Prisoners' Legal Services
A Project of the West Coast Prison Justice Society

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VIA E-MAIL: owen.adams@cma.ca

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Canadian Medical Association
1867 Alta Vista Drive
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Dear Mr. Adams:

RE: New international standards regarding the role of physicians working in prisons

I write to draw your attention to new international standards regarding the role of physicians who work in prisons. We ask that the Canadian Medical Association consider issuing a policy to its members, and to each jurisdiction's regulatory body for physicians, to make them aware of these new standards, and to encourage compliance with them.

By way of introduction, I am the executive director and supervising lawyer for Prisoners' Legal Services, the only legal aid clinic for prisoners in Canada. We provide legal services to federal and provincial prisoners in British Columbia on issues that affect liberty rights, including the use of solitary confinement.

The 2015 *Mandela Rules*

On May 22, 2015, the United Nations member states passed, as a resolution, the *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. The *Mandela Rules* update the original rules on the treatment of prisoners adopted in 1955. The *Mandela Rules* are intended to be adopted by countries to ensure that prisoners are treated with respect and dignity, and are not subjected to "torture or other cruel, inhuman or degrading treatment or punishment".

Significantly, the Mandela Rules prohibit indefinite solitary confinement and prolonged solitary confinement, which is considered "torture or other cruel, inhuman or degrading treatment or punishment" (Rule 43).

Solitary confinement is defined as "the confinement of prisoners for 22 hours or more a day without meaningful human contact". Prolonged solitary confinement is defined as "solitary confinement for a time period in excess of 15 consecutive days" (Rule 44).

The Mandela Rules also prohibit the use of solitary confinement for prisoners who have mental or physical disabilities when their conditions would be exacerbated by its use (Rule 45).

The effects of solitary confinement

In his August 5, 2011 report[1], UN Special Rapporteur Juan Méndez finds that the imposition of solitary confinement on prisoners with mental disabilities, for any duration, is cruel, inhuman or degrading treatment and violates article 7 of the *International Covenant on Civil and Political Rights* and article 16 of the *Convention Against Torture*.

The Special Rapporteur reviews the work of experts internationally who conclude that negative health effects can surface after only a few days in solitary confinement. Negative health effects worsen the longer an individual is kept in isolation. He points to research that shows that the social isolation, minimal environmental stimulation and minimal opportunity for social interaction in solitary confinement causes "psychotic disturbances" or "prison psychoses" with symptoms including anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia and psychosis, and self-harm.

The Special Rapporteur warns that some of the effects of solitary confinement are long-term, including continued sleep disturbances, depression, anxiety, phobias, emotional dependence, confusion, and impaired memory and concentration. He notes "lasting personality changes often leave individuals formerly held in solitary confinement socially impoverished and withdrawn, subtly angry and fearful when forced into social interaction" that impairs a person's ability to readjust to prison life outside of segregation and makes successful community reintegration difficult. He asserts that "long periods of isolation do not aid the rehabilitation or re-socialization of detainees" which is contrary to the essential goals of rehabilitation and reintegration of offenders into society.

[1] Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Interim Rep. of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ¶ 76, U.N. Doc. A/66/268 (Aug. 5, 2011) (by Juan Méndez).

The *Mandela Rules* that relate to health care professionals working in prisons

I have attached to this letter the complete 2015 *Mandela Rules*. The rules that relate to health care professionals working in prisons can be found at Rule 24-35 and 46. These include the following obligations of health care professionals (paraphrased in some cases):

Rule 26
All prisoners should be granted access to their health care files upon request. Prisoners may appoint a third party to access their medical files (such as a lawyer).

Rule 27
Clinical decisions may only be taken by the responsible health-care professionals and may not be overruled or ignored by non-medical prison staff.

Rule 31
The physician or, where applicable, other qualified health-care professionals shall have daily access to all prisoners who complain of physical or mental health issues. All medical examinations shall be undertaken in full confidentiality.

Rule 32
The relationship between the physician or other health-care professionals and the prisoners shall be governed by the same ethical and professional standards as those applicable to patients in the community, including an absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment.

Rule 33
The physician shall report to the prison warden whenever he or she considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or any condition of imprisonment (including solitary confinement).

Rule 34
If a health-care professional becomes aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report it to the competent medical, administrative or judicial authority. Proper procedural safeguards shall be followed in order not to expose the prisoner to foreseeable risk of harm.

Rule 35
Physicians shall regularly inspect and advise the prison warden on conditions of confinement, including food quality, hygiene and cleanliness of the institution and prisoners, temperature, lighting and ventilation, prisoners' clothing and bedding, and observance of rules concerning physical education and sports. The warden shall take into consideration this advice and reports under this rule and rule 33 and shall take immediate steps to give effect to the advice and

recommendations. If the warden does not agree with the recommendations, he or she must submit a report containing the physician's recommendations to a higher authority.

Rule 46
Health-care personnel shall not have any role in the imposition of disciplinary sanctions or other restrictive measures. They shall, however, pay particular attention to the health of prisoners held under any form of involuntary separation, including by visiting such prisoners on a daily basis and providing prompt medical assistance and treatment at the request of such prisoners or prison staff.

Health-care personnel shall report to the director, without delay, any adverse effects of disciplinary sanctions or other restrictive measures on the physical or mental health of a prisoner subjected to such sanctions or measures and shall advise the director if they consider it necessary to terminate or alter them for physical or mental health reasons.

Health-care personnel shall have the authority to review and recommend changes to the involuntary separation of a prisoner in order to ensure that such separation does not exacerbate the medical condition or mental or physical disability of the prisoner.

Requested policy directive

Prisoners' Legal Services requests that the Canadian Medical Association issue a policy directive to its members regarding the above referenced provisions of the *Mandela Rules*, and recommend that each provincial and territorial regulatory body for physicians incorporate these rules into their policies or guidelines for members.

Specifically, Prisoners' Legal Services requests that the Canadian Medical Association clarify that health care professionals who work in prisons must not play any role in approving prisoners to be held in solitary confinement:

- if they suffer from a mental disability, or a physical disability that could be exacerbated by isolation; or
- for more than 15 days.

As described above, solitary confinement of prisoners with mental disabilities, or of anyone for a period of over 15 days, constitutes either torture or cruel, inhuman or degrading treatment. *Mandela Rules* 32 and 46 prohibit health care professionals from playing any role in the solitary confinement of prisoners.

Prisoners' Legal Services further requests that the Canadian Medical Association clarify that physicians must report to the warden whenever they consider a prisoners' physical or mental health at risk by continued solitary confinement, under Rule 33, and must report the use of solitary confinement on prisoners with mental disabilities, or prolonged solitary confinement (more than 15 days) to the applicable regulatory College of Physicians, the federal Correctional

Investigator or provincial Investigation and Standards Office, and the federal or provincial Minister of Justice, under Rule 34.

Current practice in federal and BC prisons

Federally, the Correctional Service of Canada uses solitary confinement against prisoners on a routine basis (solitary confinement is called segregation in the federal system). There is no prohibition against prisoners with mental disabilities being held in solitary confinement, and no limits on the amount of time that prisoners may be held in solitary confinement.

Prisoners' Legal Services has had many federal clients who have been held in solitary confinement for many months, and sometimes in excess of a year. These include clients with mental disabilities where community medical professionals have opined that the isolation exacerbated their conditions. We have had clients who are held in long-term solitary confinement while certified under the *Mental Health Act*.

Correctional Service of Canada policy does not adequately incorporate the standards contained in the *Mandela Rules*. Policy merely requires that a mental health professional assess and report on the mental health status of prisoners in administrative segregation at least once in the first 25 consecutive days, and once every subsequent 60 days of administrative segregation. Policy states the assessment should include a file review and interview, but "the file review can be cursory" and "the interview only needs to assess the mental health status and risk for self-injurious or suicidal behaviors at the time of the assessment."

Our clients report to us that health professionals who do segregation rounds generally interview them through the meal slot of their cell doors. The meetings are limited to a few minutes. Our clients report that they may not speak with health care professionals because they are uncomfortable speaking through the cell door where other prisoners and prison guards can hear, or they do not trust the health care professionals who routinely rubber stamp their continued solitary confinement.

For example, in the case of a certified prisoner who had been in solitary confinement for approximately seven weeks, the mental health professional's review indicates no concerns of suicide or self-harm, and "based on a limited file review and in the absence of a comprehensive assessment including interview, there do not appear to be any indicators that would preclude his segregation status." This prisoner has now been in solitary confinement for over a year.

A psychiatrist discharged a prisoner from a Correctional Service of Canada psychiatric hospital because he felt the prisoner, who was certified, would have "more time out of his cell" and a "better quality of life" in solitary confinement at a maximum security prison than he had at the treatment centre.

Under Correctional Service of Canada policy, prisoners at risk of suicide or self-injury are placed in observation cells, which are often in segregation units. Prisoners on suicide watch are

generally locked up for 23 hours per day. They are monitored regularly, usually by correctional officers, to ensure that they are not engaging in suicide or self-harm, but are not relieved of their isolation.

Similarly, BC Corrections allows prisoners to be held in solitary confinement (called segregation or separate confinement) for indefinite periods of time without any prohibitions for prisoners with mental disabilities. BC prisoners also have limited interactions with health professionals who often do not object to their prolonged solitary confinement. We have had provincial clients remain in solitary confinement for months on end, and frequent reports of certified prisoners held in solitary confinement.

BC Corrections policy requires a mental health professional to review the impact of separate confinement after every 30-day period. The results of the review are considered in consultation with the deputy warden, but there is no requirement that the person be removed if the separate confinement is having a negative impact on the prisoner (Adult Custody Policy Manual, Chapter 1.22.9(8) and (10)).

Prisoners' Legal Services has requested a similar policy directive from the Canadian Psychological Association, the Canadian Nurses Association, the BC College of Physicians and Surgeons, the BC College of Registered Nurses and the BC College of Psychologists.

Please do not hesitate to contact me if you would like more information about solitary confinement in BC and Canada. I would be happy to consult on any policy directive that the Canadian Medical Association decides to draft. Thank you for considering my request.

Yours truly,

PRISONERS' LEGAL SERVICES

Jennifer Metcalfe
Executive Director
Barrister and Solicitor