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MENTAL HEALTH SERVICES FOR PENITENTIARY INMATES

Correctional Law Review
Working Paper No. 9
February, 1988

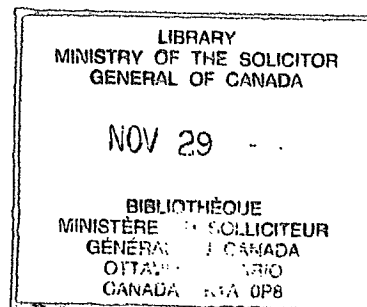
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CORRECTIONAL LAW REVIEW

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PREFACE

The Correctional Law Review is one of more than 50 projects that together constitute the Criminal Law Review, a comprehensive examination of all federal law concerning crime and the criminal justice system. The Correctional Law Review, although only one part of the larger study, is nonetheless a major and important study in its own right. It is concerned principally with the five following pieces of federal legislation:

- . the Solicitor General Act
- . the Penitentiary Act
- . the Parole Act
- . the Prisons and Reformatories Act, and
- . the Transfer of Offenders Act.

In addition, certain parts of the Criminal Code and other federal statutes which touch on correctional matters will be reviewed.

The first product of the Correctional Law Review was the First Consultation Paper, which identified most of the issues requiring examination in the course of the study. This Paper was given wide distribution in February 1984. In the following 14-month period consultations took place, and formal submissions were received from most provincial and territorial jurisdictions, and also from church and after-care agencies, victims' groups, an employee's organization, the Canadian Association of Paroling Authorities, one parole board, and a single academic. No responses were received, however, from any groups representing the police, the judiciary or criminal lawyers. It is anticipated that representatives from these important groups will be heard from in this, the second, round of public consultations. In addition, the view of inmates and correctional staff will be directly solicited.

(ii)

Since the completion of the first consultation, a special round of provincial consultations has been carried out. This was deemed necessary to ensure adequate treatment could be given to federal-provincial issues. Therefore, whenever appropriate, the results of both the first round of consultations and the provincial consultations have been reflected in this Working Paper.

The second round of consultations is being conducted on the basis of a series of Working Papers. A list of the proposed Working Papers is attached as Appendix A. The Working Group of the Correctional Law Review, which is composed of representatives of the Correctional Service of Canada (CSC), the National Parole Board (NPB), the Secretariat of the Ministry of the Solicitor General, and the federal Department of Justice, seeks written responses from all interested groups and individuals.

The Working Group will hold a full round of consultations after all the Working Papers are released, and will meet with interested groups and individuals at that time. This will lead to the preparation of a report to the government. The responses received by the Working Group will be taken into account in formulating its final conclusions on the matters raised in the Working Papers.

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MENTAL HEALTH SERVICES FOR PENITENTIARY INMATES

EXECUTIVE SUMMARY

INTRODUCTION

Outlines the aims of the paper, which are to:

- examine and discuss questions surrounding mental health services for penitentiary federal inmates that can be addressed in federal correctional legislation;
- put questions concerning mentally disordered offenders in context by providing a sense of the mental health service problem in broad terms; and
- present proposals for consultation that attempt to provide a legal framework that will allow reliable programs and treatments of benefit to the inmate.

PART I

Sets out the dimensions of the mental health services problem, provides necessary definitional and statistical data and discusses the critical issue of jurisdiction.

PART II

Examines the nature and scope of a right of treatment, and any legal and practical limits that may confine an obligation to provide treatment to mentally disordered offenders. Attempts to define a right or obligation respecting mental health services in federal correctional legislation.

PART III

Reviews the issue of consent to treatment, and the right to refuse treatment. The requirements of informed consent are set out and the substance of legislation to govern consent issues is examined.

PART IV

Addresses the issue of force-feeding and attempts to resolve the ambiguity which faces both correctional administrators and inmates in force-feeding situations.

PART V

Examines the changes that would be required in legal rules to ensure that mental health needs of offenders are taken into account at such critical points as placement, classification, transfer, disciplinary proceedings and parole release or mandatory supervision decisions.

PART VI

Examines the issue of transfer of mentally disordered federal inmates to provincial health facilities, and reviews options for dealing with the problem.

PART VII

Reviews issues related to confidentiality of medical records and the inmate-patient's right to know what is on his or her own file, and the concern that arises when the doctor's ethical responsibility regarding confidentiality and the patient's interest in keeping matters private conflicts with the professional need to share information, or with the institutional or public interest in being forewarned about risks of patient "dangerousness".

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MENTAL HEALTH SERVICES FOR PENITENTIARY INMATES

INTRODUCTION

This Working Paper is one in a series of papers produced by the Correctional Law Review. A Framework for the Correctional Law Review (June, 1986) set out the constitutional and legislative framework governing the prison and parole system, outlined the relevance of certain international laws and treaties, the influence of case law, the potential impact of the Canadian Charter of Rights and Freedoms and considerations affecting decisions to review the current legal framework. This paper carries forward several of the themes raised in that paper and discusses questions surrounding mental health services for federal inmates that can be addressed in federal correctional legislation.

The immediate context of this paper is the policy framework for the Criminal Law Review as a whole which was developed in The Criminal Law in Canadian Society¹, together with the first two Working Papers of the Correctional Law Review (Correctional Philosophy and the Framework paper mentioned above). In a broader perspective this paper reflects the concerns of a number of reports or studies dealing with mental health needs and programs at the federal level.²

The issues surrounding mentally disordered inmates are particularly complex. The purpose of this paper is to provide an up-to-date description of the mental health needs of inmates and the services currently available, and, most importantly, to discuss issues that can be addressed in correctional legislation.

It is not intended that the paper will deal with all the mental health service delivery problems that face the system, but rather that it will examine the narrower issue of what federal correctional legislation can do. The problems of mental health services cut across both our health care and criminal justice systems. However, given the mandate of the Correctional Law Review, the focus of this paper is necessarily a limited one. Although the paper contains a discussion of the larger problems surrounding mental health services,

and points to the need to address service delivery and operational problems, it does so to provide the context within which the narrower questions (such as right to treatment and confidentiality of records) that are amenable to federal correctional legislation, can be addressed. At the same time, the broader operational issues are being dealt with by way of a major project currently being carried out within the Correctional Service of Canada (CSC).

Part I of this paper attempts to put the whole mental health services issue in context by providing a sense of the problem in broad terms; by setting out necessary definitional and statistical data, as well as outlining the current structure for delivery of mental health services to penitentiary inmates, and by discussing the critical issue of jurisdiction.

Parts II to VII address issues in developing legislation to govern mentally disordered inmates; examined are issues related to a right to treatment and the nature and scope of such a right, the right to refuse treatment, force-feeding, transfers to provincial facilities, confidentiality of medical/treatment records, and the implications of these matters in regard to institutional decision-making. Reference is made to the Canadian Charter of Rights and Freedoms and its impact upon the mental health needs of inmates. At the conclusion of each section, proposals as to what should be contained in federal corrections legislation have been made to generate discussion. These proposals are consistent with the approach developed in the Framework Paper, which examined the reasons why matters governing inmate rights should be specified in statute or regulation.

One reason is that legislative provisions are particularly important where the Charter is concerned. Because the Charter is drafted in general, abstract terms, legislative provisions play a crucial role in articulating and clarifying Charter rights and any restrictions on them that are necessary in the corrections context. This latter point is most significant, as limitations or restrictions on Charter rights must be "prescribed by law", and it appears that limitations in policy directives may not be consistent with the Charter's demands.

In addition, development of legislative provisions at this time appears vastly preferable to a future of incremental and potentially inconsistent change forced upon the correctional system by the courts. Although judicial intervention plays an important role in providing outside inspection and scrutiny, the courts should be relied on as a last resort, rather than a first measure. In short, there is a need for legislative provisions to be developed in a way which does justice to all participants, in an effort to improve their collective enterprise. Litigation, in contrast, results in a win or loss for one side or the other, and often results in maximizing polarity.

In considering long-term solutions, the need to resort to the courts should be avoided by developing legislative rules that recognize yet structure discretion consistent with principles that are understandable to inmates, prison staff and administrators, and the public. Legislative rules that are based on clearly stated principles and objectives would structure discretion to allow for the necessary degree of flexibility while ensuring the greatest possible degree of accountability.

It should be noted that the proposals in this paper do not represent the government's position, as no decisions have been taken concerning appropriate legislation. At this stage, the proposals are intended to raise issues for discussion and consultation. The government is not committed to a particular course of action, but is actively soliciting public and professional input before a final determination is made.

Before setting out the dimensions of the mental health services problem it is useful to discuss the meaning of "mental health services" as used in this paper. It is important to understand not only what the term means to correctional and professional staff working with inmates, but also what sorts of illnesses or disorders are included in the term and what types of treatments or programs are contemplated. "Mental health services" as used in this paper includes services for severe psychiatric illnesses such as those that are suscept-

ible to acute, sub-acute or chronic long-term care, as well as, severe behavioural disorders. This paper relies on the classification and terminology used in the Mental Disorders Needs Identification Study³ carried out by the Ministry of the Solicitor General (see Appendix B). Although the classification and definitions set out in that study may be subject to criticism, they do provide a basis for discussion. It will be appreciated at once that "mental health services" is not confined to services for recognized psychiatric illnesses; moreover, the term implies reliance on a wide range of professionals including medical, nursing, psychological and chaplaincy personnel.

In 1972 when the Chalke Report⁴ recommended the construction of regional psychiatric centres, the focus of attention was on (1) psychiatric illness of an acute nature (such as psychosis, severe depression, panic attacks, confusional states or toxic reactions) requiring medical treatment in a hospital for up to 60 days, (2) sub-acute psychiatric illnesses, as above, but requiring treatment for more than two months, and (3) chronic patients including those suffering from schizophrenia, epilepsy, organic brain damage, or mental retardation, and requiring continuing care.

However, there is a large group of inmates suffering not from acute or chronic psychiatric illnesses but from severe behavioural disorders or other deficiencies. Included in this category are persons suffering from severe (1) alcohol or drug problems, (2) sexual dysfunction, (3) violence or aggression control problems, (4) stress management deficiencies, (5) depression other than above, (6) thought disorders of a non-acute type, and (7) lack of life skills or other social/cultural skills.

Treatment of the acutely ill has generally been by way of drug therapy under medical supervision, either within the penitentiary health service or on transfer to a provincial facility. Behavioural disorders or deficiencies, by contrast, tend to be approached from a therapeutic/ counselling/education perspective, frequently in the form of group sessions. Treatment, programs, and services are found to be

useful at the pre-release stage in the institution as well as after release on parole or mandatory supervision in the community. To date, an emphasis has been given to treatment of severe psychiatric disorders. The Carson Report,⁵ the Nielsen Report,⁶ and the Needs Identification Study⁷ suggest that there is an increasing demand for mental health services for behavioural disorders as well as for psychiatric illnesses. In addressing mental health services for penitentiary inmates, the concern is not simply that the "certifiably insane" be separated from the general prison population, nor is it just that the acutely ill be given psychiatric treatment and care. The concern now is also that the large category of inmates with behavioural disorders be given proper treatment. Group programs of a therapeutic-educative nature can be delivered, and if they're not provided, the individuals concerned, their fellow inmates, and the staff of the penitentiaries may suffer stress and unnecessary violence.

As with psychiatric care and treatment, there is no guarantee that such programs provide a "cure" for recidivism. However, access to both psychiatric and therapeutic-educative programs is consistent with the statement of purpose of corrections set out in the Correctional Philosophy Working Paper, which places high priority on encouraging offenders to prepare for eventual release and successful re-integration into society through the provision of a wide range of program opportunities responsive to their individual needs. A large number of offenders come into the correctional system with multiple problems, including psychiatric and behavioural disorders, which may contribute to their criminality. Society and the correctional system want to help the offender deal with these problems.

Providing programs, however, raises questions of resources. In an era of economic restraint, it must be recognized that the larger, and perhaps most intractable, issue is that of resource allocation. Yet at the same time the provision of needed mental health services has been identified as a priority by CSC and by various studies and reports on corrections.

PART I: DIMENSIONS OF THE MENTAL HEALTH SERVICES PROBLEM

At the risk of oversimplification, the problem for the correctional system is that increasing numbers of offenders in federal penitentiaries have serious psychiatric illnesses or are suffering from a range of serious behavioural disorders.⁸ Lack of sufficient treatment or other services for such offenders, who constitute 25% or more of the inmate population of some federal penitentiaries, gives rise to violence, stress, and crises that are damaging to the offender concerned and to other inmates. Moreover, the failure to address the basic human needs of so many inmates creates a debilitating and demoralizing work environment for staff and management.

The Carson Committee commented on the need for mental health services and the inadequacy of present services:

We think that this situation is seriously straining the mental health resources of the Service. We heard concerns that disturbed offenders disrupt the normal functioning of institutions, can irritate and provoke other inmates, and that they generally interfere with the delivery of programs because of the excessive attention they demand from staff.

Estimates of the proportion of inmates who suffer from some form of serious mental disturbance range up to 25 per cent. Although several specialized regional facilities are available, only the most chronic cases can be accommodated on a long-term basis. Most cases must be quickly returned to their home institution. We are concerned that seriously disturbed individuals will be even more disrupted by such "bus therapy" that does not attend to their underlying problems in a systematic fashion. Administrative segregation often becomes the only possible means of managing these individuals within a regular institutional setting.

A further problem is that the Service's psychiatrically oriented facilities are hesitant to treat inmates who are not clearly mentally ill or who are particularly disruptive. There are many offenders who fall in the uncertain border between normalcy and mental illness, but who display both severe mental and behavioural problems. Greater attention needs to be focused on ways to provide services for this marginal population⁹.

The problem, then, is of importance at various levels: at the individual level there is a right to have basic health needs met; at the administrative level, taking care of the basic mental health needs of inmates enhances the working environment of staff and the effective and efficient management of the prison; for the community, taking seriously the mental health needs of offenders promotes security and respect for the basic human dignity of persons generally; and at the national and international levels, providing for offenders' basic health care needs fulfills the requirements of law and international obligations, and contributes to a more safe, secure and humane society.

The Size and Nature of the Problem

A large proportion of the federal penitentiary population is in serious need of mental health services. As indicated above, these needs fall into two categories. Recent estimates are that about 15% of the federal prison population suffer from a serious psychiatric illness of an acute, sub-acute or chronic nature, and an additional 20 - 30% suffer from serious illnesses or behavioural disorders that do not require medical treatment in a hospital. These illnesses and disorders include (1) violence and aggression including significant problems in handling extreme anger, (2) serious sexual dysfunction; (3) mental/social incompetence, including mental retardation and difficulty in coping with everyday life without causing serious administrative problems in the prison; (4) suicidal tendencies; (5) serious depression; and (6) thought disorders and milder depressions responsive to treatment without hospitalization.¹⁰

It should be noted that the population identified as being in need of mental health services does not include the category of inmates who suffer from serious alcohol or drug abuse, although many inmates may fall within both categories. When prisoners with a serious problem in this regard are included, the percentage of the federal prison population in need of mental health services almost doubles in every region. It should also be noted that specific figures are difficult to interpret, due to the fact that many inmates suffer from multiple specific behaviour disorders, and different studies deal with this problem in different ways. CSC is currently undertaking a needs identification study which will produce current figures on the magnitude of the problem and clear up any ambiguity which may have arisen through comparison of figures from different studies carried out in the past. The results of the CSC study are expected to be available in the fall of 1988.

What health services are currently provided? Latest CSC figures indicate that there are approximately 1500 federal inmates suffering from an acute, sub-acute or chronic categories of mental disorder. CSC has a total of 455 beds for both psychiatrically and behaviourally disordered inmates - nearly 300 for acute, sub-acute and chronic illnesses, with the remainder for inmates with special problems such as those who are sex offenders or those with personality or behavior disorders.

These figures, as well as the Needs Identification Study and Operational and Resource Management Review No. 11, Review of Mental Health Services¹¹, indicate that there are far more incarcerated offenders in need of mental health services than are currently being treated. In addition, problems remain in the delivery of health services to inmates on parole, mandatory supervision and the large proportion of inmates currently estimated to be suffering from one or more behavioural disorders.

To address behavioural disorders, various treatment-oriented or educational programs are offered, in both regional psychiatric centres and penitentiaries, with a specialized focus

such as alcohol abuse, drug abuse, how to handle aggression and anger, sexual dysfunction, and life skills. In particular institutions, when inmates who suffer from substance abuse are included, up to 60% of the population is said to be in need of such mental health services. The Nielsen Task Force Report on The Justice System commented on the problem in these terms:

Although it is sometimes suggested that penitentiaries should cease trying to fulfill aims beyond punishment and incapacitation, the study team has concluded that the other efforts which go on inside the penitentiary (although some could be done more effectively and efficiently) are justified, and their abandonment would be irresponsible on government's part.

People who end up in prison present a multiplicity problems (sic): 40 per cent are functionally illiterate; at least as many have a drug or alcohol dependency; and most have few marketable skills and a history of sporadic employment; many have learning disabilities, poor social skills, family problems, a low maturation. A few have severe mental disorders but cannot be accommodated by the mental health system. Far from concluding that the effort to deal with these problems is a "frill" which cannot be justified in an era of restraint, the study team finds that discouragingly little is being done about these problems.¹²

Another factor bears further investigation. Relying largely on American analysis, the suggestion is made that in recent years the mentally disordered are being "criminalized". The argument is that with the closing down of large psychiatric institutions and the treatment of mentally ill persons in community-based facilities or on an out-patient basis, more and more mentally ill offenders, instead of being diverted into the health care system, are being diverted into the prisons. While it is difficult to make an absolute judgment about the so-called "criminalization" of the mentally disordered, it is clear that further empirical evidence is needed.

Jurisdiction

A fundamental question arising from the problem of providing mental health services for penitentiary inmates is one of responsibility or jurisdiction of the federal and provincial governments. Two issues arise: (1) whose responsibility is the provision of service, and (2) what can or should be done about the regional inequality of services which is caused by variations in the health services provided at the provincial level.

The issues are important and complex, but for the purposes of this paper it is accepted that health care, including mental health, is the constitutional responsibility of the provinces. However, the federal government has the constitutional responsibility for penitentiaries and thus the custody and care of all inmates received into penitentiary. (Section 16(1) of the Penitentiary Act provides for a period of time -usually 30 days- during which inmates sentenced to two years or more remain in provincial custody to permit them to file an appeal unless they waive their right to do so).

The Ouimet Committee stated in 1969, and it has remained true, however, that "there are instances where provincial authorities flatly refuse to accept for treatment mentally disordered inmates from the penitentiary. The theory of the officials who do not wish to accept these inmates for treatment is based upon the proposition that the penitentiaries should provide their own mental health services. It is more important that all available services be employed to their fullest extent than individuals to suffer severely because one governmental agency insists that the responsibility lies with another governmental agency. The Canadian Committee on Corrections recognizes a need for the federal government to provide additional resources."¹³

Accordingly, the Regional Psychiatric Centres (RPC) were set up during the 1970's in order to fill gaps in available provincial service for federal inmates. Analogous provisions have been made for the Canadian Armed Forces and the RCMP.

Medical services have also been established in penitentiaries, through qualified professionals employed by the federal government or through purchase of service from the private sector.

Some disagreement over who should pay arises from the joint federal-provincial medicare scheme and the various provincial health acts under which "residents" of a province are entitled to receive "insured services" at no cost. For example, the British Columbia Mental Health Act states that every resident of the Province is entitled to receive service and accommodation in the facilities created pursuant to the Act. Are penitentiary inmates "residents" of a province for the purpose of the Mental Health Act and medicare legislation? The Alberta Health Care Insurance Act, for example, appears to exclude penitentiary inmates from Alberta medicare and excludes, as well, members of the RCMP and the Armed Forces. The Canada Health Act expressly exempts from medicare legislation "a person serving a term of imprisonment in a penitentiary as defined in the Penitentiary Act". It would seem therefore, that federal authorities must pay for medical services for penitentiary inmates independently of any provincial medicare scheme. This is also true of offenders on day parole, who are deemed to be serving their sentence in penitentiaries. Offenders in the community on parole and mandatory supervision, however, are covered by provincial medicare schemes.

In short, the federal government provides for the health care needs of persons sentenced to penitentiary terms. If the federal government feels that it could provide health care services to federal inmates more efficiently by having a certain range of medical services included under the medicare agreements with particular provinces, then that option is open to the federal government when the federal-provincial medicare cost-sharing agreement comes up for re-negotiation. Otherwise, the federal government can provide its own medical services or purchase them from the private sector. The issue would appear to be more a question of who pays and how the services are delivered than they are of jurisdiction per se.

The related issue of inequality of service is sometimes mixed with the jurisdictional issue. As can be seen above, especially on release, availability of public mental health services may vary from province to province. The same issue arises when an inmate is transferred to a provincial mental health facility. Penitentiary inmates in one province, for example, may have the benefit of a broader range of services than inmates in another province. Such provincial differences arise from differences in wealth and political priorities in the various provinces. However, the federal government's constitutional responsibility for penitentiary inmates is not altered by either parole release or transfer to a provincial health facility; such inmates remain under the jurisdiction of CSC until the expiration of their sentence. In meeting its responsibilities, CSC may have to consider supplementing provincial services in order to remove disparities for federal inmates.

Hospital Orders

Proposed amendments to the Criminal Code pertaining to mental disorders provide for a court, at time of sentencing and with the consent of the Crown, the offender, and the hospital, to make hospital orders. The court would be able to order persons suffering from mental disorder in acute phase, for whom immediate treatment is urgently needed, to serve up to 60 days in a psychiatric facility.

Hospital orders present several issues that relate to costs, such as whether the federal government will cost-share any of the costs of the provincial administration of hospital orders imposed upon offenders who will eventually go to penitentiary. Such issues are beyond the scope of this paper.

PART II: RIGHT TO TREATMENT

The previous section described the present system of mental health service delivery and many of the problems which it faces. This section, and those following, narrows the focus to examine issues that can be addressed in corrections legislation.

In this section of the working paper the nature and scope of a "right to treatment" is examined and any basis in common law, statutory law or the Charter for a "right to treatment" is identified. The matters to be addressed are whether there is an obligation on the state to provide treatment and the extent of such an obligation. Also to be considered are the legal and practical limits confining any obligation to provide treatment and, finally, the degree to which a right to treatment should be specified in legislative form.

It is important to distinguish between a legal and a moral obligation to provide medical services to inmates. In everyday language we tend to use the term "rights" in several different ways. Sometimes we use "right" to refer to a claim that the courts will enforce, but often we use the term more loosely simply to assert a moral claim or a social expectation which does not have legal force in the sense that a court would enforce such a claim.

In law, right and duty are often converse sides of the same coin. Accordingly, where the individual offender has a right to treatment in the legal sense, it follows that the state is obliged, by virtue of a legal duty, to provide treatment. The failure to do so would give rise to a remedy in the courts or other appropriate tribunals. In this paper we are using "right" in the strict legal sense of the word.

Right to Treatment: Pre-Charter

Leaving aside for the moment the impact of the Charter, it appears that under the law there exists no substantive general "right" to health services. This may sound strange

to Canadians covered by a system of medicare which provides universal access to a doctor irrespective of ability to pay. A perusal of the federal and provincial health acts, however, fails to disclose an express right to health services. The federal Act at first glance appears to grant a right by providing for federal payment of medical care in cooperation with the provinces. Section 10 of the Canada Health Act states that:

In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred percent of the insured persons of the province to the insured services...

Section 12 of the same Act attempts to ensure universal access by banning "extra billing" for insured services. The question remains, however, whether removing financial and other barriers to a doctor's office thereby confers a "right to" medical services. An argument might well be made that requesting an appointment with a doctor does not give you a right to an appointment. The doctor is under no legal duty to see you.

In addition, both federal and provincial health care statutes expressly exclude certain classes of persons from coverage under the medicare scheme. As already indicated, persons "serving a term of imprisonment in a penitentiary" and members of the RCMP and the Canadian Forces are expressly left out. As a result, federal prisoners have no right to health care arising under general health legislation.

An exception to the fact that the law (with the possible exception of the Charter, discussed below) does not, in general, recognize a right to health services is drawn for persons who, because of age, infirmity or other reason, are under the care or guardianship of others. Indeed, the exception is deemed to be so important in guarding against abuses that parents, heads of families and guardians are under a duty to provide "necessaries" to children, spouses or other persons under their "charge" if that person, by reason of

detention, age, illness or insanity, is unable to withdraw herself or himself from that "charge" and unable to provide herself or himself with the "necessaries of life". Breach of that duty under circumstances leading to death, or likely to endanger the life or cause permanent injury to the health of the person is a Criminal Code offence. These provisions have been interpreted to include providing such medical services as blood transfusions or insulin treatment.

To date, no prisoner has brought criminal charges against prison officials for failing to provide necessary mental health services. For one thing it may be difficult to prove "permanent injury". Moreover, the Criminal Code sections were drafted almost ninety years ago and seem to be more concerned with such necessities as tend to preserve physical life than with necessities in the sense of preserving mental health.

The present Penitentiary Act contains no specific right to health services. The Penitentiary Service Regulations (PSRs) do, however, contain the following:

Medical and Dental Care

16. Every inmate shall be provided, in accordance with directives, with the essential medical and health care that he requires.

The policy objectives of several of the Commissioner's Directives are of particular interest. The policy objective of CD-800, entitled Medical, Dental and Health Care Services is:

To ensure that offenders are provided with medical, dental and health care services in keeping with generally accepted practices in Canadian society.

The policy objective of the CD on Psychological Services (CD-840) has as its policy objective:

To ensure the provision of psychological services to offenders in order to assist them

with the resolution of psychological problems and behavioural disorders and to help them learn and adopt socially acceptable behaviour patterns.

In addition, the policy objective of the CD on Mental Health Services and Programs (CD-850) is:

To promote the mental health of offenders by ensuring appropriate and equitable access to professional mental health services, thereby contributing to offenders' adjustment within the institution and assisting them to become law-abiding citizens.

While the directives recognize the responsibility of CSC to provide mental health services to inmates, it is not accepted that the directives have the status of law in the same way as statutes and regulations do. The Supreme Court of Canada in its decision in Martineau and Butters (No.1)¹⁴ said that the directives in question are not 'law' and a court will not enforce them.

At the present time, whatever their legal status, the health care directives reflect the policy of the Correctional Service of Canada. That policy not only recognizes an implicit duty to provide medical care but it sets a standard of care, that standard being the range and quality of medical care available to the public at large.

Right to Treatment and the Charter

There can be no doubt that the Charter is having a profound effect upon Canadian law. To begin with, being a constitutional document, unlike the Canadian Bill of Rights, it is part of the supreme law of the land and confers a broad power on the courts to provide remedies. These remedies include the ability of the courts to strike down legislation that is found to be in breach of Charter rights and freedoms. In

relation to prisoners, the Charter has already had important effects on parole procedures, prison transfer decisions and other administrative procedures affecting inmates' constitutional rights.¹⁵

Courts have stressed that the Charter is aimed at promoting respect for the dignity of persons and at upholding the ideal of a person as a rational autonomous individual with a capacity for making individual choices. This respect for individual conscience and judgement lies at the heart of our democratic political tradition.¹⁶ Consistent with those traditions, the rights and freedoms outlined in the Charter are not absolute; section 1 of the Charter states that a right or freedom may be limited by law. But the section goes on to set a standard against which such limits must be justified¹⁷.

With respect to mental health services for inmates, section 7 (life, liberty and security) and section 1 are of major importance. In addition, section 12 prohibits "cruel and unusual treatment or punishment" and section 15 prohibits unequal treatment or discrimination. Each of these provisions will be discussed in regard to impact on a right to treatment and its scope.

Life, Liberty and Security of the Person

The principal Charter provision for present purposes is section 7 which states that "everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice". Although not yet settled, these words have been given a broad meaning by several lower courts so that the right to life would embrace more than bare physical survival and include life of at least a minimal level of decency in Canadian society.

If there is a right to treatment, and conversely, an obligation to provide treatment under the Charter, what criteria define the scope of the obligation or right?

What is most problematic is the range of health services that may fall within section 7 and the degree to which they must be provided by the correctional system. The scope of the right to "life" or "security of the person" in terms of mental health services may be interpreted by the courts to cover psychiatric care and treatment for acute, sub-acute and chronic cases as well as mental health or therapeutic services for other disorders.

Cruel and Unusual Treatment or Punishment

There is a relationship between arbitrary imprisonment and cruel and unusual punishment or treatment, as prohibited by section 12 of the Charter. Aspects of cruel and unusual punishment include arbitrary or capricious punishment, wanton and unnecessary punishment, punishment without rational penological purpose, and disproportionate or excessive punishment. Since these conditions of punishment can be equally applicable to treatment, it gives some indication of what types of treatment and of which failures to offer treatment may be unconstitutional.

While section 12 of the Charter clearly states that treatment cannot be cruel or unusual, higher Canadian courts have not as yet interpreted the section in the present context. Some assistance can be gained by looking at the American counterpart to section 12. The United States Supreme Court has said that a failure to provide treatment does not constitute cruel and unusual punishment unless the failure showed "deliberate indifference to serious medical needs of prisoners," such deliberate indifference constituting "an unnecessary and wanton infliction of pain."¹⁸ The American courts look for a series of incidents¹⁹ or a pattern of neglect rather than an isolated incident. In addition, a "totality of the circumstances" test is used in finding wanton neglect. A pattern of repeated examples of negligent acts or proof of systemic gross deficiencies in staffing, facilities, equipment or procedures are looked to as evidence of wanton neglect.

Equality of Treatment

Having argued that there may be a right to treatment and an obligation to offer treatment, what implications might follow in terms of equal access to services?

Prior to the Charter the problem was viewed as a moral one, dependent for its solution on the political will of governments to provide needed resources, both human and financial. The common law provided no legal remedy by which to enforce a moral expectation of equality under law. While statutory enactments that followed the horrors of World War II prohibited discrimination based on race, colour, religion and other proscribed status or conditions, they conferred no general legal right to equality under the law.

Beyond the common law and human rights legislation, the Canadian Bill of Rights purported to guarantee equality before the law. The courts, however, interpreted the Bill narrowly, holding that it was enough if the law was applied equally in its administration; the Bill was construed as permitting the courts to turn a blind eye to distinctions between groups or classes, providing there was some valid legislative objective in drawing the distinction. On this basis only arbitrary, capricious or irrational distinctions could be found to be invalid.

The equality provisions of the Canadian Charter of Rights and Freedoms were carefully drawn to overcome these earlier gaps in the law. The Charter mandates not simply equality before the law but also "under the law", as well as equal protection of law and equal benefit of the law:

15.(1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Issues raised by these new requirements for equal treatment under the law are several. First, there may be a concern over exclusion of federal inmates from the medicare legislation, as indicated above. Second, is differential access to services including those services offered to federal offenders released on day parole as opposed to those on full parole or mandatory supervision, now prohibited? This problem arises because, as indicated above, persons released on full parole and mandatory supervision, being regarded as "residents" of the province, are shifted over to provincial medicare schemes for health services; day parolees are not. Moreover, since a number of provinces do not include psychological services as an "insured service" under medicare, some prisoners on release have access to needed therapeutic programs while others do not unless the federal government purchases such services from the private sector. Third, does the Charter prohibit differentiation in treatment within the prison, such differences not being dependent upon different classes of parole release?

Without going into detail, it is possible to speculate on whether excluding federal inmates from medicare legislation violates the Charter. It is unlikely that the courts will prevent governments from making that kind of distinction in delivery of health care services. To find otherwise, the court would have to be persuaded that the distinction, considering its purposes and effects, is unreasonable, unfair and unjustified.²⁰

The second issue, variability in availability of health care services based on the status of the offender (i.e. whether on day parole with access to federal institutional programs or on full parole or mandatory supervision and eligible for

provincial community-based services) may also invite litigation under section 15. The argument here is that both groups of inmates are "similarly situated" and that their status is not a legitimate basis for making injurious distinctions. Again the purpose and effects of the distinction will be assessed, for not every distinction is a violation of section 15; indeed, to fail to draw distinctions in some cases may be discriminatory. In making its analysis, the court will be asked to consider whether the purposes behind the distinction could have been achieved by some reasonable alternative so as to avoid any injurious effects.

Distinctions based on residence or region may also raise questions under section 15. For example, if a wider range of after-care health services are available to offenders in the custody of CSC in Ontario than to those in British Columbia, does this violate Charter rights under section 15? Does the Charter require uniformity of services regardless of province or region where the responsibility is a federal one?

Is it permissible for the federal government to fail to provide basic mental health services in one institution or region when such services are available in other institutions or regions? Distinctions based on region or area of residence alone may raise concerns. Again, the purpose and effects of the distinctions will have to be assessed.

International Obligations and Standards

International treaties and statements of standards for prisons have long addressed the state's obligation to provide basic services to prisoners. The International Covenant on Civil and Political Rights, to which Canada is a signatory, states in Article 10 that:

All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

The penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation.

While the Covenant is not, in its present form, part of the domestic law of Canada, courts are bound to resolve ambiguities in law in favour of an interpretation that is consistent with international obligations.

Canada feels obliged to conform to the United Nations Standard Minimum Rules for the Treatment of Prisoners, although these are not part of our domestic law. It is useful to note Rule 62:

The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end.

Other Rules provide for the removal of "insane" prisoners to mental health facilities and for the treatment of prisoners with "mental diseases or abnormalities" in specialized institutions. While some disagreement may be expressed with regard to the detail of the Rules, including their narrow focus on medical and psychiatric treatment instead of a broader therapeutic approach, the expectation is that something positive be attempted in the way of offering mental health services to prisoners.

The set of standards developed by the Canadian Criminal Justice Association and CSC for Canadian prisons contemplates a broad range of mental health care services for prisoners, but the specific standards tend to focus on psychiatric services on-site with reliance on transfers out to "appropriate" mental health facilities in cases of "severe emotional disorders".

Other Factors

The scope of a right to treatment can also be defined to some extent by addressing questions such as "what type of need leads to a right to treatment?"

In the absence of relevant Canadian case law, it is useful to look at the leading American case of Bowring v. Godwin²¹ as it may provide guidance in developing Canadian law. In that case the court held that the prisoner was entitled to psychiatric or psychological services. The case is useful in identifying positive factors helpful in determining whether treatment ought to be granted. Those factors include a consideration of availability of any suitable treatment programs that are known to be effective in treating the disorder:

We therefore hold that Bowring (or any other prison inmate) is entitled to psychological or psychiatric treatment if a physician or other health care provider, exercising ordinary skill and care at the time of observation, concludes with reasonable medical certainty (1) that the prisoner's symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; and (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial.²²

The language of the Bowring test has been criticized as covering only "blatantly obvious" abnormal behaviour and excluding disorders discoverable only on psychiatric or psychological evaluation. Moreover, Bowring's insistence that the disorder be "curable" or "substantially alleviated" appears to leave chronic disorders outside the scope of the rule. Finally, the requirement that there be a risk of "substantial harm" upon failure to provide services may leave untouched disorders leading to progressive psychic deterioration and catch only foreseeable physical harm, a gap that ought to be closed.

Nevertheless, the Bowring case is helpful not only in suggesting criteria that set justifiable limits on the right to treatment, but in addressing as well the question of who makes the decision as to treatment. Clearly, Bowring does not impose a duty on doctors to give treatment on demand; rather, the right to treatment is no more than a right of access to treatment, with the final decision firmly resting in medical hands as it does in relation to the public generally. This is the current practice in CSC under the Commissioner's Directives.

A related issue concerns whether a right to treatment includes a right to a second opinion by outside psychiatrists or other mental health professionals of the inmate's choice. Second opinions are recognized as a valuable measure and are available to the community at large. The Canadian Medical Association Code of Ethics states that:

5. An Ethical Physician will recognize that ... the patient ... has the right to request of that physician opinions from other physicians of the patient's choice.

This right is particularly important in the prison context, where the patient cannot simply go to another doctor at will.

Even though recognition of a right to a second opinion could mean a significant cost burden, it appears necessary to ensure that health measures that are provided in the community are available to inmates within an institution. Nonetheless, it may be argued that in an institutional environment, limits of some sort should be placed on access to second opinions. In order to avoid any abuse that may arise through frivolous claims to a second opinion, present CSC policy imposes a limit. CSC pays for a second opinion where the institution's health professionals, or the Regional Manager of Health Services, are of the view that it is a legitimate demand; otherwise, an inmate can have a second opinion only if he or she pays for it. This does mean that inmates with sufficient resources will be able to purchase additional medical services. On the other hand, it can be argued that

these services have been identified as unnecessary by qualified medical personnel who are governed by professional standards of medical care, including the CMA provision with respect to second opinions quoted above.

An important question for discussion is therefore whether inmates should have an unqualified right to a second opinion, as set out in our proposal or whether limits (and the extent of such limits) should be placed on such a right in an institutional context.

And finally, in attempting to define the extent of a right to treatment, regard must be had to, amongst other things, public expectations and professional standards of proper treatment. This includes knowing the level of professional competence and expertise in the area of concern. It may well be that public expectations respecting mental health services and treatment exceed current medical expertise, with resultant moral, ethical and legal difficulties.

Undoubtedly, the public has an expectation that inmates suffering from sexual dysfunction, emotional disorders, severe stress and aggression management problems, for example, should be offered treatment. Institutional management, too, often looks to psychiatrists, psychologists, and others for assistance in making transfer, disciplinary and release decisions involving persons with behavioural or mental disorders. Some judges, as well, feel that it is "not safe" to make a sentencing decision without appropriate psychiatric, psychological or medical reports. Society and the official prison bureaucracies look to the health professions as an aid not only in protecting society but also in bettering prison/parole management and as a means of doing something constructive for the inmate. The call for mental health services is clear, yet the limitations of both psychiatry and psychology in delivering the expected product is well documented. Whatever the content of an obligation to treat may be, it cannot exceed current levels of professional competence. It will be useful to review the limits of professional expertise as a relevant factor in determining the content of a right to treatment.

The problems with reliability of professional decision-making in relation to rehabilitative services have been well documented in a series of impressive reports over the last decade. Webster's Deciding Dangerousness: Policy Alternatives For Dangerous Offenders²³ reviews the current state of the art with particular reference to psychiatry. It is not simply a problem of unreliable prediction, however; there is a problem of differing views as to appropriate criteria indicative of a specific illness or disorder, such criteria differing in part by reason of professional training or viewpoint.²⁴ Given problems of categorization or classification, it is not surprising to find considerable variation in diagnoses as well. Moreover, in general, there is little demonstrated reliability in treatment programs. In 1981, in the United States, the Panel on Research on Rehabilitative Techniques reported that "the search for rehabilitative techniques and programs has borne little fruit". The Panel went on to urge continuing efforts to find effective treatments for prisoners but warned against basing social policy upon an assumption of rehabilitation.²⁵

Given the many uncertainties to be faced in the delivery of mental health services and programs, there is a need for the careful, systematic formulation of programs based on the best professional judgment. The objectives are reliable programs and treatments of benefit to the inmate and, ultimately, to society, under conditions which respect the inherent dignity and autonomy of the person. The proposals presented throughout this paper attempt to provide a legal framework that will allow these objectives to be accomplished. The first step in this regard would be defining a right or obligation respecting mental health services in federal corrections legislation. It should be noted that these proposals are set out to generate discussion about what such legislative provisions should look like, what degree of specificity is appropriate, and what impact such proposals might have on correctional operations.

1. Federal correctional legislation should explicitly recognize that the Commissioner of Corrections has a duty to provide needed mental health services to offenders within the

custody of Correctional Service of Canada. The determination of mental health service needs shall be made by authorized medical staff or health services teams. This determination should be subject to an offender's right to request a second opinion.

2. "Mental health services" should be defined in federal correctional legislation to mean any approved treatment, program or service professionally designed and administered for the treatment of a mental disorder of thought, mood, perception, orientation, or memory that significantly impairs judgement, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life.

3. Federal correctional legislation should provide for an obligation to offer mental health services to persons in the custody of Correctional Service of Canada at a level or standard that is consistent with standards commonly available to the public at large, and to offer programs to meet the special needs of inmates.

Comment

The definition of mental disorder includes but goes beyond psychiatric disorders and contemplates resort to a broad range of mental health resources, including psychological, nursing, educational, and chaplaincy. The definition is derived from the proposed Uniform Mental Health Act. While our definition covers a wide range of illnesses and behavioural disorders, it is limited to those that "significantly impair".

PART III: CONSENT TO TREATMENT

Accepting that there is a duty to provide treatment, then, is there a reciprocal duty to submit to such treatment or is consent necessary? In reviewing the issue of consent to treatment, or the right to refuse treatment as it is sometimes called, reference will be made to common law and constitutional principles, to international standards, and to codes of professional ethics. The requirements of informed consent (or, conversely, waiver) at common law will be set out along with an outline of relevant exceptions to the common law principle. This section will close with an examination of the substance of legislation to govern consent issues.

The common law and the Charter both recognize that each individual enjoys a right to be free of unnecessary and unjustifiable state interference. Each person has a right to inviolability of the person and to integrity of the person. These values are reflected in the Criminal Code, (for example, in the crime of assault) and in the civil law through an action in damages for battery, trespass, or other injury to the person. The law provides a remedy for negligence against doctors or others who undertake surgery or other medical trespasses upon the person that go beyond the patient's instructions or consent. Inmates are entitled in general to equal protection and benefit of the law; neither the common law nor the Charter excludes them from the general law regarding consent to treatment. The right to be left alone includes the right to refuse treatment or to discontinue treatment once given. The basis of the right has been said to be rooted in a right to privacy, or in some cases, freedom of thought, conscience, or religion.

The common law and the Charter reflect a respect for the dignity of persons, for the person as an autonomous individual with a capacity to choose and a responsibility for his or her own decisions and actions. The Charter reflects these values either expressly or implicitly in various sections but particularly in section 7, the guarantee of right to security of the person and the right not to be deprived thereof except in accordance with principles of fundamental justice. As

discussed previously, section 1, while authorizing limitations on rights, requires such limits to be prescribed by law, as well as to be reasonable and demonstrably justified in a free and democratic society.

Existing CSC policy, contained in CD 803 Consent to Medical, Dental and Psychiatric Treatment, recognizes the principle of informed consent. The Law Reform Commission of Canada in its various reports relating to dispositions and sentences,²⁶ health services, and consent to medical care²⁷ has invariably re-affirmed the general principle of informed consent as a requirement of law:

To ensure the protection of the person, all laws, whether federal or provincial, require that informed and free consent be given before any treatment is undertaken.²⁸

However, with few exceptions, the principle of informed consent is not expressly set out in legislation. Some provinces do not address the issue of consent at all, and to the extent that they do so it is usually under the mental health acts providing for compulsory commitment and treatment under certain conditions. An exception to the general absence of legislative direction is found in Quebec where the Civil Code recognizes the principle of inviolability of the person and the principle of consent to treatment. Unlike other provinces' laws, the Quebec Civil Code also creates a duty, binding on all persons, to assist in preserving life in cases of emergency. This principle is of relevance because of its potential as a springboard for imposing treatment without consent in certain cases as outlined below.

Professional codes of ethics also recognize the principle of informed consent. The Canadian Medical Association Code of Ethics states as follows:

5. An Ethical Physician will recognize that the patient has the right to accept or reject any physician and any medical care recommended

to him. The patient having chosen his physician, has the right to request of that physician opinions from other physicians of the patient's choice;

14. An Ethical Physician will, when the patient is unable to give consent, and an agent is unavailable to give consent, render such therapy as he believes to be in the patient's interest.

Provincial psychological associations also call for informed consent.

A factor that has received attention in the past in relation to consent is experimentation. International covenants and treaties, professional codes of ethics and the common law have all warned about the risks to human dignity and liberty arising out of medical experimentation. The leading Canadian case of Halushka v. University of Saskatchewan²⁹ involved a university student who suffered substantial injury after 'agreeing' to partake in an experiment for a sum of money. The court insisted on a standard of full disclosure of risk as a pre-condition to a valid consent.

The Canadian Medical Association's Code of Ethics expounds a similar standard:

Clinical Research

17...(the doctor) will, before initiating any clinical research involving human beings, ensure that such clinical research is appraised scientifically and ethically, and approved by a responsible committee, and is sufficiently planned and supervised that the individuals are unlikely to suffer any harm. He will ascertain that the previous research and the purpose of the experiment justify this additional method of investigation. Before proceeding he will obtain the consent of those individuals or

their agents, and will do so only after explaining the purpose of the clinical research and any possible health hazard which he can foresee.

Similar restrictions are to be found in ethical standards of the various provincial medical associations. In addition, the International Covenant on Civil and Political Rights, Article 7, prohibits medical or scientific experimentation on humans without their "free consent". Our recommendation concerning experimentation, at pp. 34-35 below, is consistent with this approach.

It is no surprise to find that the law requires informed consent, i.e. a voluntary consent made with understanding upon a disclosure of risks including the seriousness of the risks such as a reasonable person would want to know about as relevant to his or her decision to go ahead with the treatment. Thus the case law does not leave it to the doctor to disclose such risks as he or she may see fit. Moreover, the patient-client is entitled to know the profession's generally prevailing opinion of a particular treatment, not just the particular doctor's view of the treatment and its risks. In short, the patient-doctor relationship is not to be construed as a paternal relationship, but rather as a democratic relationship wherein due respect is paid to the patient's decision. The law does not require the patient to make a "rational" or even a conventional decision. The sole requirements are that the decision be made voluntarily with an understanding and competent mind upon disclosure of the risks involved.

Exceptions are made for those who are too ill to exercise an informed consent. Under existing provincial mental health legislation persons may be found to be incompetent and committed to a mental health facility involuntarily. The criteria for such committals vary. In some provinces, a distinction is not made between "competency" for committal purposes and the capacity to understand and consent to or refuse treatment. Once committed, the practice seems to be to administer without consent such treatment as the profes-

sionals concerned think proper and appropriate. The proposed Uniform Mental Health Act distinguishes between competency and consent and provides for the consent even of involuntarily committed patients. Section 26(14) of the proposed Act would permit any person who is able "to understand the subject matter in respect of which consent is requested and able to appreciate the consequences of giving or refusing consent" to make an individual choice. The proposed Act goes on to provide for substituted consent in terms roughly parallel to some existing provincial legislation. That is, where the patient is not able to give an understanding consent, a decision may be made by next of kin, an appointed guardian or by a Review Board.

Incompetency under most provincial mental health statutes can be found where the person (1) is suffering from a mental disorder and (2) demonstrates a lack of ability to care for himself or herself, (3) is likely to do serious injury to him/herself, or (4) is likely to injure others. Should behaviour constituting a "management problem" (given proof of a mental disorder) justify certification and consequent treatment without consent? The alternative to certification may be a transfer to segregation, or to a provincial health facility on consent.

Provincial criteria for incompetency govern the certification of federal penitentiary inmates whether the certification is done on transfer to a provincial facility or to one of the Regional Psychiatric Centres. Given the variations in certification criteria from province to province there may be some inequality of treatment among federal penitentiary inmates as a whole. The variations, however, may be "demonstrably justified" and therefore meet the section 1 test, given the problems that would attend any attempt by the federal government to achieve uniformity for its inmates by devising its own criteria for certification. If the Uniform Mental Health Act is adopted this particular inequality will disappear.

What criteria ought to govern the decision to impose treatment on a person who lacks capacity to make an understanding

choice in the matter? The Law Reform Commission of Canada in Working Paper 43, Behaviour Alteration and Criminal Law, states that there must be a proportionality between benefits and risks. Such a proportionality could be said to be lacking, for example, in the case of an experimental lobotomy upon a person convicted of an offence of violence, and allegedly suffering from an inability to handle stress without resort to violence. The proportionality principle requires a balancing of the degree of invasion of personal privacy and autonomy against the risks, the chances of success, and the foreseeable side effects of treatment. Related factors include the validity of the proposed treatment and its acceptance by professionally competent people. Other criteria mentioned in the literature would require that the treatment be intended solely for benefit of the inmate-patient; that the treatment decision be generally consistent with the type of treatment decision that would be made in a non-prison setting; and that the treatment be no more than is reasonably required to bring the inmate-patient around to a state of understanding and independent decision-making.

Where there is an understanding mind, the consent must be voluntary and not coerced. This requirement has led the Law Reform Commission of Canada to say in Working Paper 43 that treatment offered to inmates as a condition to their gaining early release runs afoul of the risk of coerced treatment. Indeed, there is some suggestion that any consent obtained in the atmosphere of a penal institution is by its very nature coercive and involuntary. The U.S. case of Kaimowitz³⁰ reached this conclusion, holding that an inmate's signing of a consent form authorizing psychosurgery, intended to reduce aggressive stimuli in the brain, was not a true consent; the contemplated experimental procedure was said to be contrary to the "right to privacy of the mind".

A distinction should perhaps be drawn between coercive conditions which imply an element of unfairness or lack of reasonableness and conditions that only weigh heavily towards a certain conclusion but are no more "coercive" than many other factors affecting daily decision-making. Inmates suffering from illiteracy, lack of social skills or alcoholism, for

example, may not wish to take courses or educative counselling programs. But is it unfair or coercive to expect them to take approved programs as a precondition to early release? Probation often involves "coerced" attendance at educational or health services. Children are required to attend school until age 15 years, presumably in the public interest in an educated, socially skilled citizenry. Differences in the degree of invasion of bodily integrity distinguish such behavioural programs from the kind at issue in Kaimowitz. The United States cases, in general, reflect a concern for informed consent in prison settings, a concern that is based upon a recognition of the inherent dignity of persons with a capacity to choose whether to exercise their right to privacy. Kaimowitz represents one application of the principle under circumstances posing a grave risk to the inmate.

CSC policy requires obtaining consent before treatment in programs offered at the Regional Psychiatric Centres is undertaken. Programs at such centres offer treatment to the severely psychiatrically ill (drug therapy) and group counselling for behavioural disorders relating to aggression/violence and sexual dysfunction. A consent form that is cast in general terms is used. Supplemental verbal disclosure of a kind that meets the educational level of the inmate would be required as in the normal doctor-patient relationship. However, it may be useful to supplement the consent forms with additional material that describes the program or treatment involved and includes a statement of the length and duration of anticipated effects or consequences (both positive and negative) of any drug therapy involved. The professional codes of ethics, referred to above, contain useful criteria for such reasonable, informative disclosure.

With respect to voluntary admissions to Regional Psychiatric Centres or other health care units within the prison system, it is not persuasive to argue that an application for admission must be seen, by itself, as a consent to whatever treatment is prescribed upon entry. The argument is a variation of the argument that the patient has given an implied waiver of his right to withdraw consent. Waiver of a right to

refuse treatment should be clear and unambiguous, just as waiver of other constitutional rights, such as the right to counsel, must be clear, unambiguous, and made with a knowledge and appreciation of the consequences. The recent Supreme Court of Canada decision in *R. v. Clarkson*,³¹ while addressing waiver of the right to counsel, serves as an analogy. The waiver of a constitutional right to refuse or withdraw from treatment should not be assumed by virtue only of an application for admission to a mental health facility. No doubt there can be valid express waivers of a right to refuse treatment, but a simple signature on a consent form as part of an admissions procedure would not suffice.

To summarize this part, then, the inmate's voluntary, informed consent must be obtained and respected. Even where the inmate is "committed" under the provincial health legislation on the ground of incompetency, the evolving test appears to be the inmate-patient's informed understanding in regard to particular treatment. Absent such capacity to understand, substituted choice or consent can be made under the relevant provincial statutes. The need for uniformity between the provinces in respect of certification criteria and consent is apparent.

Finally, the decision to provide treatment to those who are certified to be incompetent and who, moreover, lack capacity to understand the consequences of treatment should be governed by criteria of reasonableness and proportionality not only with respect to the degree of invasion of privacy and autonomy but also with respect to the degree of risk involved and the likelihood of success.

4. Federal correctional statutes should expressly recognize the principle of voluntary, informed consent to treatment made by a person with a capacity to understand the subject matter in issue and an appreciation of the consequences of his or her decision.

5. Federal correctional legislation should expressly recognize the right of every such person within the custody of CSC to refuse treatment.

6. Federal correctional legislation should provide that
 - a. experimentation should be conducted only within strict criteria for professionally approved programs, and with the offender's consent.
 - b. offenders may participate in therapeutic experimental research programs, provided that (1) the program has been approved as medically sound and in conformance with medically accepted standards; (2) the offender has given full voluntary and informed written consent; (3) in the case of psychosurgery, electrical stimulation of the brain, and aversive conditioning, approval has been given by an appropriate court after a hearing to determine that the program is sound and that the offender has given informed consent.
 - c. a program should be considered medically sound and in compliance with medically accepted standards only after it has been reviewed by a committee established by law to evaluate its medical validity.
 - d. an offender should be considered to have given informed consent only after that consent has been reviewed by an independent committee, consisting of lay persons, including offenders or ex-offenders.
 - e. for the purposes of correctional legislation, "informed consent" means that the offender is informed of (1) the likely effects, including possible side effects, of the procedure; (2) the likelihood and degree of improvement, remission, control or cure resulting from the procedure; (3) the uncertainty of the benefits and hazards of the procedure; (4) the reasonable alternatives to the procedures; and (5) the ability to withdraw at any time.

Treatment Without Consent

7. Federal correctional legislation should provide the following:
 - a. Where an offender has lost the capacity to give an informed consent, upon an application under the mental health act of a province, the offender may be found to be men-

tally incompetent, and in such event, the offender's next of kin, or guardian, or the director of mental health services for the mental health facility may authorize appropriate treatment.

- b. Where treatment is given without the offender's personal consent, only that treatment shall be administered as is the least intrusive means available and feasible to restoring the patient to a state of competency.
- c. In an emergency, an offender who is suffering from a severe mental disorder and who refuses consent to treatment may be transferred to a provincial mental health facility without prior judicial authorization providing
 - (i) the offender poses a substantial risk of harm to others or to himself or herself; and
 - (ii) the Director of the mental health facility consents to the transfer and directs such reasonable treatment as may be necessary.

PART IV: FORCE FEEDING

At first glance, force-feeding may be thought to be unrelated to mental health services for prisoners, but it raises many of the same questions that underlie the right to refuse treatment.

Canadian case law gives no clear answer to the question of whether the state is obliged to force feed prisoners or others who deliberately and in full understanding refuse treatment or the necessities of life. In a life-threatening situation, a Quebec court granted an order authorizing forced treatment for surgery for the removal of a wire from the throat of a disappointed immigrant who had been refused entry into Canada.³² Mr. Niemiec, the immigrant, had refused to consent to allow removal of the wire, saying it was better to die than go back to Poland. It is important to note the implicit manipulation of governmental officials as a factor in the case, as the same may be the case in many hunger strikes in the corrections context. Whether this factor was present in the mind of the court we do not know, because the decision to authorize treatment was expressly based on the state duty to preserve life, a duty which the judge found to override individual autonomy. As already indicated, the Quebec Civil Code imposes an obligation to give treatment in emergencies; this may also have coloured the court's approach to the case. Moreover, collective notions of the common good have issued from Quebec's courts.

In British Columbia, the Court of Appeal refused to order correctional officials to provide medical treatment in order to save the life of a fasting Doukhobor inmate, Mary Astaforoff, who had made a deliberate and conscious decision to starve herself to death.³³ The Court was not convinced that there was a duty requiring correctional officials to force-feed an inmate in such circumstances. Neither did the court specify that there was no such duty.

According to American case law, where the inmate's refusal of treatment appears to be aimed at manipulation of the system to his or her immediate gain, the court may override the inmate's refusal of necessities.

In one American case involving an application for permission to force-feed an inmate, the dissenting judge was not persuaded that the state interest in preserving the life of the inmate in order to obtain his conviction on outstanding charges overrode the right to privacy and to self-determination. The judge did not accept that allowing the inmate to refrain from eating amounted to assisting in a suicide. Rather, he saw it simply as a case of respecting the inmate's right to be left alone and to make personal decisions affecting his own well being. The inmate's decision to starve himself did not trespass on the rights of others, said the judge, and a decision not to force-feed was not aiding a suicide but merely leaving it to the inmate to speed the natural processes of death. In his dissent Douglas, J., set out useful criteria for consideration in developing law in this area.

I would, therefore, require that any prisoner seeking to avoid force-feeding must petition the institution for a hearing before a neutral official to determine (1) that the prisoner has no condition or demand he is seeking to extract or manipulate from corrections personnel in return for his not fasting; (2) that he is competent and is voluntarily and knowingly entering into his fast with an understanding of the consequences; (3) that he has been examined by a physician who has explained to him the physical phases and reactions his body will endure (informed consent); (4) that he executes a voluntary release of all civil or criminal liability (including any claim under 42 U.S.C. 1983) to the employees and government confining him; (5) that he waive appointment of any guardian seeking to exercise "substituted judgment" for him when he deteriorates to the point of mental incompetency; and (6) that he agree that the authorities will neither aid nor assist him in any way by medical attention; in other words, he must die truly unassisted by the government.³⁴

CSC policy allows forced feeding in limited cases. CD 825, entitled Hunger Strikes, states:

4. Involuntary feeding procedures shall only be used when it has been determined by psychiatric advice that the inmate's capacity for rational judgement is impaired and that according to medical advice it is the only reasonable solution left to preserve life.

In summary, although Canadian case law does not explicitly recognize a "right to die" neither does it set out an express duty to preserve the lives of inmates in federal prisons who intelligently and with full understanding refuse treatment and necessities even to the point of death. The ambiguity which faces both correctional administrators and inmates in force-feeding situations must be resolved.

It is proposed for purposes of consultation that correctional legislation should clearly state the general rule that a competent person's decision to refuse all necessities shall be respected, for example:

8. Federal correctional legislation should provide that the Commissioner of Corrections shall not authorize force feeding of inmates, and that no person shall force feed an inmate.

This raises for discussion whether this should be the case regardless of the grounds for the decision; whether for religious conviction, or for personal or political reasons, and whether there should be any exceptions to the general rule.

Where an inmate's physical condition deteriorates to the point where hospitalization is necessary, transfer to an outside hospital would and should be authorized on medical grounds. Medical care, including the possibility of force feeding, is then the responsibility of that provincial facility, and federal correctional legislation would no longer apply.

Where the inmate is judged by a psychiatrist to be incompetent to make rational decisions with respect to eating, the inmate may be transferred to a psychiatric facility and, pursuant to the relevant provincial legislation governing the treatment of persons found incompetent to give or withhold consent, may be treated. This facility could be a provincial mental health facility or a CSC treatment or psychiatric facility. An exception to the general rule might be framed:

- (1) force feeding may only be authorized in CSC facilities in accordance with the appropriate provincial legislation governing involuntary treatment.

Is this an appropriate exception?

In addition, we wish to raise for consultation the question of whether there are situations where an inmate's decision to starve to death can be said to "trespass on the rights of others" or actually place the lives of others in danger, and whether situations of this type could ever justify force feeding.

PART V: IMPLICATIONS OF RIGHT TO TREATMENT FOR INSTITUTIONAL DECISION-MAKING

Given a duty to provide treatment (or alternatively a right to treatment) and a right to refuse treatment, what implications flow for institutional decision-making at such critical points as placement, classification, transfers, disciplinary proceedings and parole release or mandatory supervision decisions? What changes if any would be required in terms of existing law or regulation? To begin with, what legal rules or policy directives now in place at the above stages of the process direct officials to take mental health needs into account?

Intake/Placement

At the intake or placement stage, the Penitentiary Service Regulations require "... an investigation into the medical, psychological and social ... condition and history of the inmate ...", and placing inmates in an " ... institution that seems most appropriate having regard to protection of society and ... the program of correctional training considered most appropriate for the inmate." Commissioner's Directive 500 entitled Reception and Orientation of Offenders calls for a reception process that will ensure that all new inmates undergo a full assessment of their program and security needs which may include medical, psychological, psychiatric, vocational and educational assessments (s.2).

Classification

Apart from the general statements in the Regulations referred to above, there are no specific references to mental health needs in the classification process, although the above Commissioner's Directive directs officials at this stage to take into account "program needs of the offender", as well as other factors such as security needs, in making placement decisions (s.9).

Transfers

On transfer, again there is no specific direction in the Regulations respecting mental health needs. The Commissioner's Directive on Transfer of Inmates (CD-540) provides that one of the reasons for the transfer may be to provide adequate medical and psychological treatment (s.11). In practice, security needs far outweigh other considerations in the transfer process. This is especially so where an emergency transfer is undertaken.

"Crisis transfers" to regional psychiatric centres in B.C. and Saskatchewan do occur, as for example on a suicide attempt, without the inmate's consent, only pursuant to the involuntary committal procedures of the relevant provincial mental health legislation, as they are accredited hospitals. Kingston will, however, take other involuntary patients transferred by CSC into its programs. These transfers in B.C. and Saskatchewan are of varying duration under provincial law, ranging from one to 30 days. After the relevant time period, the transfer must be reviewed and the inmate committed for a longer period or returned to the penitentiary. In the meantime, as indicated in the analysis of treatment without consent, mental health needs are attended to.

In general the R.P.C. staff resist requests by management for the transfer of prisoners who are not treatable or for whom the centre has no appropriate program. A less stringent standard would reduce the centres to an incapacitative role from their present therapeutic role.

Crisis transfers out to provincial mental health facilities, as with the case of RPC transfers, must meet legislative criteria in the applicable mental health act and the professional standards of the staff in question. Thus, a failure by CSC to specifically address mental health issues means that provincial and professional criteria apply. Most provincial mental health legislation does not recognize behavioural disorders as a mental illness qualifying for a transfer; the proposed Uniform Mental Health Act does.

Disciplinary Proceedings

Regulations and Directives do not address health care needs in the disciplinary process. An exception is made at the Regional Psychiatric Centres, where the Case Management Policy and Procedures Manual states that " ... no inmate shall fail to earn remission ..." because of mental or physical disability while he or she is under treatment. In practice, a mentally disordered inmate may receive special consideration either in the guilt-finding process or in the form of disciplinary action taken. This, however, is within the discretion of the particular person in charge.

If dissociation or solitary confinement is awarded as a punishment in disciplinary proceedings, Divisional Instructions require a psychological or psychiatric assessment of inmates, and state that treatment needs are to be taken into account during dissociation. Should the required report show some special mental health need, the practice is to remove the inmate for treatment.

Parole

In the parole process, neither the Parole Act nor the Regulations specifically address mental health needs, although one of the statutory criteria for parole release is the rehabilitative needs of the offender; indeed, the concern for mental health needs arises largely in the context of offenders thought to pose a "risk to society", i.e., the dangerous offender. With regard to this category of offender, the Parole Policy Manual requires that psychiatric or psychological reports be obtained prior to a parole release decision. The orientation of policy in this respect is not treatment, but delay in release in order to "protect" the public. On the other hand, treatment is taken into account prior to release as a means of reducing risk, and treatment following release may also be required for the same reasons.

While parole board members may believe an inmate to be in need of mental health services or programs prior to release, the inmate may nonetheless be refused entry into those programs at the Regional Psychiatric Centres for lack of readi-

ness for or amenability to treatment. As a result, the inmate may feel caught in a cleft between the Parole Board telling him to show initiative and get treatment and the RPC not admitting him.

An inmate who is not released on parole by the time he or she has served two-thirds of the sentence, will be released on mandatory supervision subject to the 1986 amendments to the Parole Act that permit the National Parole Board to refuse release of persons otherwise eligible for mandatory supervision on the ground that the person is a danger to society. Like parolees, offenders on mandatory supervision are under the supervision of parole officers and are subject to various general or special conditions which may include a requirement to attend for treatment at a community based facility. However, in certain areas there are limited facilities and some inmates on release are generally unwilling participants in such services. Some community programs, it is said, do not like having them as clients. Given the uncertain effect of such programs, especially under the above conditions, parole officials often feel there is little they can do for the mental health needs of the person on mandatory supervision.

The public has an expectation that protection through supervision or treatment can be delivered; it is commonplace to observe that very little can be done "to protect" for the simple reason that very little has been shown to work. Forcing people to take treatment, moreover, is no answer to a call for protection if treatment cannot offer protection. It is apparent that parole/prison officials could attempt to avoid public criticism by transferring responsibility for difficult prisoners, prior to release, to provincial mental health facilities in certain cases. The risk here is that therapists are called upon to make such therapeutic transfers when the therapist is not able, professionally, to say that the prisoner is mentally ill or can be treated. It is not clear from reading the various reports to what extent frustration over such transfers arises from failure to deal with (1) established medical illness as opposed to (2) cases posing difficult behavioural problems and a risk of harm to others upon release, but not recognized by psychiatrists as suffering from an "illness".

Transfers to provincial health facilities are examined in greater detail in a later section. Suffice it to say here that, setting aside for the moment problems arising out of fear of public criticism and an evident desire to avoid paying for services, the problem of mental health needs at parole and mandatory supervision should be governed by the same principle as that applying within the institution; namely, an obligation to provide needed services subject to the principle of informed consent.

As to specific regulations and policies, then, at the critical decision making stages of placement, classification, transfers, disciplinary hearings and parole, there is little express direction with respect to relevance of mental health. Given their importance it is proposed that legislation direct officials to take mental health care needs, and programs and services, into account at each of these stages.

9. Federal correctional legislation should state that in all significant institutional decision-making processes including placement, classification, transfers, disciplinary proceedings and release decisions the mental health needs of the inmate shall be given reasonable consideration along with the security needs of the institution and the protection of society.

**PART VI: TRANSFERS TO PROVINCIAL MENTAL HEALTH FACILITIES:
PENITENTIARY ACT, SECTIONS 19 AND 20**

Section 19

It has long been thought desirable to transfer the severely mentally ill from penitentiaries to mental hospitals. Even if the federal government expands its facilities, there will no doubt remain cases where transfer to a provincial mental hospital is the most appropriate measure. The Penitentiary Act provides in s.19 for federal and provincial governments to enter into agreements in order to facilitate the transfer of "mentally ill" or "mentally defective" inmates to a provincial health facility. Such transfers, however, are not common. This part of the working paper reviews this transfer issue and the options that can be pursued in dealing with the problem.

Hospitals, by virtue of the constitution, fall within provincial jurisdiction; federal officials have no power to compel a provincial hospital to admit penitentiary inmates suffering from mental disorders. Indeed, hospitals are governed by provincial health legislation which, as a general rule, leaves admissions to the discretion of the hospital. Generally, the legislation does not create a duty to admit to care and treatment, although, as already noted, the British Columbia Mental Health Act grants to residents of that province an "entitlement" to mental health services offered under the Act. In general, however, the common law and statutory approach is not to grant a right to treatment nor even a duty to offer treatment, but to reserve to the government a discretion to confer certain social services as it sees fit. Since the Charter came into force, it may be argued that the extent of governmental discretion in health care matters has been reduced. The same can be said of the discretion of health care officials. Arguably, the refusal to admit a person into hospital care would now be unconstitutional if it were based on discriminatory grounds, for example. But lack of expertise or of programs suited to the patients' needs may not be an improper reason for refusing admission. In any event, even where there is a federal-provincial agreement for

the transfer of penitentiary inmates under section 19 of the Penitentiary Act, the particular hospital may still have discretion not to accept a particular patient.

Apart from problems of whether the inmate meets the Act's definition of mental illness as a pre-condition to admission, or whether he is a danger to himself or others, other reasons have been advanced for the general failure of section 19 to accomplish its purposes. Sharpe summarized the factors in 1983 as follows:

- (i) The provinces have inadequate forensic psychiatric facilities, in terms of both treatment and security.
- (ii) The provinces are overburdened with their traditional civil mental health responsibilities.
- (iii) There is a perceived danger to civil programmes and patients.
- (iv) There is an inability to reach agreement on mutually acceptable per diem rates and other cost-related factors.
- (v) There is confusion as to whether certification should be the standard for provincial acceptance during the term of imprisonment and, if not, as to whether and when civil commitment should be sought prior to scheduled release.³⁵

Except for the last mentioned factor, all of the above obstacles to action represent different views that are unlikely to be resolved by new legislation. However, as noted earlier, a narrow provincial definition of "mental illness" may preclude a transfer, but presumably a wider more agreeable definition could be provided in the transfer agreement or in section 19 itself. While the criteria for involuntary admission to mental health facilities differ from province to province in

detail, in general all require a finding that the person suffers from a mental illness or mental disorder and is a threat to himself or to others.

Certification under provincial health legislation may also be used in the Prairie and Pacific Regions in order to remove mentally ill persons from the general prison population to the Regional Psychiatric Centres which, in those regions, are accredited hospitals. Such a transfer bypasses the section 19 procedure.

The problem of any transfer, whether out to a provincial facility or over to a RPC, being subject to the vagaries of provincial definition of mental disorder or other criteria may become a thing of the past. The provinces are currently considering adoption of the proposed Uniform Mental Health Act under which "mental disorder" is broadly defined to include behavioural disorders. It is not known how many mentally disordered offenders within the penitentiaries could benefit from an improved section 19 transfer process. Apparently, section 19 has been restricted to date to cases of severe psychiatric disorders of a treatable nature. Given the trend towards closing down long term psychiatric hospital beds in the provinces, chronic cases are not likely to be transferred from the penitentiaries. The Needs Study identified a total of 805 chronic psychiatric cases in all regions across Canada. Four regions offer specific programs for chronic cases and the Atlantic offers programs for acute and sub-acute cases. Admittedly, the danger of setting up "chronic care wards" in the penitentiaries is that they may deteriorate into the hopeless "back wards" of the old insane asylums. It is not known what percentage of the 694 acute and sub-acute cases were adequately dealt with by resources within the penitentiary health service; only the Atlantic region is identified in the Needs Study as having expressly requested additional "basic" resources.

Assuming that there are a small number of acute and sub-acute cases and a large number of chronic cases whose needs are not reasonably well provided for under the present level of CSC mental health services raises a critical question for discussion that cannot, at this stage, be answered by legislation:

does the solution to these unmet needs lie with transfer to provincial facilities or does it lie in expanding federal services within the penitentiary system?

One advantage to a federal expansion of health care services over reliance on transfer to provincial mental health facilities would be the maintenance of federal control over admissions, as well as standards and quality of care. Provincial variation in available services is noted as a serious concern in the various reports dealing with mental health services.

Several disadvantages of a federal expansion of health care services have been argued. Providing health care has been said to be beyond the "secure custody" mission of the penitentiaries; yet necessary health care may be no more of an exception to the "secure custody" mission than provision of proper diet and decent living conditions. Moreover, the first Working Paper of the Correctional Law Review recommends a correctional philosophy that recognizes a place for offering remedial or therapeutic programs for offenders. This is reflected in CSC's own mission statement.

Duplication of services and the resulting inefficient use of resources has also been identified as a potential disadvantage of expanding federal health services for inmates, but this must be assessed against the federal responsibility or duty to provide treatment to inmates. Nor is it to be assumed that simply because two different levels of government provide health services within their own constitutional jurisdiction that inefficiencies result. Before coming to a final conclusion on the efficiency argument one would want to obtain data relating to overlapping clientele, the underutilization of services, and the costs of shifting to a unitary approach.

It would be useful to know the cost of providing health care through section 19 transfers as opposed to the cost of expanding federal services. Given the fact that substantially increased use of section 19 transfers would probably require an expansion of secure facilities at provincial expense, it may well be cheaper to expand existing RPC facilities.

Assuming, however, that federal services are expanded, it is still necessary to provide for an effective transfer mechanism for cases where transfer to provincial mental health facilities may be called for. As noted earlier, problems with the section 19 transfer mechanism stem from problems with scarce resources, and regardless of whatever improvements or innovations can be made in transfer mechanisms, the resource question will continue to underlie this whole issue. Therefore the present section 19 mechanism in combination with Exchange of Service Agreements between the federal government and individual provinces may be the most effective option in the circumstances. Other possible options have been suggested and are discussed here.

One such option is the creation of a federal provincial tribunal with authority to consider such transfers. Such a body could operate through a legislated framework, with authority to order such transfers, or it could run in an administrative advisory capacity. Since a province cannot delegate its powers to a federal board, the first approach would require enabling legislation by both the federal government and the province; unilateral legislation by the federal government would, of course, be insufficient. Any number of federal-provincial boards could be created by such joint legislation, but, the likelihood of such legislation coming about in the near future must surely be slim.

The second approach would see the establishment of a federal-provincial advisory board that has no actual decision-making powers. The advisory board could be comprised of federal representatives and representatives from each province (most likely psychiatrists and psychologists). Where a case of possible transfer to a mental health facility of a particular province arises, the provincial representatives of the concerned province would be consulted about treatment options, and the Advisory Board could make a recommendation as to treatment, and as to whether or not to recommend admission to provincial facilities. Even though the provincial facility would still retain discretion as to whether or not to accept the transfer, the Board's recommendation would supply a certain degree of political pressure.

In short, because penitentiary inmates are a federal responsibility there is an overwhelming case to be made that federal responsibility for medical care includes their mental health needs as well. The outstanding questions relate to costs and means. Given the reluctance of the provinces to accept federal inmates under transfer agreements the most feasible way for the federal government to fulfill its constitutional obligation is to expand health care services within the penitentiaries and to also provide community-based services for offenders on mandatory supervision and parole through purchase from community-based organizations.

Section 20

It should also be noted that section 20 of the Penitentiary Act provides an avenue to facilitate the transfer of mentally disordered offenders to provincial health facilities at the time of their discharge:

Discharge of Diseased Inmates

20. Where, on the day appointed for the lawful discharge of an inmate from a penitentiary, he is found to be suffering from a disease that is dangerous, contagious or infectious, he shall be detained in the penitentiary until such time as the officer in charge has made appropriate arrangements for the treatment of the inmate in an appropriate provincial institution or until the inmate is cured, whichever is the earlier.

This section does not create a power to transfer. Rather, it only permits penitentiary authorities to detain an inmate pending a transfer arrangement under section 19 as discussed above.

Section 20 clearly contemplates the transfer of mentally ill or mentally disordered offenders who would otherwise have to be released on the expiration of sentence. For our purposes, the section is specifically limited to persons considered to be "dangerous", as no additional criteria such as "mentally disordered" are set out. This poses a problem for, as

already outlined, provincial mental health legislation requires as a precondition to admission to a mental facility that the person be suffering from a mental illness as defined in the Act. Danger to self or to others alone is not a sufficient criterion for admission; consequently, attempted transfers based on section 20 concerns are bound to face problems if the prisoner is not "mentally ill" according to the definition found in the relevant provincial legislation.

The proposed Uniform Mental Health Act, as indicated, has a broad definition of "mental disorder" that may include the behavioural disorders of persons thought to be "dangerous" and, to this extent, would make it easier to accommodate a transfer based on section 20 conditions.

While the social interest underlying section 20 is understandable, namely protection of the public, the legislation itself is arguably unconstitutional in its attempt to detain prisoners after sentence has expired. It offends the notion of fundamental fairness for the government to decide that a person is "dangerous" and on that word alone authorize the detention of such a person. Given the unreliability of predictions of dangerousness, this is especially the case. Further, where the prediction is made within a prison environment, which itself may be productive of behavioural disorders, caution is even more appropriate. There is no reason why an inmate who has reached the date of lawful discharge should not be treated like anyone else; that is, by way of applicable provincial mental health or quarantine legislation. Section 20 is clearly out-dated, rarely used, and should be repealed. This is not meant to overlook the fact that availability of public mental health services for inmates upon release varies among the provinces. There is a pressing need to ensure that feasible alternatives for managing dangerous, mentally ill inmates at the end of their sentence are available at the provincial level. It would be untenable if such individuals were released directly into the community because of a lack of appropriate security provisions at provincial mental health facilities.

10. Section 20 of the Penitentiary Act should be repealed.

PART VII: CONFIDENTIALITY AND RIGHT TO KNOW

Further issues that arise in relation to treatment of mentally disordered inmates concern confidentiality and the inmate-patient's right to know what's on his or her own file.

Confidentiality

Confidentiality of medical records generally has been a social concern for some years, both outside and within the penitentiary context. The concern arises when the doctor's ethical responsibility to keep the patient's disclosures confidential and the patient's interest in keeping such matters private conflicts with professional need to share such information with other health professionals working on the case, or conflicts with an institutional or public interest in being forewarned about risks of patient "dangerousness".

At present, Canadian law does little to help resolve these conflicting interests. The discussion in this part will set out the doctor's ethical obligation not to disclose and the exceptions to this general ethical rule. In addition, the discussion will show how legislation relating to hospital medical records now recognizes claims of privacy and tends to limit disclosure of medical records to third parties and how the lack of a comprehensive set of rules impedes the development and carrying out of therapeutic and treatment programs in the prison/parole process. The final section deals with the inmate's right to know what is in his or her own medical file.

The Canadian Medical Association Code of Ethics places a high ethical obligation on the physician not to disclose:

6. (The physician) will keep in confidence information derived from his patient, or from a colleague, regarding a patient and divulge it only with the permission of the patient except when the law requires him to do so.

The law, however, recognizes no privilege attaching to the doctor-patient relationship. Hence, what a patient tells a doctor may be required by law to be repeated in court. The courts in general, however, are slow to force doctors to give such evidence, recognizing the social value of respecting the privacy of doctor-patient communications. Confidentiality, it is said, encourages trust and a full and frank disclosure by the patient; this in turn maximizes the likelihood of correct diagnosis and successful recovery.

Clearly, disclosure must be made to third parties when it is in the interest of developing and carrying out a treatment plan dependent upon those very individuals. Thus, disclosure to other health professionals for the purpose of facilitating a patient's treatment is seen as a necessary exception to the ethical obligation not to disclose. In the prison setting, particularly in relation to behaviour rather than medical disorders per se, does the right to disclose extend to members of the Case Management team, or to the Chaplain, for example? In some instances, disclosure to non-medical staff has been justified under circumstances where security staff are asked to watch the patient for signs of a recurring illness or disorder. These and other practical realities of the closed prison community exert strong pressures on the doctor to disclose, and raise for him or her a conflict of loyalties.

This conflict is theoretically increased where the doctor is an employee of CSC (although this is rarely the case, since most doctors provide health care services to inmates on a contract basis), and thus has an obligation to share relevant information with his or her employer. Yet as a health-care professional he or she also has an obligation to protect the confidentiality of the patient's communications. Moreover, parole officials, security staff or management may, for good institutional reasons, want to know about the inmate-patient's mental or behavioural diagnosis or treatment program. Should health care professionals be obliged to make such disclosures?

The answer may well be "it depends". For one thing, the prison therapist's duty of obedience to the employer does not compel breach of confidentiality. If there is a duty to disclose it must be based on other values. The Supreme Court of Canada addressed the employment conflict in these terms:

... an employee's duty of obedience towards his employer does not mean that the latter has any power to compel his employee to act in breach of a duty of confidentiality. The medical director of a hospital cannot release a doctor from his obligation of confidentiality towards his patient, only the latter may release him from his duty.³⁶

In support of the therapist's reluctance to disclose information to parole and prison officials is the fear that under such circumstances inmates will not "open up" and treatment will be impossible, or possibly that disclosure will result in the improper use of medical information by untrained persons. The discussion of the Tarasoff case below suggests that the first fear may be exaggerated and, further, that where disclosure has been made, the practice to date does not appear to support the fear of misuse of information.

Indeed, in general practice the traditional view is that medical files are the property of the doctor or the hospital. This "ownership" of the files feeds the reluctance to disclose to third parties, and has sometimes led to a reluctance even to transfer a medical file from one institution to another. However, the public interest in conserving resources and in facilitating a treatment program argues that the file be forwarded. In resolving this conflict of values, health care professionals should not have their professional integrity undermined by a rule that requires disclosure of confidential information at the total discretion of institutional authorities.

Current provincial and federal legislation does not resolve the conflict facing the prison therapist. For example, provincial legislation requires the doctor to disregard confi-

dentiality in certain instances by requiring him or her to report patients suffering from venereal disease and persons suspected of child abuse. Other provincial legislation aimed at hospitals requires disclosure of information on the medical record, under certain circumstances, to coroners, medical practitioners or to a person armed with a court order. The latter type of provincial legislation does appear to recognize a right of privacy to hospital records in that it requires disclosure only in certain cases. A similar pattern of restricted disclosure requirements can be found in provincial legislation governing mental hospitals.

This general respect for the private nature of hospital records is also reflected at the federal level through provisions of the Privacy Act. The Act prohibits disclosure in general, but permits certain exceptions, namely disclosure of medical information for a medical purpose (as in the course of disclosure to a medical or health-care team).

Where the patient consents to the disclosure of the medical record for certain purposes there is no conflict; such consent, as with consent to treatment, however, should be expressed in writing and made upon a full disclosure of the nature of the information and the purposes to which it will be put. That is to say, outside the prison setting the patient has a claim to privacy which must be balanced against the professional's interest in sharing the information with other professionals in order to maximize the patient's health benefits. Since law and morality place a high value on autonomy of persons and their capacity to make responsible decisions, the patient's interest, including the inmate-patient interest, in privacy should be respected. Before information is transmitted from one health care official to another or from one institution to another, the patient should be fully advised.

In an important study on confidentiality of medical records Mr. Justice Krever stated that in the ordinary case the patient's interest in privacy of medical records requires consent prior to disclosure, the exception being when an emergency or crisis makes it impracticable to get such consent.

"he Krever report takes the view that the inmate-patient is not entitled to the same level of respect for confidentiality of medical records as the person on the street. The report recommends:

... that legislation governing confidential information maintained by hospitals and health-care facilities permit the disclosure of information, concerning a patient who is confined in a correctional institution and who has been hospitalized, to the superintendent, director or medical officer of the patient's institution, for the purpose of maintaining the health of the patient, provided that the patient is notified of the disclosure.³⁷

Is this recommendation too wide? Disclosure to third parties, without consent, could only be "for the purpose of maintaining the health of the patient", but is that the best position to take? Presumably, the patient's judgements about what treatment he or she will or will not seek falls within the consent principle. If an exception to the general rule of non-disclosure is to be made could it more plausibly be supported not on paternalistic grounds of what is best for the inmate, but on a theory of countervailing rights compelling disclosure in instances of real and substantial threat to the security of other persons or the institution itself? On this basis confidential medical information may on occasion be relevant to classification, transfer or paroling authorities. Absent some clear evidence of substantial risk, however, the health care professional should not be obliged to breach confidentiality.

Canadians have viewed relevant American law on this point with considerable interest. Imagine the situation where the institutionalized patient told the therapist in confidence that upon release he intended to kill X. Suppose the therapist fails to warn X; the patient is released in due course and promptly kills X. Is the therapist liable in damages in a suit brought by X's estate for having breached a duty to warn? On these facts the California Supreme Court imposed

liability in the Tarasoff case, holding that there was a duty to warn where the risk was directed at a specific person.³⁸ The Canadian courts are also likely to hold that a duty to warn arises under circumstances of foreseeable harm to a particular person, or to a particular class of persons. Mr. Justice Krever recognized this, recommending that the law should recognize an exception to the confidentiality rule where the health-care worker has reasonable cause to believe that a patient is in such a mental condition as to be dangerous to himself or others. In such cases, the Krever Report states reporting or warning should not be considered professional misconduct. Exemption from professional misconduct, however, does not protect the prison health care professional from potential lawsuits. It would be preferable if legislation created an exception to the confidentiality rule to take care of the Tarasoff type of situation.

The competing interests in these cases include the patient's claim to privacy, the doctor's desire for an atmosphere of confidentiality in order to enhance the effectiveness of health care and treatment, the security interests of management and staff and the rights of potential victims to security of life and person. As between these competing rights, our society places a higher value on life than it does on privacy or the maximization of health care. It should be noted that studies done on the effects of the Tarasoff duty to disclose do not show that it has seriously interfered with the physician-patient relationship.

In arriving at a balancing of interests it should be remembered that the security and safety of other inmates and staff are an ever present concern in closed communities such as prisons. In such conditions the duty to disclose in the absence of consent may be higher than it would be in situations arising in the general community where the risks to other persons may be more remote or diffused and where those other persons have greater means of seeking protection than is the case in prisons. Presumably, even in respect to situations arising in the community, there ought to be a duty to warn in certain circumstances. For example, if a patient subject to sudden cardiac arrest insists on continuing to

drive an automobile or a psychiatrist knows of a serious risk of suicide or other serious harm, the right to confidentiality should not be absolute.

A serious weakness in the argument favoring compulsory reporting or disclosure in cases of anticipated risk or danger is the unreliability of predictions of dangerousness. In medical matters relating to physical disabilities there may well be a high degree of accuracy, but in relation to psychiatric or behavioural disorders predictions are still of limited reliability. In determining whether the risk is a serious one, therefore, the therapist should pay particular attention to criteria such as those recommended by Monahan³⁹ in an effort to reduce the unreliability gap.

Right to Know

Related to the issue of confidentiality is the inmate-patient's right to know what is in his file. Historically, physicians and hospitals have viewed medical files as their property, not the patient's. Various reasons are given for this somewhat paternalistic approach to patients, including an argument that disclosure would be injurious to the patient. The requirement that the law treat persons as autonomous beings capable of choice, however, would lead to just the opposite conclusion: namely, that the record should be disclosed to patients. It can also be argued that hiding the record breeds suspicion and distrust.

Mr. Justice Krever addresses this issue and gives five reasons why there should be disclosure:

First, as an incident of human dignity, a patient ought to have the right of access to the most personal information about himself or herself. No person, even though he or she may be a professional with much knowledge and experience, should be entitled to withhold that information. Second, the patient, in his or her own interest, should be able to correct any misinformation which may appear on his record.

Third, the patient will have a better understanding of his or her treatment and be in a better position to assist in future care. Fourth, access to the file will allow a patient to make an informed consent to the release of information from the file to a third party when necessary. Fifth, access creates a feeling of trust and openness between patient and health-care providers, and the quality of health care will thereby be enhanced.⁴⁰

The federal Privacy Act, while promoting a general rule of disclosure of personal information to the person concerned, draws an exception for penal institutions:

Section 24:

The head of a government institution may refuse to disclose any personal information requested under subsection 12(1) that was collected or obtained by the Canadian Penitentiary Service, the National Parole Service of the National Parole Board while the individual who made the request was under sentence for an offence against any Act of Parliament, if the disclosure could reasonably be expected to

- (a) lead to a serious disruption of the individual's institutional, parole or mandatory supervision program; or
- (b) reveal information about the individual originally obtained on a promise of confidentiality, express or implied.

Section 28:

The head of a government institution may refuse to disclose any personal information requested under subsection 12(1) that relates to the physical or mental health of the individual who requested it where the examination of the information by the individual would be contrary to the best interests of the individual.

Issues of fundamental fairness and rationality both under the common law and the Charter must be balanced against the therapist's judgement as to the effect of disclosure on the therapist-client relationship and the institutional interest in the effect of such disclosure on prison security or the security of specific individuals. The matter should be addressed in federal correctional legislation.

11. Federal correctional law should recognize:

- a. a principle of confidentiality and impose a duty on penitentiary health care officials or other persons dealing with penitentiary health care information not to disclose it;
- b. exceptions to the non-disclosure duty so as to
 - (1) require a sharing of health care information among health care officials, other institutional or community staff, or staff of private agencies under contract with the agencies, for treatment purposes; and
 - (2) impose a duty to warn institutional or parole staff or other relevant individuals where a health care official has reason to believe that an inmate in an institution or on supervised release poses a risk to the security and safety of other persons; and
- c. an obligation by health-care officials to disclose to an inmate, on request, personal health information in the inmate's institutional files, subject to an exception in cases where risk to the security and safety of other persons is likely to result from such disclosure.

CONCLUSION

The discussion throughout this paper has focused on the need for mental health services for penitentiary inmates, and the type of legislative provisions which would protect inmates' right to treatment and facilitate delivery of needed mental health services.

The importance of addressing the mental health needs of offenders is underscored by the Charter of Rights and Freedoms, in particular the section 7 affirmation of the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. This right includes an undefined right to health services that imposes a duty on the state to provide certain levels of health care. Considering the heavy concentration of individuals with severe psychiatric and behavioural disorders within the corrections system, it is important that needed mental health services be provided.

While it is believed that access to such services would reduce management problems, would assist inmates in their eventual re-integration into the community, and would result in a more peaceful and safe society, it is at the same time recognized that provision of such services raises serious questions concerning resources. It is in the area of mental health services, more than any other, that it is clear that the demonstrated need for increased services can be met only through an increased commitment of resources.

The importance of providing such services relates directly to the statement of purpose of corrections developed in the Correctional Philosophy Working Paper, which places a high priority on encouraging offenders to prepare for eventual release and successful re-integration into the community through the provision of a wide range of program opportunities responsive to their individual needs. The public, including victims groups, are convinced that "something should be done" to enable inmates such as sex offenders to

deal with any mental health problems they may have. The recommendations in this paper are aimed at facilitating delivery of needed mental health services to penitentiary inmates. They recognize a duty on CSC to provide mental health services to inmates with a psychiatric or behavioural problem which grossly impairs their ability.

END-NOTES

1. The Criminal Law in Canadian Society, (1982) Ottawa: Government of Canada.
2. The Archambault Report (Report of the Royal Commission to Investigate the Penal System of Canada, King's Printer, Ottawa, 1938) noted that there was "neither means for proper treatment nor personnel with experience" to deal with the insane prisoner; the McRuer Report in 1956 (Report of a Committee Appointed to Inquire into the Principles and Procedures Followed in the Remission Service of the Department of Justice Canada, Queen's Printer, Ottawa, 1956) counselled that "wise institutional treatment takes into consideration the education and the physical and mental health of the prisoner"; and the Ouimet Report in 1969 (Report of the Canadian Committee on Corrections, Queen's Printer, Ottawa, 1969) urged that "within the scope permitted by the sentence of the court, the discretion allowed by law, and the demands of good professional practice" the prison service should take whatever course of action was necessary to return the offender to the community as a contributing member of society". The Carson Committee Report of 1984 (Report of the Advisory Committee to the Solicitor General of Canada on the Management of Correctional Institutions, Ministry of the Solicitor General, 1984) recommended that steps be taken to effectively deal with the growing problem of mentally disturbed offenders.
3. T. Hogan and L. Guglielmo, Mental Disorder Needs Identification Study, Ministry of the Solicitor General, 1985.
4. The General Program for the Development of Psychiatric Services in Federal Correctional Services in Canada, Ottawa, 1972. (The Chalke Report).
5. Report of the Advisory Committee of the Solicitor General of Canada on the Management of Correctional Institutions, Supra Note 2. (The Carson Committee Report).

6. Improved Program Delivery, The Justice System, A Study Team Report to the Task Force on Program Review, Ottawa, 1985.
7. Supra, Note 3.
8. Most of the data referred to in this section is taken from Operational and Resource Management Review No. 11, Review of Mental Health Services, Ministry of the Solicitor General, Ottawa, 1985.
9. Carson, Committee Report, supra, note 2, at p. 49.
10. Supra, Note 8.
11. Supra, Notes 3 and 8.
12. Supra, note 6, at p. 287.
13. Ouimet Report, supra, note 2.
14. Martineau v. Matsqui Inmates Disciplinary Board (No. 1), [1978] 1 S.C.R. 118
15. The impact of the Charter is discussed in further detail in the Working Paper on Correctional Authority and Inmate Rights.
16. R. v. Big M Drug Mart et al., [1985] 1 S.C.R. 295 at p. 346.
17. The test is set out by the Supreme Court of Canada in R. v. Oakes, [1986] 1 S.C.R. 103.
18. Estelle v. Gamble, (1976) 50 L.Ed. 2d 251 (U.S.S.C.), at p. 260.
19. Robert E. v. Lane, (1981) 530 F. Supp. 930.
20. Andrews v. Law Society of British Columbia, (1986), 2 B.C.L.R. (2d) 305 (B.C.C.A.) (on appeal to the S.C.C.) and Rebic v. A.G.B.C., (1986), 2 B.C.L.R. (2d) 364 (B.C.C.A.)

21. Bowing v. Godwin, (1977) 551 F. 2d 44.
22. Ibid., p.47.
23. C. Webster and Bernard Dickens, Deciding Dangerousness: Policy Alternatives for Dangerous Offenders, (1983) Ottawa: Department of Justice.
24. See American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 3rd, 1980 (DSM-III).
25. Lee Sechrest et al, The Rehabilitation of Criminal Offenders: Problems and Prospects, National Research Council, National Academy of Sciences, Washington, D.C., 1979.
26. See Law Reform Commission of Canada, Report: Guidelines to Dispositions and Sentences in the Criminal Process, (1976) Ottawa.
27. Law Reform Commission of Canada, Behaviour Alteration and Criminal Law, Working Paper 43, (1985) Ottawa and Consent to Medical Care (1980) Ottawa.
28. Behavior Alternation and Criminal Law, supra, note 27 at p.24.
29. Halushka v. University of Saskatchewan, (1965) 53 D.L.R. (2d) 436 (Sask. C.A.).
30. Kaimowitz v. Michigan Department of Health, (1973) 42 U.S.L.W. 2063.
31. R. v. Clarkson, [1986] 1 S.C.R. 383.
32. Auditor General of Canada v. Notre Dame Hospital et al., (1984), 8 C.R.R. 382 (Que. S.C.).
33. A.G.B.C. v. Astaforoff, (1984) 4 W.W.R. 385 (B.C.C.A.)
34. Re Caulk, (1984) 480 A. 2d93 (N.H. Sup. Ct.), at p. 100.

35. Sharpe, Gilbert, Project Chief, Mental Disorder Project: Discussion Paper, Department of Justice, 1983, at p. 296.
36. Attorney General of Quebec and Keable v. Attorney General of Canada, [1979] 1 S.C.R. 218 at p. 250.
37. Report of the Royal Commission of Inquiry Into the Confidentiality of Health Information Vol. II, (Toronto: Queen's Printer, 1980) p. 343. (Krever Report).
38. Tarasoff v Regents of the University of California, (1976) 551 P.2d 334 (Cal. S.C.).
39. Monahan, J. Predicting Violent Behavior, (Sage Publications, Inc., Beverly Hills) 1981.
40. Krever Report, supra, note 37, p. 468.

APPENDIX A

LIST OF PROPOSED WORKING PAPERS OF THE CORRECTIONAL LAW REVIEW

Correctional Philosophy

A Framework for the Correctional Law Review

Conditional Release

Victims and Corrections

Correctional Authority and Inmate Rights

Powers and Responsibilities of Correctional Staff

Correctional Issues Affecting Native Peoples

Federal-Provincial Issues in Corrections

Mental Health Services for Penitentiary Inmates

International Transfer of Offenders

APPENDIX B

Extract from Mental Disorder Needs Identification Study by T. Hogan and L. Guglielmo (Ministry of the Solicitor General, 1985) at pp. 63-65:

DESCRIPTION

The following descriptions are intended to assist in identifying those inmates who require extraordinary care.

"Disturbed" - For the purposes of this study a person is considered disturbed if their mental functioning is sufficiently impaired or their problem is so overwhelming as to interface grossly with their capacity to meet the ordinary demands of daily living. Their perceptual disorganization, emotional distortion, and/or memory deficits are such that the inmate's grasp of reality is effectively lost; and/or the person's problem is sufficient to cause considerable psychological distress for the inmate and, perhaps, be very disturbing for others.

1. **Suicidal Type:** An inmate who because of an active depression or because of an hysterical immature disregard for life, threatens and/or appears to be actively contemplating and planning suicide. Cognitive confusion, emotional lability and/or impulsivity may contribute to the risk. Frequently, there is a history of suicide attempts and/or gestures.
2. **Serious Depression:** An inmate whose behaviour is marked by extreme lethargy and despair, may isolate him/herself from the "normal" prison population and appear frequently in a "black", despondent mood. The inmate may appear to have little regard for self or others, is erratic and unpredictable. "Black" moods may be quickly and unpredictably replaced with frivolous episodes of levity.
3. **Serious Thought Disorder:** Inmate's thinking is markedly confused, and behaviour responses are disoriented; emotional reactions are inappropriate. The overall

impression is that of a seriously disordered person. There may be evidence of bizarre behaviour, paranoid thinking, and/or extreme unpredictability. The onset may have been quite recent, or there may be a long history of such episodes. There may be periods of lucidity during which the inmate seems normal and "together", though the overall impression is that the inmate is seriously disturbed.

4. **Socially and Mentally - Incompetent Mental Retardation:**

The inmate who because of a psychological condition cannot live a "normal" prison life as he/she creates serious administrative problems; both the inmate and the general prison population suffer from the inmate's inclusion. He/she appears incompetent, mismanages many aspects of daily living, and the inability to cope is generally irksome. The inmate obviously requires care in dealing with day to day functioning. Certain types of distressed mentally retarded, and/or persons with chronic mental disorder might be included in this category.

5. **Violence and/or Aggression Prone:** The inmate has a significant problem managing extreme anger. A violent reaction may be triggered without sufficient provocation and the inmate is very unpredictable in this regard. The aggressive behaviour is typically not in keeping with circumstances. Rages may be intense, prolonged and occurring with increasing frequency. A person included in this category finds anger, violence, and aggression impulses quickly get out of hand so the inmate is seen as being explosive, sadistic and out of control.

N.B. - Exclude from Survey

There may be some difficulty distinguishing this person from the "tough guy" or the person who may from time to time take extraordinary measures to defend his/her self.

6. **Serious Sexual Dysfunction:** An inmate would be included in this category who have a substantial sexual disorder which (1) is a source of considerable distress for the

inmate; and/or (2) creates a problem for the general inmate population; and/or (3) will likely create problems for the public when the inmate completes his/her sentence.

N.B. - Exclude from Survey

Those inmates who may have some sexual behaviours which cause the inmate no stated concern; do not create a substantial problem for the general inmate population; will not likely be cause for criminal charges if the inmate engages in the behaviours after discharge.

tance abuse problem who demonstrates a pathological use of and/or a dependence on alcohol and/or drugs, i.e.,

- need for daily use of substance for adequate functioning;
- inability to cut down or stop use of substance;
- repeated (and unsuccessful) effort to control use of substance;
- binging (remaining intoxicated for more than 2 days);
- amnesia (black-outs);
- continuation of use of substance despite its detrimental effect on some other health or social situation;
- impairment in social and/or occupational functioning due to substance abuse;
- need for increased amounts of substance to achieve the desired effect.

A person would be included in this category who currently demonstrates an abuse problem. Also include those inmates who because of current attitudes will probably have a considerable abuse problem upon release (or when alcohol and drugs may be more readily available).

8. **Controlled Thought Disorder and/or Controlled Affective Disorder (Depression):** Inmate who may have a history of mental illness and/or probably has had intensive treatment in the past but who is managing satisfactorily in the "normal" population, probably because of medication

and/or institutional professional (medical, psychiatric, nursing, psychological) care. It is anticipated that, all things being equal, the inmate's condition will not deteriorate, although without an ongoing maintenance programme, the inmate's condition would worsen.

9. **Other Serious Disorder(s):** An inmate may have some significant psychological, psychiatric disorder other than the ones indicated above.

10. Other Significant Personal Problem Requiring

Psychological Attention: An inmate may have a significant personal problem which is distressing and detrimentally influencing daily functioning. He/she requires the special assistance of a nurse-practitioner and/or a psychologist to help.

APPENDIX C

**STATEMENT OF PURPOSE AND
PRINCIPLES OF CORRECTIONS**

The purpose of corrections is to contribute to the maintenance of a just, peaceful and safe society by:

- a) carrying out the sentence of the court having regard to the stated reasons of the sentencing judge, as well as all relevant material presented during the trial and sentencing of offenders, and by providing the judiciary with clear information about correctional operations and resources;
- b) providing the degree of custody or control necessary to contain the risk presented by the offender;
- c) encouraging offenders to adopt acceptable behaviour patterns and to participate in education, training, social development and work experiences designed to assist them to become law-abiding citizens;
- d) encouraging offenders to prepare for eventual release and successful re-integration in society through the provision of a wide range of program opportunities responsive to their individual needs;
- e) providing a safe and healthful environment to incarcerated offenders which is conducive to their personal reformation, and by assisting offenders in the community to obtain or provide for themselves the basic services available to all members of society;

The purpose is to be achieved in a manner consistent with the following principles:

1. Individuals under sentence retain all the rights and privileges of a member of society, except those that are necessarily removed or restricted by the fact of incar-

ceration. These rights and privileges and any limitations on them should be clearly and accessibly set forth in law.

2. The punishment consists only of the loss of liberty, restriction of mobility, or any other legal disposition of the court. No other punishment should be imposed by the correctional authorities with regard to an individual's crime.
3. Any punishment or loss of liability that results from an offender's violation of institutional rules and/or supervision conditions must be imposed in accordance with law.
4. In administering the sentence, the least restrictive course of action should be adopted that meets the legal requirements of the disposition, consistent with public protection and institutional safety and order.
5. Discretionary decisions affecting the carrying out of the sentence should be made openly, and subject to appropriate controls.
6. All individuals under correctional supervision or control should have ready access to fair grievance mechanisms and remedial procedures.
7. Lay participation in corrections and the determination of community interests with regard to correctional matters is integral to the maintenance of incarcerated persons and should at all times be fostered and facilitated by the correctional services.
8. The correctional system must develop and support correctional staff in recognition of the critical role they play in the attainment of the system's overall purpose and objectives.

APPENDIX D

**PROPOSALS CONCERNING MENTAL HEALTH SERVICES
FOR PENITENTIARY INMATES**

The following is a list of proposals presented for discussion:

1. Federal correctional legislation should explicitly recognize that the Commissioner of Corrections has a duty to provide needed mental health services to offenders within the custody of Correctional Service of Canada. The determination of mental health service needs shall be made by authorized medical staff or health services teams. This determination should be made subject to an offender's right to request a second opinion.
2. "Mental health services" should be defined in federal correctional legislation to mean any approved treatment, program or service professionally designed and administered for the treatment of a mental disorder of thought, mood, perception, orientation, or memory that significantly impairs judgement, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life.
3. Federal correctional legislation should provide for an obligation to offer mental health services to persons in the custody of Correctional Service of Canada at a level or standard that is consistent with standards commonly available to the public at large, and to offer programs to meet the special needs of inmates.
4. Federal correctional statutes should expressly recognize the principle of voluntary, informed consent to treatment made by a person with a capacity to understand the subject matter in issue and an appreciation of the consequences of his or her decision.
5. Federal correctional legislation should expressly recognize the right of every such person within the custody of CSC to refuse treatment.

6. Federal correctional legislation should provide that
 - a. experimentation should be conducted only within strict criteria for professionally approved programs, and with the offender's consent.
 - b. offenders may participate in therapeutic experimental research programs, provided that (1) the program has been approved as medically sound and in conformance with medically accepted standards; (2) the offender has given full voluntary and informed written consent; (3) in the case of psychosurgery, electrical stimulation of the brain, and aversive conditioning, approval has been given by an appropriate court after a hearing to determine that the program is sound and that the offender has given informed consent.
 - c. a program should be considered medically sound and in compliance with medically accepted standards only after it has been reviewed by a committee established by law to evaluate its medical validity.
 - d. an offender should be considered to have given informed consent only after that consent has been reviewed by an independent committee, consisting of lay persons, including offenders or ex-offenders.
 - e. for the purposes of correctional legislation, "informed consent" means that the offender is informed of (1) the likely effects, including possible side effects, of the procedure; (2) the likelihood and degree of improvement, remission, control or cure resulting from the procedure; (3) the uncertainty of the benefits and hazards of the procedure; (4) the reasonable alternatives to the procedures; and (5) the ability to withdraw at any time.

Treatment Without Consent

7. Federal correctional legislation should provide the following:
 - a. Where an offender has lost the capacity to give an informed consent, upon an application under the mental health act of a province, the offender may be found to be mentally incompetent, and in such event, the offender's next of kin, or guardian, or the director of mental health services for the mental health facility may authorize appropriate treatment.
 - b. Where treatment is given without the offender's personal consent, only that treatment shall be administered as is the least intrusive means available and feasible to restoring the patient to a state of competency.
 - c. In an emergency, an offender who is suffering from a severe mental disorder and who refuses consent to treatment may be transferred to a provincial mental health facility without prior judicial authorization providing
 - (i) the offender poses a substantial risk of harm to others or to himself or herself; and
 - (ii) the Director of the mental health facility consents to the transfer and directs such reasonable treatment as may be necessary.
8. Federal correctional legislation should provide that the Commissioner of Corrections shall not authorize force feeding of inmates, and that no person shall force feed an inmate.
9. Federal correctional legislation should state that in all significant institutional decision-making processes including placement, classification, transfers, disciplinary proceedings and release decisions the mental health needs of the inmate shall be given reasonable con-

sideration along with the security needs of the institution and the protection of society.

10. Section 20 of the Penitentiary Act should be repealed.

11. Federal correctional legislation should recognize:

- a. a principle of confidentiality and impose a duty on penitentiary health care officials or other persons dealing with penitentiary health care information not to disclose it;
- b. exceptions to the non-disclosure duty so as to
 - (1) require a sharing of health care information among health care officials, or other institutional or community staff, or staff of private agencies under contract with the agencies, for treatment purposes; and
 - (2) impose a duty to warn institutional or parole staff or other relevant individuals where a health care official has reason to believe that an inmate in an institution or on supervised release poses a risk to the security and safety of other persons; and
- c. an obligation by health-care officials to disclose to an inmate, on request, personal health information in the inmate's institutional files, subject to an exception in cases where risk to the security and safety of other persons is likely to result from such disclosure.