrections policies on mental health issues have received a moderate level of endorsement by independent observers. The extent of public investment in prison programs and services, while still insufficient, has demonstrated that governments are not wholly indifferent to the plight of inmates with mental health problems. In commenting on the tragic case of Ashley Smith, the young woman who died in a federal women’s prison in what appears to have been a preventable situation,<sup>50</sup> the then Minister of Public Safety

admitted that “a federal prison setting ... is really not a place where you’re going to get the best mental health care”, where “a much higher proportion of people should never be in prison” and “[p]eople fall between the cracks”.<sup>51</sup>

## B. Worrisome Trends

The lived experience of this most vulnerable segment of the prison population, as documented in virtually every evaluation, demonstrates a clear failure in the delivery of a comprehensive range of services. These lacunae start with the paucity of community supports and pre- and post-verdict diversion programs, but then move ultimately to the deprivations suffered by prisoners. As a result of recent trends in criminal justice policy, the present level of dissatisfaction with prison mental health may burgeon relatively quickly into a major crisis. Canadian criminal law is veering sharply in a punitive direction which will lead ineluctably to a huge increase in the number of inmates and an amplification of all the mentally unhealthy features of prisons. As a recent Canadian Association of Elizabeth Fry Societies Annual Report cautioned with respect to “pushes for longer and more mandatory minimum sentences”, “austere and isolating prison conditions are at best debilitating, and, at worst, brutalizing”.<sup>52</sup> In a complementary analysis, the Correctional Investigator contended that there has been “an increase in violence and deaths behind bars”, and blamed several factors, crowding, “lack of access to programs” and “the increase in the number of offenders with significant mental health issues”.<sup>53</sup>

At its 2011 conference, the Canadian Bar Association recorded the parallel concerns of the legal profession by passing two critical resolutions hitting at the heart of the renewed governmental enthusiasm for locking people up and the effect of this trend on persons with psycho-social disabilities. One condemned the widening net of minimum mandatory sentences as potentially causing “the most serious injustices, for example, when it results in incarceration of the mentally ill”.<sup>54</sup> Another observed that “significant numbers of mentally ill people have become involved with the criminal justice system, as opposed to the healthcare system” and urged governments to both “allocate sufficient resources to reduce the criminalization of mentally ill individuals” and to “develop policies to enhance the lives of those suffering from mental illness to prevent them from coming into contact with the criminal justice system”.<sup>55</sup> The press fully supported

these declarations. As a *Globe and Mail* editorial observed, while the Correctional Service of Canada “has made improving mental health services a core priority”, “the jails are under duress, and Parliament and Canadians generally should be aware of the hidden, human costs of adding to the prison population”.<sup>56</sup> A *Chronicle Herald* editorial, reacting to the Canadian Bar Association 2011 Resolutions, advanced the same worrisome themes, noting the “uproar in the legal community”, pervading “not just defence lawyers and so-called ‘liberal’ judges ... but Crown attorneys” and echoing the concerns that “limiting judges’ options means jailing more individuals who are mentally ill”.<sup>57</sup>

2011 is witnessing a chorus of objections to the direction of Canadian penal policy and its harsh side effects on persons with mental health problems. Canada continues to imprison too many citizens: “Unfortunately, our country is also distinguished as being a world leader in putting people in prison”.<sup>58</sup> Jailing so many has had disproportionate effects on people living with mental illness. The accelerating carceral trend will increase the number of inmates with mental illness and will exacerbate the existing therapeutic inadequacies of the correctional system.

The questions that remain to be answered relate to the potential for international human rights law to make a positive contribution to the existing state of affairs in prison mental health. What kind and level of advancement might be spawned with the advent of the *CRPD*? However, before turning to this contemporary outlook, it is worth pausing to examine how it is that prisoners are said to have any rights at all.

#### **IV. Conceptualizing Prisoners’ Rights: The End of Civil Death and the Slow Movement Towards Recognition of Full Citizenship**

In this part, the contrast between an earlier era wherein “prisoners’ rights” was an oxymoron and the contemporary view of governments having to justify rights intrusions will be drawn first. The danger of assuming that Canadian prisoners’ rights will continue to be respected even to the present extent will then be explored in light of recent proposals to amend the *CCRA*. Although it will be shown that some prison mental health reform has occurred, it will be argued that the human rights balance could be tipped in a reactionary direction. The section continues by advocating for a more expansive outlook on prisoners’ rights, a school of thought that has been emerging in scholarly literature despite recent public policy trends. In this part, it is concluded that the promulgation of the

*CRPD* is consonant with the aspiration of expanding prisoners’ rights to be more consistent with their status as citizens who should be encouraged to respect the rights of others.

The role of “prisoner” has always connoted some diminution of status, rights and freedoms, although the extent of this degradation has varied. No doubt progress has been made since *Ruffin v. Commonwealth*<sup>59</sup> which pronounced felons, “whom the law in its humanity punishes by confinement in the penitentiary instead of with death”, as “civilly dead”, “in a state of penal servitude to the State”, forfeiting “all his personal rights”. As the Supreme Court of Canada succinctly put it: “The law regarded them as dead”.<sup>60</sup> However, in *Ruffin*, even this extreme position was modulated by the reservation that the prisoner “retained those which the law in its humanity accords to him”,<sup>61</sup> a phrase which, it will be contended, has acquired greater resonance in light of the *CRPD*.

The spirit of *Ruffin* nonetheless does not seem to be extinct, even if the Supreme Court has denounced *civiliter mortuus* as “ancient and obsolete”.<sup>62</sup> Its ghost re-appears in the more contemporary justifications for attenuating prisoners’ rights, whether by direct or systemic discrimination. The risk of erosion will be demonstrated, notwithstanding the Supreme Court’s current dedication to recognize the entitlements of prisoners. *Sauvé v. Canada (Chief Electoral Officer)*<sup>63</sup> made it clear that, although “Certain rights are justifiably limited for penal reasons”, such as “liberty, security of the person, mobility and security against search and seizure”, “the right of the state to punish and the obligation of the criminal to accept punishment are tied to society’s acceptance of the criminal as a person with rights and responsibilities”.<sup>64</sup> Any reservation on prisoners’ rights, whether under the Charter or domestic or international human rights law, must be sustained on the basis of a justificatory process which is at least as vigorous as exemplified by *Sauvé*, as Parliament or legislatures cannot infringe rights “by offering symbolic and abstract reasons”.<sup>65</sup>

This reinvigorated necessity of respecting prisoners’ rights ought to be stated as a more positive element in the prison context. Rights should be “seen as the imperative from which all else flows”, “not as one aspect of corrections under the *CCRA* [Corrections and Conditional Release Act], but as corrections under the *CCRA*”.<sup>66</sup> With the primacy of rights in mind, it is troubling when corrections law and policy seems poised to sacrifice

or dilute its dominance. For example, in the *Roadmap*, uncharacteristically praised in *A Flawed Compass* for its stance on mental health issues, a key recommendation to amend s. 4 of the *CCRA* would facilitate the erosion of prisoners' rights (the proposed changes are underlined):

s. 4 *The principles that shall guide the Service in achieving the purpose referred to in section 3 are:*

e) *that offenders retain the basic rights and privileges of all members of society, except those rights and privileges that are necessarily removed or restricted as a consequence of the sentence, are required in order to encourage the offender to begin to and continue to engage in his or her correctional plan.*<sup>67</sup>

In this regard, *A Flawed Compass* was fair, if severe, in their condemnation of this proposal in the *Roadmap*, concluding that it reflects "a profound lack of understanding of the constitutional and correctional basis for the recognition of and legitimate limitations on the human rights of offenders".<sup>68</sup> Perhaps even more ominously, especially for prisoners with psycho-social disabilities, the Review Panel felt that the current statutory requirement under s. 4(d) of the *CCRA* requiring the Service to "use the least restrictive measures consistent with the protection of the public, staff members and offenders ... has been emphasized too much by the staff and management of CAC, and even by the courts", creating an "imbalance", which should be corrected by requiring "offenders to justify why they should have access to privileges".<sup>69</sup> The least restrictive dictate, accepted "[a]s a matter of principle"<sup>70</sup> by the Supreme Court, referring both to s. 4(d) and s. 28 of the *CCRA* (the Service shall provide "the least restrictive environment"), has been a bulwark for prisoners' rights, which the Panel would simply eliminate.

While it may seem churlish to isolate these recommendations as an illustration of the facilitation of the erosion of prisoners' rights after the generous evaluation within *A Flawed Compass* of the *Roadmap*'s mental health outlook, the point is drawn for four reasons. First, subsequent statements by "Government endorsed a comprehensive response to the recommendations of the CSC Review Panel",<sup>71</sup> as they would "help ensure we achieve excellent public safety results in an integrated and consistent manner",<sup>72</sup> which support would presumably include a willingness to further shrink the role of prisoners' rights. Second, although the Government has identified as a key area, "improved capacities to address mental health needs of offenders",<sup>73</sup> the

nation's federal corrections system approaches the future with a profound mental health services deficit in an era when prison populations are increasing and conditions, especially for vulnerable people, are deteriorating. Third, the role of international human rights law in domestic jurisprudence in general has evolved. The primacy of the norms and legal obligations required by Canada's ratification of the *CRPD* in particular should be more evident. A course must be plotted for a more generous and central place for a rights-based approach to mental health and corrections, a direction which has not yet been set by government, notwithstanding its declared commitments. Fourth, this paper of necessity concentrates on legal prescriptions, but Arbour J. has cautioned that change at the level of formal law is necessary, but not sufficient. In her *Prison for Women Report*, she found "little evidence of the will to yield pragmatic concerns to the dictates of a legal order"<sup>74</sup> and that "there is little hope that the Rule of Law will implant itself within the correctional culture without assistance and control from Parliament and the courts".<sup>75</sup> Todd Sloan concluded that "identifiable, disproportionate and long-standing restrictions on human rights persist in many aspects of the federal correctional system", where a "central contributing factor ... is the very nature of the Service's structure and culture—which make it unlikely that decisions based predominately, much less exclusively, on human rights will prevail".<sup>76</sup> The law should be made to conform with the normative premises and substantive obligations of the *CRPD*, but the inertia of rest within the Canadian corrections system will not necessarily be altered even by profound legal changes, a restraint which must be acknowledged by advocates for law reform and by legislators and officials. The *Convention* and its moral principles will have to be relied upon both for their prospective legal effects, but in addition for their possible ability to modify the public policy agenda and the attitudes of prison officials.

It is realistic to suggest that, notwithstanding good intentions by Corrections Canada and the *Roadmap* regarding some mental health concerns, the stage has been set for prospective assaults on prisoners' rights in general. This hazard looms even larger against the backdrop of the punitive atmosphere which now pervades public discourse and the difficulties in making progress on human rights within a prison system that shows signs of ossification. On the other hand, the gains that have been made in Canada regarding prisoners' human rights must be recognized as a counterweight to this

threat. There have been incremental advances including: strengthening the common law duty to act fairly; upholding Charter rights (although Michael Jackson observes that “the prospect of a golden age has been somewhat dulled”<sup>77</sup>); and the promulgation of the *Corrections and Conditional Release Act* (1992) (“a significant advance in the field of correctional law”, although “falling short of the expectations raised by the Correctional Law Review”).<sup>78</sup> Canada is thus balanced uneasily regarding the protection and advancement of human rights in prisons, with forces pulling law and policy in both directions. The John Howard Society was no doubt correct in its comment that “Today’s inmates have more rights”,<sup>79</sup> but the baseline had been set far too low historically. It was an overstatement by a Correctional Service of Canada (“CSC”) Working Group in 1997 to say that “Canada’s human rights obligations ... form the human rights foundation on which CSC’s work is based”.<sup>80</sup>

In light of the *Convention* and in the face of combined threats of a metastasizing retributivism and proposals to dilute the *status quo* of prisoners’ rights, the future development of human rights standards must be assessed. Especially for inmates with mental health problems, Canada is now obliged to offer much more than protection against unfairness and cruel and unusual treatment or punishment, however important these minimum standards are. As Mary Campbell has noted, prisoners’ rights in Canada have historically denoted “not the conferring of special entitlements so much as simply the prevention of abuse”.<sup>81</sup>

A powerful case can now be made for the kind of vision articulated by the British scholar Susan Easton: “A rights-based approach”, that will move “the prisoner from the status of a non-person towards citizenship”, comprising a “view of citizenship” that “would affirm the importance of universal rights in our culture and provide social benefits by addressing the problem of social exclusion”.<sup>82</sup> Easton argues that the broad recognition of the social rights of prisoners would facilitate rehabilitation, “focus attention on prison conditions” and promote social inclusion, while satisfying “states’ obligations under international law”.<sup>83</sup> Certainly, she is not the first to argue for a more generous acceptance of the rights of prisoners. James O’Reilly had advanced a similar series of propositions in 1988 in the Canadian context: “the right to possess rights” enabled prisoners to “gain personhood”, bringing “prison matters into the public domain”; improving both “the general quality of prison life” and “relations within prison” and making “prisoners more likely to succeed

without”.<sup>84</sup> Later, Jaysree Ghedia likewise contended that prisoner rights were human rights, which operate “as a buttress against arbitrary power of the state”<sup>85</sup> and which teach “lessons in citizenship”, helping “prisoners develop respect for the law and rights of others”,<sup>86</sup> thereby assisting in rehabilitation and community reintegration. An examination of the *Convention* will establish that these arguments for a broader conception of citizenship for prisoners are not only good penal policy, they have become positive legal obligations under the *CRPD*. They come not a moment too soon for prisoners with mental health problems given the increasing tendency by Parliament to use the custodial sanction and the spectre of diminution of human rights in prison policy.

## V. Building on the Foundation of International Human Rights Law

The *CRPD* will be influential in the development of the rights of prisoners with mental health problems, but the *Convention* explicitly builds upon several sources in its recitals, “Reaffirming the universality, indivisibility, interdependence and interrelatedness of all human rights” (Preamble (c)). It is useful to recall that international human rights law has, to some extent, moulded Canadian corrections since at least the *Universal Declaration of Human Rights* (1948) provided “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family” (Preamble) and protection against “torture or ... cruel, inhuman or degrading treatment or punishment” (*Art. 5*). Subsequent United Nations declarations enhanced these guarantees, such as the *International Covenant on Civil and Political Rights* (1966) in articles 10(1) “All persons deprived of their liberty shall be treated with humanity and with respect” and 10(3) “the penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation”. Additional directions specific to prisoners with mental illness appear in the *Standard Minimum Rules for the Treatment of Prisoners* (1975) providing: for medical services “organized in close relationship to the general health administration of the community or nation”, including “a psychiatric service” (*Art. 22(1)*); prompt examination following admission for “physical or mental illness” (*Art. 24*); the minimization of “any differences between prison life and life at liberty” which lessen “their dignity as human beings” (*Art. 60*); and “psychiatric treatment of all other prisoners who are in need” (*Art. 82(4)*).



Although such declarations have been instrumental in forming an international consensus on minimum standards for prisoners, they have not had the range of effects in Canada which were potentially derivable, based strictly on their substance. Although commenting on their use in the United States, the pronouncement by Michael Perlin and Henry Dlugacz seems apt in Canada as well. International human rights doctrines have been “A mostly hidden undercurrent in some prisoners’ rights litigation”.<sup>87</sup> As Michael Jackson has commented, the Yalden Report<sup>88</sup> concluded that Canada was generally compliant with international norms, but it observed that “the *CCRA* did not invoke or even allude to those international obligations and norms”.<sup>89</sup> As a consequence, the Yalden Report recommended “2(I) that a clear reference to Canada’s international obligations to respect the human rights of inmates and employees be incorporated in the law”,<sup>90</sup> a suggestion not yet adopted among the Principles of s. 4 of the *CCRA*.

Fortunately, the corpus of international human rights law already provides a shield against such slights, although it is not impregnable against domestic legal threats. For example, the *Body of Principles for the Protection of All Persons Under Any Form Of Detention or Imprisonment*<sup>91</sup> states in Principle 3 that “[t]here shall be no restriction upon or derogation from any of the human rights” of detainees or prisoners “on the pretext that this Body of Principles does not recognize such rights or that it recognizes them to a lesser extent”.

Complementarily, *Art. 5 of the Basic Principles for the Treatment of Prisoners*<sup>92</sup> states that except for limitations “demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out” in a broad range of United Nations covenants. Even more forcefully, the *CRPD* speaks to the special needs of prisoners with mental health problems and ensures that the principles of the *CRPD* must be reflected in Canadian law.

## VI. The *CRPD* Paradigm Shift

The *CRPD* has been heralded for its transformative potential with respect to the lives of people with mental health problems (and intellectual disabilities).<sup>93</sup> Under the *CRPD* no excuse is permitted for the perpetuation of a legal and social environment that has had the effect of impoverishing, disempowering, abusing and neglecting “the world’s largest minority”.<sup>94</sup>

Arguably, prisoners and detainees were recognized sooner, more discretely and

sympathetically in international law, compared to persons with disabilities. Possibly this was due to the conspicuous fact that prisoners had lost their liberty and were thus under the complete control of the state. The adoption of the *CRPD* by the United Nations in 2006 and Canada’s ratification of it in 2010 do seem tardy by comparison, but it seems to have taken this long to reflect the “major shift in global understanding and responses towards disability”.<sup>95</sup> The recognition of the combination of prisoners’ and disability rights is even newer, despite its obviousness. Adapting the famous dictum from the United States Supreme Court in *Wolff v. McDonnell*, it is clearly time to recognize that “[t]here is no iron curtain drawn between the [*C.R.P.D.*] and the prisons of this country”.<sup>96</sup>

The *Convention* emerged with lightning speed, by United Nations standards, once the international community took it upon itself, as expressed by the U.N. Commission on Human Rights, “to examine what might be done to strengthen both the protection and monitoring of the human rights or persons with disabilities”.<sup>97</sup> Within five years, the most rapidly negotiated human rights treaty emerged, strengthened by an unprecedented level of participation and influence by persons with disabilities and their advocacy organizations, themselves oxygenated with “the clarion cry, ‘Nothing about us, without us’”,<sup>98</sup> a spirit which permeates the substance of the *CRPD*.

The pivotal insight reflected in the *Convention* is that law and public policy must move from its familiar conceptual grounding, an outlook accepted by the Government of Canada as part of its ratification: “The *Convention* embodies an important shift toward a human dignity approach to disability and away from a charity and medical model approach”.<sup>99</sup> The contrasts between these paradigms are cogently summarized by Andreas Dimopoulos. From the perspective of the medical model, there are several critical features: “Focus on the impairment and the individual; Emphasis on individual deficits”, whereas the key elements of the social or human rights model are starkly differentiated: “Focus on the social context and the environment; Emphasis on the relationship between the individual and society; Emphasis on social barriers”.<sup>100</sup> The *CRPD* embodies the latter perspective in several articles, although section (e) of the Preamble shows its change of direction clearly:

... disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full

and effective participation in society on an equal basis with others.

As the U.N. High Commissioner for Human Rights has summarized this re-imagined analytical framework: “the *Convention* views disability as ‘a pathology of society’”, stipulating that societies “need to change, not the individual”.<sup>101</sup>

## VII. An Overview of the *CRPD*

The *CRPD* is a rich and complex treaty with an unprecedented reach. Opinions have varied as to whether it creates new rights or merely specifies and consolidates the entitlements of persons with disabilities that have been canvassed in general in other *Conventions*. Many would be inclined towards the former view, as the *CRPD* has both “modified, transformed and added to traditional human rights concepts in key respects”, but it also contains “entirely new or amplified formulations of human rights”.<sup>102</sup> Although it covers the traditional terrain of protecting the dignity and autonomy of individuals with disabilities, it extends much further, imposing a wide and novel range of positive obligations upon States Parties, at the normative, legislative, implementational and monitoring levels. Bearing in mind the universality of its intentions, a brief overview of the *Convention* will be presented first. Then, some of the provisions of the *CRPD* which seem more germane to prisoners with mental health problems will be explored more specifically.

### A. Preamble, Purpose and Definitions (Articles 1-2)

The 25 interpretative paragraphs in the preamble link the *CRPD* with its predecessor covenants, but they also contribute to a more contemporary understanding of the nature of disability and the purposes of the *Convention*, emphasizing the barriers hindering equal societal participation (*e*) and (*k*); basic principles, opposing discrimination as violations of human dignity and worth (*h*); the importance of autonomy and independence (*n*); multiple levels of vulnerability (*p*), (*q*), (*r*) and (*s*); and the grinding reality of “the negative impact of poverty” (*t*). The articulation of the purpose of the *CRPD* in *Art. 1*, to promote human rights and respect for dignity, is coupled with an explanation of its coverage, wherein persons with disabilities include those with “long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers” are hindered in their societal participation. The definitions in *Art. 2* highlight “discrimination” (imposed disadvantages which impair the equal enjoyment of human rights)

and “reasonable accommodation” (measures “not imposing a disproportionate or undue burden”, that ensure human rights).

### B. Articles 3-9; General Principles and Obligations of States Parties

These sections compendiously establish the normative targets and correlative legal obligations which are imposed by the *Convention*. The “general principles” in *Art. 3* foreground many crucial issues including: “inherent dignity, individual autonomy including the freedom to make one’s own choices” (*a*); non-discrimination (*b*); societal participation and inclusion (*c*); and respect for difference (*d*). The “general obligations” in *Art. 4* establish the unique potential for the *CRPD* to reach inside Canadian prisons. They not only require that States Parties “adopt all appropriate legislative, administrative and other measures” (*a*), but modify all inconsistent “laws, regulations, customs and practices” (*b*), refrain from contradictory acts or practices (*d*) and even take measures to eliminate private disability discrimination (*e*). Crucially, *Art. 4(5)* stipulates that the *CRPD* extends “to all parts of federal states without any limitations or exceptions”.

Articles 5-7 guarantee “equal protection and equal benefit of the law” (*Art. 5(1)*), while prohibiting discrimination (*Art. 5(2)*) and providing reasonable accommodation (*Art. 5(3)*) and recognizing the special vulnerabilities of women (*Art. 6*) and children (*Art. 7*). Article 8 specifies a range of measures to “raise awareness” and “foster respect” (*Art. 8(1)(b)*), unusual requirements for a treaty, as they attempt to delve into the attitudinal depths of societal discrimination and to compel state action to address these often elusive facets of prejudice.

### C. Substantive Rights: Articles 10-23

These articles extend protections against infringements of individual rights, but they do so more effectively than most *Conventional* mental health and disability legislation. The *CRPD* is pervasively invigorated by correlative positive duties, as compelled by the adoption of the social model, both within these provisions and further by the articles specifying economic, social and cultural rights.

Article 10 re-affirms the “inherent right to life” of all, but demands “necessary measures” to protect its enjoyment for people with disabilities, while *Art. 11* specifies the need for ensuring their “protection and safety”, in situations of risk and emergency.

Articles 12 and 13 provide equal recognition before the law and access to justice respectively,

comprising a formidable package for vulnerable people: the enjoyment of “legal capacity on an equal basis” (*Art. 12(2)*); offering commensurate supports required “in exercising their legal capacity” (*Art. 12(3)*), while preventing abuse and respecting the “rights, will and preference of the person”. The *Art. 13* assurance of “effective access to justice”, coupled with “appropriate training” for justice personnel will, as developed later, assist prisoners.

Article 14 safeguards liberty and security of the person, forbidding deprivations which purport to be justified on “the existence of a disability”. Article 15 prohibits “degrading treatment or punishment and orders States Parties to take preventative measures”. Section 16(1) assures that steps will be taken to protect against “exploitation, violence and abuse”, while recovery and reintegration of victims in supportive environments are provided.

Articles 17-20 protect “physical and mental integrity” (*Art. 17*), freedom of movement (*Art. 18*) and independent living in inclusive communities (*Art. 19*), wherein personal mobility and independence are ensured (*Art. 20*).

Article 21 guarantees freedom of expression and communication supports. Article 22(1) condemns arbitrary or unlawful interference with privacy and offers additional specific promises regarding health and personal information. Article 23 eliminates discrimination relating to intimate relationships and provides specific legal promises for children in relation to family life.

#### **D. Articles 24-30: Economic, Social and Cultural Rights**

These articles are an integral part of the overall purpose of the *CRPD* to “ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities” under *Art. 1*. They supplement the foregoing mainly individual rights provisions in ways which should assist in altering the social context faced by persons with disabilities, thereby lessening the likelihood or effects of rights violations.

Article 24 recognizes a broad right to education which will enable “persons with disabilities to participate in a free society (*Art. 24(1)(c)*). Article 25 sustains non-discriminatory and preventative health services, equivalent to those “provided to other persons”. Article 26 demands habilitation and rehabilitation services to promote independence, ability, “inclusion and participation in all aspects of life”.

Articles 27-30 endeavour to forge broader and more equitable links between people with disabilities

and society. Article 27 recognizes the right to work in an “environment that is open, individual and accessible”. Article 28 tackles the perennial obstacle of poverty, recognizing basic needs for “adequate food, clothing and housing” (*Art. 28(1)*), but further referring to “poverty reduction programmes” (*Art. 28(2)(b)*) and public housing (*Art. 28(2)(d)*). Articles 29 and 30 move beyond materialist prescriptions for social inclusion and guarantee participation “in political and public life” (including an endorsement of disability advocacy organizations (*Art. 29(b)*)) and in “cultural life, recreation, leisure and sport” (*Art. 30*).

#### **E. Articles 31-50: Implementation, Monitoring and Administration**

Effectiveness and accountability are sought through data collection (*Art. 31*), international co-operation (*Art. 32*) and national implementation and monitoring (*Art. 33*), all of which aims are meant to be achieved with the active participation of people with disabilities.

Article 34 attempts to promote measures by States Parties to give effect to the *Convention* by establishing the committee on the Rights of Persons with Disabilities, that will receive (*Art. 35*) and consider (*Art. 36*) regular comprehensive and co-operatively prepared national reports (*Art. 37*), which will be used by the Committee to “make suggestions and recommendations” to the General Assembly and to the Economic and Social Council every two years (*Art. 39*).

#### **F. The Optional Protocol**

Although unhappily as yet unsigned by Canada, the Optional Protocol would invigorate the other reporting and accountability measures within the *CRPD*. The Committee would be entitled under *Art. 1* “to receive and consider communications” from individuals and groups whose rights have been violated. The Committee may make interim rulings for “urgent consideration” to forestall “irreparable damage” (*Art. 4*), but may also consider “reliable information indicating grave or systemic violations” (*Art. (1)*), which may result in the transmission of findings to the State Party (*Art. 6(3)*), with the duty to respond.

#### **VIII. The Implications of the *CRPD* for Canadian Prisoners**

With the ink on Canada’s ratification of the *Convention* barely dry, it is somewhat speculative to comment upon the strategic directions and the more focused substantive implications which ought to be inspired for prisoners by the *CRPD*. That said, this is

a propitious juncture to think about the course of the *Convention*, especially as there is the opportunity to influence its effects on the prisons of Canada. Certainly, there will be an abundance of activity generated by the *CRPD*.

Some developments will occur in the international domain. For example, the *Standard Minimum Rules for the Treatment of Prisoners* will require revision, a process already in play.<sup>103</sup> International organizations will continue to refine their positions on criminalization issues in general and, more precisely, on the need for *CRPD*-inspired refinements for prisoners. For instance, The *Trenčín statement on prisons and mental health* from WHO Europe in 2007 establishes “the essential need for greater focus on mental health problems among people in custodial settings”<sup>104</sup> and makes a number of recommendations for policies to ensure prisons stop moving “closer to becoming twenty-first century asylums for the mentally ill”, but it does not consider the *CRPD*.

Under the *CRPD*, the Committee on the Rights of Persons with Disabilities will be expecting each State Party to submit its initial progress report on “measures taken to give effect to its obligations” (*Art. 35(1)*), after which the reports will be considered and then be subject to “suggestions and general recommendations” (*Art. 36(1)*). A sample of seven of the early reports available in English at the time of writing was not auspicious: Australia, Austria, Azerbaijan, Korea, Spain, Sweden and Tunisia. Cumulatively, these reports do not yet evince that States Parties have adequately focused on the needs of prisoners with mental health problems. None had developed a comprehensive response to the *CRPD* as it applies to this segment of the population. Some, *e.g.*, Australia, commenting on *Art. 14*, broadly recognized the “particular challenges in relation to the treatment of persons with mental illness in both the health and criminal justice context”.<sup>105</sup> Five of the reports described training initiatives for justice personnel or, in three of these, more specifically for “custodial officers” (Australia), “personnel of penitentiary institutions” (Azerbaijan), or “the Prison and Protection Service” (Sweden), in general human rights and discrimination issues or the more specialized needs of prisoners with intellectual disabilities. The Committee, one would hope, will gradually come to grips with the difficulties encountered by prisoners with psycho-social disabilities and will provide appropriate feedback on the necessity of more attuned responses.

At the domestic level, the deep general obligations of *Art. 4*, extending “to all parts of federal States” (*Art. 4(5)*), should compel corrections authorities to urgently examine their “laws, regulations, customs and practices” (*Art. 4(1)(b)*) to modify anything that constitutes discrimination under the broad umbrella of the *Convention*. “[A]ppropriate information” will have to be collected to “help address” implementational issues and identify barriers (*Art. 31(2)*). International co-operation will be demanded of Canada under *Art. 32* “in support of national efforts for the realization of the purpose and objectives” of the *CRPD*. National implementational duties will include the development of “independent mechanisms” which involve persons with disabilities” (*Art. 33(2)*). Canada will also have to prepare its initial report to the Committee.

The manner in which the *CRPD* might alter Canadian law has been more extensively discussed by this author elsewhere.<sup>106</sup> The *CRPD* will be argued as a primary source of law and an interpretative aid regarding statutory and Charter provisions in both the courts and review boards. Existing statutes should be construed as having given effect to the treaty. Courts may presume current legislation already conforms to the *CRPD* or they may bring in the *Convention* to aid any legislative or Charter interpretative exercise. The broad trend is to take international human rights law into consideration whenever it is feasible. In addition, international law requires States Parties to perform their treaty obligations in good faith. That duty, coupled with the *CRPD* general obligations of *Art. 4*, should inspire statutory reforms to implement this *Convention*, without hiding behind division of powers excuses.

The *Convention* will be brought into the political arena as advocacy organizations use it as a vehicle for advancing the rights of persons with disabilities in law and public policy reform processes. Given the chasm between law reform and effective institutional change that has been observed in prisons, particularly as experienced by persons with psycho-social disabilities, some of the more significant effects of the *Convention* will be wrought by its being overtly incorporated into the political agenda on behalf of prisoners. Altogether, Canada will be busy as it responds to the dictates and invocation of the *CRPD*.

## IX. Some Thematic Directions for Law, Policy and Service Suggested by the *Convention*

The re-imagination and alteration of the relationship of persons with disabilities to Canadian society through a human rights lens will not be easy or quick. Prejudices, stigma and discrimination are so deeply ingrained that the structures and targets of the *CRPD* cannot be expected to be implemented as expeditiously as the urgency of the unmet needs of persons with disabilities demands, *a fortiori* for doubly stigmatized prisoners. As Lance Gable and Lawrence Gostin have cautioned in their global assessment: “despite the promise of expanding applications of human rights to mental health, achieving this reality remains elusive”<sup>107</sup>.

The tense social situation of the prison in society complicates the struggle of inmates with mental health problems for dignity and equality enormously. Many prisoners with mental illness ought never to have been subjected to the punitive processes of the criminal justice system. Of those offenders who are sentenced to imprisonment, a significant proportion would fare better using some form of community-based sanction and they would be less likely to re-offend if they were not subjected to the harshness of a prison environment. Some inmates who have had mental health difficulties when living in the community will markedly deteriorate in prison, developing serious mental illnesses. Behavioural issues may arise while incarcerated that attract the authorities’ attention and may result in additional sanctions or prolonged stays. Despite the legal and human rights requirements to improve mental health policies and services for inmates, prisons ought not to become simply custodial psychiatric communities further recreating the vast civil warehouses of citizens facing mental health difficulties of the 1950s. Neither can the answer be to shift whole populations from prisons to re-invented coercive hospital or community settings.

Although these complex cross-currents cannot be set aside, the legal, policy and service standards that emerge from the *CRPD* mandate significant improvements across a comprehensive array of benchmarks for prisons. What will emerge, both for prisons and the community, from this exacting new microscope should be something quite different. The prison environment has been rightly condemned as profoundly anti-social and mentally unhealthy, but yet it has been persistently unresponsive to modern expectations for dignified, competent and humane mental health treatment and social supports. Within the balance of this article, a single image of a

*CRPD*-informed prison environment will not emerge. Instead, a number of consistent thematic directions will be identified, with the expectation that a more concrete and implementable vision will gradually appear as the depth of change demanded by the *CRPD* becomes apparent. For present purposes, it is hoped that this section will stimulate discussion and debate and that the proposed reforms will gradually be refined and concretized.

### A. The Involvement of Persons with Mental Health Problems

The character of the *CRPD* was largely shaped by people facing mental health difficulties and their advocates. Their input radically influenced the substance of the treaty and the policy and service reform processes that spring from it. The Preamble (para. (o)), “persons with disabilities should have the opportunities to be actively involved in decision-making processes about policies and programmes” and the general obligations (*Art. 4(3)*), “States Parties shall closed consult with and actively involve persons with disabilities”, demonstrate that no change in prisons should occur that is not heavily influenced by people who have experienced mental health problems in custody. Mental health advocacy organizations often have difficulty sustaining themselves in the community, let alone in prisons. The additional recognition in *Art. 29(b)(ii)* that States Parties shall promote an environment which encourages participation in public affairs, including “[f]orming and joining organizations of persons with disabilities to represent persons”, suggests that correctional authorities should foster such nascent associations to advise them so that people living with psycho-social disabilities will affect the nature of institutional change. The further check and balance in *Art. 33(3)*, stipulating that persons with disabilities shall “participate fully in the monitoring process”, provides an additional incentive for the creation of specialized inmate consultation groups.

### B. Improvement in Staff Training

The framers of the *CRPD* were well aware of the novelty of its provisions, which are neither self-explanatory nor self-executing in a social context where “persons with disabilities continue to face barriers ... and violations of their human rights” (Preamble, para. (k)). Therefore, several articles oblige correctional officials “[t]o promote the training of professionals and staff working with persons with disabilities in the rights recognized” (*Art. 4(1)(i)*) in the *CRPD*. Indeed, a specific prescription obtains “for those working in the field

of administration of justice, including police and prison staff”, promoting “appropriate training ... to help to ensure effective access to justice” (*Art. 13(2)*). For health professionals, including those providing care in prisons, States Parties must raise “awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training” (*Art. 25(d)*). These articles make it evident that corrections officials must create a pervasive rights-awareness initiative for staff, beyond any program which was offered prior to the *CRPD*.

### C. Public Awareness-Raising

Prisons are expected by the public to be a world apart from society, a characterization which is in part accurate, given the role of prisons “to separate offenders from society, where necessary” (s. 718(c) of the *Criminal Code*). The walls of the prison create vast social and attitudinal barriers that conceal the additional purpose of the prison, to assist in “the rehabilitation of offenders and their reintegration into the community” (*CCRA*, s. 3(b)), guided by the principle that the (federal Correctional) Service enhances “its effectiveness and openness”, through communication to, among others, the public (*CCRA*, s. 4(c)). The CSC is also responsible for “s. 5(e) maintaining a program of public education about the operations of the Service”.

The stigma of the inmate with mental illness runs rampant in society, unchecked by the correctional system and fuelled by the media. The *CRPD* requires States Parties “to combat stereotypes, prejudices and harmful practices relating to persons with disabilities” (*Art. 8(1)(b)*), including “public awareness campaigns” (*Art. 8(2)(a)*) and “[e]ncouraging all organs of the media to portray persons with disabilities in a manner consistent” with the *CRPD* (*Art. 8(2)(c)*). Although the suggestion runs counter to the impetus of many to vilify, corrections systems should try to reverse the tide of vitriol directed against prisoners, and especially those with mental illness, by reaching out to the public and presenting a humane picture of inmates of all descriptions. Such initiatives would be consistent with the *CCRA* and the fresh positive awareness-raising duties under the *CRPD*. Correctional services should initiate such efforts, but they will likely be more effective if they join forces with other anti-stigma campaigns, such as those organized by the Mental Health Commission of Canada and the Canadian Mental Health Association.

### D. Protection Against “torture or cruel, inhuman or degrading treatment or punishment”

Article 15(1) of the *Convention* is intended to prohibit unacceptable “treatment or punishment”, while *Art. 15(2)* requires all measures to be taken to prevent persons with disabilities from being subjected to such abuses. No definitions are offered in the *CRPD*, but the kinds of maltreatment sought to be avoided can be elucidated through an examination of the positive values promoted by the *Convention*: “full and equal enjoyment of all human rights” and “respect for their inherent dignity” (under *Art. 1*), statements which are reiterated as general principles (under *Art. 3*), with additional co-extensive norms, such as “individual autonomy” and “independence” (*Art. 3(a)*), “Non-discrimination” (*Art. 3(b)*) and “Respect for difference” (*Art. 3(d)*). Any treatment or punishment which is an egregious affront to these values and to which people with disabilities are subjected to discriminatorily could qualify for prohibition. The case can be made that the *CRPD* has enlarged the compass of the protections previously available under similarly worded guarantees in international and domestic law.

Exactly what is connoted by the article will have to be clarified against the background imparted by this disability-specific treaty. The starting point for a review faithful to the *CRPD* could be the reminder from the *Roadmap*, that “the offender goes to a penitentiary *as* punishment, not *for* punishment”. Any law, regulation or practice mandating a treatment or punishment which demonstrates a gross or reckless disregard of the needs of prisoners with mental health problems, which dilutes the purposive statement of the *CRPD* (“safe and humane custody” and “assisting the rehabilitation of offenders and their reintegration”, *CCRA*, ss. 3(a), (b)) and which does not comport with the normative base of the *CRPD*, should qualify for examination under this compendious standard. The *CRPD* should confer a greater level of protection than that of s. 12 of the Charter, which enshrines the right not to be subjected to any cruel and unusual treatment or punishment.

An obvious example requiring an urgent re-assessment is the issue of segregation. As the Office of the Correctional Investigator has recently reminded the Government of Canada: “I have been very clear on the point that mentally disordered offenders should not be held in segregation or in conditions approaching solitary confinement”.<sup>108</sup> While the same Report noted that “an operational

examination”<sup>109</sup> was initiated by the Correctional Service “subsequent to the death of Ashley Smith”,<sup>110</sup> any such study must refer to the human rights standards promulgated by the *CRPD*. While heavily criticizing the inattention of the *Roadmap* to the salience of this issue, *A Flawed Compass* condemns this “most powerful form of carceral authority” as “the best documented example in Canada of the abuse of correctional power”.<sup>111</sup>

The critical issue of the use of segregation does not exhaust the agenda for review mandated by *Art. 15*. Other correctional responses to difficulties faced by prisoners should be re-examined as well, such as “self-harm incidents” and the “use of restraints for health care purposes”.<sup>112</sup> Any examination of a prisoner’s behaviour or the response by penal authorities must consider the extent to which unsatisfied mental health needs ground these problems. Given that the boundaries of tolerable institutional norms have narrowed under the rights promoting aegis of the *CRPD*, a thorough reconsideration should lead to a radical shift in law, policy and services. The review under the impetus of *Art. 15(1)* should not stop at the margins of exceptional situations involving segregation, self-harming incidents or the use of restraints.

#### **E. Freedom from “exploitation, violence and abuse”**

Prisoners with mental health problems (and intellectual disabilities) are acutely vulnerable in closed institutions, at risk of “abuse, sexual assault and violence by other prisoners”<sup>113</sup> and by staff. The *CRPD* extends another literal lifeline in *Art. 16*, demanding States Parties take all measures “to protect persons with disabilities ... from all forms of exploitation, violence and abuse”.

While already statutorily directed, for example, by the *CCRA* s. 3, to ensure “safe and humane custody”, corrections authorities should conduct a study of the extent of risk and harm that prisoners with mental illness face in penal environments from all sources. Article 16(5) obliges States Parties to ensure that “instances of exploitation, violence and abuse ... are identified, investigated and, where appropriate, prosecuted”. A baseline audit would assist in discharging this duty and provide a foundation for an innovative approach to ensure that inmates receive the maximum amount of protection. These steps would conduce to advancing the correlative responsibility under *Art. 16(3)*, to guarantee that “facilities and programmes ... are effectively monitored by independent authorities”. Existing services, such as the Office of the

Correctional Investigator or its provincial counterparts, may already partially serve this protective function, but the *CRPD* implies a renewed mandate that recognizes that prisoners with disabilities require exceptional safeguarding owing to their compound vulnerabilities.

#### **F. Ensuring “Equal recognition before the law” and “Access to justice”**

The interrelated premises of arts. 12 and 13 offer enhanced protection of the enjoyment of “legal capacity on an equal basis” and “effective access to justice for persons with disabilities” respectively. They endeavour to provide buttresses to “[e]qual recognition before the law” (*Art. 12*), specifying that this recognition should have a forum and remedy by ensuring the justice will be within the reach of persons with disabilities (*Art. 13*). The *CRPD* accepts that due to the additional barriers faced by people with disabilities, appropriate measures have to be taken to “provide access” to the support required (*Art. 12(3)*) and there must be “procedural and age-appropriate accommodations” in the justice system (*Art. 12(1)*).

The needs of prisoners with mental health problems wherein the twin issues of equal recognition and access to justice arise cover a very wide spectrum. They span the whole range of typical legal problems confronted by prisoners, but with the nuance that the inmate’s ability to make decisions or participate in the legal process may be compromised, often only in the view of others, by his or her mental health difficulties. Assertions of legal capacity and the ability to participate in proceedings are enhanced by the provision of legal counsel, but for prisoners in general and inmates with mental disabilities in particular, huge gaps in service have been revealed at the international and domestic levels. The United Nations Office on Drugs and Crime articulates a sweeping standard:

*In order to ensure that individuals with mental health needs who come into contact with the justice system are not disadvantaged, it is vital that they have immediate and regular access to legal counsel during their whole period of arrest, detention or imprisonment.*<sup>114</sup>

Australian and Canadian studies confirm the breadth of legal difficulties faced by prisoners and the additional challenges faced by those with mental illness. A New South Wales report reveals the expected array of criminal, civil and family law problems emerging from pre-custodial conflicts, but supplemented by detention-related concerns “as the person is suddenly excised from their everyday

life” and additional “[l]egal issues particular to being a prisoner”, including “prison disciplinary action, classification and segregation”.<sup>115</sup> A Canadian Department of Justice study replicated these results, noting also involuntary transfers, conditional release and “issues related to the accuracy of their files” as being urgent problems.<sup>116</sup> In terms of availability of legal services, a participant in a contemporary British Columbia project made a representative summative comment. A prison legal service was “unable to meet the demand. Public scrutiny is unlikely in all but the most extreme situations and of all the groups in society, prisoners are seen as the least ‘deserving’”.<sup>117</sup> The policy of the prisons in general appears to demonstrate general acceptance of the need “[t]o ensure respect for the rights of inmates by providing them with reasonable access to legal counsel and the courts”, although some limits are noted. For example, “there is no automatic right to counsel for minor disciplinary proceedings” and “[s]hould legal aid be unavailable ... legal fees will be paid by the inmate”,<sup>118</sup> a proviso which could leave many prisoners without counsel.

The same sources note the special needs of persons with mental health difficulties. The New South Wales study revealed many barriers to “prisoners’ capacity to identify and deal with legal issues they are facing and to actively participate in legal processes”, including “comprehension capacity”, “high rates of illiteracy, mental health issues, alcohol and other drug misuse and cognitive impairments”.<sup>119</sup> The Department of Justice Canada recommended the “need for ‘patient advocates’ similar to those provided in some provincial mental health facilities, as many inmates with mental disorders are often confused and cannot make informed decisions about treatment”.<sup>120</sup> The study further cited the requirements of “legal advice and support for disciplinary hearings” and during “annual or biannual reviews”, as such inmates “tend to be shy and don’t understand”.<sup>121</sup> The British Columbia report concluded realistically: “Another important point is that accused persons with mental or cognitive disabilities ... may require representation in all criminal proceedings”.<sup>122</sup>

The implementation of arts. 12 and 13 of the *CRPD* in Canadian prisons demands the generous allocation of resources to support the delivery of appropriate legal services to inmates with mental health problems and the amplification of corrections policies to recognize and facilitate

access to legal services for this needy category of prisoners.

### G. The Balance between Deprivations of Liberty, Criminalization and Social Rights

Article 14 of the *CRPD* ensures that people with disabilities enjoy liberty and security of the person equally, although lawful deprivations are tolerable, presuming that such intrusions conform with the “objectives and principles of the present Contention” and acknowledging that disability *simpliciter* “shall in no case justify a deprivation of liberty”. Canadian prisoners with mental health problems who are the subject of a lawful and fairly imposed sentence under the criminal law would not be seen as victims of discrimination using the criteria of *Art. 14*, as long as the deprivation of liberty is not solely, or perhaps primarily, a function of “the existence of a disability” and any attenuation is consistent with the *Convention*.

This standard raises foundational policy issues that take one back to the basic nature of the criminalization process. Clearly many people are brought within the control of the criminal justice system in situations where the behaviour constituting the offence emerges virtually exclusively from a mental health problem and related social barriers. Alternative measures that assist in answering the person’s needs for supports and services in the community would often forestall the use of the blunt instrument of the criminal law. With the impetus of the *CRPD*, such threshold topics should be confronted more urgently and perhaps Canadian society will improve its preventative strategies and provide more modulated justice system responses.

However well accepted the avoidance of criminalization is in general, until there is a major repositioning of public policy, Canada will house a disproportionate number of people with mental illness in its jails and penitentiaries. For such inmates, several questions required by *Art. 14* will remain for prison authorities. How can the public be assured that the continuing deprivation of liberty or additional restrictions on liberty are not simply based on “the existence of a disability?” How can it be guaranteed that the deprivation or attenuation is carried out in a manner which is consistent with international human rights law and the values of the *Convention*? These are hovering, omnipresent standards, which should haunt legislators, corrections officials and the judiciary. The *Convention* should provide additional support for



legal and constitutional challenges to inadequate treatment of inmates.

Among the many dilemmas presented by *Art. 14* is the extent to which a lawfully imprisoned person with a mental illness is afforded the guarantees “on an equal basis with others” inherent in the broad economic, social and cultural rights enshrined in arts. 24-30. These provisions are critical to achieving the goals of the *Convention*, but their fulfillment for an imprisoned person is compromised and the possibilities of attaining each objective must be balanced against restrictions imposed by valid penological purposes.

Articles 24-30 cumulatively sustain the general principles of *Art. 3*, including respect for dignity and autonomy, non-discrimination, inclusion and diversity, by providing for necessary societal changes. Some of the rights may be more readily operationalized in the prison setting, but it seems more consistent with the protection of human rights under the *Convention* to strive to articulate interpretations which are, as far as possible, dictated by the primacy of human rights, as opposed to other more typical corrections concerns.

### (1) Education

The rights in *Art. 24* to an education which is inclusive and directed to the “development of human potential” and “respect for human rights” and the enabling of effective societal participation can be achieved within the prison context. The *CCRA* (s. 76) already requires the Correctional Service to “provide a range of programs designed to address the needs of offenders and contribute to their successful reintegration”. The *Forum on Corrections Research* indicated their endorsement of the view that, in general, “[e]ducation in prisons is a really very sad story ... very limited in range and very poor in quality”.<sup>123</sup> The *Roadmap* reviewed the programs offered by CSC, but did not comment on the nexus between prisoners with mental health problems and the nature or execution of the various streams, although the panel did express concern at the low “completion rate for all educational programs” (31%)<sup>124</sup> and recommended a consequent review. *A Flawed Compass* makes a more searching effort to connect education (and work) to their human rights analysis, as “the provision of opportunities for people to advance their capacity to live constructively in free society is not only consistent with but essential to” respect for human dignity.<sup>125</sup> As in so many other instances, the design of educational programming suitable for persons with mental illness and consistent with the *CRPD* is not

as elusive as locating and providing the resources to deliver the necessary services.

### (2) Health Care (and Habilitation)

The right to mental health care (and habilitation services) for prisoners, “the enjoyment of the highest attainable standard of health without discrimination” provided for in *Art. 25* of the *Convention* (and *Art. 26* for habilitation services), is again within reach despite this being a wholly unfulfilled promise in Canada and worldwide. The foundations for provision of prison health care were already well delineated before the *CRPD*, “based on the principle of equivalence ... the level and quality of the basic health services should be the same as in the community”,<sup>126</sup> with prisoners having “access to the health services available in the country without discrimination on the grounds of their legal situation”.<sup>127</sup> The *CCRA* further particularizes the equivalence norm in s. 86, demanding that “every inmate” have “essential health care” and “reasonable access to non-essential mental health care” contributing to rehabilitation and re-integration and conforming to “professionally accepted standards”.

The failure of Canadian prisons to meet these standards suggests that a crucially different approach should be taken. The Trenčín Statement demonstrates the acceptance of the need for this change by WHO Europe. The mental health of prisoners cannot be left as an issue only for prison authorities” and “prison health services should be viewed as an integrated part of the society’s national health system”.<sup>128</sup> As Edgar and Rickford opined in the British context, although suitably repeated here, the justice system holds virtually exclusive authority for prisoner health, and “managing prisoners’ needs is not easily shared with other social agencies”.<sup>129</sup> The current situation, wherein federal offenders are specifically excluded from the *Canada Health Act* (which establishes they are not “insured persons” under s. 2 and thereby are not eligible to receive “insured health services” pursuant to that Act), as are other groups, such as members of the Canadian Forces and R.C.M.P., need not be permanent.

Why should prisoners not receive health care on an unexceptional basis especially as there are reasons to believe that the present situation is so problematic? A 2004 Library of Parliament study found that, although “the federal government does not do the work alone”,<sup>130</sup> “the question then arises as to whether the federal government adheres to the *Canada Health Act*”<sup>131</sup> and “there is currently no mechanism for ensuring the federal government’s

adherence”.<sup>132</sup> Arising out of the chronic insufficiency of the mental health care system in Canadian prisons, a reconfiguration of responsibilities should be studied.

Relocating control over prison mental health care services, to either share responsibility with provincial public health authorities or to divest the Correctional Service of this mandate entirely, could have a greater chance of curing the deficit. While not going this far in its recommendations for improving mental health care for prisoners, the *Roadmap* did propose that “Health Canada formally recognize the importance of addressing the mental health problems of offenders”,<sup>133</sup> although its suggestions are more grounded in its positioning mental health “as a critical factor in the Government’s public safety agenda”<sup>134</sup> than human rights. The *CRPD* specifically says that its provisions “extend to all parts of federal states without any limitations or exceptions” (*Art. 4(5)*), which suggests that the obligation to deliver the “highest attainable standard of health” should be a competence-based question, as opposed to being linked to the criteria of inconsistent statutory allocations of health care responsibilities. In a similar vein, an argument can be made for comparable provision of “comprehensive habilitation and rehabilitation services ... in the areas of health, employment, education and social services” under *Art. 26* within prisons.

### (3) *Adapting Other Social, Cultural and Economic Rights to the Prison Setting*

Articles 27-30 are meant to compel States Parties to set the societal stage for inclusion and dignity. Many aspects of these directives have a closer bearing for people living in the community, but this is not to say that their injunctive content is irrelevant for prisoners. A brief examination of each article demonstrates that some additional human rights promoting measures are necessary for prisoners in light of these articles of the *CRPD*.

#### (i) *Work and Standard of Living*

As part of its emphasis on participation and inclusion, the *Convention* recognizes the importance of accessibility to the social and economic environment (Preamble (v)) and the right to work “on an equal basis with others” (*Art. 27(1)*), while ensuring that persons with disabilities are protected from “forced or compulsory labour” (*Art. 27(2)*). International human rights and domestic law establish the juridical setting for prisoner work,

which needs to be infused with the principles of the *CRPD*. The United Nations Office on Drugs and Crime observes that, as part of mental and physical well-being, prisoners with mental disabilities must have “access to a varied set of prisoner programmes, including work”.<sup>135</sup> The *Standard Minimum Rules* establish a general regime that dictate that prisoners “shall be required to work, subject to their physical and mental fitness”,<sup>136</sup> as long as the labour is not “of an afflictive nature”.<sup>137</sup> The *Basic Principles for the Treatment of Prisoners* require authorities to create conditions “enabling prisoners to undertake meaningful remunerated employment”, facilitating re-integration and financial contributions to their own and their families’ support.<sup>138</sup> The *CCRA* obliges the Correctional Service to provide a range of programs, which may include payments to offenders for work (s. 78) and work release, for “work or community service outside the penitentiary” (s. 18(1)).

Corrections authorities must ensure the work experience which is made available for prisoners with mental health problems is non-discriminatory, voluntary in most respects (outside the basic duty to perform some work if possible) fairly remunerative and offers “protection from harassment” (*Art. 28(1)*). In the harsh environment of the prison, establishing such work programs does present considerable difficulties, but the recognition of their necessity under the *CRPD* and the regulation of aspects of their nature should conduce to more sensitized employment ventures for vulnerable prisoners. Neither the *Roadmap* nor *A Flawed Compass* develops work-related proposals in ways which are linked specifically to prisoners with mental health problems, although at least the latter document endeavours to connect work, education and re-integration planning to “self actualization”, “opportunities to make choices about one’s future” and ensuring “human needs are met beyond those that relate only to physical survival”, a perspective consistent with their human rights-oriented analysis.<sup>139</sup>

Article 28, sets out the right “to an adequate standard of living ... without discrimination” which may be more directly related to programming, discharge planning and post-release support issues. The reminder by the *CRPD* that “the majority of persons with disabilities live in conditions of poverty” (Preamble (t)) should alert correctional authorities to the special needs of persons with mental health problems, in order “to break the cycle of release, re-offending and imprisonment”<sup>140</sup> inherent in criminalization described by the United

Nations Office on Drugs and Crime. The *Standard Minimum Rules* prerequisites to provide “for the prisoner a gradual return to life in society”<sup>141</sup> and “after-care directed towards the lessening of prejudice”<sup>142</sup> contemplate the likelihood of poverty for inmates with psycho-social disabilities upon their release. The knowledge that poverty is virtually inevitable for discharged prisoners who experience mental health problems should infuse the issues of prison programs and release planning.

(ii) *Participation in Political and Public Life*

Article 29 guarantees “political rights” and “participation on an equal basis”, comprising voting rights and participation in non-governmental organizations, including under *Art. 29(b)* those “of persons with disabilities to represent persons with disabilities”. While the *Sauvé* case recognized the harms of depriving prisoners of the right to vote “as an important means of teaching them democratic values and social responsibility”,<sup>143</sup> it did not otherwise extend the right to political participation. There should be more information in the political process about the situation of Canadian prisoners in general and of those experiencing mental health problems in particular. This would benefit public life by providing a humane antidote to the retributive climate that has characterized sentencing issues. More opportunities to participate in the political process should be offered to prisoners.

The other major component of *Art. 29*, encouraging the formation of and membership in disability advocacy organizations is attainable, as there are already many recognized inmate associations. The positive aspects of self-help or peer support groups for members’ mental health has been widely accepted.<sup>144</sup> The additional strength that emerges from disability advocacy organizations in changing public attitudes or in lobbying for legal policy and service changes is apparent, which should encourage prisoners to join together. Article 29 requires States Parties, including prison authorities, “to promote actively an environment” in which such organizations are fostered. Living up to this obligation would assist prisoners and contribute to the functioning of institutions.

(iii) *Participation in cultural life, recreation, leisure and sport*

The entitlements of *Art. 30* “to take part on an equal basis with others in cultural life” and “recreational, leisure and sporting activities” requires “appropriate measures” to ensure access and

participation. In the prison setting, the importance of these activities has been recognized with the *Standard Minimum Rules* requiring exercise and physical and recreational training and “cultural activities” (*Art. 21*) “for the benefit of the mental and physical health of prisoners” (*Art. 78*). The latter notion is accepted in the *Basic Principles for the Treatment of Prisoners*, *Art. 6*, wherein taking part in cultural activities is “aimed at the full development of human personality”. As in other areas of the *Convention*, the focus emerging from this article is to direct the whole range of activities contemplated within it towards positive mental health and preventative measures. This overall goal is seen as a key criterion for success in the *Trenčín Statement*: “Promoting mental health and well-being should be central to a prison’s health care policy”.<sup>145</sup>

## X. Conclusion: Moving Towards a State of Readiness for *Convention* Reforms before Being Held Accountable

In the *CRPD*, Canada has a genuine opportunity to improve the lives of prisoners and, in particular, those with mental health problems. The country is clearly obligated to adopt “measures for the implementation of the rights” and to “modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities” (*Art. 4(1)*) and the extent of this challenge must be recognized. The stigma that surrounds mental illness sometimes seems ineradicable when combined with the prejudices surrounding criminality, especially when criminal justice policy seems to have become so ideologized.

Canada’s prisons certainly provide more resources for inmates with psycho-social disabilities compared to many other nations, but this kind of relative measurement should provide little comfort to a rich democracy, imbued with the rule of law and always worried that its human rights leadership in the world might be besmirched. Canadian prisoners with mental illness deserve more than they have received and the *Convention* provides a new incentive to heighten the human rights level of compliance for those in custody.

A recent *Canadian Medical Association Journal* editorial raises the stakes for Canadian legislators, courts and corrections officials:

*That so many inmates in jails and prisons have mental health disorders—often untreated—is an indictment of society’s values and understanding of mental health disorders.*<sup>146</sup>

This charge cannot be ignored in 2011. Before the *CRPD*, it should have been morally and politically

unacceptable for Canadian prisoners with mental illness to have suffered so much, even as legal and constitutional challenges seemed ineffective. Since Canada's ratification of the *Convention*, their deplorable situation has become unacceptable under this disability-centred human rights treaty. Canada will soon file its initial report to the Committee on the Rights of Persons with Disabilities. The country should be held to the highest standards by the Committee, for which nation, if not Canada, can be expected to attain conformity with the dictates of the *CRPD*? If Canada screws up its courage and finally signs and ratifies the Optional Protocol, individuals or groups "who claim to be victims of a violation" (*Art. 1(1)*) can complain to the Committee, a direction which at present seems unavoidable.

Canada should promptly initiate a conscientious examination of the nation's prisons in order to fulfil its obligations under the *CRPD* for inmates with mental health problems. If it fails to do so and is held accountable on the international stage, how will the nation plead to the indictment? What can it say in mitigation? The time has passed for weak excuses

[*Editor's note*: H. Archibald Kaiser is a Professor at the Schulich School of Law, Dalhousie University, where he teaches Criminal Law, Criminal Procedure and Mental Disability Law, areas where he researches and writes as well. He is cross-appointed to the Department of Psychiatry in the Faculty of Medicine at Dalhousie where he teaches Legal Issues in Psychiatry in the Residency Training Program. He is a member of the Board of the Canadian Mental Health Association, Nova Scotia Division and the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada. He has served on the Boards of other advocacy organizations and has also provided counsel services to persons with mental health problems and health care practitioners.]

<sup>1</sup> Although the term "criminalization" may be broadened to consider all the harmful aspects of the experience of persons with mental illness within the criminal justice system, for present purposes a simpler definition will suffice: "The term 'criminalization of the mentally ill' refers to the increased likelihood of people with mental illness being processed through the criminal justice system instead of through the mental health system". *The Sentencing Project, Mentally Ill Offenders in the Criminal Justice System: An Analysis and*

*Prescription* (The Sentencing Project: Washington, 2002), at 2. The Canadian Mental Health Association, British Columbia Division, provided a similar definition in March 2005, in "Criminalization of Mental Illness": "where a criminal legal response overtakes a medical response to behaviour related to mental illness" online: <www.cmha-bc.org>. The Bazelon Center for Mental Health Law summarized the key elements of criminalization in "People with Serious Mental Illnesses in Jail and Prison; Their Stories", Fact Sheet # 2; "People with mental illnesses often come into contact with the criminal justice system ... Many lack access to adequate services through the public mental health system ... The criminal justice system is used to fill the void ... Once people are in the criminal justice system, their mental health needs are not met". Online: <www.bazelon.org>.

<sup>2</sup> United Nations Office on Drugs and Crime, *Handbook on Prisoners with Special Needs* (Vienna: United Nations, 2009).

<sup>3</sup> *Ibid.*, at 10.

<sup>4</sup> *Ibid.*, at 11.

<sup>5</sup> *Ibid.*, at 11-12.

<sup>6</sup> *Ibid.*, at 12-18.

<sup>7</sup> Lars Møller, Heins Stöver, Ralf Jürgens, Alex Gatherer and Haik Nikogosian, eds., *Health in prisons; A WHO guide to the essentials in prison health* (Copenhagen: WHO, 2007).

<sup>8</sup> *Ibid.*, at 133.

<sup>9</sup> *Ibid.*, at 134.

<sup>10</sup> *Supra*, note 1, at 3.

<sup>11</sup> *Ibid.*, at 4.

<sup>12</sup> *Ibid.*, at 7.

<sup>13</sup> The Council of State Governments, Criminal Justice Mental Health Consensus Project, Chapter IV, "Incarceration and Reentry", at 126.

<sup>14</sup> Bazelon Center for Mental Health Law, "Fact Sheet # 1; Criminal Justice System Involvement of People with Serious Mental Illnesses", online: <www.bazelon.org>.

<sup>15</sup> Henry Steadman, Fred Osher, Pamela Robbins, Brian Case and Steven Samuels, "Prevalence of Serious Mental Illness Among Jail Inmates" (2009) 60(6) *Psychiatric Services* 761.

<sup>16</sup> *Ibid.*, at 764.

<sup>17</sup> Bazelon Center for Mental Health Law, "New Study Shows Alarming Rates of Serious Mental Illnesses

- Among Inmates, Particularly Women, In Jail”, Press Release, June 1, 2009.
- 18 K. Edgar and D. Richford, “Neglecting the mental health of prisoners” (2009) 5(3) *Int. J. of Prisoner Health* 166.
- 19 *Ibid.*, at 170.
- 20 A. Fraser, “Mental health in prisons: A public health agenda” (2009) 5(3) *Int. J. of Prisoner Health* 132, at 139.
- 21 (U.K.), 30 & 31 Victoria, c. 3.
- 22 R.S.C. 1985, c. C-46.
- 23 The Collaborating Centre for Prison Health and Education of the University of British Columbia, in “General Information on Canadian Prisons”, recently collated statistics showing that: “In 2007/08, on a given day 36,330 adults and 2,018 youth ... were in custody in Canada, for a total of 38,348 inmates”, of whom “13,581 were in federal custody”. The Centre also noted that 30% of the B.C. Corrections population had a substance use disorder and “[a]n additional 26% were diagnosed with a mental disorder unrelated to substance use”, while “80% of the final prison population has received a psychiatric diagnosis”. Online: <[www.familymed.ubc.ca/ccphe/Resources/General\\_information\\_on\\_Canadian\\_Prisons.htm](http://www.familymed.ubc.ca/ccphe/Resources/General_information_on_Canadian_Prisons.htm)>. The Canadian Mental Health Association, Ontario, in “Justice and Mental Health”, concluded that: “Provincial jails have become crowded repositories for people with mental disorders ...” online: <[www.ontario.cmha.ca/justice.asp](http://www.ontario.cmha.ca/justice.asp)>.
- 24 [2000] S.C.J. No. 59, [2000] 2 S.C.R. 780.
- 25 S.C. 1992, c 20.
- 26 *Annual Report of the Correction Investigator, 2003-2004*.
- 27 Canadian Public Health Association, “A Health Care Needs Assessment of Federal Inmates in Canada”, (2004) 95(1) *Can. J. of Public Health* 548.
- 28 *Supra*, note 26, at 41.
- 29 *Annual Report of the Correctional Investigator 2004-2005*, at 13.
- 30 *Annual Report of the Correctional Investigator 2005-2006*, at 8.
- 31 *Annual Report of the Correctional Investigator 2006-2007*, at 23.
- 32 *Annual Report of the Correctional Investigator 2007-2008*, at 36.
- 33 *Annual Report of the Correctional Investigator 2008-2009*, at 12.
- 34 *Ibid.*, at 13.
- 35 *Ibid.*, at 16.
- 36 *Annual Report of the Office of the Correctional Investigator 2009-2010*, at 5.
- 37 *Ibid.*, at 6.
- 38 John Service, *Under Warrant: A Review of the Implementation of the Correctional Service of Canada’s ‘Mental Health Strategy’*, at 3.
- 39 *Ibid.*, at 30.
- 40 *Ibid.*, at 31.
- 41 Correctional Service of Canada Review Panel, October 2007, *A Roadmap to Strengthening Public Safety*.
- 42 *Ibid.*, at 54.
- 43 *Ibid.*, at 225.
- 44 Michael Jackson and Graham Stewart, *A Flawed Compass: A Human Rights Analysis of the Roadmap to Strengthening Public Safety*.
- 45 *Ibid.*, at xxxiv.
- 46 *Ibid.*, at 10.
- 47 *Ibid.*, at 11.
- 48 *Ibid.*, at 12.
- 49 *Ibid.*, at 11-12.
- 50 See, The Ombudsman and Child and Youth Advocate of New Brunswick, *The Ashley Smith Report*, June 2008; Office of the Correctional Investigator, *A Preventable Death*, June 20, 2008.
- 51 CBC News, “Mentally ill inmates fall through cracks: Van Loan”, January 8, 2010 <<http://www.cbc.ca/news/health/story/2010/01/08/van-loan-prisons008.html>>.
- 52 Canadian Association of Elizabeth Fry Societies, Annual General Meeting 2011, Executive Director’s Report, at 2.
- 53 “Watchdog says prison violence on rise; Toews says it has decreased” *The Globe and Mail* (8 August 2011).
- 54 Council of the Canadian Bar Association, Resolution 11-09-A, “Justice in Sentencing”, August 13-14, 2011.
- 55 Council of the Canadian Bar Association, Resolution 11-07-A, “Mentally Ill Persons in the Criminal Justice System”, August 13-14, 2011.
- 56 Editorial, *The Globe and Mail* (10 August 2011). See also, Kirk Makin, “Why Canada’s prisons can’t cope with flood of mentally ill inmates”, *The Globe and Mail* (21 January 2011).
- 57 Editorial, “Tough-on-Crime Plans; Guilty of Inflexibility” *The Chronicle Herald* (19 August 2011).

- <sup>58</sup> *R. v. Gladue*, [1999] S.C.J. No. 19, [1999] 1 S.C.R. 688, at para. 52.
- <sup>59</sup> *Ruffin v. The Commonwealth*, 62 Va. 790; 1871 Va. LEX 1589; 21 Gratt. 790.
- <sup>60</sup> *May v. Ferndale Institution*, [2005] S.C.J. No. 84, [2005] 3 S.C.R. 809, at para. 23.
- <sup>61</sup> *Supra*, note 59 at 796.
- <sup>62</sup> *Sauvé v. Canada (Chief Electoral Officer)*, [2002] S.C.J. No. 66, [2002] 3 S.C.R. 519, at para. 43.
- <sup>63</sup> *Ibid.*
- <sup>64</sup> *Ibid.*, at para. 47 [emphasis added].
- <sup>65</sup> *Ibid.*, at para. 23.
- <sup>66</sup> Todd Sloan, “Shifting the Orbit; Human Rights, Independent Review and Accountability in the Canadian Corrections System” (June 2003), The Office of the Corrections Investigator, at 18-19 [emphasis in original].
- <sup>67</sup> The statutory purpose of the correctional system is stated in s. 3 of the *CCRA*:
- 3.** The purpose of the federal correctional system is to contribute to the maintenance of a just, peaceful and safe society by
- (a) carrying out sentences imposed by courts through the safe and humane custody and supervision of offenders; and
- (b) assisting the rehabilitation of offenders and their reintegration into the community as law-abiding citizens through the provision of programs in penitentiaries and in the community.
- <sup>68</sup> *Supra*, note 44, at xviii.
- <sup>69</sup> *Supra*, note 41, at 16.
- <sup>70</sup> *May v. Ferndale Institution*, *supra*, note 60, at para. 55.
- <sup>71</sup> Mary Beth Wolicky, “Background to Transformation”, 33(1) *Let’s Talk* (Correctional Service Canada), September 16, 2008.
- <sup>72</sup> Don Head, “Building on a Strong Foundation: The Way Forward” 33(1) *Let’s Talk* (Correctional Service Canada), September 16, 2008.
- <sup>73</sup> Vic Toews, (Minister of Public Safety), “Minister’s Message”, Correctional Service Canada – Report, Treasury Board of Canada Secretariat, Reports on Plans and Priorities, 2011-2012.
- <sup>74</sup> Louise Arbour, *Commission of Inquiry into Certain Events at the Prison for Women in Kingston*, s. 3.12, “The Breakdown of the Rule of Law”, at 153.
- <sup>75</sup> *Ibid.*, at 156.
- <sup>76</sup> *Supra*, note 66, at 20.
- <sup>77</sup> Michael Jackson, *Justice Behind the Walls; Human Rights in Canadian Prisons* (Vancouver: Douglas and McIntyre, 2002), at 59.
- <sup>78</sup> *Ibid.*, at 66.
- <sup>79</sup> The John Howard Society of Alberta, “Inmates Rights and Criminal Options”, 1998, at 1.
- <sup>80</sup> Correctional Service of Canada, Max Yalden, Chair, “The Human Rights Legislative Framework”, in *Human Rights and Corrections: A Strategic Model* (1997), at 1 [Yalden Report].
- <sup>81</sup> Mary Campbell, “Revolution and Counter Revolution in Canadian Prisoners’ Rights” (1996) 2 *Can. Crim. L. Rev.* 285 at 286.
- <sup>82</sup> Susan Easton, “Constructing Citizenship: Making Room for Prisoners’ Rights”, (2008) 30:2 *Journal of Social Welfare and Family Law* 127, at 128.
- <sup>83</sup> *Ibid.*, at 143-144.
- <sup>84</sup> James W. O’Reilly, *Prisoners as Possessors of Rights in Canadian Law*, LL.M. Thesis, University of Ottawa, 1988, at 206-207.
- <sup>85</sup> Jayshree Ghedia, *Prisoners: Rights, Rhetoric and Reality*, LL.M. Thesis, University of British Columbia, 2002, at 15.
- <sup>86</sup> *Ibid.*, at 19.
- <sup>87</sup> Michael L. Perlin and Henry A. Dlugacz, “‘It’s Doom Alone That Counts’: Can International Human Rights Law Be An Effective Source of Rights in Correctional Conditions Litigation?” (2009) *Behav. Sci. & L.* 675 at 676.
- <sup>88</sup> *Supra*, note 80.
- <sup>89</sup> *Supra*, note 77, at 609.
- <sup>90</sup> *Supra*, note 80, Annex H: Summary of Recommendations, The Corrections and Conditional Release Act.
- <sup>91</sup> United Nations General Assembly resolution 43/173, annex.
- <sup>92</sup> United Nations General Assembly resolution 45/111, annex.
- <sup>93</sup> For more thorough discussions of the *CRPD* by this same author, see also H. Archibald Kaiser, “Canadian Mental Health Law: The Slow Process of Redirecting the Ship of State” (2009) 17 *Health L.J.* 139-94, esp. at 159-64; and Hy Bloom and Richard Schneider, eds., “Law and Psychiatry in the Age of the

- Convention on the Rights of Persons with Disabilities*”, in *Law and Mental Disorder: A Practical and Comprehensive Approach*, (Toronto: Irwin, publication forthcoming, Fall 2011).
- <sup>94</sup> U.N. Enable, “Some Facts About Persons with Disabilities”, online: <[www.un.org/disabilities/Convention/facts.shtml](http://www.un.org/disabilities/Convention/facts.shtml)>. See also World Health Organization, *World Report on Disability* (Geneva: WHO, 2011).
- <sup>95</sup> World Health Organization, *Summary: World Report on Disability* (Geneva: WHO, 2011), at 7.
- <sup>96</sup> 418 U.S. 539 (1974), at 555-56.
- <sup>97</sup> M. Robinson, “Foreword”, in G. Quinn and G. and T. Degener, *Human Rights and Disability: The current use and future potential of United Nations human rights instruments in the context of disability* (New York: United Nations, 2002).
- <sup>98</sup> M.L. Perlin, “‘A Change is gonna come’: The implications of the United Nations *Convention on the Rights of Persons with Disabilities* for domestic practice of constitutional mental disability law” (2009) 29 N. Ill. U.L. Rev. 483 at 489.
- <sup>99</sup> Foreign Affairs and International Trade Canada, Government of Canada, Press Release, “Canada ratifies UN *Convention on the Rights of Persons with Disabilities*” (11 March 2010).
- <sup>100</sup> A. Dimopoulos, *Issues in Human Rights Protection of Intellectually Disabled Persons* (Burlingham, Vt.: Ashgate, 2010), at 10.
- <sup>101</sup> Office of the High Commission for Human Rights, Foreword in *Monitoring the Convention on the Rights of Persons with Disabilities: Guidance for human rights promoters* (New York: United Nations, 2010).
- <sup>102</sup> R. Kayess and P. French, “Out of darkness into light? Introducing the *Convention on the Rights of Persons with Disabilities*” (2009) 8:1 H.R. L. Rev. 1 at 32.
- <sup>103</sup> For example, see Tina Minkowitz, “WNUSP Submission on Revision of the Standard Minimum Rules on the Treatment of Prisoners”, which suggests several required changes in the SMR.
- <sup>104</sup> WHO Europe, *Trenčín statement on prisons and mental health* (Copenhagen: WHO Europe, 2008) 18 October 2007.
- <sup>105</sup> Australia’s Initial Report under the *Convention on the Rights of Persons with Disabilities*, 3 December 2010, at para. 92.
- <sup>106</sup> *Supra*, note 93, especially “Law and Psychiatry in the Age of the *Convention on the Rights of Persons with Disabilities*”, at 17-19.
- <sup>107</sup> Lance Gable and Lawrence O. Gostin, “Global Mental Health: Changing Norms, Constant Rights” (2008) Wayne State University Law School Legal Studies Research Paper Series No. 08-26 83, at 86.
- <sup>108</sup> *Supra*, note 36, at 6.
- <sup>109</sup> *Supra*, note 41, at 14 [emphasis in original].
- <sup>110</sup> *Ibid.*, at 7.
- <sup>111</sup> *Supra*, note 42, at xviii.
- <sup>112</sup> The 2009-10 *Report of the Office of the Correctional Investigator* identified these issues as having mental health connections. See pp. 7-10.
- <sup>113</sup> *Supra*, note 2, at 15.
- <sup>114</sup> *Supra*, note 2, at 27.
- <sup>115</sup> Anne Grunseit, Suzie Forell and Emily McCarron, *Taking justice into custody; The Legal Needs of Prisoners* (Sydney: Law and Justice Foundation of New South Wales, 2008), at xvii.
- <sup>116</sup> Thérèse Lajeunesse, *Study of the Legal Services Needs of Prisoners in Federal Penitentiaries in Canada* (Ottawa: Department of Justice Canada, 2002), at 2.
- <sup>117</sup> Leonard T. Doust, *Foundation for Change; Report of the Public Commission on Legal Aid in British Columbia*, (Vancouver: Public Commission on Legal Aid, 2011), at 38.
- <sup>118</sup> Inmates’ Access to Legal Assistance and the Police, Commissioner’s Directive, Policy Bulletin 124, Correctional Service of Canada, 2011.
- <sup>119</sup> *Supra*, note 114, at xx-xxi.
- <sup>120</sup> *Supra*, note 115, at 2.
- <sup>121</sup> *Ibid.*, at 37.
- <sup>122</sup> *Supra*, note 116.
- <sup>123</sup> Forum on Corrections Research, “Staff Development and the Formulation of curriculum in Prison Education”, online: <<http://www.csc-sec.gc.ca/text/pblct/forum/e031/e0311-eng.shtml>> (Date accessed August 26, 2011).
- <sup>124</sup> *Supra*, note 41, at 44.
- <sup>125</sup> *Supra*, note 44, at 118.
- <sup>126</sup> *Supra*, note 7, at 134.
- <sup>127</sup> *Supra*, note 92.
- <sup>128</sup> *Supra*, note 104, at 5.
- <sup>129</sup> *Supra*, note 18, at 170.
- <sup>130</sup> Nancy Miller Chenier, *Federal Responsibility for the Health Care of Specific Groups* (Ottawa: Library of Parliament, 2004), at 2.
- <sup>131</sup> *Ibid.*, at 15.
- <sup>132</sup> *Ibid.*, at 16.
- <sup>133</sup> *Supra*, Recommendation 49, note 41, at 225.

<sup>134</sup> *Ibid.*, Recommendation 48, at 225.

<sup>135</sup> *Supra*, note 2, at 36.

<sup>136</sup> United Nations, *Standard Minimum Rules for the Treatment of Prisoners* (1955), Art. 71(2).

<sup>137</sup> *Ibid.*, Art. 71(1).

<sup>138</sup> *Supra*, note 92, Art. 8.

<sup>139</sup> *Supra*, note 44, at 119.

<sup>140</sup> *Supra*, note 2, at 38.

<sup>141</sup> *Supra*, note 136, Art. 60(2).

<sup>142</sup> *Ibid.*, Art. 64.

<sup>143</sup> *Supra*, note 62, at para. 38.

<sup>144</sup> See *supra*, note 2, in which peer counseling is propounded for its ability “to supplement the professional mental health care provided” (at 31) and its contribution to suicide and self-harm prevention programs (at 32).

<sup>145</sup> *Supra*, note 104, at 6.

<sup>146</sup> Noni MacDonald, Stephen J. Hucker, Paul C. Hébert, “The Crime of Mental Illness” (2010) 182:3 CMAJ 1399 at 1400.

## • GIVING VOICE — DECADE THREE OF PROTECTING MENTAL HEALTH PATIENT RIGHTS IN ALBERTA •

Fay Orr, Mental Health Patient Advocate at Government of Alberta

Established in 1990, Alberta’s Mental Health Patient Advocate (the “Advocate”) is still the only provincial investigative body created specifically to protect legislated rights and to deal with complaints from or relating to persons detained under mental health certificates in designated psychiatric facilities. In 2007 Alberta’s *Mental Health Act*, R.S.A. 2000, c. M-13 [*MHA*] was amended to expand the jurisdiction of the Advocate to include persons under one admission certificate and persons subject to community treatment orders (“CTOs”).

Given the Advocate’s more than two decades of experience and recent expansion of jurisdiction, now is a good time to assess how this unique body is doing. Is it meeting the expectations of the legislators who created it and providing a valuable service for persons with mental illness and those acting on their behalf?

### BACKGROUND

Prior to 1990 in Alberta, the provision of advocacy services on behalf of involuntary mental health patients was left to the discretion of individual hospitals. The investigation of complaints from or relating to such patients was handled by the provincial ombudsman. There was no external body mandated to provide rights advice. For years, people in Alberta and across Canada had been lobbying their respective governments for something more, specifically, the

establishment of patient advocate offices with staff skilled in mental health and sufficient resources to advocate full-time for involuntary patients living with a mental disorder.

In Alberta, the government responded with Bill 29 which amended the *MHA* to, among other things, establish for the first time in the province a Mental Health Patient Advocate. In explaining the government’s rationale during second reading of the Bill in 1988, then Minister of Health, the Honourable Marvin Moore, had this to say:

*Our judgment was that it was important to have this aspect of an individual’s rights highlighted by the appointment of an individual whose single and sole purpose, full-time, 365 days a year, is to be an advocate for involuntary mental health patients. So we took the decision knowing full well that there would be some concerns on behalf of the Ombudsman, who in the past – and I speak not only of the existing Ombudsman but others – has done an excellent job of looking after the concerns of involuntary mental health patients. But we took it with a view that this would strengthen even further the ability of an individual to ensure that all of their rights are protected under our legislation. (Hansard; May 30, 1988)*

### REPORTING STRUCTURE

The resulting legislation provides for the Lieutenant Governor in Council to appoint an Advocate to act as an investigative body. The Advocate is independent from the entities that are subject to investigation and reports directly to the Minister of Health and Wellness on legislative matters. While operating at arm’s length, the



Advocate reports administratively to the Deputy Minister of Alberta Health and Wellness. The law requires the Advocate to submit an annual report summarizing the Advocate's activities in that year to the Minister who must table it with the Legislative Assembly immediately if the legislature is in session or, if not, within 15 days of the start of the next session.

### **POWERS OF THE ADVOCATE**

The Advocate's powers and responsibilities are set out in s. 45 of the Act and in the Patient Advocate Regulation. The Advocate is specifically authorized to conduct an investigation with or without complaint and provide rights advice.

The Advocate's power to investigate without complaint is limited by s. 4 of the Patient Advocate Regulation to:

- any procedure relating to the admission of a person detained in a facility pursuant to the Act;
- any procedure of a facility for (1) informing a patient of his or her rights or (2) providing information as required by the Act to a patient and to guardians, nearest relatives or designates of a facility patient, and;
- any procedure of a regional health authority or an issuing psychiatrist relating to the issuance, amendment or renewal of a CTO.

The Advocate does not have jurisdiction to investigate complaints from or relating to voluntary patients. However, the Advocate can investigate if the concern is about something that happened while the complainant was under certificate or CTO.

### **JURISDICTION**

Originally, the Advocate's jurisdiction was limited to formal patients, who are individuals under two admission or renewal certificates. As mentioned above, in 2007 the legislation was amended to extend the Advocate's jurisdiction to patients under one admission certificate. The change was done partly in response to input from the Advocate's

office that it was receiving calls from patients under one certificate in emergency and on hospital units. These patients were perplexed about their detention and needed somewhere to turn for information about their legal status and rights. They also wanted an independent body to investigate and resolve their concerns.

As well, jurisdiction was extended to cover persons subject to the new, for Alberta, option of CTOs. The Alberta government introduced CTOs to provide a less restrictive alternative to hospital care. Family and advocacy groups had lobbied for CTOs for a number of years, based on the view of mental health experts worldwide that community-based care leads to better health outcomes for individuals with serious and persistent mental health disorders. The tipping point in Alberta was reached in 2006 when a public inquiry report into the shooting deaths of RCMP Corporal James Galloway and Martin Ostopovich recommended CTOs be introduced as a way to ensure persons with severe mental illness living in the community received needed treatment and supervision.

Under a CTO, an individual is given a personalized treatment and care plan which provides the support people need to stay in the community. The hope is CTOs will help people avoid repeated returns to hospital for stabilization, commonly known as the "revolving door syndrome". Given that persons subject to CTOs also have rights enshrined in the *MHA*, it made sense to provide them with access to the Advocate's services when this new care option was added to the legislation.

### **INVESTIGATING COMPLAINTS**

All inquiries made by the Advocate into complaints and concerns are called investigations, which may be informal or formal. The vast majority of complaints are resolved through informal investigation and conciliation. Concerns range from detention, treatment, care and/or control of a patient against his or her will, to lack of privileges, privacy and access to information. Many of these concerns are resolved through discussion between the patient, Advocate staff

(known as Patient Rights Advocates) and members of the treatment team.

Only the Advocate may authorize a formal investigation. Formals are reserved for concerns that cannot be easily resolved, such as allegations of abuse. By law, the Advocate is required to notify the facility board, regional health authority or issuing psychiatrist of the intent to conduct a formal investigation. As well, the Advocate is required to write an investigation report and send a copy to the board, health authority or issuing psychiatrist. A report containing recommendations must state the reasons for them. If after a reasonable time, the Advocate is of the opinion that appropriate action has not been taken on any of the recommendations, the Advocate is required to send a copy of the report to the Minister, along with a copy of the response, if any, from the above noted respondents.

Since its inception, the Advocate's office has investigated thousands of complaints. According to its 2009/10 annual report, the office opened 1,500 new files, resulting in 470 investigations during that year. While most investigations have been informal, there have been a number of formals that have resulted in the acceptance of numerous recommendations to enhance the protection of patient rights and improved treatment and care. Many of the recommendations have called for better staff and physician training and education. But there have also been calls for disciplinary action and improvements to policy and procedures for providing rights information and the use of restraints, for example.

#### **EVOLVING ROLE**

Over the years, the Advocate's role has evolved beyond its legislated mandate of investigating complaints. From its inception, the Advocate's office has worked to educate patients and others about their rights and responsibilities under the *MHA* through onsite patient visits and presentations to care providers and organizations throughout the province. The Advocate's office provides important linkages to other programs and oversight bodies and has worked to prevent problems from arising whenever possible.

It also provides coaching and support to individuals, ensuring their voice is heard and considered by the treatment team, and helping them navigate the system.

As well, the Advocate has responded to numerous and wide-ranging requests to provide input into legislation, policies and services that impact individuals and families living with mental illness. For example, the Advocate provided input into the *MHA* amendments of 2007 and continues to participate on a committee established to evaluate their implementation.

In 2010 the Advocate provided a written submission to the Minister's Advisory Committee on the *Alberta Health Act*. In its submission and in past annual reports, the Advocate promoted the concept of a patient charter, something the Alberta government has now committed to developing, along with a Health Advocate to help uphold it.

The Advocate was part of a stakeholder committee that provided input to the Ministry on its recently released addiction and mental health strategy. The Advocate is also a member of a cross-ministry government initiative to improve discharge planning from the health and corrections systems. In 2009, the Advocate accepted an invitation from the Ministry of Children and Youth Services to participate on a blue ribbon panel reviewing Alberta's child intervention system.

#### **PROMOTING THE CONCEPT OF RECOVERY**

The Advocate's office has also joined with others in the mental health advocacy field to promote the concept of recovery for persons living with a mental illness. Recovery doesn't necessarily mean a "cure", but the ability of an individual to learn how to manage and live with mental illness in a supportive environment. Ensuring the legislated rights of patients is fundamental to the recovery approach. Results from an evaluation done on the Advocate's office last year showed information and services provided to patients by the office empowered them to become actively involved in their recovery by giving them a better understanding of the province's mental health system.

Generally, patients who contact the Advocate's office have expectations of the health system similar to any other patient. Patients often speak of wanting to be heard and respected. They talk of wanting to feel supported in their journey of recovery and of wanting to be involved in decisions that impact their life. Like anyone, those living with a mental illness want to feel hope for a better future.

Judging from some of the comments the Advocate's office receives from clients, its services help people feel "heard" and supported. Some actual comments from patients over the past year include:

*You have a calming voice that helped me immensely*

*Thank you for listening to me during this difficult time away from my loved ones*

*You keep calling back. That is an angel's move*

*You have given me the courage to ask the questions I needed to ask today*

## EMERGING TRENDS AND ISSUES

For the most part, Alberta Health Services ("AHS"), the provincial body in Alberta responsible for province-wide delivery of health care services, has staff working in the mental health sector who are very supportive and cooperative in respecting the rights of patients who come under the Advocate's jurisdiction. In recent years, however, the Advocate's office has heard from an increasing number of patients with both mental health and medical needs that have been placed on medical or surgical units where staff are less familiar with the requirements and implications of the *MHA*.

As a result, patient rights have been affected. For example, there have been failures to provide patients with copies of their mental health certificates as required by law. There have also been failures to ensure timely renewal of certificates, which resulted in the patient being illegally detained, and to provide legislated rights information. To remedy this situation, the Advocate has been intervening to address specific concerns and working with AHS to

explore better ways of educating and training staff and physicians on non-psychiatric units about the importance of compliance with mental health legislation and how it protects this vulnerable population.

Access to patient charts by legal counsel and by the patient has been an issue in recent years, and one the Advocate continues to monitor. Patients receiving care under the *MHA* have the right to appeal their detention, CTO, and the physician's opinion regarding their competence. Appeals are heard by a Review Panel that is independent of AHS. Decisions of the Review Panel may be further appealed to the Court of Queen's Bench. Patients have the right to be represented by legal counsel at these hearings, with Legal Aid Alberta providing, on request, legal counsel at no cost for Review Panel hearings.

Legal Aid lawyers have reported challenges in gaining timely and complete access to patient charts in order to prepare for Review Panel hearings. AHS interprets the *Health Information Act*, R.S.A. 2000, c. H-5 [*HIA*] as giving it authority to sever patient charts of information, such as information that relates to third parties (s. 11(2)). The severing process takes time and can result in legal counsel not gaining access to the complete chart, or they may not have access to the chart until the same day of the Review Panel hearing. However, *HIA* also provides that it does not limit information otherwise available by law to a party to legal proceedings. Ongoing discussions this year among the Advocate, AHW and AHS resulted in agreement that existing legislation provides the Review Panel with the authority to remedy access and timeliness issues.

## CONCLUSION

Since its inception, the Advocate's office has played a unique and effective role in Alberta's mental health system. However, only a small proportion of individuals with mental health issues fall under the Act with their rights enshrined in legislation. The majority of Albertans who experience mental illness and seek or receive care do so outside of the *MHA*. As mentioned earlier,

the Alberta government has committed to developing a patient charter and a Health Advocate to help address concerns and complaints throughout the health system. Officials working on the draft legislation have stated their intent to look to the Mental Health Patient Advocate as a model, a strong testament to the value and effectiveness of this now more than 20-year-old office.

[*Editor's note:* Fay Orr has been a member of the Alberta Public Service for 23 years. Her current duties as Alberta's fourth Mental Health Patient Advocate include providing information and

assistance to patients, investigating complaints, advising policy makers, and promoting awareness of rights related to issues in mental health.

Fay has also served Albertans as deputy minister of numerous Government of Alberta ministries including Children and Youth Services; Tourism, Parks, Recreation and Culture; Community Development; and Government Services. Prior to becoming a Deputy Minister, Fay was Managing Director of the Public Affairs Bureau and Communications Director for the Office of the Premier.]

**INVITATION TO OUR READERS**

**Do you have an article that you think would be appropriate for  
*Health Law in Canada* and that you would like to submit?**

**AND/OR**

**Do you have any suggestions for topics you would like to see featured in future issues of  
*Health Law in Canada*?**

**If so, please feel free to contact Gilbert S. Sharpe at**

**[hlic@lexisnexis.ca](mailto:hlic@lexisnexis.ca)**