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VIA EMAIL

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RE: CAN/HSO 34008:2024 Correctional Service Canada Health Services Public Review

The BC Civil Liberties Association ("BCCLA") works to promote, defend, sustain, and extend civil liberties and human rights in British Columbia and Canada through litigation, law and policy reform, public legal education, and community-based advocacy.

The BCCLA has had a longstanding involvement in advocating for prisoners' rights issues in Canada. Over the years, a portion of the BCCLA's casework has been spent on investigating complaints of prisoners and parolees. This has included responding to prisoners' complaints regarding the use of solitary confinement, lack of exercise, compulsory drug testing, body searches of inmate visitors, disciplinary procedures and a wide range of other issues.

We are pleased to provide these comments on the draft Correctional Service Canada Health Services Standard. We have identified four issues on which to provide specific feedback:

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I. Addressing Solitary Confinement

The BCCLA has brought several court challenges to the use of isolation by Correctional Service Canada ("CSC"), including successful challenges to the former Management Protocol and Administrative Segregation regimes, and an ongoing challenge to the use of prolonged and indefinite lockdowns.

We are aware that CSC continues to use other forms of isolation, such as restrictive general movement routines, dry cells, medical observations cells, voluntary limited association ranges and what the Correctional Investigator calls "hidden cells". The evidence of the harms of isolation on prisoners' health is overwhelming and uncontroverted. The BCCLA is pleased to see that this is recognized and addressed throughout the Standard. However, we believe there are opportunities to improve the language in the Standard and strengthen procedures to better address this issue.

Terms and Definitions

Recognizing that the definitions section of the Standard is yet to be completed, the BCCLA has two recommendations for definitions of terms used throughout the Standard.

Isolation

The BCCLA underscores the need to define isolation broadly and in a client focused manner. Isolation must be defined in terms of the experience of prisoners, rather than by physical location or official status within the prison such as Structured Intervention Units. Isolation should also not be conflated with solitary confinement, as the harmful effects of isolation can occur well short of the legal definition of solitary confinement.

Section 5.1.7 refers to "[p]hysical, chemical and environmental restraints (isolation)". Based on this language, it appears that isolation may be defined by forms of restraint. Instead, it is important that the concept of meaningful human contact be incorporated into the definition of isolation. For example, a prisoner could be given freedom to use an entire range but be completely isolated from other prisoners. It is not clear if this would amount to an "environmental restraint" but should still be considered isolation. Time spent out of a cell is not a useful way to identify isolation.

The definition should also make it clear that "voluntariness" is irrelevant to whether a prisoner is experiencing isolation. Efforts should be made to alleviate isolation whether it is imposed by prison officials or whether it is chosen or consented to by the prisoner.

Proposed definition:

> Isolation: a prisoner experiences isolation when their access to meaningful human contact is limited for any duration and in any way, including through physical, chemical or environmental restraints, whether or not that limitation is consented to or voluntary on the part of the prisoner.

Signs of abuse

The term "signs of abuse" is used throughout the Standard. Team members are instructed to identify, document and, with the consent of the client, report any signs of abuse. The BCCLA recommends including guidance within the Standard on what may constitute abuse within the prison context. International law instruments would be helpful in this regard.

For instance, specific limits on the use of isolation can be found in Rules 43, 44, and 45 of the Mandela Rules and Rule 22 of the Bangkok Rules. Explicit reference to these Rules would provide helpful guidance for when intervention or reporting by medical staff becomes necessary in the face of abusive uses of isolation.

While we have focused this portion of our submissions on the abusive use of isolation in prisons, we recognize that prisoners are also subjected to many other forms of abuse. Beyond isolation, the Mandela Rules and the Bangkok Rules provide minimum standards respecting many matters that impact health and wellbeing such as: personal hygiene, clothing and bedding, searches, contact with the outside world and the use of restraints.

The Standard should make it clear that team members must be familiar with international law standards, and that failure to meet these standards by prisons necessarily constitutes abuse. However, the BCCLA would emphasize again that these are *minimum* standards, and that abuses may occur short of violating a specific international law.

Other Specific Provisions

Section 3.1.1

…The client's experiences of disciplinary sanctions or other restrictive measures, such as isolation or use of force, are also assessed and documented, and recommendations are made to stop or alter them to protect the health of the client where ~~necessary~~ appropriate [or warranted].

Rationale: Team members should be proactive in addressing potential harm to clients.

Section 3.1.6

…The client's experiences of disciplinary sanctions or other restrictive measures, such as isolation or use of force, are also assessed and documented, and recommendations are made to stop or alter them to protect the health of the client where ~~necessary~~ appropriate [or warranted].

Rationale: Team members should be proactive in addressing potential harm to clients.

Section 4.1.2

When ~~needed~~ appropriate [or warranted], recommendations are made advocating for the client's access to health promotion, including regular opportunities for physical and outdoor exercise, especially when placed in isolation.

Rationale: Team members should be proactive in addressing potential harm to clients.

Section 5.1.7

Currently the sections states: the team follows the organization's procedures on the use of least restraints as a last resort when providing care. There is no indication that the organization is required to have such procedures in place, or what those procedures should include. Language should be added to require such procedures.

Section 7.1.1

Advocacy. The team is committed to advocating for the client's health and well-being when an operational decision ~~has been made to place the client in a structured intervention unit.~~ has the potential to negatively impact the client. This includes all decisions to isolate or restrain the client.

Rationale: As discussed above, there are many forms of isolation beyond the structured intervention unit. There are also many operational decisions that can negatively impact prisoners' health and wellbeing beyond the use of isolation.

Section 7.2.5

A thorough understanding of the complex health needs of incarcerated people, ~~and~~ their rights to health services, and their rights to be free from abusive treatment is essential to the provision of high-quality and safe care in a correctional environment.

In addition, the list provided in this section should include the impacts of isolation, restraint and other potentially abusive practices on the health and wellbeing of prisoners. It should also include international and domestic legal requirements regarding the treatment of prisoners.

Rationale: Team members have a duty to identify, document and report potential abuses, and so must maintain sufficient knowledge about this issue.

II. Independence of Healthcare Workers

Health care workers assisting incarcerated clients must maintain their clinical independence by recognizing that they are separate from other CSC staff. For instance, health care workers should never act as agents of the police or correctional services, nor participate in punitive activity. Their role should strictly be the provision of medical treatment, to the standard of care that is required of their profession and owed to the broader community.

To clarify this position, we recommend adding language throughout the Standard, but particularly in Section 1:

Section 1.1.1

The organizational leaders establish policies and procedures to uphold client rights to care according to applicable laws and international standards. Team members have a duty of care, loyalty, and confidentiality toward their clients, and must maintain clinical independence from other CSC staff.

Rationale: Team members individually carry these duties, in addition to their requirement to follow policies and procedures established by their organizational leaders. Also, clinical independence should be named within the section to underscore the need for team members to provide care free from undue influence or organizational pressures which may perpetuate situations of coercion, exploitation, discrimination, or abuse.

Section 1.1.1 Guidelines

Respecting, promoting, and protecting client rights is the foundation of client-centered care.

The organization's policies and procedures uphold client rights to care, including the right to

- be treated with dignity, respect and compassion;
- have their privacy and confidentiality protected;
- be protected from coercion, exploitation, discrimination, and abuse;
- receive timely, equitable, high-quality, and safe care, to the same standard as is available in the community;
- receive culturally safe and trauma-informed care, in accordance with their expressed preferences;
- make informed decisions about their care and provide prior consent;
- have timely access to their health information, recognizing privacy limits on third-party information;
- refuse care or refuse to have certain people involved in their care, unless exigent circumstances render this unfeasible; ~~with reasonable explanation and within the limits of feasibility~~;
- decide who they would like to participate in their care, such as a designated support person or advocate;
- take part in or refuse to take part in clinical research without negative consequences;
- submit a complaint related to their care, report a violation of their rights to care, and share concerns without negative consequences, and receive a timely response;
- receive legal services related to their care or circumstances; and
- receive care from team members who maintain decision-making authority and clinical independence in matters related to care, and advocate for clients' health and well-being.

Rationale: Suggested changes seek to protect client's rights as much as possible. For example, clients should be able to refuse the involvement of certain people whether or not they have a reasonable explanation – just as clients outside the carceral system are allowed to do. This removes the onus on clients to have to prove conditions of abuse, racism, sexism, or other concerning factors, and puts the focus on ensuring that the client receives quality care.

Section 1.1.3

The team follows the organization's ethical decision-making approach to enable the delivery of high-quality and safe care, and meets the required standards as set in applicable laws and international standards such as the Canadian Charter of Rights and Freedoms and the United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules).

Rationale: This was an excellent inclusion under previous sections and is equally applicable to ethical decision making. The referenced legal instruments speak directly to the examples of ethical challenges presented in this section.

We also recommend including additional sections to further clarify these requirements within the Standard:

Section 1.1.25

Team members may not, under any circumstances, participate in punitive measures toward incarcerated clients, including assisting correctional staff in the use of punitive measures. No request from police, prison staff, or other people should override the team members' clinical independence, and duties of care, loyalty, and confidentiality toward incarcerated clients.

Rationale: While healthcare workers may feel a sense of collegiality with other correctional staff, it is important to make it absolutely clear that their duty belongs to the incarcerated client. This does not preclude advising correctional staff not to proceed with punitive measures due to negative health consequences.

III. Indigenous Independence and Sovereignty

We are very pleased to see the drafters’ intention to fully respect the rights of First Nations, Inuit and Métis peoples as described in Section 2. However, we note that consultation with Indigenous groups is not enough to meet this standard. There is a need for Indigenous sovereignty and independence in health care, including in the context of correctional facilities.

Section 2.1.1 of the Standard references the *United Nations Declaration on the Rights of Indigenous Peoples Act* (UNDRIPA), which adopts the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP) into domestic law. Articles 21(1), 23, 24(1) and 24(2) of UNDRIP are relevant provisions affirming Indigenous sovereignty. In particular, Article 23 states:

> Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be **actively involved in developing and determining health, housing and other economic and social programmes affecting them** and, as far as possible, to **administer such programmes through their own institutions.**

Similarly, a 2024 report *Decolonization: Recognizing First Nations Sovereignty*, from the Southern Chiefs’ Organization <https://scoinc.mb.ca/health-transformation/decolonization-report-2024/>, describes the fundamental importance of Indigenous rights to access, control, and establishment of healthcare:[1]

> Page 11: “[H]ealth and the determinants of health linked to colonization, have uniquely and detrimentally affected First Nations people. SCO member Nations’ have inherent rights to self-govern and, importantly, share governance in those areas, general or otherwise, where their people are affected.”

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[1] Southern Chiefs’ Organization, *Decolonization: Recognizing First Nations Sovereignty*, (July 2024), online: <https://scoinc.mb.ca/health-transformation/decolonization-report-2024/>.

> Page 12: "Canada must go further to recognize that every aspect of First Nations health has been, and continues to be, affected by colonization. It follows that health reconciliation requires true and complete decolonization."

Recommendations 24, 26, 27, and 29 of this report are also particularly relevant to the importance of ensuring Indigenous sovereignty over healthcare matters in the Standard.

Based on the above considerations, the rules under Section 2 of the Standard should explicitly prioritize Indigenous sovereignty over healthcare practices for Indigenous peoples. Indigenous governments and Indigenous-led health organizations should be permitted and encouraged to provide healthcare for Indigenous people held in custody, and their operations should be recognized as fully independent from the CSC and from colonial healthcare providers.

We strongly suggest developing these rules in consultation with Indigenous rights holders and Indigenous-led organizations. We also suggest revising some of the existing sections to better ensure recognition of Indigenous sovereignty and independence:

Section 2.1.1

The organizational leaders provide teams with policies and procedures, developed with Indigenous governing bodies, communities, and organizations, for respecting, promoting, and protecting the distinct rights of First Nations, Inuit, and Métis clients, and the independent self-governance of Indigenous nations.

> Rationale: Colonial healthcare systems have had a negative history of interaction with Indigenous peoples, and the development of any policies or procedures must be Indigenous led. It would be out of step with UNDRIPA to impose policies and procedures on Indigenous clients while claiming to respect, promote and protect their distinct rights.

Section 2.1.2

The organizational leaders ~~collaborate~~ recognize and will provide support for the independence and sovereignty of ~~with~~ First Nations, Inuit, and Métis governing bodies, communities, and organizations to design culturally safe health programs and services to achieve First Nations, Inuit, and Métis health and wellness goals and objectives.

Rationale: This language ensures that the development of culturally safe programs and services is decolonialized to the extent that it can be within a colonial carceral setting.

Section 2.1.4

The team facilitates and supports the involvement of Elders, Healers, Knowledge Keepers, and Indigenous Liaisons to provide culturally safe and trauma-informed care to the First Nations, Inuit, or Métis client, on the client's request and by informing clients of these options.

Rationale: Access to resources is only useful if clients are aware of these resources. This language places the onus on the team to facilitate involvement in culturally safe and trauma-informed practices. It also indicates that Elders, Healers, &c are not members of the staff to be directed by the team.

We strongly urge that Section 2 of the Standard be reviewed by and further developed in consultation with Indigenous communities, Indigenous rights holders, and Indigenous-led organizations.

IV. Gladue Reports and Factors

Indigenous sovereignty and independence in healthcare also includes the appropriate use of tools such as *Gladue* factors, as referred to in the guidelines under Section 2.1.3. We are pleased to see these efforts to ensure that Indigenous clients receive trauma-informed care that is free of systemic discrimination. However, it is essential that the Standard does not enable practices that retraumatize Indigenous clients. If the team does have access to *Gladue* reports, which contain highly sensitive and private information, these reports must only be used in so far as they relate to providing healthcare.

We recommend creating a separate section specifically for the use of *Gladue* factors and *Gladue* reports, rather than leaving it as a guideline under Section 2.1.3. As a suggested template, we have separated the information about *Gladue* factors from Section 2.1.3 into its own section:

Section 2.1.6

Gladue factors are the unique systemic and background factors that should be considered in decision-making for First Nations, Inuit, and Métis clients. These factors must not be used to

justify restrictions or punitive measures. Rather, understanding past and present colonial impacts on spiritual, cultural, family, and community supports can help develop strategies to effectively provide client care.

> Rationale: There is a difference between *Gladue* factors, which are broader systemic issues as described above, and a *Gladue* report, which is specific to the client's experiences and often contains very private information. By separating out this section and the next, team members will be better guided on how to provide support and reduce systemic barriers, without retraumatizing their clients.

Section 2.1.7

Gladue reports may be used by the team only if a client provides their voluntary, informed, and prior consent to do so, and the information contained in these reports may only be shared with the client's consent. The team will offer clients the option of providing a redacted or shortened *Gladue* report, focused on the information most relevant to their immediate medical care.

> Rationale: *Gladue* reports can provide highly relevant information and assist team members in providing trauma-informed care for Indigenous clients, but they can also include deeply private, personal and traumatic details that may not be relevant to the patient's immediate medical care. The client should have control over who has access to this kind of information, and to what degree.

We strongly recommend that these two new sections be developed in consultation with Indigenous-led organizations like the BC First Nations Justice Council or Ontario's Aboriginal Legal Services, which specialize in providing *Gladue* reports for Indigenous clients in a trauma-informed and supportive manner.

Sincerely,

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