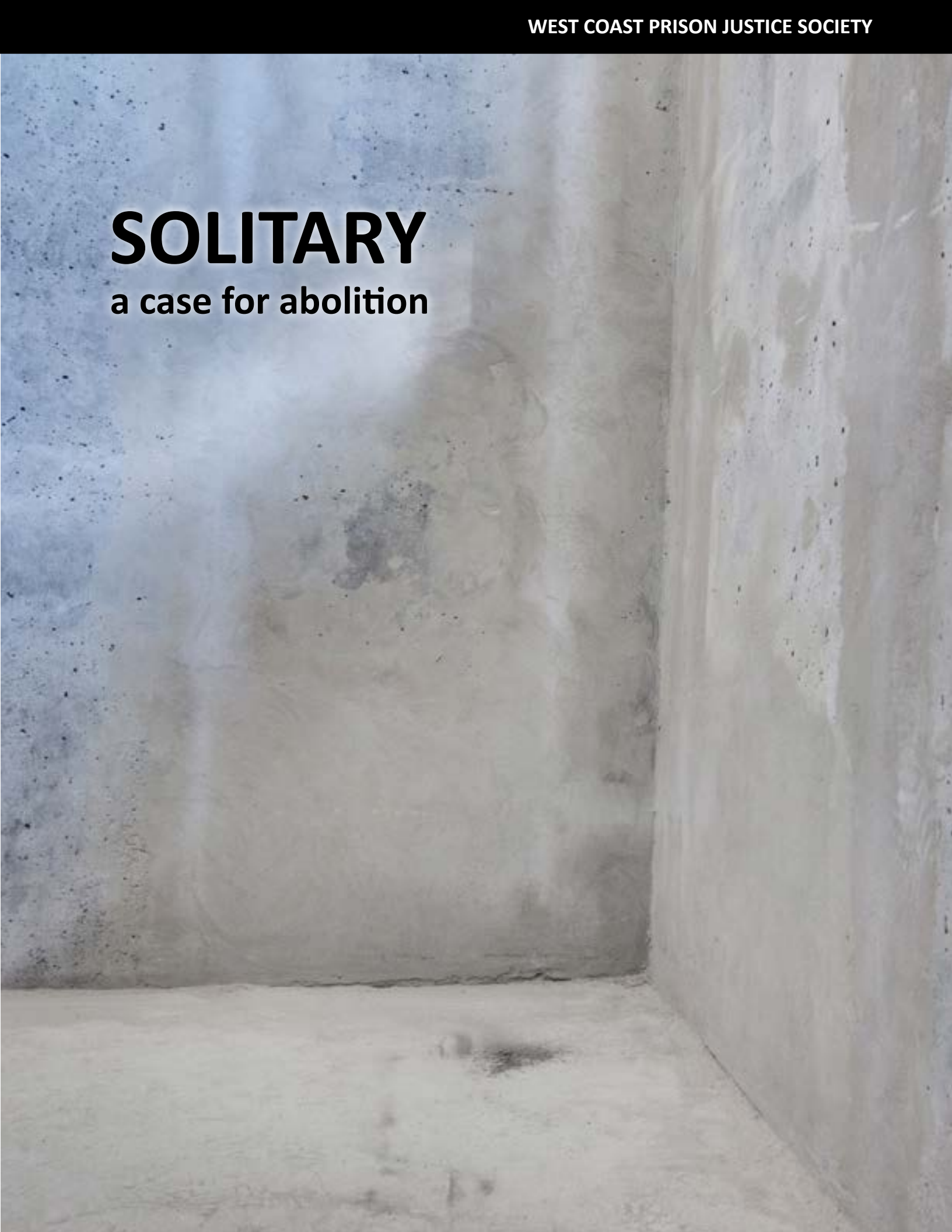


SOLITARY

a case for abolition



West Coast Prison Justice Society
SOLITARY: A CASE FOR ABOLITION

November 2016

Dedicated to Chris Roy.

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The West Coast Prison Justice Society operates Prisoners' Legal Services, a legal aid clinic for federal and provincial prisoners in British Columbia. This report was written by staff at Prisoners' Legal Services and was developed with input from our clients. We thank our clients for sharing their experiences with us in support of this report and we hope that in doing so, they may help others to avoid their suffering from being placed in solitary confinement.

We also thank Professor Michael Jackson for his invaluable contribution to this report.



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EXECUTIVE SUMMARY

“[Solitary confinement is]...the most individually destructive, psychologically crippling and socially alienating experience that could conceivably exist with the borders of a country.”

Michael Jackson, Q.C.

Evidence shows that solitary confinement makes prisoners with existing mental disabilities worse, and can cause severe psychological symptoms, including self-harm and suicide, in prisoners without existing mental disabilities.¹ Its use on prisoners with mental disabilities is considered cruel treatment by the United Nations, and its use on prisoners without pre-existing mental disabilities is considered torture or cruel treatment after only 15 days.² Solitary confinement does nothing to rehabilitate prisoners – in fact, it makes their successful reintegration back to society more difficult.

Prisoners’ Legal Services calls for the abolishment of solitary confinement for all prisoners. The Correctional Service of Canada and BC Corrections should strive to do more than prevent torture or cruel treatment for the people in their care by ensuring that prisoners are treated with dignity, and live in an environment where rehabilitation is prioritized. For these reasons, we call for correctional authorities to end the practice of solitary confinement entirely, rather than merely placing limits on its use where it is considered to have crossed the line of torture or cruel treatment.

The practice of solitary confinement has come under increased scrutiny across jurisdictions over the past several years, from various entities. Its use is being questioned in terms of its cost,

both human and financial, its efficacy and its compliance with domestic and international law.

Although the Correctional Service of Canada and BC Corrections have taken some measures to limit the use of solitary confinement over the years, our clients continue to be held in long-term isolation and continue to report disturbing examples of staff misconduct and conditions of confinement that violate basic standards of human dignity. In our view, any scheme that continues to allow for the solitary confinement of prisoners for any amount of time would allow such abuses to continue. Inherent in a scheme that would allow for the isolation of people without daily meaningful human contact is a culture that does not respect basic human dignity.

It is easy to point to the deleterious effects of solitary confinement and say that it should be abolished. What is more difficult is to establish alternatives to the use of solitary confinement that will increase the safety of prisoners, prison staff, and ultimately society. This report draws upon history, research and examples from other jurisdictions and contexts, to provide a set of recommendations for establishing best practices for the care of one of the most vulnerable populations in Canada – prisoners at risk of solitary confinement.

Prisoners’ Legal Services calls on the governments of Canada and British Columbia,



and their correctional services, to do more than abolish solitary confinement. We call on them to establish adequate numbers of specialized mental health units to address the specific therapeutic needs of prisoners, and to widely implement a trauma informed approach, dynamic security and de-escalation practices in all correctional settings in order to prevent the behaviours that have led prisoners to be placed in solitary confinement. External oversight of

correctional population management practices and mental health supports are necessary to ensure that correctional practices do not slip back into old, abusive habits.

The Correctional Service of Canada and BC Corrections will not succeed in abolishing solitary confinement without legislative reforms, additional resources at the outset, strong leadership and a significant change to the culture of corrections.

INTRODUCTION

“Ultimately, the goal of a more secure society will only be achieved through a criminal justice system that is fair and just, and where the dignity of all detained persons is respected”.³

Canadian prison officials often deny that Canada uses “solitary confinement”. In its response to a legal challenge launched in 2015 against the use of solitary confinement, the Canadian government stated: “It is different from and not analogous to the concept of solitary confinement referred to in many foreign jurisdictions and should not be confused with it...inmates in administrative segregation do not suffer from the alleged effects as a result of their placement”.⁴

According to Juan Méndez, the United Nations Special Rapporteur of the Human Rights Council on Torture and other cruel, inhuman or degrading treatment or punishment:

There is no universally agreed upon definition of solitary confinement. The Istanbul Statement on the Use and Effects of Solitary Confinement defines solitary confinement as the physical isolation of individuals who are confined to their cells for 22 to 24 hours a day. In many jurisdictions, prisoners held in solitary confinement are allowed out of their cells for one hour of solitary exercise a day. Meaningful contact with other people is typically reduced to a minimum. The reduction in stimuli is not only quantitative but also qualitative. The available stimuli and the occasional social contacts are seldom freely chosen, generally monotonous, and often not empathetic.⁵

Association for the Prevention of Torture

Solitary confinement, administrative segregation, separate confinement, enhanced supervision, observation cells – regardless of the language used, the practice involves keeping prisoners isolated with little meaningful human contact or interaction.⁶ While not all conditions of solitary confinement are the same across jurisdictions, “[t]hree main factors are inherent in all solitary confinement regimes: social isolation, with little meaningful contact or interaction, reduced activity and environmental input, and loss of autonomy and controls over almost all aspects of daily life.”⁷

It is clear to the staff at Prisoners’ Legal Services that when federal and provincial clients are subjected to administrative segregation, separate confinement, observation or enhanced supervision, they are in solitary confinement.

The practice of solitary confinement in Canada has garnered attention due to reporting of several disturbing deaths, including Ashley Smith, Edward Snowshoe, Christopher Roy and recently the case of Terry Baker.

Ashley Smith died of self-strangulation on October 19, 2007 while on suicide watch at Grand Valley Institution, after spending a considerable amount of her sentence in solitary confinement. She had a long history of self-harm. In 2013, the Coroner’s Inquest jury in her case came back with a finding of homicide, indicating that the actions of others

contributed to her death. No one was ever convicted for their role in Ms. Smith's death. The coroner's inquest into her death made 104 recommendations, which have yet to be substantially implemented.

Edward Snowshoe was a federal prisoner who spent 162 days in solitary confinement and eventually hanged himself in 2010, while housed in solitary confinement at Edmonton Institution, a federal maximum-security institution. The inquiry into his death resulted in 12 recommendations, including one for external oversight of segregation reviews. This recommendation was not implemented.

Christopher Roy was a federal prisoner housed at Matsqui Institution, a medium-security prison in British Columbia. Mr. Roy hanged himself on June 3, 2015 after spending 60 days in solitary confinement. Evidence was heard at a British Columbia Coroner's Inquest that Mr. Roy's requests for reading material or access to a television were denied, despite the fact that his mental health was deteriorating.⁸

The necessity for the immediate implementation of the Ashley Smith recommendations, and other recommendations, becomes even more pressing when one looks at the death of Terry Baker, a female federal prisoner also housed at Grand Valley Institution. Ms. Baker was found unresponsive in her segregation cell (the same unit where Ashley Smith was housed at her death) on July 4, 2016. Reports indicate that she was found with a ligature around her neck.⁹ She died two days later after being removed from life support. The similarities to Ashley Smith's death are undeniable, as is the feeling that Ms. Baker's death was preventable. Like Ms. Smith, Ms. Baker had "significant and well-documented mental health issues,"¹⁰ yet despite this and despite the recommendations in the Ashley Smith Inquest, she was still placed in solitary confinement.

These are only a few tragic examples of the devastating effects that solitary confinement has on prisoners in Canada. Since January 1, 2012, Prisoners' Legal Services has received 728 calls from federal prisoners requesting assistance regarding their segregation placement. Of those, 36 calls were from women. During the same period, Prisoners' Legal Services received 424 calls from provincial prisoners seeking help with their separate confinement placement. Of the provincial calls, 20 were from women. The vast majority of these clients have suffered at the hands of the Canadian and British Columbia governments what the United Nations considers to be either torture or cruel treatment.

Federal and provincial prisoners often complain to Prisoners' Legal Services about their conditions of confinement. All of these prisoners report being held in a small cell for at least 23 hours per day with very little human interaction. Prisoners often report that many staff treat them with disdain in a manner that undermines their basic human dignity.

Prisoners describe segregation cells as being small and sparse rooms, containing a bed, desk, shelves, toilet and sink. Prisoners sleep and eat all meals in their cell, in close proximity to the toilet. They report that food is often served cold and the cells are often filthy.

Both federal and provincial prisoners report that contact with correctional, medical and psychological staff is limited to very brief visits, usually through the cell door where there is no privacy from guards or other prisoners. Access to school, chaplains, Elders and other religious leaders is limited. Contact with other prisoners is usually limited to yelling through cell doors. Prisoners report that they do not have access to programs.

Both federal and provincial clients report that psychological reviews last about 10 minutes. When our clients tell psychological staff that

they need more human interaction, they report feeling that staff are impatient with no time to really talk. Our clients often report feeling that psychological staff ignore their feelings of isolation. It is not uncommon for people to express their mistrust for institutional mental health and health care staff, in part due to the way they are treated by some staff and also in their observations of the close relationships health care staff have with correctional staff.

Federal and provincial prisoners on suicide watch are held in cells in administrative segregation units. These are not therapeutic environments conducive to recovery. Prisoners' Legal Services has received numerous reports of provincial prisoners being held in separate confinement units locked up 23 hours per day for weeks while certified under the *Mental Health Act* waiting for a bed at the Forensic Psychiatric Hospital, with no greater access to psychiatric care than other prisoners in separate confinement.

Federal and provincial prisoners report that they are often denied their hour of outdoor exercise. They are often provided an hour of time total for exercise, showering, cell cleaning and phone calls, including those to legal counsel.

In BC Corrections' segregation units, prisoners are not permitted televisions and are left with nothing to occupy their minds. Prisoners can be held in segregation units as punishment for disciplinary infractions, and also under separate confinement status which can last for months or even years. Federal prisoners are also sometimes denied access to television. Both federal and provincial prisoners report difficulty accessing books and personal effects.

Both federal and provincial prisoners often report that they are denied request and complaint forms.

Some prisoners become so affected by the constant isolation and lack of any control over any aspect of their lives, that they resort to

flooding their cells, or even throwing urine or feces at correctional officers.

Although both federal and provincial prisoners receive regular segregation or separate confinement reviews, these reviews appear to be *pro forma* proceedings that do not adequately address mental health concerns. Prisoners report feeling that the decision makers' minds were made up at reviews, and that it did not matter what they had to say. They report not being given any idea of what they needed to do to get out of solitary confinement. In provincial centres, prisoners are not provided an in-person review. Rather, they are simply provided a document outlining the outcome of their review with sparse reasons explaining their continued solitary confinement placement.

The people our governments are putting in solitary confinement are vulnerable and marginalized. The Correctional Investigator of Canada's research demonstrates that federal prisoners who have a history of segregation are more likely to have behavioural issues, mental health issues, and issues with cognitive thinking.¹¹ Eighty-seven percent of prisoners with a history of self-injury have spent time in segregation.¹²

The overall prison population is comprised of people who have experienced above average rates of childhood and adult trauma and victimization.¹³ Close to 70 percent of federally sentenced women report histories of sexual abuse and 85 percent report having been physically abused.¹⁴ For many, the trauma began with childhood abuse. Figures from the United States show that the rates of trauma experienced by male prisoners is also significant.¹⁵ It is recognized that traumatic experiences correlate to an increased risk of self-injurious behaviour.¹⁶

The link between childhood abuse and adult victimization, mental health issues, substance

abuse and criminality is widely acknowledged.¹⁷ It is estimated that the prevalence of mental health issues in federal prisons is two to three times higher than in the general community,¹⁸ with 62 percent of incoming female prisoners requiring further mental health evaluation and 50 percent of incoming male prisoners requiring further mental health evaluation.¹⁹

Up to 90 percent of the federal prison population have a substance abuse problem.²⁰ BC Corrections estimates that 56 percent of provincial prisoners have mental health or addiction problems,²¹ although the number is likely higher.

Sixty-nine percent of federal prisoners flagged with mental health issues in maximum security federal prisons had been in long-term solitary confinement in the last six months at mid-year 2015-2016, with an average stay of 81 days. This statistic is virtually identical to the period prior.²² The average length of stay for all prisoners in solitary confinement was 27 days in 2014-2015.²³

Indigenous and black prisoners are over-represented in federal segregation.²⁴

The total number of federal admissions into administrative segregation between 2010 and 2015 remained fairly steady. In the 2014-15 fiscal year, there were 6,726 admissions to administrative segregation.²⁵

Between March and December, 2015, the federal rates of administrative segregation decreased by 34 percent, and the number of prisoners spending more than 60 days in solitary confinement decreased by 52 percent. From April 2014 to March 2016, the national administrative segregation rate fell from 5.1 percent to 3.1 percent.²⁶ This reduction on the reliance on solitary confinement followed public criticism of the Correctional Service of Canada's lack of action after the release of the Ashley Smith inquest recommendations, and media reports of the death of Edward Snowshoe.²⁷

This dramatic reduction on the use of solitary confinement is encouraging, and we commend the federal government and Correctional Service of Canada for their efforts to reduce reliance on this repressive tool. The old refrain that solitary confinement is the only option no longer rings true. If it is possible to reduce the numbers so significantly over a short period of time, it is possible to eliminate its use entirely.

It is difficult to estimate the rates of prisoners segregated by BC Corrections, including those with mental disabilities or cognitive impairments. Prisoners' Legal Services made several requests to BC Corrections for data prior to publishing this report. BC Corrections failed to provide any meaningful recent data by the date of printing. Based on limited snap-shot data from April 2014, we know that the number of prisoners held in segregation or separate confinement for more than 15 days, or in Enhanced Supervision Program (ESP) by BC Corrections was approximately 8.3 percent of the total prisoner population.²⁸

Prisoners' Legal Services is concerned that the rates of solitary confinement in British Columbia prisons are excessively high, and that the number of prisoners with mental disabilities who languish in solitary confinement without adequate treatment is disturbing.

Both Canada and British Columbia have a long way to go toward eliminating reliance on solitary confinement. In this report, we will look at the history and developments related to the use of solitary confinement in Canada and British Columbia, and offer a path to corrections that respects the dignity of all prisoners, that will produce better outcomes in terms of rehabilitation for prisoners and the overall safety of our communities, inside and outside of prison.

DEINSTITUTIONALIZATION

The rise in the numbers of prisoners with mental illnesses in Canada and British Columbia is largely due to the deinstitutionalization of psychiatric hospitals in the mid-20th century, which happened across North America and parts of Europe. Inpatient beds at psychiatric hospitals were closed and psychiatric patients were discharged into the community.²⁹ The idea behind deinstitutionalization was to reduce the high cost of inpatient services and reallocate the savings toward more community supports that could help more people.³⁰ The intent was also to end the “warehousing” of mental health patients in asylums and allow them to be active participants in their own treatment plans, while living in the community. In reality, what happened was an influx of people with psychiatric illnesses onto the street with inadequate community based resources to help them.

This led to unintended consequences, including “poor nutrition, access to legal and illegal drugs and abysmal housing”³¹, as well as the criminalization and incarceration of many people with serious mental illnesses. People with severe mental illness were, and continue to be, arrested for minor crimes that are often reflective of the symptoms of their illnesses.³²

British Columbia opened the Hospital for the Mind on the Riverview lands in Coquitlam in the early 20th century. Over the course of half a century, the hospital was downsized and renamed several times, but eventually, in 1966, it was renamed Riverview Hospital.³³

In 1964, a new *Mental Health Act* was passed in British Columbia that encouraged community operated mental health services as a

replacement for the larger, centralized, asylum-like psychiatric hospitals that were in use at the time.³⁴ This led to the downsizing of Riverview Hospital and the transfer of patients closer to their home communities, and theoretically their support networks. The population of Riverview continued to decline over the next half-century, until it eventually closed in 2012.

This type of decentralization was happening all across Canada. According to Statistics Canada, between 1965 and 1980, there was a decrease in psychiatric hospital beds in Canada from 69,128 beds to 20,301. In British Columbia, between 1965 and 1981 there was a 47 percent decrease in inpatient psychiatric hospital beds, from 6,371 to 3,372.³⁵ Although closure of these institutions was largely considered positive due to the alleged abuses and overall failures of this system, the Canadian and provincial governments ultimately failed to adequately resource community-based alternatives.

As a consequence of this, the criminal justice systems, and specifically the prison system, has taken over the role of the psychiatric hospitals, despite lacking the appropriate infrastructure, training or institutional culture to care for people with mental illnesses. Often these prisoners exhibit behavioural problems caused by mental illness, and end up in solitary confinement.



THE ORIGINS OF SOLITARY CONFINEMENT

“I believe it, in its effects, to be cruel and wrong...I hold this slow and daily tampering with the mysteries of the brain, to be immeasurably worse than any torture of the body...”

*Charles Dickens: Charles Dickens’s “Philadelphia, and its Solitary Prison,”
Ch. 7 in American Notes (1842).*

While the use of solitary confinement is now widely condemned as an inhumane and excessive form of punishment, its origin was well-intentioned.

Prisons designed to administer solitary confinement first surfaced in England in the 1700s. After a crime wave resulted in prison overcrowding in the 1750s, it was felt that there

was a need for options other than execution or exiling prisoners to the penal colonies.³⁶ Prison reformers of the 1770s, including John Howard, were concerned with establishing the authority of rules in prisons, to be applied to both staff and prisoners, and to be enforced by outside inspection.³⁷ Solitary confinement was central to this new conception of prisons, and was considered to be a humane punishment. However, the form of constant isolation that was implemented in English prisons was far from the solitude, in combination with group labour and communal exercise, which John Howard had envisioned.³⁸

The first use of solitary confinement in the United States was with the construction of a Quaker run prison in Philadelphia, Pennsylvania, known as Walnut Street, in 1790. Walnut Street implemented the Philadelphia method, which used hard labour and complete isolation, or solitary confinement, for some prisoners. Keeping prisoners in total isolation was seen as the most effective and humane way to reform criminals.³⁹

Others were critical of the practice. Charles Dickens wrote about his visits with prisoners held under the Philadelphia model of solitary confinement:

I hesitated once, debating with myself, whether, if I had the power of saying 'Yes' or 'No,' I would allow it to be tried in certain cases, where the terms of imprisonment were short; but now, I solemnly declare, that with no rewards or honours could I walk a happy man beneath the open sky by day, or lie me down upon my bed at night, with the consciousness that one human creature, for any length of time, no matter what, lay suffering this unknown punishment in his silent cell, and I the cause, or I consenting to it in the least degree.⁴⁰

In 1821, the prison at Auburn, New York, implemented a system of solitary confinement modeled after the Philadelphia method. French criminologists Gustav de Beaumont and Alexis de Tocqueville described its implementation as follows:

This experiment, of which such favourable results had been anticipated, proved fatal for the majority of prisoners. It devours the victim incessantly and unmercifully; it does not reform, it kills.⁴¹

Following this failed experiment, Auburn implemented a new system of outdoor group labour during the day, with a strict rule of silence, and individual lock-up at night. This method became known as the Auburn system.⁴²

Despite much criticism, the Philadelphia method continued to be used in the United States and Europe. Doctors in Germany began documenting a sharp increase in psychosis among prisoners, which they attributed to the use of solitary confinement. The Supreme Court of the United States condemned the use of solitary confinement in 1890 in *In re Medley*, where it stated "a considerable number of prisoners... fell, even after a short confinement, into a semi-fatuous condition...and others became violently insane; others still, committed suicide."⁴³ The court went on to state: "those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community."⁴⁴

After *In re Medley*, solitary confinement was used less in the United States, due in large part to public condemnation, but also due to the prohibitive cost of housing prisoners separately. By the late 1910s the practice of running entire institutions on a model of solitary confinement became scarce.⁴⁵

SOLITARY CONFINEMENT IN THE FEDERAL SYSTEM

THE HISTORY OF SOLITARY CONFINEMENT IN CANADA

Canada's history of using solitary confinement dates back to the first *Penitentiary Act* in 1834 and the opening of Kingston Penitentiary in Ontario in 1835. The purpose of Kingston Penitentiary was deterrence and rehabilitation through solitary confinement, labour and religious instruction. This was considered a more humane approach than the "Bloody Code", which was based on deterrence of crime by threat of capital punishment, in force before these reforms took place.⁴⁶ From the start, Kingston Penitentiary operated on the Auburn system of group work under silence and solitary confinement at night.⁴⁷

In 1848, Kingston Penitentiary was the subject of the Brown Commission – a royal commission that investigated the "barbarous and inhumane" conditions that developed under the Auburn system. The Brown Commission recommended that a limit of six months be placed on the use of solitary confinement upon admission to prison, followed by prisoners being subjected to the rule of silence. Prisoners who repeatedly breached institutional rules would also be sent to solitary confinement.⁴⁸

The Brown Commission found that the system established by the 1835 *Penitentiary Act* for inspections had failed at controlling the abuses that were taking place under the authority of the warden at Kingston Penitentiary. The Brown Commission recommended the appointment of

national inspectors to visit and investigate into prison management, with the authority to make rules and regulations, directly responsible to the executive of the government.⁴⁹

The Brown Commission's recommendations for external oversight over prison administration due to concerns regarding inhumane conditions, abuses of authority and lack of compliance with the rule of law were the first of many similar reviews and recommendations on the administration of solitary confinement in the centuries to come.

Subsequent federal prison legislation referenced solitary confinement, stating that all prisoners "shall be kept in a cell at night and during the day when not employed," and no prisoner was allowed to speak to another prisoner, "nor to any guard, or other servant of the Institution, except with respect to the work at which he is employed, and then only in the fewest possible words and in a respectful manner."⁵⁰

While the use of the term solitary confinement gradually disappeared from statutes, regulations and directives governing Canadian prisons, its use did not. The phrase was replaced by the term 'dissociation', or, as it was known on the inside, 'segregation' or 'the hole'.⁵¹

In 1962, regulations allowed prisoners to be placed in dissociation if the institutional head found it necessary to maintain "good order and discipline in the institution", or for "the best interests of the inmate".⁵² If a prisoner was placed in dissociation for a reason other than

punishment, he was “not [to] be deprived of any of his privileges and amenities”, unless those privileges could only be enjoyed in association of other prisoners, or it was necessary due to the workings of the dissociation area.⁵³

In 1973, Jack McCann, a prisoner at the BC Penitentiary who had been held in solitary confinement for 754 days, challenged his isolation as cruel and unusual treatment or punishment, with the assistance of Professor Michael Jackson, Q.C. In *Prisoners of Isolation*, Professor Jackson writes about Mr. McCann and the appalling conditions of confinement experienced by him and other prisoners at the BC Penitentiary’s segregation unit, known as the “Penthouse”.⁵⁴

Harsh as they were, it was not just the physical conditions in the solitary confinement unit that constituted the principal basis for pain and suffering. The prisoner, upon climbing the stairs to the unit and entering the doors that isolated it from the rest of the prison, both literally and symbolically entered a different world. In the Penthouse, the worst things about prison – the humiliation and degradation, the frustration, the despair, the loneliness, and the deep sense of antagonism between prisoners and guards – were intensified. In my interviews with prisoners, and in their testimony before the court, they talked about how that antagonism often reached the point of gratuitous cruelty. Jack McCann testified that after a prisoner in solitary had slashed himself, an officer offered him (Mr. McCann) a razor blade so he, too, could “slash up.” Evidence was given of mentally unstable prisoners being goaded by guards and beaten when they reacted...⁵⁵

Andy Bruce, who gave evidence in the *McCann* case⁵⁶, described how much more difficult it is to serve time in administrative segregation than

to serve a punitive sentence in segregation for breach of an institutional rule:

[Punitive dissociation]’s easier. It’s a hell of a lot easier when you know when you’re getting out, you’ve got a date in your mind and you know that’s when you’re going to be released and you’re going to go to the population. When you’re doing indefinite seg it just hangs over your head. You don’t know what you’re supposed to do to get out of there because there is nothing you can do. It’s entirely up to them. They say it depends on your behaviour but there’s nothing you can do. You can’t do nothing except get worse, and when you do get worse, they say that’s why you’re up there.⁵⁷

After the McCann trial began, the Solicitor General created a Study Group on Dissociation. The Study Group made its recommendations a week before the McCann case was decided. The Study Group report found that the Canadian Penitentiary Service had failed to comply with existing laws and policies on solitary confinement. The Study Group recommended the establishment of segregation review boards, chaired by the warden of the penitentiary, and that serious disciplinary hearings be chaired by an independent chairperson. These recommendations were implemented two years later.⁵⁸

In 1977, the House of Commons Sub-Committee on the Penitentiary System in Canada decided that the potential value of independent adjudication in segregation reviews could not be judged until it had been tried in disciplinary hearings. It recommended that the system be reviewed in two years. This review did not happen.⁵⁹

Between McCann and the passing of the *Corrections and Conditional Release Act* in 1992, a number of prisoner rights cases were decided at the Supreme Court of Canada, establishing a

duty to act fairly in segregation reviews.⁶⁰ Policy changes were made to provide for additional procedural fairness, but they failed to make any real changes to the regime because they allowed too much discretion without external oversight.

THE CORRECTIONS AND CONDITIONAL RELEASE ACT

The *Corrections and Conditional Release Act* came into force on November 1, 1992 replacing the Penitentiary and Parole Acts that previously governed the operations of the Correctional Service of Canada.⁶¹ The *Corrections and Conditional Release Act* is the law that governs the Correctional Service of Canada to this day.

The *Corrections and Conditional Release Act* allows prisoners to be held in segregation for both punitive and administrative reasons. Hearings of serious disciplinary charges are conducted by independent chairpersons, who must be satisfied beyond a reasonable doubt that the prisoner committed the offence before imposing a sanction of up to 30 days in segregation (or a maximum of 45 days for more than one conviction).⁶²

By contrast, prisoners can be held in administrative segregation merely on a reasonable belief that they may act in a manner that jeopardizes the security of the penitentiary or the safety of any person, and that their presence in the general population would either jeopardize security or safety or would interfere with an investigation that could lead to a criminal or serious institutional charge.⁶³ Although prisoners are to be released from segregation “at the earliest appropriate time”⁶⁴ and should only be segregated if there is “no reasonable alternative to administrative segregation”⁶⁵, administrative segregation is not subject to independent adjudication and there

are no limits on the amount of time a prisoner can be held in administrative segregation.

Despite these legislative reforms, without time limits and independent adjudication of administrative segregation placements, prisoners continued to be held in poor conditions in long-term solitary confinement, with often tragic consequences.

THE ARBOUR REPORT

In April 1994, a series of events unfolded at the Prison for Women (P4W) in Kingston that exposed to public view and scrutiny the operations of the Correctional Service of Canada and its use of solitary confinement. The videotaped strip-searching of women prisoners by a male emergency response team shocked and horrified many Canadians when it was shown a year later on national television. The strip search and the subsequent long-term segregation of the prisoners became the subject of both a special report by the Correctional Investigator and a report by the Commission of Inquiry conducted by Justice Louise Arbour. Justice Arbour’s report contained a clear indictment of the Correctional Service of Canada’s general attitude regarding non-compliance with the law.

The women involved in the April incident remained in segregation from that date until December 1994 or January 1995.⁶⁶

The Arbour Report traces the conditions of their confinement, the reasons given by the Correctional Service of Canada for its necessity, the segregation review process through which it was maintained, and the impact of the segregation on the women.

Justice Arbour concluded her review with an assessment and indictment of the impact of prolonged segregation on the prisoners at the P4W.

In October of 1994, the prison's psychologists advised the prison staff of the psychological ill effects being suffered by the women. Their report read:

Many of the symptoms currently observed are typical effects of long-term isolation and sensory deprivation... The following symptoms have been observed:

- perceptual distortions
- auditory and visual hallucinations
- flashbacks
- increased sensitivity and startle response
- concentration difficulties and subsequent effect on school work
- emotional distress due to the extreme boredom and monotony
- anxiety, particularly associated with leaving the cell or seg area
- generalized emotional lability at times
- fear that they are "going crazy" or "losing their minds" because of limited interaction with others which results in lack of external frames of reference
- low mood and generalized sense of hopelessness

Part of this last symptom stems from a lack of clear goals for them. They do not know what they have to do to earn privileges or gain release from segregation... Their behaviour has been satisfactory since their return from RTC [the Regional Treatment Centre at Kingston Penitentiary] but has not earned them additional privileges, nor have they been informed that their satisfactory behaviour will result in any change of status.

If the current situation continues it will ultimately lead to some kind of crisis, including violence, suicide and self-injury. They will become desperate enough to use any means to assert some form of control

of their lives. The constant demands to segregation staff [are] related to needs for external stimulation and some sense of control of their lives. The segregation of these inmates continued for between two and a half to three months after these observations were made....⁶⁷

The prolonged segregation of the inmates and the conditions and management of their segregation was again, not in accordance with law and policy, and was, in my opinion, a profound failure of the custodial mandate of the Correctional Service. The segregation was administrative in name only. In fact it was punitive, and it was a form of punishment that courts would be loathe to impose, so destructive are its consequences....

The most objectionable feature of this lengthy detention in segregation was its indefiniteness. The absence of any release plan in the early stages made it impossible for the segregated inmates to determine when, and through what effort on their part, they could bring an end to that ordeal. This indefinite hardship would have the most demoralizing effect and, if for that reason alone, there may well have to be a cap placed on all forms of administrative segregation....

Eight or nine months of segregation, even in conditions vastly superior to those which existed in this case, is a significant departure from the standard terms and conditions of imprisonment, and is only justifiable if explicitly permitted by law. If it is not legally authorized, it disturbs the integrity of the sentence....

The bitterness, resentment and anger that this kind of treatment would generate in anyone who still allows herself to feel anything, would greatly outweigh the

short-term benefits that their removal from the general population could possibly produce...

If prolonged segregation in these deplorable conditions is so common throughout the Correctional Service that it failed to attract anyone's attention, then I would think that the Service is delinquent in the way it discharges its legal mandate.⁶⁸

Justice Arbour made recommendations concerning segregation and the legal and administrative regime she deemed necessary to bring its management into compliance with the law and the *Canadian Charter of Rights and Freedoms*. She recommended that the management of administrative segregation be subject preferably to judicial oversight but alternatively to independent adjudication.⁶⁹

Justice Arbour also called for a "profound change in the mindset of the entire organization"⁷⁰ in order for reforms to be meaningful. In her view, it would be necessary for officials at the management level of the Correctional Service of Canada to embrace the rule of law for any culture change within the organization to be successful.⁷¹

Justice Arbour's recommendations for independent adjudication were not implemented.

THE TASK FORCE ON ADMINISTRATIVE SEGREGATION

In 1996, following Justice Arbour's recommendations, the Task Force on Administrative Segregation was convened to complete a comprehensive review of the use of solitary confinement by the Correctional Service of Canada and to recommend changes to improve the effectiveness and fairness of decision-making.⁷² The Task Force was comprised of representatives of the Correctional Service of Canada and the Office of the Correctional Investigator, as well as two outside experts, Professor Michael Jackson and Professor Patricia Montour Angus.⁷³

The mandate of the Task Force was to address the recommendations and issues raised by the Arbour Report, to examine whether the Arbour Report findings were applicable to other institutions and to ensure that all Correctional Service of Canada staff were knowledgeable of, and compliant with, legal and policy requirements concerning the use of solitary confinement.⁷⁴

The Task Force concluded that it would be necessary for a shift in culture to take place to change staff members' and managers' views of the purpose of segregation,⁷⁵ and for the Correctional Service of Canada to minimize the use of segregation and safely reintegrate segregated prisoners into less restrictive units.⁷⁶

In 1997, the Task Force recommended that a pilot project be conducted on the use of independent adjudication in segregation reviews.⁷⁷ Initially the Correctional Service of Canada accepted this recommendation, but later it rejected it.⁷⁸

Instead of implementing the Task Force's recommendation to pilot independent segregation reviews, the Correctional Service of Canada implemented a system of regional

oversight over segregation placements at the 60-day mark, and a review of a sampling of segregation placements at the 30-day mark. Professor Jackson was critical of this approach: “The appointment of a new regional official who would inevitably be part of the culture and hierarchy of the Service entrenches, rather than redresses, exactly the kind of bias against which independent adjudication is directed.”⁷⁹

Clearly, the reforms that took place following the Arbour and Task Force recommendations did not go far enough to prevent the tragedies suffered by prisoners held in solitary confinement in the years to come.

A WORK IN PROGRESS REPORT

On May 29, 2000, the House of Commons Standing Committee on Justice and Human Rights tabled the report of its subcommittee, *A Work in Progress*. The report identified the importance of maintaining Canada’s commitment to respecting the rights of prisoners and recognized that the *Corrections and Conditional Release Act* was based on international human rights standards.⁸⁰

The subcommittee members toured federal prisons, including segregation units, and agreed with Justice Arbour’s description of the impact of administrative segregation on prisoners. The subcommittee recommended independent adjudication of administrative segregation placements, and that the Correctional Service of Canada continue to develop alternatives to administrative segregation. The subcommittee recommended that independent adjudication take place at 30 days, because this is the maximum segregation sentence that can be imposed by a disciplinary independent chairperson, in acknowledgement that the conditions of disciplinary and administrative segregation are the same.⁸¹

The Correctional Service of Canada failed to implement the subcommittee’s recommendations.

THE DEATH OF ASHLEY SMITH

On October 19, 2007, Ashley Smith died in solitary confinement at the Grand Valley Institution for Women in Kitchener, Ontario, after spending over 11 months in solitary confinement.

On June 20, 2008, the Correctional Investigator published his report, “A Preventable Death”, about Ms. Smith’s case. The Correctional Investigator identified how Ms. Smith’s segregation violated law and policy and contributed to her inhumane treatment. He also discussed the need for independent adjudication:

I believe strongly that a thorough external review of Ms. Smith’s segregation status could very likely have generated viable alternatives to her continued and deleterious placement on such a highly restrictive form of confinement. There is reason to believe that Ms. Smith would be alive today if she had not remained on segregation status and if she had received appropriate care. An independent adjudicator – as recommended by Justice Arbour – would have been able to undertake a detailed review of Ms. Smith’s case and could have caused the Correctional Service to rigorously examine alternatives to simply placing Ms. Smith in increasingly restrictive conditions of confinement. At that point, if it had been determined that no immediate and/or appropriate alternatives to segregation were available for Ms. Smith, the independent adjudicator could have caused the Correctional Service to expeditiously develop or seek out more suitable, safe and humane options for this young woman.⁸²

The Correctional Investigator recommended independent adjudication of solitary confinement placements of prisoners with mental health concerns.⁸³

On December 19, 2013, the Ashley Smith Coroner’s Inquest jury released its list of 104 recommendations. The jury recommended that the use of solitary confinement should not exceed 30 days. Other recommendations include that “a non-prison-like mental health setting (including provision for community based out-patient supports) be available for federally sentenced women with serious mental health issues”, and “that the focus of such facilities should be on treatment and/or preparation for treatment, as opposed to a security focused mode.” The jury recommended that management and intervention decisions be made by clinicians with input from the prisoners, rather than by security staff. The jury further recommended that staff be trained in trauma-informed care and that women’s prisons should develop working relationships with academic health sciences centres.⁸⁴

While the Correctional Service of Canada has acknowledged the recommendations made by the jury and Prime Minister Trudeau has tasked the Minister of Justice with implementing the Ashley Smith jury recommendations, to date, no comprehensive response to the recommendations has been made and no significant steps have been taken to implement them.

THE DEATH OF EDWARD SNOWSHOE

In 2010, Edward Snowshoe hanged himself after spending 162 days in solitary confinement at Edmonton Institution. In 2014, a Public Fatal Inquiry into his death found

that corrections officials were unaware that Mr. Snowshoe had attempted to kill himself at least two or three times previously, and that he had been in solitary confinement for as long as he had, even though that information was readily available. According to the Inquiry, Mr. Snowshoe “fell through the cracks”. The Inquiry found that Mr. Snowshoe’s five-day segregation review was conducted by an institutional parole officer who had never met him, and Mr. Snowshoe did not attend it. During this review, Mr. Snowshoe’s history of mental illness was not raised, despite being flagged in his institutional records.

The Inquiry found that “nothing was done to attempt to set up psychological communication with [Mr. Snowshoe] even though the psychology department had been advised by the admitting nurse of the prior suicides [sic] and self harm incidents”, apart from one initial attempt to interview Mr. Snowshoe, which he declined.⁸⁵

The Inquiry also found that Mr. Snowshoe’s regional 60-day review did not happen.

The Inquiry made 12 recommendations, including external oversight of mandatory segregation reviews and that a review of all prisoners placed in segregation be implemented to ensure that, when appropriate, the prisoner is transferred to a special handling unit in accordance with their mental health or medical needs.⁸⁶

Again, no external oversight was implemented, and mental health services remained under-resourced.

THE DEATH OF CHRISTOPHER ROY

On June 3, 2015, Christopher Roy hanged himself after spending 60 days in solitary confinement at Matsqui Institution in British Columbia.

The British Columbia Coroner's Inquest jury recommendations regarding Mr. Roy's death included two aimed specifically at the Canadian government to implement legislated caps on the duration of a solitary confinement placement for prisoners with mental health issues or a history of self-harm.⁸⁷

The jury also made recommendations that the Correctional Service of Canada employ a full-time Registered Psychiatric Nurse in segregation units and improve psychiatric services at all institutions, and that psychiatrists conduct regular psychiatric assessments of segregated prisoners. The jury recommended that the Correctional Service of Canada increase segregation yard time, provide mental health training for segregation staff, provide access to specialized one-to-one trauma-informed mental health and substance abuse treatment for segregated prisoners, and provide units for prisoners with special needs "with the view to eliminating or reducing the need for administrative segregation". The jury recommended that sufficient resources be allocated to allow wardens to hire sufficient mental health care staff, among other recommendations. The final jury recommendation is that their, and other, recommendations on conditions and events at prisons "be taken seriously".

Mental health resources in federal prisons remain under-funded.

THE CORRECTIONAL INVESTIGATOR'S 2014-2015 ANNUAL REPORT

The Office of the Correctional Investigator has been raising concern over the Correctional Service of Canada's over use of segregation for more than 20 years. In its 2014-2015 Annual Report, the Correctional Investigator noted that "administrative segregation has become the most commonly used population management tool to address tensions and conflicts in federal correctional facilities", and that it "is also commonly used to manage mentally ill offenders, self-injurious offenders and those at risk of suicide".⁸⁸

According to the Correctional Investigator, disciplinary segregation placements represented only 2.5 percent of all segregation placements made in the 2014-15 reporting year. The Correctional Investigator found that despite the statutory obligation to rely on the disciplinary process to address disciplinary infractions, "it appears that circumventing the disciplinary process to isolate, contain, separate, control, manage or even punish has become common".

The Correctional Investigator is critical of the Correctional Service of Canada for rejecting recommendations to limit its use of solitary confinement.

The Correctional Investigator recommends that the Canadian government make legislative reforms to amend the *Corrections and Conditional Release Act* "to significantly limit the use of administrative segregation, prohibit its use for inmates who are mentally ill and for younger offenders (up to 21 years of age), impose a ceiling of no more than 30 continuous days, and introduce judicial oversight or independent adjudication for any subsequent stay in segregation beyond the initial 30 day placement."

In his 2015-2016 Annual Report, the Correctional Investigator reported that he remained frustrated with the Correctional Service of Canada's continued failure to respond appropriately to the Ashley Smith Coroner's recommendations.

The practice of solitary confinement and associated abuses continue in federal institutions, despite all of the recommendations for alternatives, limits and independent oversight that have been made over the years.

These reports have included the recurring theme that the culture of corrections has little respect for the rule of law, and that a change to this culture is necessary in order to prevent the abuses of solitary confinement. In order to finally put an end to the culture within corrections that allows the cruel treatment of prisoners, solitary confinement must be abolished completely, and independent oversight over management practices must be implemented.



THE CORRECTIONAL SERVICE OF CANADA'S CURRENT SCHEME

The current scheme governing the Correctional Service of Canada's use of solitary confinement is set out in the *Corrections and Conditional Release Act*, the *Corrections and Conditional Release Regulations* and Commissioner's Directive 709, "Administrative segregation".

As discussed above, the *Corrections and Conditional Release Act* provides the grounds for segregation and requires an internal review process. Prisoners are to be released from segregation "at the earliest appropriate time"⁸⁹ and should only be segregated if there is "no reasonable alternative to administrative segregation".⁹⁰

The *Corrections and Conditional Release Regulations* require that a prisoner be provided written reasons for the administrative segregation within one working day of the placement.⁹¹ The warden must review the order within one working day and either confirm the use of segregation or release the prisoner to the general population.⁹² An internal segregation review board is required to conduct a hearing within five working days, and at least once every 30 working days thereafter.⁹³ The prisoner must be given three working days' notice of the hearing, an opportunity to attend the hearing and to make representations at the hearing, and the review board's written recommendations and reasons for recommendations to the warden.⁹⁴

A Correctional Service of Canada regional review is required once every 60 days of a person's administrative segregation.⁹⁵

In 2015, the Correctional Service of Canada completed a review of its internal policy on the use of administrative segregation.

Commissioner's Directive 709 "Administrative Segregation" (CD 709) was amended with some positive changes.

There is now a right to have an advocate present at segregation review board hearings if a prisoner has "acute or high (elevated/substantial) level of mental health needs". However, the advocate must be approved by the warden. CD 709 makes no mention of the right to legal representation by a lawyer in a segregation review hearing.

In addition, CD 709 requires that, normally before admission to administrative segregation, the Correctional Service of Canada consider whether it is appropriate for the prisoner to be referred to mental health services such as acute psychiatric hospital care, intermediate mental health care or primary care.⁹⁶ However, no additional funding was made available in order to provide enhanced mental health care to these prisoners. A mental health care professional is now required to be a permanent member of the review board.⁹⁷

The Correctional Service of Canada segregation review boards continue to be conducted internally, with no external oversight. CD 709 provides for review by the "Regional Complex Mental Health Committee" in cases when a prisoner is identified as having acute or high mental health needs, at the request of the chair of the institutional review board. The Regional Complex Mental Health Committee is tasked with identifying alternatives to segregation, and has 30 days to complete this task. If this committee is unable to identify any alternatives, "an expert determined by the Regional Complex Mental Health Committee will conduct an external review". This "external" reviewer is chosen by the Correctional Service of Canada, and may only make recommendations to the warden on how to minimize the use of solitary confinement. There are no time limits identified in CD 709 for this review to be completed.

CD 709 places no limits on the maximum stay of a prisoner in administrative segregation. As previously described, this is in stark contrast to the legislated limits on disciplinary segregation where the sanction for a single disciplinary offence is up to 30 days with no more than 45 days for multiple offences.

ALTERNATIVES TO SOLITARY CONFINEMENT ATTEMPTED IN THE FEDERAL SYSTEM

Over the years, the Correctional Service of Canada has implemented various programs as alternatives to solitary confinement, with varying degrees of success or failure.

Prisoners with mental health concerns

In 2004, the Correctional Service of Canada unveiled its Mental Health Strategy for Corrections in Canada, which is described as a multi-year undertaking aimed at addressing the increasing population of prisoners with mental health issues.⁹⁸

The vision of the Mental Health Strategy was to ensure that prisoners with mental health problems have “timely access to essential services and supports to achieve their best possible mental health and well-being”.⁹⁹

The Mental Health Strategy follows a continuum of care model, from the initial intake of a prisoner through to the end of sentence. It was founded upon the following five key components:

1. mental health screening at intake;
2. primary mental health care;
3. intermediate mental health care;

4. intensive care at the regional treatment centres; and
5. transitional care for release to the community.

According to the Correctional Service of Canada, these five components are “supported by various management practices such as training and professional development, research and performance measurement, and tools to support front-line staff”.¹⁰⁰

While four of the five components were implemented in some form over the following years, the commitment to the third component, the implementation of Intermediate Mental Health Care Units (IMHCUs) did not happen for another ten years.

Intermediate Mental Health Care Units

In 2010, Dr. Margo Rivera produced a report for the Correctional Service of Canada with a blueprint for the implementation of Intermediate Mental Health Care Units that would accommodate prisoners who suffer from non-psychiatric conditions including depression, anxiety, insomnia, learning disabilities, attention deficit hyperactivity disorder, post-traumatic stress disorder and antisocial or borderline personality disorders.¹⁰¹ Dr. Rivera’s report will be discussed in greater detail later in this report.

The Correctional Investigator repeatedly called for the Correctional Service of Canada to reallocate resources in order to implement the Intermediate Mental Health Care Units,¹⁰² yet these calls went unanswered, until 2015, when the first units were established in various institutions across the country.

According to the Correctional Service of Canada, the goal of the Intermediate Mental Health Care Units is “to address the needs of offenders who are unable to cope in regular institutional settings, but whose mental health problems are

not so severe as to require care in a psychiatric facility (i.e. Regional Treatment Centre).”¹⁰³

Admission criteria for the Intermediate Mental Health Care Units include prisoners diagnosed with serious mental illness with moderate impairment who do not need access to 24-hour nursing but who would benefit from being in a more supportive environment. This may include prisoners with fetal alcohol spectrum disorder, personality disorders or a chronic history of self-harm.¹⁰⁴ The Intermediate Mental Health Care Units are further divided into two units: High Intensity Intermediate Care and Moderate Intensity Intermediate Care.

While the implementation of the Intermediate Mental Health Care Units is a positive step, there is concern that it has been under-resourced and has come at the expense of psychiatric beds. Despite calls for additional funding, the Correctional Service of Canada implemented the Intermediate Mental Health Care Units using a cost-neutral model. The Correctional Investigator, in his 2014-15 Annual Report, noted that the Correctional Service of Canada’s plan would provide intermediate level care beds at the expense of the number of psychiatric beds available.¹⁰⁵

By the end of November 2015, the Correctional Service of Canada’s statistics show that while the number of High Intensity Intermediate Care beds implemented regionally met its planned capacity at 316, the number of Moderate Intensity Intermediate Care beds implemented was lower, at 225 beds, versus the 268 beds planned for.¹⁰⁶

The Correctional Investigator addressed his concerns with the Intermediate Mental Health Care Units model in his 2014-15 Annual Report, stating:

At the end of the reporting period (March 31, 2015), the CSC had plans to increase the total number of “mental health beds” in federal corrections to 778, which includes

150 psychiatric beds and 628 intermediate-level care bed spaces.

...

[B]ased on a total in-custody population of approximately 15,000 the Office estimates that CSC actually requires more than 500 acute psychiatric care beds and nearly 1,000 intermediate beds just to keep pace with current needs and demands. In other words, the refined model could be short by about half the number of required bed spaces to match current, let alone, future needs.¹⁰⁷

The implementation of the Intermediate Mental Health Care Units shows that the Correctional Service of Canada is both recognizing and making attempts to address the needs of prisoners with mental disabilities. With the implementation of the Intermediate Mental Health Care Units being so recent, it is difficult to comment on whether they will have the desired benefit for prisoners with mental health issues. Unfortunately, early anecdotal evidence seems to indicate that some of the Intermediate Mental Health Care Units are not focusing on providing a therapeutic environment due in large part to the lack of unit staff buy-in and a lack of adequate mental health resources.

Complex Needs Program

In 2010, the Correctional Service of Canada implemented a pilot of the Complex Needs Program in the Pacific Region. This was an attempt to address the mental health needs of prisoners with a history of self-harm. In 2012, the Complex Needs Program model was refined and it became a 10-bed parent-institution located at the Regional Treatment Centre in the Pacific Region. The Complex Needs Program was a multi-security-level unit for prisoners with an extensive history of self-harm. Its purpose was to aid prisoners in developing new skills and

abilities that would help them cope with their day-to-day difficulties and improve their quality of life.¹⁰⁸

The Complex Needs Program was divided into three phases that participants were meant to cascade through while learning new skills at each phase. Each phase was intended to allow progressively more opportunities for individuals to use their newly acquired skills.

Unfortunately, the implementation of the Complex Needs Program was not successful. A 2012 Correctional Service of Canada review of the Complex Needs Program found a number of difficulties plagued the program, including staff recruitment issues, issues with the physical infrastructure that prevented participants from being able to interact with each other, staff fatigue and the possibility of the “contagion” effect where it was seen that one incident of self-harm led others in the unit to also engage in self-harm.¹⁰⁹ The program was ultimately abandoned in approximately 2013.

Complex Mental Health Committees

In place of the Complex Needs Program, the Correctional Service of Canada established regional and national Complex Mental Health Committees made up of senior executives to monitor complex mental health cases. In his 2015-2016 Annual Report, the Correctional Investigator reported that from April 1, 2015 to February 8, 2016, 215 prisoners were monitored by these committees.

The Correctional Investigator provided the following examples of prisoners who were being monitored by these committees:

- a prisoner who was certified at a treatment centre where force and isolation were used to control him, without a therapeutic plan in place to treat his mental illness;
- a prisoner who self-harmed and was transferred back and forth between treatment centres and maximum security prisons where he would be placed in long-term segregation and where force was used against him for self-harming; and
- a certified prisoner who self-harmed and was charged with disciplinary offences while being physically restrained at a regional treatment centre.

The Correctional Investigator reported that he could not see the value added by monitoring women prisoners, other than increased “basic, consistent, and humane interactions that the extra staff provided”. He reported that, while funding was provided for external psychological assessments, no additional funding was provided to implement the recommendations made in the assessments.

Clearly, the Complex Mental Health Committees are not the complete answer for prisoners with complex mental health needs who may be at risk of self-harm or suicide.

Special Handling Unit (SHU)

The Correctional Service of Canada operates the Special Handling Unit, or SHU, in the Quebec Region, which is a 90-bed, high security facility intended for prisoners who cannot be integrated into a maximum-security prison. Prisoners are meant to be placed at the SHU for as short a time period as possible, to be stabilized and returned to an open maximum security unit. Programs are available to prisoners who are willing to participate in them. The Office of the Correctional Investigator reports that there are now less than 40 prisoners held at the SHU.

Fraser Valley Institution for Women

The Fraser Valley Institution for Women opened in 2004, following on the Task Force on Federally-Sentenced Women recommendation that P4W in Kingston be closed and replaced by regional women's prisons across Canada. In its report, *Creating Choices*, the Task Force recommended that women's prisons be based on empowerment, meaningful and responsible choices, respect and dignity, supportive environments, and shared responsibility. The Fraser Valley Institution for Women was intended to be based on these principles and operated on the basis of dynamic security. Correctional officers did not wear uniforms. This approach was intended to create an environment where solitary confinement would rarely be considered necessary.

Since its opening, the Fraser Valley Institution for Women has increasingly used static security over dynamic security. Correctional officers now wear uniforms, which one long-term staff person at a federal women's prison believes are unnecessary and "create barriers between officers and offenders that make conditions less stable and safe".¹¹⁰ Long-term staff at federal women's prisons also found that the commitment to the *Creating Choices* principles were slipping.¹¹¹

Between 2003 and 2011, the Fraser Valley Institution, and all other federal women's prisons, used a program called the Management Protocol, which was a step-down program exclusively for women prisoners.

Under the Protocol, women were subjected to the same conditions as if they were placed in solitary confinement – 23-hour-a-day lock-up, no access to programming and severe restrictions on their movement. The Protocol "added significant procedural layers [that] were very difficult for inmates to navigate."¹¹² This included "exacting behavioural standards used to assess the conduct of segregated women and

adjudicate their entitlement to basic liberties."¹¹³ The result was that women subjected to the Protocol faced segregation for indefinite periods of time. The Protocol had three phases – from segregation, to additional liberty, to integration into the population – but only two of seven women under the Protocol ever succeeded in getting off the protocol, as the strict behavioural rules set women up for failure.

The Protocol was implemented quietly, "without the democratic process or political attention that might be expected for a coercive governmental regime."¹¹⁴

The Protocol was criticized by Howard Sapers, the Correctional Investigator of Canada, for being too broad and attempting to substitute the need for treatment for a small group of women with a deprivation-based policy that could be applied arbitrarily.¹¹⁵ Mr. Sapers concluded that "the application of the Protocol tends toward the punitive as opposed to the corrective – a situation that is inconsistent with the Service's guiding philosophy for women offenders as outlined in *Creating Choices*."¹¹⁶

The Protocol was abandoned in 2011 after a lawsuit was filed challenging its constitutionality. Prisoners' Legal Services received anecdotal evidence for some time after the announcement of the end of the use of the Protocol that the name "Management Protocol" may have been abandoned, but the practice was still in use. Recent accounts from our clients seem to indicate that its use has now been abandoned, and women at the Fraser Valley Institution are generally removed from segregation quickly after placement.

The Fraser Valley Institution has also implemented programs that are effective in preventing prisoners with mental health issues from ending up in solitary confinement. The prison operates a unit that provides intensive support for medium security women with

mental health needs, called the Structured Living Environment. The Structured Living Environment staff includes a psychiatric nurse, psychologist and behaviour counsellors. Unfortunately, it can house only up to 12 women, and not all women who require the program meet the criteria for admission.

The Fraser Valley Institution for Women has been successful in keeping the number of women in solitary confinement low, and in ensuring that women are released from solitary confinement in a short period of time. Across Canada, many fewer women are placed in solitary confinement than men, and most women are released before their five-day segregation reviews.¹¹⁷

Other mental health units and the Regional Treatment Centre

Other federal prisons across Canada have from time to time implemented informal mental health units, including one at Kent Institution, the maximum-security men's prison in the Pacific Region. These units have been successful as long as they have been staffed and resourced appropriately. Unfortunately, these units tend to become, eventually, under-resourced.

With the implementation of the Intermediate Mental Health Care Units on a cost-neutral basis, in the Pacific Region, no new mental health units were implemented in institutions outside of the Regional Treatment Centre. Within the Regional Treatment Centre, psychiatric hospital beds were converted into intermediate health care beds. Overall, the Pacific Region was required to implement the program with fewer resources.

This means that the Pacific Regional Treatment Centre is forced to do the best it can with insufficient resources. Prisoners' Legal Services often sees prisoners with mental disabilities, who we believe would benefit from therapeutic

treatment, denied placement at the Regional Treatment Centre. Other clients are removed from the Regional Treatment Centre if they engage in disruptive behaviour. They are often sent to maximum security because they are deemed to have high "institutional adjustment" needs.

FEDERAL PRISONER ACCOUNTS

Federally, the majority of complaints received by Prisoners' Legal Services concerning conditions in solitary confinement have come from Kent Institution, located in Agassiz, BC. In 2012, the Correctional Investigator conducted an investigation into conditions in Kent segregation based upon a series of disturbing complaints about conditions and treatment of prisoners. Although conditions appeared to have improved after that investigation, we have received some similar complaints from clients in Kent segregation more recently. We do believe the current warden at Kent Institution is doing the best she can with limited resources and other constraints.

Although the rates of federal segregation have declined dramatically in the past few months, and the number of reports of abuses Prisoners' Legal Services has received recently have also declined, the following prisoner accounts warn of the abuses that can take place in a regime that allows for the long-term isolation of prisoners without adequate external oversight. Without strict legislative protections and a corresponding change to the culture of corrections, these abuses could easily re-emerge.

Between 2009 to 2010, Prisoners' Legal Services received a number of accounts by prisoners in Kent segregation that included the following concerns:

Temperature and Cell Fixtures: Cells had excessively cold temperatures in winter and excessively hot temperatures in summer. Many cells had no power, cable, lights or adequate water pressure. Guards often turned off power, lights, and water for extended periods as punishment. In other cases, lights were kept on for several days even during the night.

Cleanliness: Cells were often not cleaned prior to new occupancy, and cells often contained bio-hazards including blood, urine and feces. There were inadequate opportunities to clean cells, usually limited to twenty minutes per week and with inadequate or contaminated cleaning supplies. In many cases no toilet brush was provided and supplies such as rags, gloves, mops and mop water were often shared between prisoners. Most mattresses and blankets were dirty and possibly contaminated.

Air Quality: The entire segregation unit was contaminated with mould. The air ducts and vents were dusty and infrequently cleaned.

Flooding: Regular flooding in the unit often resulted in one to three inches of raw sewage and water in cells and hallways. Plumbers and the biohazard team were not called quickly. There could be a wait of 12 hours. Often prisoners were not given an opportunity or equipment to clean in the interim.

Meals: Meals were often cold and quantities inadequate. Three meals were served within 8 to 10 hours, and nothing further was served for 14 to 16 continuous hours. Many prisoners reported that their food had been tampered with (for example, with spit) or that they did not receive everything that others receive in a meal (for example, at lunch the sandwich would be missing).

Programming: Jobs, vocational training and rehabilitative programming were not available in segregation at Kent. Staff described the programming in segregation as the “Shower

Program”, “Feeding Program”, “Exercise Program” and “Phone Call Program.”

Personal Hygiene: Showers in segregation were often dirty, and were offered only every two days. Prisoners reported not being provided hygiene items, bedding and clothing for days upon admission to segregation.

Exercise and Yard: Prisoners in segregation are supposed to receive one hour per day of yard time. There were two yards: “J Yard”, which was a concrete bullpen approximately 10 feet by 30 feet; and “K Yard”, which contained several fenced off areas. Most prisoners in segregation, and typically all of those with mental disabilities, are required to be alone during yard time. Most prisoners preferred K yard so that they could have some contact with another prisoner on the other side of the fence. Guards would often only offer J yard. Prisoners often missed their yard time as it was commonly offered to them at 6 a.m., which is before breakfast and the 7 a.m. wake time. If prisoners did not accept yard time when it was offered to them, it would not be offered again that day. Many prisoners in segregation spent weeks without going outside, either because yard time was offered at inconvenient times or because they declined to make use of the facilities offered, which they found to be deficient. (In 2016, a new yard was opened for J unit similar to the K unit yard which offers more space and views to the outside.)

Phone Calls: Prisoners in segregation at Kent were typically allowed two legal calls per week during business hours, and two personal calls a week during evening hours. Access to phone calls tended to be very inconsistent; some prisoners would receive a great deal more than this typical practice and others would receive no access to phone calls for extended periods.

Medical Care: Response times to prisoners pushing their emergency cell call buttons was often very slow. Prisoners had the impression

that guards felt emergency buttons were over-used and that prisoners were just “crying wolf”. Prisoners in segregation do not have roommates who could press the emergency button for the person in distress. For these reasons, prisoners in segregation who faced a medical emergency were at a heightened level of risk of not receiving a timely medical response.

Noise: Prisoners reported that guards make loud noises throughout the night. During the day, the segregation unit was loud from prisoners and guards yelling, and prisoners banging their doors. Prisoners reported that it was disturbing to listen to the mental anguish that was often vocalized by some prisoners in segregation, throughout the day and night.

Segregation Reviews: Prisoners were allowed to speak during segregation reviews, but decisions to maintain segregation rarely referred to or addressed their concerns or explanations in any meaningful way. Prisoners were not informed of any opportunity to be represented by legal counsel, and reported that they did not know this was a possibility.

Prisoners complained that staff in Kent segregation created living conditions so difficult that prisoners would “lose it”, resulting in the use of the emergency response team and chemical agents. Staff often did not respond to basic requests from prisoners, such that prisoners resorted to covering their windows, taking the yard or shower “hostage” or acting out in some other way in order to see the Correctional Manager and have their needs met. Many prisoners reported that the guards were often abusive, disrespectful, provocative and threatening toward prisoners.

The most troubling complaints from Kent segregation concerned the treatment of prisoners with mental disabilities by unprofessional guards working in the unit. Prisoners’ Legal Services received a number

of complaints of guards giving razor blades to prisoners who are known to engage in self-harm, and whispering “Why don’t you just kill yourself?” over the prisoner’s cell intercom. Disturbingly, this replicates a scenario that the 1977 Parliamentary Sub-committee on the Penitentiary documented at the BC Penitentiary.¹¹⁸

Prisoners’ Legal Services also received reports of guards assaulting prisoners in segregation, and instructing prisoners to assault other prisoners while providing the opportunities for assaults to take place.

Clients reported the following quotes by officers working in Kent segregation from 2009 to 2010:

- “Fucking rat goof skinner.” (These are fighting words in prison, which put the prisoner in the position of having to respond to the guard violently or risk being victimized by other prisoners for not responding.)
- “Stop whining like a big baby.”
- “Shut the fuck up and go to bed like a good little girl.”
- “Stop being a bitch, take the shit off your window and go to sleep, punk.”
- “You ain’t getting shit, motherfucker!”
- (In response to an invitation to fight) “Fighting you wouldn’t even be a challenge, I would only be fighting a little girl.”
- “You don’t want us to come in your cell, we would fuck you up bitch!”
- “Pussy.” (For letting segregation break a prisoner after only a few days.)
- “Mommy, mommy, I want my mommy!” (Accompanied by crying noises.)

AY (2009-2012)

AY was in segregation at Kent Institution for 233 days between 2009-2012.

The temperature on the upstairs units is crazy. The air is so hot that the walls became sticky and the only way to cool my body down was to stand on the toilet and continuously flush it until the steel became cold, which then cooled my feet down. Even when I cleaned the air vent in my cell, no air would come out.

When I brought the condition of the cell to the attention of one of the guards, he looked at the mattress and said, “yeah, that’s shit, but don’t they call you ‘dirty’,” laughed and walked away. I was moved later that day into a cell that had a cup of feces and urine beside the toilet, the mattress had no cover and reeked of urine and again there was feces on the walls.

The showers in segregation are also dirty and often covered in feces. In April 2012, the upstairs shower on K side wouldn’t drain. It had garbage floating in the bottom of it. When I was returned to segregation in June of 2012, approximately two months later, the same shower still wouldn’t drain.

There are also not enough chances to clean your cell. I was generally given less than 20 minutes a week to clean my cell – usually on a Saturday or Sunday. On cleaning day, after I had my shower, I would be given a dirty bucket of water to use to clean my cell. I would be given a toilet brush, handed to me through the meal slot in my cell door. The same brush would be used for all toilets, so it would be dripping dirty water as it was handed to me. The wet toilet brush was kept in the same bucket as the broom and dustpan that were given to prisoners to sweep their cells. I was expected to clean my cell with it, which I refused to do. I would

ask for a ‘toilet cleaning’ kit from ISS, which consisted of one rubber glove, one green scrub pad and a blue cloth. I would try to use this to clean my cell instead. Prisoners only get issued four of these kits a year, so I had to make it last. Even having to reuse the kit was better than using the cleaning supplies that they gave to us.

At one point in time, the floor was stripped on a unit and re-done to remove asbestos. After this was finished, they didn’t clean the vents or air ducts at all.

The toilets would flood regularly, or the upstairs toilet would backup and cause the downstairs toilets to bubble over.

I would keep my fan in my cell on a couple of rolls of toilet paper to keep it off the floor, just in case water and raw sewage came into my cell, which it did regularly.

When it flooded, I would try to block the bottom of my door to keep the water and raw sewage out. I would see feces floating by my cell door.

I would refuse my meals when the flooding happened because I didn’t want to take the meal tray from guards who were standing in raw sewage. I was served my meals by guards who were wearing dirty gloves.

One time, when I was on bag feed because I was on three-guards-on-one protocol, the guard threw my lunch bag in the toilet. I believe this was done on purpose, as the guard really had to try to angle it correctly to get it in the toilet – it’s not something that he could have done without some effort.

While on bag feed before, I have opened the bag to see spit dripping down the inside of the bag. This happened to me on more than one occasion.

Other times I would receive my bag lunch and think that it felt very light. I would open it up and see that it contained only carrot sticks and broccoli. I would ask my friend what he got for lunch and be told that in addition to carrot sticks and broccoli he also received a sandwich. Having the main portion of my meal removed was also a regular occurrence.

On one occasion I asked a guard for toilet paper as I was almost out. He told me he'd get it to me on his next walk of the unit. When he came back he'd forgotten to bring it and told me that he'd get it right away. I waited another hour and then, because I was so desperate, I finally started kicking the door to get the guard's attention and ask again. The guard responded by saying, "no, you kicked your door, now you can wait."

Another time, I got into an altercation with a guard and I spilled water after punching a door. The guard said that I threw water on him so he turned off my water. It was kept off for three days.

When I was placed in segregation but I didn't know why, a guard kicked my door at 10:00 at night and said, "hey, you piece of shit, read the papers I just slid under your door."

Guards have put words in my mouth before, saying that I said things when I didn't. They also play games with the prisoners. I've been told by guards that I'm not getting yard time or a phone call because I refused them, when I hadn't.

I've been retaliated against when I tried to speak up about things happening. When I heard guards refusing my friends yard time, or when I heard them say yes to yard, but they were not given yard, I would say to the guards that I heard them say 'yes', and because of that, the next day I would be refused yard.

Kent segregation is like an insane asylum and all it did was make me hateful and full of rage for the way the guards acted.



JT (2006-2009)

JT is a federal parolee who suffers from frontal lobe deficits, attention deficit hyperactivity disorder and complex post-traumatic stress disorder.

JT began his sentence in 1995. He experienced numerous uses of force and segregation placements during the first 10 years of his custodial sentence. Beginning in 2006 until 2009, JT engaged in increasing incidents of self-harm in the form of head-banging. The Correctional Service of Canada put JT under a Behaviour Management Protocol that required him to be locked in his cell if he engaged in head-banging,

and to remain there for 24 hours without banging his head. If he did not stop banging his head, the protocol directed that he would be given an order to stop and then force, including chemical agents, would be used against him.

An independent psychiatrist warned that JT was at risk of serious brain damage or death from banging his head. An independent psychologist opined that suggesting to JT that force, chemical agents or isolation would be used against him would “increase his physiological arousal, retraumatizing him with the threat of that which he most fears.” She stated that putting someone with attention deficit hyperactivity disorder in segregation is “akin to mental torture”.

Between 2006 and 2009, JT was transferred back and forth between the Regional Treatment Centre and Kent Institution, where he was usually put in segregation. These transfers out of the treatment centre and back to segregation at Kent were often in response to JT’s self-harming, and often involved the Emergency Response Team using force against him, including chemical agents. In the course of approximately one year and four months, JT underwent 10 transfers back and forth from the Regional Treatment Centre and Kent Institution. Between June 2008 and March 2009, JT was in segregation for 246 of 274 days, and engaged in head-banging over 100 times.

JT was released to the community in 2009. In 2011 he was suspended and returned to custody. In 2012, a guard offered him a razor blade and said that he should slash himself. JT refused the razor. The following day, JT had a panic attack and while he was banging his head in his cell, a razor blade was slipped under his door. He used the blade to slash his arm, cutting to the bone.

When I am afraid that CSC will use force against me and place me in segregation, I have a panic attack and I often cannot

stop myself from banging my head. I have difficulty controlling my anxiety and bang my head when I am in segregation or isolation.

In segregation I am locked in my cell for 23 hours per day. In isolation [observation cell or quiet room at the Regional Treatment Centre] I am locked in my cell with no human contact and all I am given is a mattress on the floor, suicide smock and underwear.

When I experience a panic attack, it begins with a feeling of increased hyper-vigilance and a knot in my stomach and throat. I try to stop the panic attack when I feel this way by splashing cold water on my face and holding my breath at intervals. If I cannot stop the attack, my face gets hot, my palms sweat, my heart pounds, I feel dizzy, I tremble and shake all over and I feel an overwhelming sense of impending doom. I experience sudden verbal rage attacks. I feel like my heart is going to burst from my chest and I think I am going to die. I lose focus on my surroundings and cannot hear what people are saying to me. I feel disconnected from the present moment.

When this happens, I cannot stop myself from banging my head against my cell door or walls. When I bang my head, I feel numb. I bang my head so severely that my head bleeds and becomes very swollen and disfigured. On occasion I have lost consciousness from head banging, I have had blood come from my ears, and I have experienced nausea, vomiting and dizziness after banging my head. I have had dozens of concussions from banging my head. After one incident, health care staff told me I had a 12-day concussion.

After I bang my head, I clean up the blood from my head and apply compression bandages. I practice slow, deep, rhythmic breathing and I use visual imagery to bring myself to a safe and quiet place. Then I use

bleach to clean the blood splatters from my cell wall, floor and sink. If I have symptoms of concussion, I try to stay awake and will go to health care, unless I am afraid CSC will put me in isolation for banging my head.

When I was in custody before 2009, I had a continuous sense of hopelessness and despair about my future. I was afraid I would die in prison because I was not able to stop banging my head in prison.

Prisoners' Legal Services assisted JT with a human rights complaint regarding his solitary confinement and lack of appropriate accommodation of his mental disabilities. JT is now on community supervision and has gained control of his self-harming. He still suffers from flashbacks and nightmares.

TD (2006-2007)

TD is an Indigenous transgender woman who was held in Kent Institution (a prison for men), from 2006-2007. She reported experiencing harassment by male officers at Kent Institution and other difficulties related to being a woman held in a men's institution that led to her being placed in segregation for approximately six weeks for her own protection.

TD was required to be searched each time she left or returned to her cell. There were often no female staff working in the segregation unit available to conduct her searches, so TD often remained in her cell 24 hours per day, and was unable to shower or have time outside. TD was in a segregation unit by herself for the first part of her time in segregation. She was not able to see the Elder, the inmate committee or Native Brotherhood. The only person she was permitted to see was her lawyer once or twice during the time she was in segregation.

I was in turmoil, I was depressed, I was angry, hurt. I felt betrayed. I had a lot of

things going on with my emotions. My lawyer was the only thing that kept me going at times.

I was in a seg unit by myself and I wasn't allowed any contact with anyone. I was bored. Even the cleaners didn't come. I had no face-to-face contact with anyone other than my lawyer once or twice. I would put on the TV just to hear the voices so I would feel like I had some human contact with the world. The only time a psychologist came was when they were going to put me back on a unit toward the end of my time in the hole.

I tried not to think about what I was going through. Even trying to call my lawyer was a major issue. Sometimes I would cry.

One time they stuck me out in the yard when it was freezing cold, raining, with no jacket – for three hours. They said they were doing a cell check. You are supposed to be out for an hour a day, but after that it was rare that I would go out to the yard. I put on, like, 50 pounds being in isolation for 24 hours a day!

A week after I was put in the hole they put a guy down there with me. When it was just me, they did a check every three or four hours. When the guy came the checks were more regular. One guard would go to his cell and ask him how he was doing. At first I thought he was being nice, but then I realized he was trying to provoke him. I didn't know the guy was mentally handicapped until a female guard let me out to have my shower and I, being nosy, peeked into his cell to see who he was. This poor guy had nothing in his cell.

This guard would provoke him. The guy would get on the top bunk and he would jump on the cement floor, and face-land on the floor. He would do belly flops like in the pool. That's what he would do onto the concrete floor. I would hear the guard say

“Ha, ha! Why did you do that? See what you’ve done?” I would scream: “I know who you are and what you’re doing!” I told the guy to call for me when the guard came, so he would know he wasn’t alone. At times he broke his nose or teeth after jumping.

One time, the guy knocked himself out after jumping off the sink after the guard was harassing him. After a few minutes, the guard called his partner who came and they opened his door. They yelled that they would call the emergency response team. They would say: “Come on, get up...” After 5-10 minutes, they said “we’ll have to get the infirmary”. They agreed to say they were doing their rounds when they came upon him. Infirmary came running down. I saw blood splattered all over the floor and the side of the wall.

The guy came back a couple days later with bandages on his face and a neck brace on. He was still in the hole when I got out. I used to pray for him. I’m sure they terrorized him after I left.

I know what it was like for me in the cell for 23, 24 hours a day. Even if you have a book, it’s like repeat, repeat, every day. I can’t imagine what it was like for him.

Up until then, I knew there were a few bad guards but I didn’t know how bad it was. After I was let out of the hole and came back to the unit, I would have panic attacks and anxiety attacks every time they called me to go to school or anywhere.

CL (2010-2016)

CL is a prisoner at the Fraser Valley Institution for Women. She is Cree from the Opaskwayak band. She was born and raised in Winnipeg, Manitoba. Relatives on both sides of her family, including her grandparents, were in residential school. One of her aunts was a victim of the 60s scoop. CL has two brothers and six younger sisters.

I have been doing drugs since I was eight, and alcohol since I was 12. I came from a broken home where I had to learn to fend for myself by the age of 12. Ever since I was a young child I can remember being physically abused. During two periods in my life I was sexually abused by a family member and a family friend. My dad was violent and left when I was eight. After that my mom got into her addiction to alcohol and cocaine.

CL first went to jail at 18 and received her first federal sentence at 20. She had been in segregation at the Fraser Valley Institution for Women for eight days at the time of her interview. She reports that she spent six months in solitary confinement in the Winnipeg Remand Centre in Manitoba before she was federally sentenced. She has been in segregation approximately five times federally, usually for five days to two weeks.

Some days are harder than others in seg. The last time I got placed in seg I felt overwhelmed and stressed out, I felt helpless because my behaviour didn’t match with the accusations being made, but I was still placed in seg.

When you’re stressed out, you just want to walk around, but you can’t do that in seg. Half the time it’s not worth going outside to yard because you’re in a little box and you’re just looking at four brick walls. It made me feel like a dog in a cage.

Sometimes you just want to be around people but you can't because of minimal contact. The most contact I had was when the Elder came to see me for a few minutes, or when my parole officer came to see me for a few minutes.

In the past, after I was in seg for six months at the Winnipeg Remand Centre, I went to federal max. After being in seg for so long it was overwhelming. I wasn't used to being around other people. I didn't want to come out of my room to interact with other people. Being locked in a room for a long time, it gets to you and it makes you go a little bit crazy.

CM (2014-2015)

CM is an Indigenous prisoner from Saskatchewan. His mother was a residential school survivor. When he was two, he was put in foster care for 13 years and was separated from his siblings. He was placed in approximately 10 different homes, where he reports being physically and mentally abused. He has a grade nine education. At approximately 13, he remembers being diagnosed with a mental disability and being prescribed anti-psychotic medication. CM entered the prison system at a young age.

At age 22, in 2014-2015, CM was segregated at Saskatchewan Penitentiary for approximately eight months. During this time, he was on special handling protocol. He was strip searched "all the time" and was escorted by five guards with his hands cuffed behind him any time he was moved from his cell. He reports always feeling hungry while in segregation. He had no radio or television in segregation, no access to school, and had nothing to do. He submitted requests to guards for meetings with a psychologist but reports, "I'm pretty sure they didn't give the requests to the psychologist".

CM saw a Segregation Intervention program facilitator about four times while in segregation. "I had so much on my mind that we ended up just talking and she listened to me". CM reports that guards took his phone card and he could not afford the \$5 to purchase a new one, so he was unable to phone anyone, or arrange any visits. His only contact with other prisoners was talking through the food slots or through the window when he was in the yard for his hour out. He eventually got a job as a range cleaner which helped him feel busy.

CM asked for a mediation with the prisoners he was in conflict with, which was the reason for his segregation. Mediation never happened. CM spent four months in segregation.

I started feeling like I was going crazy. I was getting angrier and angrier because the guards were harassing me and laughing at me. They would always have something to say to me – they would laugh at me and constantly bang my door. They would dis me because I didn't talk much, but I didn't do anything to provoke them. The guards were the ones that set me off. They had a really bad attitude towards me.

... I couldn't handle this treatment anymore. I was feeling really down. I barricaded myself in my cell and broke my lights. They had metal rods in them that I was going to use as spears. The institution sent in the Emergency Response Team and I fought them because I was so angry...

After that incident, it was a constant battle between me and the guards ...When I was allowed to leave my cell for my hour out the guards would go in and rip up letters and photos of my family. They'd also take things I'd bought from the canteen. This made me angrier.

One time, about six guards took me out of my cell to a back area and beat the shit out of me. They told me they were taking me out of my cell for an exceptional search. The area they took me to had no cameras. They cut off all my clothes. I have never felt more humiliated. I ended up with two black eyes, a busted lip and I thought my leg was broken. I was bleeding when they brought me back to my cell, but they put a spit mask on me, I think to hide the blood from the cameras. The guards wouldn't let me get medical treatment...

I started having really negative thoughts. I thought I'd be in segregation forever. It was the worst time of my life, especially not knowing when I would get out of segregation...

I started to feel really desperate and gave up on myself. I didn't care about anything anymore and wanted to die. I felt like my family didn't care about me and that no one would care if I died ...

I wanted to kill myself, but couldn't do it, so instead I self-harmed as a cry for help. I thought about what I was going to do and in the end I took a razor and cut off my nose. I cut it right down to the bone.

After I did it I started to panic because I was bleeding so much and thought I was going to die. I alerted the guards by hitting my cell call button. The guard came and ... I was taken to health care in the prison and waited for the ambulance to come.

At the hospital they stopped the bleeding. I think I was only there for about an hour, and then I was sent back to the Institution and spent one night in a medical observation cell. After that I was sent to RPC [the Regional Psychiatric Centre].

Before being put into segregation, there was only one other time that I self-harmed and that was when I was a teenager. I slashed my wrist.

CM was eventually returned to segregation at Saskatchewan Penitentiary. He reports having a hard time adjusting to life after segregation. He was shy and found it difficult to talk to people. He returned to the Regional Psychiatric Centre and was placed in the Intermediate Mental Health Care Unit where he is enrolled in programming, the General Wellness program and art therapy.

CS (2008-2011)

CS is a federal prisoner who was held in multiple periods of long-term solitary confinement at Kent Institution from 2008-2011. CS cannot read or write. He suffers from fetal alcohol spectrum disorder and intellectual disability. His cognitive development is estimated to be at the level of a seven to nine year old child. He has frontal lobe brain damage and has a history of severe self-harm.

CS spent limited periods of time at the Pacific Regional Treatment Centre, but would be transferred back to Kent segregation after engaging in self-harm or emotional outbursts. CS is at a lower risk of self-harm in treatment centres and does much better when he is in a therapeutic environment.

CS has difficulties living in regular prison units in maximum security because he is often victimized by other prisoners.

CS reports that guards taunt and provoke him in segregation. He reports that guards have yelled "kill yourself" at him. He reports having very little contact with psychologists. He is unable to participate in regular prison programming.

CS does not do well in solitary confinement. He cannot sleep, and feels despair about his future. He suffers from anxiety and frustration in isolation to the point that he cuts himself. He has required blood transfusions from outside hospital after self-harming in solitary confinement, only to be immediately returned to solitary confinement.

A psychological report of CS indicates that he requires permanent accommodation in a therapeutic treatment centre.

LS (2014)

LS was the victim of childhood sexual abuse. He has a history of suicide attempts. In 2014, he was experiencing recurring nightmares and flashbacks of his childhood trauma, and had thoughts of suicide. He told his Institutional Parole Officer that he was having difficulty living with sex offenders at Mountain Institution, a medium security prison. He was put in solitary confinement two days later after being accused of planning assaults of sex offenders. LS denied the allegations.

Six days later, LS hanged himself in his segregation cell. He was found nonresponsive and was brought to outside hospital. He survived, and the next day he was returned to solitary confinement at Mountain. He was accused of attempting to manipulate health care and psychology staff. LS denies that he was attempting to manipulate anyone.

These accusations made me feel like I was being re-victimized. For many years I kept the secret of my childhood sexual abuse. When I finally reached out to the institution for help, I found no support and indeed, aggression against me. Because of this I am very hesitant to seek further counselling regarding this issue.

After his suicide attempt at Mountain, LS was diagnosed with post-traumatic stress disorder

and a psychologist confirmed that his suicidal tendencies were not attempts to manipulate.

LS was transferred to Kent Institution a couple months later and was held in segregation until he was released from custody after three months. LS did not receive his property from Mountain at Kent until he was released from segregation. It took approximately a week for him to receive a towel. He never received toothpaste or a toothbrush despite several requests. He had no television, and requests for library books took two weeks after making two or three requests.

The only interaction LS had with other segregated prisoners at Kent was yelling from cell to cell. There were no programs available for segregated prisoners. He could do self-study with a teacher who came down twice a week. A chaplain would come to the segregation unit once a week. LS is Jewish and a Rabbi would visit once per month, behind glass, with LS handcuffed from behind. The Rabbi visits were the only face-to-face human contact he had in Kent segregation. Interactions with any staff were done through his cell door.

LS reports that he was handcuffed when brought to shower – sometimes so tightly that he would lose circulation in his hands. He reports staff leaving him sitting in the shower until the water turned cold, and he would have to wait, shivering, until an officer came to escort him back to his cell.

While I was in Kent segregation I was suicidal and depressed. I was placed on suicide watch multiple times. On these occasions, they would take everything out of my cell. I was not offered therapy.

Generally interactions with psychologists in segregation are cursory: they generally appeared at my cell door, asked me how I was doing and left immediately after I said I was fine. I would mostly tell staff that I was fine because I often did not know who I was

speaking to and I just wanted to cooperate with everyone and get out of segregation.

There have been several incidents where staff used force against me in segregation. I have had my hands cuffed behind my back and staff have lifted me by my cuffed hands so far above my head that I believe it tore my rotator cuff. Staff have emptied so much mace on me that I could feel it dripping off of my face. I have been pushed into corners of rooms with shields and hit with sticks. I have been punched with iron-coated gloves weighted with buckshot that protect staff hands and thus allow them to punch harder. I have been hog-tied, where my hands have been cuffed behind my back and my leg shackles have been tied to the handcuffs.

My segregation experiences, particularly the one at Kent, left me depressed, angry, hateful, bitter and resentful of the institution and correctional system in general.

LB (2012)

LB has been in and out of custody since 2002 and started his first federal sentence in 2009. He has been in segregation on a number of occasions.

In 2012, LB was transferred from medium security Mission Institution to maximum security Kent Institution after being accused of assaulting a guard. He was criminally charged for the assault, and during the trial evidence emerged that the guard hit LB first. Less than an hour after the incident, LB reports that a group of guards at Mission turned off security cameras in a hallway and assaulted LB. LB was found not guilty of the assault in criminal court.

LB was segregated at Kent for approximately 30 days. In segregation, he had no pillow, books, television or radio. He reports that the walls were filthy, splattered with feces, nasal mucus,

other bodily fluid, dirt, drawings and peanut butter and jam. Kent staff controlled the lights in Kent segregation, including the cell lights. During all of his time in Kent segregation, he reports that his cell light was never turned off. His cell was extremely hot during this placement in the summer. During a subsequent segregation placement in winter, his cell was extremely cold with no heat source in the cell.

LB had difficulty sleeping due to prisoners screaming and kicking their door, and he became sleep-deprived. He felt lonely with no direct interactions with other prisoners.

I found the guards in Kent segregation to be, in general, grumpier and meaner than in open population, though some were nicer than others. The culture of guards in Kent segregation seemed to me more stern, strict and rude – I observed that guards were more frequently snappy and disrespectful to segregated prisoners than those in open population.

During my second Kent segregation placement I noticed guards constantly taunting a prisoner whose name was [X]. A guard would speak to him over the public address system in a singsong voice, calling him by name and telling him that it was recreation time. Oftentimes he would yell that he did not want to take his recreation time, at which point the guard would repeat his message with the same ominous tone. Eventually they would extract him from his cell, beat him and pepper spray him. This happened every day. I could hear the sounds of the beating and [X] screaming, and I could smell the pepper spray through the ventilation system...

Sometimes guards would make comments like “I hope you enjoyed your lunch [or dinner] today,” their mocking tone suggesting that they had tampered with my food. Due to the allegations that I had assaulted a staff

member, such retribution seemed to me to be a distinct possibility.

One particular guard, referring to the assault allegation, told me “go ahead, why don’t you try that shit here, we’ll smash you.”

The psychologist would come through Kent segregation every second week. Due to this schedule, I only spoke with the psychologist once, during my first Kent segregation placement. My exchange with the psychologist was brief: the psychologist approached my door, asked me how I was feeling through the meal slot, and I said “fine.” The psychologist then said “ok, bye,” and left.

I did not wish to speak any more with psychology because I was still in shock from being criminally charged for the alleged staff assault. I was depressed, agitated and angry. I did not feel like I deserved to be criminally charged or in segregation after I had been attacked by a guard. I felt betrayed, and I felt that prison staff in general did not have my best interests at heart and were working primarily for the prison’s interests, including the psychiatrist...

After my release from my first Kent segregation placement I felt a great deal of resentment and distrust. I was depressed and angry. These feelings created anxiety and negatively affected the way I interacted with people, resulting in volatile interactions. This was aggravated by the fact that I had so few interpersonal interactions in segregation before being released into a closed, intense social environment like open population with many politics and possible repercussions for poor social decision-making.

GW (1994-2015)

GW was adopted as a baby and has never had contact with his biological parents. He has no knowledge of his family background. As a child he was diagnosed with attention deficit disorder and prescribed Ritalin and Dexedrine. He now believes that his childhood behavioural problems arose because he was sexually abused by an older cousin.

GW spent much of his youth in custody in juvenile institutions. As an adult, GW has been placed in segregation on a number of occasions in Kent Institution, Saskatchewan Penitentiary, Millhaven Institution and the Special Handling Unit.

In 1994, GW spent approximately six-and-a-half months in segregation at Kent Institution.

Psychological reviews were done in a cursory manner. A psychologist would visit once a month after the first 30 days in segregation. The reviews were completed in an interview room behind the staff office. There were never many questions asked, and the process was never in depth. No matter what my responses were the reviewer would always write that there were no concerns. I told them that I was raging to the point of literally seeing red, and that I would see things in my cell that weren’t there. I felt that these reviews were done in a pro forma manner to comply with the Regulations...

The six-and-a-half months I spent in segregation at Kent were mentally frustrating and emotionally exhausting. The hardest thing was that there was no end in sight. There was never any way to know when the segregation would end. There was no light at the end of the tunnel. This was especially true because I had a life sentence. I felt that I could stay in there forever. This made me feel as though my situation was

completely hopeless, and made me very depressed.

I have always wanted to believe in a greater good, but this experience chipped away at me. I saw that people, many that I knew and liked from other scenarios, were willing to follow orders without any human consideration. I understand that my own actions put me in that situation, but I felt as if I was treated as an animal.

I saw firsthand that the legal mechanisms related to segregation provide no real protection. The reviews and hearings were performed, but only in a pro forma manner. They never led to anything of consequence. This realization had a severe psychological and emotional impact on me. It was all-consuming, like a fire. It took a long time to get over the feeling that if any little thing happened I would find myself back in the hole.

GW has spent other periods of time in segregation up to 2015, including in medium security institutions. He describes the conditions in the Matsqui and Mission segregation units as “disgusting”.

Overall my time in segregation has had a lasting effect on me. It made me more uptight and less trusting. It has given me a complete lack of faith in those who are in charge of me. I find it very difficult to go to them for help. For instance, when I struggle with addiction I worry about seeking assistance for fear of being placed back in segregation. There is no doubt that segregation had a serious negative effect on me, and that this spilled over to society. It did nothing but undermine my efforts to rehabilitate and hinder my ability to reintegrate into society.

Forty years after the McCann case heard evidence of very serious misconduct on the part of guards working in the segregation unit of the BC Penitentiary, Prisoners’ Legal Services again received reports from prisoners held in Kent segregation of guards slipping razor blades under the cell door, encouraging prisoners to kill themselves. Forty years later, we continued to receive reports of guards taunting prisoners with developmental disabilities to humiliate and harm themselves.

Without significant legislative reform to the federal solitary confinement regime, Prisoners’ Legal Services is concerned that the appalling incidents referred to above will be allowed to continue.



SOLITARY CONFINEMENT WITHIN BRITISH COLUMBIA CORRECTIONS

THE HISTORY OF SOLITARY CONFINEMENT IN BC PRISONS

The legislative authority for the use of solitary confinement in British Columbia can be traced back to the 1925 *Gaol Rules and Regulations*, which allowed a warden to sentence a prisoner to “solitary confinement in a dark cell, with or without bedding, not to exceed six days for any one offence, nor three days at any one time”.¹¹⁹ This authority applied to punishment of offences, as opposed to the use of solitary confinement for administrative purposes. A prisoner could also be deprived of his normal food rations, instead being given only bread and water, as punishment.¹²⁰

In 1929, the regulations were revised to remove any reference to the duration of solitary confinement permitted.¹²¹

The inclusion of a legislative time limit did not occur again until 1961,¹²² when a limit of up to 15 days for solitary confinement was imposed. An increase to 30 days was permitted on the direction of the director.¹²³ Prisoners who were placed in solitary confinement were required to “forfeit all normal privileges, including remission of sentence, earnings and smoking”.¹²⁴

In the 1978 *Correctional Centre Rules and Regulations*, we see the first authority for the

use of solitary confinement (or segregation as it is referred to in these regulations), for reasons other than a disposition due to a disciplinary infraction. The regulations allowed the director to place a prisoner in a segregation cell if the prisoner “exhibits behaviour likely to endanger himself or other persons” or “obstructs or impedes the proper management, order or discipline of the correctional centre”.

Under these regulations, the prisoner could be held in segregation for only up to 24 hours in very limited circumstances, including if the prisoner was charged with an offence for the act that led to the confinement.

In 1985, the *Correctional Centre Rules and Regulations* were amended to include a new section, “Separate Custody”, which gave the authority to the director of the institution to house a prisoner in separate confinement, in order to maintain the safety and order of the institution. Under this section, the director was required to review a prisoner’s placement at least once every seven days. The regional director had to review a decision to keep a prisoner in separate custody within 30 days. Prisoners in separate custody were not to be denied any of the privileges afforded to other prisoners, except for those that “cannot reasonably be granted ...having regard to the limitations of the area in which he is kept...”¹²⁵

BC CORRECTIONS' CURRENT SCHEME

Legislation

In 2005, the *Correction Act Regulation* was introduced¹²⁶, which included an amendment to the Separate Custody section of the earlier regulations, now referred to as “Separate Confinement”.

Section 17 of the *Correction Act Regulation* authorizes prisoners to be kept in separate confinement for up to 72 hours if there are “reasonable grounds” to believe the prisoner is, or is likely to be, a danger to people or to the security of the institution, among other grounds, including due to mental illness.¹²⁷ In 2015, the *Correction Act Regulation* was amended to remove the authority to place a prisoner in solitary confinement due to mental illness or while waiting for a transfer to a Provincial mental health facility.¹²⁸ This was a positive step taken by the province that goes toward recognizing that prisoners with mental health issues must be accommodated, not punished. Unfortunately, prisoners with mental disabilities are still routinely placed in solitary confinement in British Columbia prisons under other grounds. Prisoners’ Legal Services has seen separate confinement forms that still indicate the justification for the placement as “medical” or behavioural with the reason describing the prisoner’s mental illness.

A separate confinement placement under s 17 of the *Correction Act Regulation* can be extended under s. 18, Separate confinement – longer term, for one or more periods of 15 days if the person in charge believes it is warranted.¹²⁹ Prisoners’ Legal Services rarely sees our clients released after 72 hours. Many of our clients are placed under long-term separate confinement under s. 18 of the *Correction Act Regulation*, and

these placements are often continued with very little procedural fairness for months at a time.

The amount of time a prisoner can spend in solitary confinement as punishment for a breach of an institutional rule is 15 or 30 days, depending on the offence¹³⁰, and a total of 45 consecutive days for more than one breach.¹³¹ Prisoners are routinely held in segregation pending a disciplinary hearing under s. 24 of the *Correction Act Regulation*. Prisoners’ Legal Services sees many prisoners returned to administrative separate confinement after serving a sentence of segregation for a breach of an institutional rule.

The current legislative scheme in British Columbia prisons has no limits on the use of solitary confinement for administrative reasons. The allowable use of administrative solitary confinement has ballooned since it was first regulated in 1978 with a limit of 24 hours. The time limits for the use of solitary confinement as a disciplinary sanction are much higher today than they were in 1925, when it was limited to three days at a time. The current disciplinary limits of 15 or 30 days for one offence date back to 1961.

Under the *Correction Act Regulation*, the warden must give written reasons for placement in separate confinement within 24 hours under s. 17 (short term), and within 24 hours of a decision to extend the separate confinement under s. 18 (long term). The written notice for long-term separate confinement must include the reasons for the confinement, the period of time the prisoner will be in separate confinement and the reason for the length of time. Prisoners are to be given a “reasonable opportunity to make submissions about why the separate confinement should not continue or why the separate confinement should be for a shorter period of time.” The warden is to consider the prisoner’s submissions before

deciding whether to confirm, vary or rescind his or her decision.

The legislation does not require an oral hearing of placement in solitary confinement. It does not provide for any external oversight of decisions to place or continue prisoners in solitary confinement. In the experience of Prisoners' Legal Services, the reasons provided for placing our clients in separate confinement are limited to one or two paragraphs, which are often a mere restatement of the legislative criteria for placement. They do not provide our clients with a meaningful opportunity to rebut the allegations against them. They are often based on a client's history of behaviour rather than on a current assessment of actual risk. They rarely include the period of time of placement or the reasons for the period of time. Section 18 placements are often renewed without a change to the justification for the placement.

According to BC Corrections' policy, at the 30-day mark a deputy warden is to review decisions to maintain separate confinement, and a mental health professional is to review the "impact of separate confinement".¹³² Every 60 days the warden is notified of the prisoner's "overall status".¹³³

Prisoners placed in separate confinement for medical reasons are to be provided a care plan and monitored at least once per nursing shift. Mental health status is assessed and documented, including "level of consciousness; overall level of orientation; general mood and affect; and any other observed disturbances in behaviour or thought patterns (e.g. acute warning signs of suicide or self-harm), which may result in a referral to the mental health coordinator or health care practitioner in urgent cases".¹³⁴

Although "mental illness" is no longer a ground for separate confinement, policy requires prisoners held in separate confinement due to a mental illness to be provided an appointment

with a psychologist or psychiatrist and to be reassessed daily by a mental health coordinator, nurse, psychologist or psychiatrist to determine level of consciousness, orientation, mood and affect and other disturbances in behaviour or thought. The role of mental health professionals is limited to determining "care, including monitoring scope and frequency". Health care staff are required by policy to enter alerts into the client's correctional file and to notify a correctional supervisor of health care concerns relevant to correctional staff "to ensure awareness of the inmate's condition and needs, as well as to advise of any threats to the safety of inmates or correctional staff".¹³⁵ This policy does not appear to apply to prisoners with mental health concerns who are held in separate confinement for other reasons. Policy does not require correctional staff to remove prisoners with mental health concerns from separate confinement.

Enhanced Supervision Placement (ESP)

In addition to separate confinement, BC Corrections uses Enhanced Supervision Placement (ESP) – a policy-based practice that involves keeping prisoners locked up in their cells alone for extended periods of time each day.

ESP is a step-down program in which prisoners are to advance to greater levels of liberty based on good behaviour. Step-down programs tend to set prisoners up for failure by requiring strict adherence to rules while under the repressive conditions of isolation.

ESP is concerning because it requires people to control their behaviour while being denied meaningful human contact. This is a difficult task, especially when prisoners feel that they have been treated unfairly and when many may suffer from mental disabilities that make it difficult to control their impulses. The program

represents a catch-22 – you will only be granted additional freedoms if you can withstand the isolation.

No legislation governs the use of ESP. ESP is set out in the BC Corrections Adult Custody Policy Manual and each institution has its own ESP procedures. In general, ESP involves keeping prisoners under behavioural contracts at three levels of the program. Provincial institutions generally keep prisoners at stage one of ESP for three weeks. Until June 2016, stage one involved isolating the prisoner in a cell for 23 hours per day. Since June 2016, prisoners in ESP are to be afforded at least three hours out-of-cell time each day. The second and third phases of ESP involve incrementally more time out of cell lock-up.

ESP was developed for prisoners who “routinely exhibit behaviours or participate in activities that are (a) detrimental to the operation of a correctional centre; or (b) likely to endanger others or themselves.”¹³⁶ The factors enumerated in the Adult Custody Policy Manual¹³⁷ that may cause a prisoner to be placed on ESP are vague and ambiguous and allow for the possibility of arbitrary decisions being made that are difficult for the prisoner to challenge.

The lack of transparency and procedural fairness in the ESP scheme is also concerning. Prisoners are not given the opportunity to make submissions concerning their placement on ESP, there is no hearing, no right to counsel and no right to appeal. Prisoners can be classified to ESP if they are considered high risk due to a mental or physical disorder.¹³⁸

As with separate confinement, there is no independent adjudication of a decision to place a prisoner on ESP. Rather, it is often the warden of the institution (or a designate), in consultation with a classification officer, who makes the decision. Some procedures are in place that allow for prisoners to make submissions

concerning their case plans, but this is only after they have already been placed on ESP. There is a weekly classification review, but again, this is only after the prisoner has been placed on ESP.¹³⁹

Over the years, Prisoners’ Legal Services has received reports from prisoners that they have not been permitted to speak with other prisoners when on ESP. This is reminiscent of the legislation of approximately 140 years ago that imposed a code of silence on prisoners. Our clients described how frustrating it was to be forced to abide by the silence rule and not say hello to their fellow prisoners, when they were at the same time expected to engage in and develop pro-social behaviour.

Much like the now abandoned federal Management Protocol for women, the behavioural expectations in ESP are often vague, and prisoners report that they have no sense of when or what they need to do to graduate through the program to a regular living unit. This is coupled with increased monitoring where staff scrutinize prisoners’ behaviour and record observations daily. Prisoners do not have access to these observations, or an opportunity to rebut them. One seemingly minor incident can result in a failure to graduate the program. The outcome is that prisoners can remain on ESP for months at a time with no idea of when or how they can regain their liberty.

As of June 2016, BC Corrections has revised its ESP policy to require at least three out-of-cell hours per day. This takes ESP out of the United Nations’ definition of solitary confinement. In our view, this does not solve the other problems with the practice.

BC Corrections’ lack of compliance with law and lack of oversight

In 2010, Jamie Bacon challenged his long-term solitary confinement at the Surrey Pretrial

Services Centre at the BC Supreme Court. The court found that BC Corrections' treatment of Mr. Bacon in solitary confinement constituted cruel and unusual treatment under s. 12 of the *Charter*, and an unlawful deprivation of his rights to security of the person under s. 7 of the *Charter*.¹⁴⁰

Mr. Justice McEwan found that torture existed at the Surrey Pretrial Services Centre. Psychologist Craig Haney gave expert evidence that the conditions in segregation were "very harsh and truly severe" being "equivalent in most respects" to the "most severe solitary or 'supermax'-type facilities...in the United States". Justice McEwan found that:

The petitioner is kept in physical circumstances that have been condemned internationally. He is locked down 23 hours per day and kept in the conditions Professor Haney described as "horrendous". These conditions would be deplorable in any civilized society, and are certainly unworthy of ours. They reflect a distressing level of neglect.

...

The deplorable physical conditions described by Prof. Haney, the unlawful deprivations, and the institutional lack of concern for the physical and psychological harm occasioned by those deprivations, suggest an institution operated in a manner at serious odds with its purposes...¹⁴¹

The Court in *Bacon* found that BC Corrections had failed so miserably at applying law and policy that it was impossible to consider the constitutionality of the *Correction Act* and *Correction Act Regulation*:

The statutory, regulatory and policy framework meant to govern the respondent in her dealings with the petitioner have been ignored or misapplied in a manner that

renders their constitutionality an abstract question. I therefore decline, at this time, to address the issues related to the substantive constitutionality of the *Correction Act* and the *Correction Act Regulation*, as such. It appears that the procedures outlined in the Adult Custody Policy Manual are meant to give form and substance to the framework of directives contained in the legislative instruments. There would have to be a good faith attempt to abide by its terms before its adequacy as a template for due process could be meaningfully assessed.¹⁴²

This significant lack of compliance with law and policy governing BC Corrections' use of solitary confinement begs the question: was there no oversight of BC Corrections' operations? The answer is no. In June 2016, the BC Office of the Ombudsperson published a report entitled "Under Inspection: The Hiatus in BC Correctional Centre inspections" that concerned a "significant gap" in periodic inspections of BC Corrections prisons between 2001 and 2012.¹⁴³

Prior to 2003, the *Correction Act* required the independent Investigations, Inspections and Standards Office within the Ministry of Attorney General to conduct inspections of BC correctional centres. In 2003, the *Correction Act* was amended to transfer the responsibility of inspections to the Corrections Branch of the Ministry of Public Safety and Solicitor General. Since that time, the Ombudsperson report finds that "the minister had no consistent process with which to monitor how well centres were complying with their legislative, regulatory and other requirements."¹⁴⁴

The Ombudsperson report found that the Corrections Branch lacked a clearly defined purpose for inspections, which made it difficult to assess compliance or non-compliance with standards.¹⁴⁵ The Ombudsperson recommended that the Corrections Branch develop guiding

principles for inspections that gives “priority to inmates’ human rights, health and safety”.¹⁴⁶

The Ombudsperson found that the inspection checklist for Separate Confinement failed to allow for the adequate assessment of whether health, safety and human rights issues were being addressed.¹⁴⁷ He also found that there was no assessment related to the use of force by staff on prisoners.¹⁴⁸

The Ombudsperson considered the 2015 Mandela Rules in making his recommendations, which require regular external and independent inspections of prisons.¹⁴⁹ He recommends that at least one member of all inspections teams be independent from the Corrections Branch.

The BC Minister of Public Safety and Solicitor General has accepted the Ombudsperson’s recommendations, including the recommendation for independent inspections.

ALTERNATIVES TO SOLITARY CONFINEMENT WITHIN BC CORRECTIONS

Most provincial institutions have mental health units, which our clients report provide a more supportive environment than regular living units. However, in our view, there are an insufficient number of beds in these units. Prisoners are required to meet behavioural expectations in order to remain in mental health units. Many prisoners with mental disabilities are unable to meet these expectations and end up in separate confinement or ESP.

The Alouette Correctional Centre for Women

The Alouette Correctional Centre for Women takes a trauma-informed approach to

corrections, in recognition that the vast majority of women prisoners have a history of trauma. Only women are employed as staff in living units, and correctional officers interact with prisoners on a more personal level. The institution employs men in other roles, as it is believed that they can serve as positive examples for women who may not have any positive experience interacting with men.

The Alouette Correctional Centre for Women operates a Complex Needs Unit, which they state has allowed them to reduce the rates of women in solitary confinement at the institution. The women housed in the Complex Needs Unit have higher needs than those housed in the general population and are usually precluded from taking traditional programming. The Complex Needs Unit is for women who display mental health issues, medical issues or functional issues. The Complex Needs Unit provides enhanced support systems for its participants and provides programming aimed at self-management, anger management, problem solving and life skills. The Complex Needs Unit is intended to be a transitional unit with the goal of participants moving onto a regular living unit and eventually into the community.¹⁵⁰

PROVINCIAL PRISONER ACCOUNTS

Provincial prisoners report that they are provided very little human contact in separate confinement or segregation. In the segregation unit, the cell conditions are reportedly worse than the federal segregation cells. The cells are described as filthy, with blood and bodily fluids on the walls. The cells in segregation do not have televisions, and there is often limited access to books and writing materials. There is no access to programming. Prisoners are often denied their hour of

outdoor exercise as punishment for behavioural problems. The yards are small and often do not afford much natural light. They are described as “runs”. Prisoners report that many correctional staff and health care providers do not treat them respectfully in segregation.

On December 16, 2015, BC Corrections issued a memorandum to all staff explicitly stating that other activities are to be permitted in addition to an hour of outdoor exercise. Prisoners’ Legal Services continues to receive reports that this directive is not being complied with.

Provincial prisoners are often double-bunked in segregation or separate confinement, which often leads to prisoners being assaulted by their roommates, who may be experiencing mental health problems. Double-bunking also significantly exacerbates the stress of solitary confinement, as prisoners are forced to get along with another person in a small cell for 23 hours every day.

CK (2013-2014)

CK was a provincial prisoner at both Surrey Pre-trial Services Centre and North Fraser Pre-trial Centre between late 2013 and 2014. CK suffers from attention deficit hyperactivity disorder and was housed in solitary confinement for five months. During this time he received no treatment for his attention deficit hyperactivity disorder. The reason for his solitary confinement was often noted as “suffers from a mental illness” on his paperwork. There are several notes on his file from health care that he did not seem to need to be placed in solitary confinement.

Medical records indicate that at the time of his intake at Surrey Pretrial, medical staff were concerned that CK may be suicidal and noted a suicide attempt two months earlier. Despite this concern, he was placed in solitary confinement.

He was not provided anything, such as a television, to occupy his mind.

I asked to be treated for my ADHD but the doctor refused.

I remember the feeling of hopelessness that my solitary confinement would never end.

Staff who were sympathetic to me would talk to me. They would give me some hope by saying if you control your behaviour for a week, you can get out of separate confinement. But after meeting with classification, they would say: “give it another week”. I tried so hard to control my behaviour but I wasn’t let out and this would go on week after week. I felt that my solitary confinement was indefinite. I felt like there was no point to trying to behave when they were never going to let me out anyway.

When I think about my time in segregation, I re-live the fear and confusion that I felt. I felt like I was erased from society with no support other than my lawyers. I felt no one cared and I was forgotten about. At times I thought I would never get out, I would be in there for the rest of my life.

When I remember my experiences at Surrey Pretrial and North Fraser, I feel humiliated. I feel that the majority of staff saw me as scum and nothing more. I feel that I was treated like an animal.

At one point while at Surrey Pretrial, CK refused to be moved to segregation. An Emergency Response Team was brought in to forcibly move him to the observation cell in the separate confinement unit. Four guards (including one female guard) in riot gear approached his cell. One guard banged on the door and yelled his name. The guard yelled at him to follow directions peacefully and that failure to comply would result in force being used against him as well as the use of chemical agents. The guard

continued to yell at him so quickly that it was difficult to hear the words.

When the guard opened the door, CK was sitting on the floor with his back to the door. Four officers rushed in, pinned him to the floor, and cuffed him from behind. CK was dragged down the hall by the four officers to the solitary confinement cell. Once in the cell, the guards ordered CK to lie on his stomach and they proceeded to cut off his clothes. CK was compliant with the officers. CK was then left naked, shackled and cuffed on the bed, uncovered for four hours. He reports that the guards laughed at him.

When they were cutting off my clothes, I felt like they were stripping my dignity away.

When CK was transferred to North Fraser, his solitary confinement continued. He was locked up for 23 hours per day and was left with no stimulation for extended periods of time. He was not provided a pillow, television or writing materials and was often denied books. His tap and toilet were broken and he was not provided supplies to clean his dirty cell. His condition deteriorated to the point that he would not wash himself for days and went on hunger strikes.

On one occasion, CK had returned from a court appearance and he was told by an officer to lock up in a holding cell. CK asked to be returned to his regular cell, and when his request was denied he asked to speak with a Correctional Supervisor. He explained to the guards that he was not doing well and referred to his mental state. The guard pointed to direct CK, and CK pleaded with the guard. The guard un-holstered his pepper spray and moved toward him. CK backed away from the guard, put his hands out and the guards rushed at him, bringing him to the floor. Approximately 17 guards rushed to the scene and approximately five piled on top of CK.

He was cuffed from behind and taken backward, to a holding cell. He was eventually taken to a segregation cell, where his cuffs were finally removed through the hatch almost three hours later.

I was in pain and humiliated from the force used against me. I hid under the bench, crying.

A note by a registered nurse in CK's medical file indicates that he suffered injuries to his wrist and hand due to the tightness of the cuffs. CK was kept in solitary confinement after this incident, and was not given the medication he needed to stabilize.

Segregation is really playing on me. The isolation is very difficult to handle. My windows are covered and I get no contact at all.

In another instance, after spending several days at the Forensic Psychiatric Hospital where he did quite well, CK was returned to North Fraser and was told he would be moved to segregation in handcuffs and leg irons.

I was upset by this news and asked the officers for the reason why. The officers yelled at me and I yelled back without thinking.

CK did not act out physically, but three guards rushed his cell and pushed him down on the bed, restrained him and applied handcuffs and leg irons before moving him back to solitary confinement.

Officers used painful pressure points behind my ear. One officer whispered "struggle and I'll snap your fucking wrist".

In March 2014, a doctor included an entry in CK's file stating that he was completely isolated for two months and was not doing well, and that prolonged segregation placement for CK "is not ideal for his adjustment."

I don't want to 'fuck up' but the longer I'm alone in seg the harder it gets.

CK is now living in the community, yet still experiences the effects of the time he spent in solitary confinement.

Sometimes when I wake up at night and my bedroom door is locked, I panic because I feel trapped. My heart races whenever I see police in the community because I'm terrified of returning to prison. I feel panic when I'm in public in a crowded, loud area and need to go home to be alone. This is a new reaction that I didn't experience before my solitary confinement with BC Corrections.

I've been prescribed Ativan to control my panic attacks and anxiety.

I struggle with taking orders when someone is yelling at me. It reminds me of being in solitary confinement where the outcome would be that I'm locked up longer or lose my hour out for that day. On the job, I'd just walk away, but I'd eventually yell back and lose my job.

Nothing in my life has caused as much trauma as the five months I spent in solitary confinement at SPSC and NFPC.

BC (2015-2016)

BC is an Indigenous prisoner from the Key First Nation who has been in the custody of British Columbia Corrections since July 2014. Since January 2015, he has been kept primarily in solitary confinement. He was certified twice under the *Mental Health Act* while in solitary confinement, awaiting bed space at the Forensic Psychiatric Hospital. His earlier Separate Confinement Notification forms include "suffers from a mental illness" as a ground for his solitary confinement status. There are several notations in his file of him possibly having fetal

alcohol spectrum disorder and suffering from depression.

In early 2015 he was admitted to the Forensic Psychiatric Hospital from the North Fraser Pre-Trial Centre. Upon release, his Discharge Summary from the Forensic Psychiatric Hospital indicates that he expressed fear of being returned to "the pit" at North Fraser, and that he wished to remain at the Forensic Psychiatric Hospital. The report notes that he settled well, socialized and joked with peers and never required seclusion. He was not agitated or angry when he was not held in isolation at the Forensic Psychiatric Hospital. He was returned to North Fraser on anti-depressant medication and was placed in solitary confinement two days later. His medical records indicate that for the most part, while he was in solitary confinement, his interactions with medical staff were brief and through his segregation cell door.

At one point, a psychologist noted that BC suffers from "situational stress of segregation". Several months later he was assessed with possible psychosis, and unpredictable and hostile behaviour. He remained in solitary confinement. A note in his file indicates that he "remains psychotic in the context of likely FAS/FASD". He complained to staff of being in solitary confinement for 56 days, at that point. A different psychologist believed he might be malingering and cancelled his certification and transfer request to the Forensic Psychiatric Hospital.

Shortly after, an independent psychologist assessed BC as suffering from prolonged isolation and sensory deprivation. Several medical staff questioned whether "a change of venue would be worth considering". He was eventually moved to an isolation unit where he was still in solitary confinement, but was given a television.

The psychologist opined that BC “has become increasingly depressed since he was placed in segregation.” BC is now held in “voluntary” separate confinement, although he would like to be moved to a mental health unit.

I don't do well in solitary confinement. It's not good. There are voices that keep talking to me. It's hard for me. I keep seeing these dreams and visions about the end of the world. Why am I going through this and why is this bad stuff happening to me? All I do is sit in my room and I try to read the bible and all this bad stuff keeps happening to me. I don't have anything. I'm by myself in isolation.

It's boring – I try to watch TV. It doesn't feel good. I'm in a big deep hole and I can't get out. I'm trapped. I workout. I do push-ups, numerology, numbers and stuff. These people are treating me bad and I don't know what to do.

I feel alone, I feel trapped. I feel abused. It's a scary place because I don't have anyone to talk to. I feel secluded. I just want to go to a mental health unit.

CT (2014-2016)

CT is a 29-year-old man who has been diagnosed with schizophrenia, bipolar disorder, post-traumatic stress disorder, attention deficit hyperactivity disorder, fetal alcohol spectrum disorder, and borderline personality disorder. He has difficulty with impulse control and has a well-established pattern of self-harm, especially when held in solitary confinement. He has been charged under prison disciplinary offences for self-harming and placed in solitary confinement multiple times.

CT was sexually assaulted as a child and had his clothes cut off by his abusers. Cycling in and out of youth detention and prisons since the age of

12, he has spent the majority of his institutional life isolated in separate confinement.

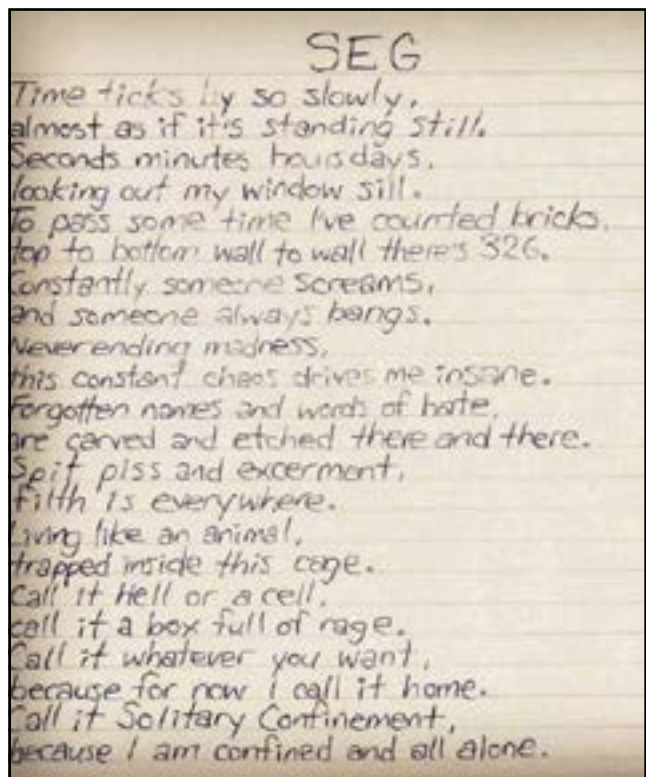
When I was younger, my stepmom used to abuse me, locking me under the stairs in a crawlspace. There were bugs in there and it was dark. And she would make me sit in there, sometimes for six or seven hours.

When I'm in that cell, I feel like I'm that kid again, locked in that crawlspace.

I use self-harm as a coping mechanism to relieve stress. In 2014, I self-harmed 50 times while housed in segregation.

I don't hurt myself to try to kill myself. It kind of grounds me and brings me back from my flashbacks. It brings me back to the present.

On one occasion in 2016, CT was walking calmly from the medication wicket after waking up in the morning when seven guards came rushing



Poem by CT

at him. The first guard pointed a can of OC spray at him and yelled at him to get on the floor. CT immediately complied. All seven officers restrained him on the floor, and carried him to segregation. In a segregation cell he was bent over the bed while six officers held his limbs down and the seventh officer used scissors to cut his clothes off. CT was not provided an opportunity to comply with a strip search. He begged and pleaded with the officers not to cut his clothes off, because it triggered his childhood sexual abuse. This use of force was approved by senior management.

The ERT came in with way too much excessive force. They stuck the handcuffs into my wounds, applied pressure points where I was injured. They made me lie down in my own blood. They cut my clothes off and then one of them touched my buttocks. I was lying naked with handcuffs on the floor. They came back and rushed me again; this after they cut my clothes off, just like when I was sexually abused as a kid.

CT was then picked up from the bed and an officer attempted to do an oral inspection for weapons. CT allegedly kicked the officer in the groin at this time. The officer pepper sprayed CT and left him naked in the cell with handcuffs behind his back for what he estimates to be at least an hour. His face was not decontaminated and he was not provided clothing. He was not provided any mental health support. Shortly after this incident, CT slashed his arms with a razor blade to cope with the emotional trauma. Since the incident, he has experienced anxiety, fear and paranoia. He reports being in a constant state of fear that he will be attacked by officers whenever he goes through doorways or when he goes to get his medication.

CT has a behaviour plan that stipulates that if he self-harms, he will lose his rights to psychological support, books and phone calls. He is required to

follow his behaviour plan if he is to be released from separate confinement and returned to a regular living unit.

I feel like I am being set up for failure and mental torture. Especially if I did self-harm, then I am no longer able to move units. I do not have the skills to just stop doing it. If I could have, I would have. I am being punished for being mentally ill.

JP (2015)

JP was a prisoner at the Kamloops Regional Correctional Centre who was held in separate confinement. Before suffering from a brain injury, he was trained as a firefighter and psychiatric nurse. In custody, he was denied access to the phone for 16 days because the telephone system voice recognition would not recognize his name due to background noise when it was originally recorded, and staff refused to allow him to re-record his name. In protest, JP refused inspections. In response, Kamloops Regional Correctional Centre authorized an emergency response team to extract JP from his cell. Staff acknowledged that JP has mental health issues and that his behaviour was deteriorating.

JP had covered himself in feces. The emergency response team arrived at JP's cell in riot gear and gas masks. They sprayed OC spray into his cell through the meal slot before opening the door and rushing him, spraying him with more OC spray and shining a strobe light in his face while restraining him and using pain compliance on him. Officers walked JP out of his cell to decontaminate in the shower. He was brought to another cell where he was held on the floor and officers cut his clothes off with scissors. JP reports being in pain and that the OC spray was still burning his skin. During the entire ordeal, JP told the guards that all he wanted was a phone call to his family.

JP was left in this cell, where he banged his head against the door window. The window was dripping with blood. The officers returned and carried him out of the room, placing him face down, naked, on the floor in the hall. The officers then placed JP in the wrap (a restraint device). JP remained compliant.

Why are you torturing me? You're helping me not hurt myself by hurting me. Just ask me to not hurt myself and I'll comply... Am I banging my head? No. My ankles hurt like hell...

The officers carried JP to a cell and put a spit mask on him, despite not having attempted to spit on anyone. He was left in the wrap and spit mask, otherwise naked.

My skin burns. No one came when I cried for help. They put people in segregation for two-and-a-half months and they beat them up and traumatize them, and they wonder why they're the way they are. Six men dressed up to beat me up and I'm the one who has to go see a psychologist. It's humorous.

I have no desire to self-harm. I want to be removed. I'd like to speak with a psychologist. I'd like to speak with a doctor. I'd like to speak with a nurse, please! I'd like medical attention please! My ankles hurt. I'm in pain. My skin is burning from OC spray. I'm not combative – I'm non-violent. I'd like to speak with someone who has an education. I'm perfectly calm.

A nurse came into the cell to examine JP. After this, guards came in to loosen the wrap around his ankles after his feet turned purple. He was left in the wrap and spit mask for seven hours. Twice during the seven hours, his spit mask sealed against his mouth from condensation when he breathed in, and he hyperventilated out of panic and lost consciousness.

The following day, JP was provided access to the phone. He was kept on suicide watch for a month with no pillow or clothing – all he was provided was a suicide smock. He reports that he was not suicidal, and that it felt like he was being punished for protesting his denial of phone calls.

PY (1994-2009)

PY struggled with an addiction to heroin and cocaine for almost 20 years until 2009, when she got clean. During that time, she was in and out of provincial custody in British Columbia and spent a number of placements in segregation at the Burnaby Correctional Centre for Women (which closed in 2004), the women's unit at Surrey Pretrial Services Centre and the Alouette Correctional Centre for Women. Her longest segregation placement was for 14 days.

PY was sexually abused by a family friend at the age of 10. She was diagnosed with bipolar disorder in 2004, at the age of 26. Her first time in jail was at the age of 16.

When I first went to seg in BCCW I was coming off heroin and cocaine and I was having seizures. They wanted to monitor me in the medical observation side. But they put me on the segregation side. I was having seizures once an hour. I would wet my pants, and wake up on the floor. I don't see how that benefited me where no one could monitor my medical problems. I was in withdrawal and they put me in seg as soon as I came in.

The first four to five times I was in seg, I had chronic anxiety. Time seemed like it was endless. I couldn't handle being locked in there. It was driving me insane. I would self-mutilate – if I had anything sharp, I would cut my wrist. I would do anything to get them to

*open the door, so I could lose that trapped,
panicked, claustrophobic feeling.*

*The hours and minutes went by so slowly.
There is not a lot to do in seg. There was a
box of books, but it's the same old books. I
couldn't even read a book – I just couldn't
focus. I didn't have TV. If you're self-harming
they won't even give you a pencil.*

*One time I was in seg at Surrey Pretrial. It
was difficult because they said I had heroin,
but I didn't. It was so frustrating – I was in
for five days for something I didn't do. I felt
like I wasn't getting anywhere. They had no
proof, no reason. Just suspicion.*



BC Corrections is not required to report publicly on its use of solitary confinement or on its treatment of prisoners with mental disabilities, including uses of force. It is impossible to know how widespread the abuses of power, described above, are within provincial prisons. Broad legislative reform is necessary in order to ensure that others are spared the cruel treatment experienced by these provincial prisoners.

THE CONSEQUENCES OF SOLITARY CONFINEMENT

“Tortured by it, such individuals are unable to stop dwelling on it. In solitary confinement ordinary stimuli become intensely unpleasant and small irritations become maddening”.

Stuart Grassian, “Psychiatric Effects of Solitary Confinement”

MENTAL AND PHYSICAL HEALTH EFFECTS

Research overwhelmingly indicates that there are damaging psychological and physical health effects on prisoners held in solitary confinement. Most researchers agree that it is the lack of control, and the reduction of meaningful social contact and environmental stimuli that lead to mental health symptoms.¹⁵¹ Medical research has confirmed that the lack of meaningful human contact can lead to “isolation syndrome” which includes symptoms of anxiety, depression, anger, cognitive disturbances, paranoia, psychosis, self-harm and suicide.¹⁵²

Solitary confinement is known to exacerbate mental health symptoms in prisoners with pre-existing conditions and cause mental health problems in previously un-afflicted prisoners.

Despite some criticism concerning the methodology of studies on the use of solitary confinement, the symptoms have been consistently identified in personal accounts of prisoners as well as by mental health professionals who are employed in prisons, and in research conducted on its use and effects.¹⁵³

Some maintain that solitary confinement can have minimal psychological effects when administered humanely, but international authorities disagree.¹⁵⁴ The detrimental effects of its use have been recognized by international instruments and monitoring bodies, such as Juan Méndez, the United Nations Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, the World Health Organization, the United Nations Convention Against Torture and the Istanbul Statement on the Use and Effects of Solitary Confinement (the Istanbul Statement).¹⁵⁵

Dr. Sharon Shalev, a leading international expert on solitary confinement, in her publication, *A Sourcebook on solitary confinement*, provides an overview of both historical and contemporary findings on the deleterious effects of solitary confinement.¹⁵⁶ Dr. Shalev points to a publication by Drs. Grassian and Friedman in which they cite 37 reports and articles from Germany between 1854 and 1909 where solitary confinement was seen as “the single central factor in the development of psychotic illness among prisoners”.¹⁵⁷ Early researchers in the United Kingdom and the United States, as well as more contemporary studies, make the same observations.

Psychologist Dr. Craig Haney has extensively studied the effects of solitary confinement on prisoners. In 1993, he published his study of 100 prisoners housed in Pelican Bay Security Housing Unit, a supermax prison in California. The symptoms of psychological trauma experienced by these prisoners included anxiety and nervousness, irrational anger, confused thought processes, chronic depression and hallucinations. He found that the majority of prisoners experienced overall deterioration in their psychological health.¹⁵⁸

In 2003, Dr. Haney published another study in which he provided an overview of the abundant evidence that has been produced detailing the harmful effects of solitary confinement.¹⁵⁹

The consensus among researchers is that prisoners in solitary confinement often experience the following physical and psychological effects:¹⁶⁰

- Physical symptoms, including heart palpitations, sudden excessive sweating, insomnia, back and joint pains, deteriorating eyesight, poor appetite, weight loss, lethargy, weakness, shaking, feeling cold and aggravation of pre-existing medical problems;
- Anxiety, persistent low level of stress, irritability, fear of impending death and panic attacks;
- Depression, hopelessness, mood swings, social withdrawal and major depression;
- Anger, including hostility (often manifested toward correctional officers), poor impulse control, unprovoked anger leading to physical and verbal outbursts;
- Cognitive disturbances, including short attention span and concentration, poor memory, disorientation and tunnel vision (the fixation on something intensely unpleasant and the inability to shift attention)¹⁶¹;

- Perceptual distortions, including hallucinations, and disorientation in time and space; and
- Paranoia and psychosis, including ruminations, paranoid ideas and persecutory fears.

In addition to these symptoms, there is evidence of increased self-harm and suicidal ideation among prisoners subjected to solitary confinement. A 2014 study of New York City Jail prisoners housed in solitary confinement found that they were seven times more likely to try to self-harm or commit suicide than those prisoners never housed in solitary confinement.¹⁶²

In the 2011-12 *Annual Report of the Office of the Correctional Investigator*, it is noted that close to one-third of reported self-harm incidents in federal institutions in Canada in the 2010-11 fiscal year occurred while the prisoner was housed in solitary confinement.¹⁶³ Prisoners' Legal Services has often had clients placed in solitary confinement as a response to self-harm incidents.

Evidence also suggests that prisoners who are placed in solitary confinement for seemingly unjustified reasons, will "inevitably suffer severe psychological pain" even if they were previously fairly resilient.¹⁶⁴ Prisoners placed in administrative segregation or separate confinement, as opposed to disciplinary segregation, often see the placement as arbitrary. Prisoners report that the indefinite nature of administrative segregation or separate confinement is particularly difficult as they are unable to see an end to it.

Prisoners who have been denied mental stimulation and recreation will become bored and irritable, which can lead to hostility and violence.¹⁶⁵

The negative effects of solitary confinement do not necessarily end when a prisoner is released to a regular unit. Research as well as anecdotal



evidence illustrates that many experience “continued intolerance of social interaction, a handicap which ...often severely impairs the inmate’s capacity to reintegrate into the broader community upon release from imprisonment”.¹⁶⁶

Despite the abundance of evidence that solitary confinement causes psychological harm and sometimes physical harm to prisoners, correctional administrators argue that it is a necessary evil in order to ensure the safety and security of institutions.

THE SAFETY AND SECURITY JUSTIFICATION FOR SOLITARY CONFINEMENT

The legislative reasons for the use of segregation or separate confinement include safety and security in both the federal and British Columbia provincial schemes.

The Court in *Bacon v Surrey Pretrial Services Centre* did not accept the argument that safety and security concerns necessitate the use of solitary confinement:

This sets up a manifestly false dichotomy. Inhumane treatment cannot be justified on the basis of a choice between physical safety and psychological integrity. The submission strongly implies that for a certain class of inmate deemed unsuitable for release into

the general population, the only alternative is to keep them alive in circumstances that threaten their psychological health and safety. This is so far from the imaginable range of ameliorative options (small secure courtyards attached to separated cells, video links as a substitute for direct visits, etc.) that it can only be read as a rationalization of resource limitations that are assumed but unspoken.¹⁶⁷

The Court continued, with respect to British Columbia's position that it was constrained by lack of resources: "it simply means that the government has to do better. Discretion over expenditures stops when treatment falls below a constitutional minimum."¹⁶⁸

A 2014 American Civil Liberties Union (ACLU) Briefing Paper on the overuse of solitary confinement in the United States questions the efficacy of solitary confinement in the long-run. According to the ACLU, there is no empirical evidence that shows that solitary confinement reduces prison violence, nor that it acts as a deterrent. The paper notes that in some instances, incidents of violence have gone up with the increased use of solitary confinement.¹⁶⁹

Given that community re-entry is a core purpose of corrections, both federally and provincially, the use of solitary confinement is especially concerning as, in most cases, it precludes prisoners from engaging in rehabilitative programming. A correctional plan is an essential part of a federal prisoner's rehabilitation and is meant to aid reintegration into society. Federal prisoners who do not complete correctional plans will often not be released on parole or statutory release, where they would be under community supervision. Instead, prisoners who have not completed their correctional plans are more likely to be held until their warrant expiry dates and released into the community with

no monitoring in place, potentially putting the public at greater risk.

The ACLU Briefing Paper notes that there is a strong correlation between being released directly to the community from solitary confinement and the risk of recidivism. Studies from several American states show that rates of recidivism for prisoners released from solitary confinement can be as much as 20 percent higher than for those who were not released from solitary confinement.¹⁷⁰ Even more troubling are studies that have found that prisoners who are released directly from solitary confinement to the community are more likely to commit violent crimes.¹⁷¹ These studies cast serious doubt on solitary confinement proponents' claims that its use can contribute to public safety.

FISCAL COST IMPLICATIONS

It is not surprising that with the tighter security controls and increased labour intensity associated with solitary confinement, its use causes costs to institutions to increase. If prisoners are locked in a cell for up to 23 hours per day, everything has to be brought to the prisoner. If prisoners need to attend health services, they will often be brought there under "three-on-one" protocol – meaning that three correctional officers will be responsible for accompanying each prisoner. This will undoubtedly lead to increased costs to the prison.

In 2011, the Correctional Investigator, responding to a government report about the rising costs of prisons in Canada stated: "The more you keep people inside, the more you keep them at higher security, and the more you use segregation, the more your costs are going to go up".¹⁷²

The cost of incidents of self-harm is also high, as they lead to transfers to higher levels of security, uses of force, and hospital admissions requiring security escorts. Research shows that incidents of self-harm are higher in solitary confinement.¹⁷³

The use of solitary confinement can also lead to expensive litigation. There are currently a number of legal challenges to the use of solitary confinement in Canada.¹⁷⁴

While the exact cost of housing a prisoner in solitary confinement in Canada is difficult to discern due to the lack of available information, data from several American states illustrates the significant cost disparity between prisoners housed in a regular unit and those housed in solitary confinement. In 2010-2011, statistics from California's Pelican Bay institution showed that it was almost \$20,000 more expensive to house one person in solitary confinement for a year.¹⁷⁵

The Canadian Association of Elizabeth Fry Societies has reported that in Canada, the cost difference for housing a woman in general population in a federal institution versus solitary confinement is shocking: \$175,000 for the former, with a staggering \$250,000 for the latter.¹⁷⁶

The cost of providing alternatives to solitary confinement, such as additional therapeutic services and additional training for staff, is also high. However, this cost could be offset in the long-term by the savings of having fewer prisoners held in solitary confinement and higher levels of security.

The biggest savings would likely come from reducing the number of prisoners held in custody. The youth system in British Columbia is an inspirational example, where the increase in the use of police diversion, enhanced community based alternatives to custody, the limited use of remand and sentenced custody

and a change to the youth justice system culture, all contributed to a dramatic decrease in the numbers of youth in custody, to the point that youth custody centres were closed, resulting in considerable cost savings.¹⁷⁷

If the current federal and provincial governments take a broad approach and invest in more community-based mental health supports, work to reform criminal laws to reduce the number of prisoners held in custody as opposed to under community supervision, and amend legislation to allow prisoners with mental disabilities to be housed in lower levels of security, the costs of eliminating the use of solitary confinement could easily be mitigated.

CANADA'S OBLIGATION UNDER INTERNATIONAL LAW

Respect for human dignity “constitutes a norm of general international law not subject to derogation.”

*The International Covenant on Civil and Political Rights*¹⁷⁸

Canada has obligations under international law to dramatically reduce its reliance on solitary confinement.

Under international law, Canada must not allow its public officials to participate in torture or cruel, inhuman or degrading treatment or punishment. Canada acceded to the United Nations International Covenant on Civil and Political Rights on May 19, 1976 and ratified the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment on June 24, 1987. Under these international instruments, Canada has agreed that “no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment”¹⁷⁹ and has committed to “take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.”¹⁸⁰

Juan Mendez, the United Nations Special Rapporteur, considers more than 15 days of solitary confinement to be either torture or cruel, inhuman or degrading treatment or punishment, depending on the circumstances.¹⁸¹ He concludes that any amount of solitary confinement for someone suffering from a mental disability amounts to cruel, inhuman or degrading treatment.¹⁸²

The Special Rapporteur found that solitary confinement cannot be justified as a means of punishment for a breach of a prison rule if it results in severe pain and suffering.¹⁸³ In 1990, Canada adopted the Basic Principles for the Treatment of Prisoners, which states: “efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be encouraged.”¹⁸⁴

The Special Rapporteur makes several recommendations to improve procedural fairness for prisoners held in solitary confinement, including independent review and the right to counsel.¹⁸⁵

In 2015, the Standard Minimum Rules for the Treatment of Prisoners were revised and adopted as the Mandela Rules. The Mandela Rules stipulate that given its disturbing impact on both physical and mental health, solitary confinement should only be used in exceptional cases, as a last resort, for as short a time as possible, after authorization by a competent author, and must be subject to independent review.

The Mandela Rules prohibit the use of indefinite and prolonged solitary confinement, which is defined as more than 15 days. Solitary confinement is prohibited for prisoners with

“mental or physical disabilities that would be exacerbated by such measures.”¹⁸⁶

The Mandela Rules encourage prison administrators to use mediation or other alternative dispute resolution techniques to resolve conflicts and require training on security and safety, including the concept of dynamic security.¹⁸⁷

The Mandela Rules follow on the 2007 Istanbul Statement, which was the product of a working group of 24 international experts who came together to address the increasing use of solitary confinement and its harmful effects. The Istanbul Statement calls on states to limit the use of solitary confinement to very exceptional cases, for as short a time as possible, and only as a last resort. The Istanbul Statement recognizes that solitary confinement may cause “serious psychological and sometimes physiological ill effects,”¹⁸⁸ and calls for serious efforts to be made to increase the amount of meaningful social contact for prisoners held in solitary confinement. The Istanbul Statement calls for the prohibition of the use of solitary confinement for mentally ill prisoners and for prisoners under the age of 18.¹⁸⁹

The United Nations Rules for the Treatment of Female Prisoners and Non-Custodial Measures for Women Offenders (the Bangkok Rules), adopted by the UN General Assembly in 2010,¹⁹⁰ recognize that women prisoners are particularly vulnerable due to their victimization in the community and the potential for re-victimization within prison. The circumstances under which women commit crimes is different from that of men and must be acknowledged in order for women’s needs to be addressed while incarcerated. The Bangkok Rules supplement the United Nations Standard Minimum Rules for the Treatment of Prisoners and the Tokyo Rules on alternatives to imprisonment. The Bangkok Rules require women to be treated with humanity and with dignity. They prohibit solitary confinement

or disciplinary segregation for pregnant women, women with infants and breast-feeding mothers.¹⁹¹

In 2010, Canada ratified the Convention on the Rights of Persons with Disabilities. It defines persons who are disabled as those who have “long-term physical, mental, intellectual or sensory impairments.”¹⁹² Its preamble recognizes “that discrimination against any person on the basis of disability is a violation of the inherent dignity and worth of the human person...” Article 15 requires states to “take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.”

Given the UN Special Rapporteur’s statement that the use of solitary confinement for persons with mental disabilities amounts to cruel, inhuman or degrading treatment or punishment, Canada and British Columbia are in violation of the Convention on the Rights of Persons with Disabilities, as well as the Mandela Rules, by continuing to place prisoners with mental disabilities in solitary confinement.

By refusing to limit the amount of time a prisoner spends in solitary confinement to a maximum of 15 days, above which is considered either torture or cruel, inhuman or degrading treatment or punishment, Canada and British Columbia are in violation of the International Covenant on Civil and Political Rights, and the Mandela Rules.

Canada and British Columbia are also in violation of the Basic Principles for the Treatment of Prisoners, by continuing to use, and failing to restrict the use of solitary confinement as a punishment for a breach of a prison rule, and of the Mandela Rules when the punishment is in excess of 15 days.

A 2015 report by the United Nations Human Rights Committee examined Canada's compliance with the International Covenant on Civil and Political Rights. The Committee expressed concern over the "many cases of administrative or disciplinary segregation, sometimes for long periods of time, including of detainees with mental illness..."¹⁹³ The Committee urged Canada to "limit effectively the use of administrative or disciplinary segregation as a measure of last resort for as short a time as possible and avoid such confinement for inmates with serious mental illness".¹⁹⁴

The Correctional Investigator of Canada encourages the Government of Canada to sign the Optional Protocol on the Convention against Torture that would allow national and international inspection of prisons.¹⁹⁵

Prisoners' Legal Services has witnessed the abuses that take place under Canada's and British Columbia's current legislative and policy schemes. These abuses are not authorized by law or policy. Canada and British Columbia must take significant legislative measures to ensure that no prisoner is at risk of torture or other cruel treatment or punishment in our prisons.

LESSONS LEARNED FROM OTHER JURISDICTIONS AND CONTEXTS

There is growing momentum internationally to address the harms caused by solitary confinement, with alternatives being implemented in other jurisdictions and contexts. The following are a few examples of the lessons that can be learned by these reforms.

UNITED STATES

The use of solitary confinement has likely been much more prolific in the United States than any other jurisdiction in the world. There is currently a movement throughout the United States of challenges and reforms to the use of solitary confinement, and work toward its end for at least the most vulnerable prison populations, including youth and those with mental health issues.

At a congressional budget hearing in 2015, U.S. Supreme Court Justice Anthony Kennedy opined that “solitary confinement literally drives men mad...We simply have to look at this system that we have”.¹⁹⁶ Justice Kennedy essentially invited constitutional challenges to long-term isolation and the “terrible price” it exacts.

Earlier this year, the U.S. Department of Justice released its first-ever direction to corrections administrators on best practices for solitary confinement. The report, entitled, *Report and Recommendations Concerning the Use*

of Restrictive Housing includes calls for the elimination of the use of solitary confinement for juveniles, the reduction of the use of solitary for prisoners needing protective custody, and the diversion of prisoners with serious mental illnesses away from solitary confinement and into treatment. United States President Obama announced that he has adopted the report’s recommendations.¹⁹⁷

This is an important victory for those people fighting for the reform of solitary. In response to President Obama’s announcement, David Fathi, director of the American Civil Liberties Union’s National Prison Project stated:

With these reforms, the president has added full weight of the United States government to the movement to end our jails and prisons’ addiction to solitary and its cruelty. We have lost too many to a punishment that hurts us all.¹⁹⁸

Some jurisdictions in the United States have already begun to address their over-use of solitary confinement, including Colorado, California and New York City.

Colorado

In 1993, the state of Colorado, through the Colorado Department of Corrections, opened its first correctional institution entirely dedicated

to solitary confinement. The Colorado State Penitentiary was built to house prisoners in complete isolation. Originally, it was considered a safety measure. Prisoners housed there had either been physically violent toward staff or other prisoners, or were at risk of violence being directed at them. Over time, these criteria expanded until it became common practice to house even prisoners with minor infractions, or those who were suspected of gang affiliations, in solitary confinement.¹⁹⁹

Opponents of solitary confinement began advocating for a reformation of Colorado's Administrative Segregation program, and in 2011, the Colorado Senate passed Bill 11-176. The bill addressed the use of solitary confinement in Colorado state prisons and required the Executive Director of the Colorado Department of Corrections to provide a report annually to the Senate and House judiciary committees regarding the use of solitary confinement, and any reform efforts. It also required that any cost savings achieved as a result of these reforms be redirected to mental health services. Further, it appropriated resources to support mental health services, behaviour-modification programs and other programs designed as viable alternatives to solitary confinement.²⁰⁰

In late 2013, a residential treatment program was implemented to aid in the transition of prisoners with serious mental health issues out of solitary confinement. The Colorado Department of Corrections removed and banned administrative segregation assignments within the residential treatment programs – problematic behaviours would instead be addressed through treatment.

In 2014, Colorado legislatures went a step further and passed Bill SB 64 (2014). The bill prohibits the Colorado Department of Corrections from placing a person with serious mental illness in long-term administrative

segregation unless exigent circumstances are present. It also created a working group to advise the Colorado Department of Corrections on policies and procedures related to the proper treatment and care of prisoners with serious mental illness.²⁰¹

Notably, the bill increased state funding for Colorado Department of Corrections staffing and for expanding the Residential Treatment Program.²⁰²

Colorado's measures to limit the use of solitary confinement are a rare example of legislative, rather than policy based reform.

The American Civil Liberties Union (ACLU) of Colorado conducted a one-and-a-half-year review of the Colorado Department of Corrections' reforms to its use of solitary confinement and the mental health services it provided in place of solitary confinement. Its review found that many of the reforms "resulted in tangible, measurable changes for prisoners". The review identified some areas for improvement, but recognized the significance of the changes that had been made to date: "Given the massive sea change you have undertaken, particularly with a staff that has been accustomed to the wide use of prolonged solitary confinement for nearly twenty years and the punitive culture that goes along with such a regime, it is to be expected that fully realizing the reforms will take time and significant additional resources, and require persistent monitoring and correction."²⁰³

The Colorado ACLU's review applauds the Colorado Department of Corrections' dramatic reduction in the number of prisoners held in long-term solitary confinement – from 1,500 (seven percent of the prison population) in August 2011 to 177 in September 2015 (one percent of the prison population). The number of women prisoners held in solitary confinement went from 39 (two percent of the female prisoner population) in 2011 to zero.²⁰⁴

Policy was changed to prohibit placement of prisoners in solitary confinement unless they had “committed a specific, discrete, violent or highly dangerous act”.

The Colorado ACLU remained critical of the harsh conditions in the segregation units, where prisoners spend 22 or more hours per day alone in their cells. It was also critical that some prisoners who were removed from solitary confinement were placed in transitional units that allowed only four hours of socializing out of cells each day. Prisoners were held in these units for longer than a “transitional” period of time.

The Colorado Department of Corrections was successful in removing all prisoners identified with serious mental illnesses out of solitary confinement in only a few months. The residential treatment program had a much greater success rate than a program that was operated in the administrative segregation unit. The administrative segregation program for prisoners with mental illness had a failure rate of 61 percent – the failure rate in the residential treatment program was only nine percent. The Department of Corrections attributed this progress to a demonstrated “change in the program’s philosophy to work with offenders despite their noncompliance or resistance to therapy”. Prisoners remained in the residential treatment centre for longer periods of time, reflecting a willingness to allow prisoners to make progress on their mental health problems rather than discharging them from the program for any early signs of non-compliance or disruptive behaviour.²⁰⁵

All prisoners in the residential treatment program are required by policy to be afforded 20 hours of time out of cells each week, with 10 hours of therapeutic time out of cells, including one-on-one therapy. The Colorado ACLU’s review found that prisoners were offered 10 hours of out-of-cell therapeutic time each week, but that many prisoners refused these opportunities

because the programs offered were limited to mental health groups that were poorly run and seen as having little value.

The Colorado Department of Corrections took the position that the lack of participation in therapeutic time, which rose to more than 75 percent, was because many prisoners were resistant to treatment. However, Dr. Jeffrey Metzner, a member of a Colorado solitary confinement working group, explained that a well-run prison mental health program can expect a refusal rate of up to 25 percent, but a refusal rate of more than 30 percent is an indication that there are systemic problems with program delivery, such as timing, relevance and quality of treatment.

The Colorado ACLU’s review found that the rate of refusal to participate in *individual* mental health treatment was less than 15 percent. It recommended that prisoners be offered additional opportunities for meaningful individual mental health therapy.

The definition of “serious mental illness” was expanded beyond Axis I disorders to include prisoners “regardless of diagnosis, indicating a high level of mental health needs” who “demonstrate significant functional impairment within the correctional environment”. This definition is inclusive of prisoners who engage in self-harm or who have other “significant functional impairment”, but who are diagnosed only with an Axis II personality disorder. The ACLU of Colorado notes:

According to national mental health experts, this tendency against finding prisoners with a personality disorder to have a serious mental illness has been a problem in corrections departments around the country, resulting in many severely impaired individuals being subject to the harmful effects of extreme isolation. The changes in Colorado and some other jurisdictions reflect a far better

understanding of mental illness, disruptive prisoners, and the impacts of isolation on human beings. [The Colorado Department of Corrections]’s definition of serious mental illness appears intended to prohibit a broader spectrum of prisoners with mental illness from placement in long-term solitary confinement and to ensure provision of the highest level of mental health care to prisoners who need it.

The Colorado ACLU’s review also identified understaffing of mental health care professionals to be a significant barrier to the ability to provide the necessary quality and quantity of services. It was also critical of prison mental health staff reassessing prisoners with long-diagnosed serious mental illnesses as not having a serious mental illness. In reviewing the mental health files of segregated prisoners, the ACLU identified many instances of prison clinicians inappropriately attributing disruptive behaviour exclusively to personality disorders or to malingering, rather than to serious mental illness, which they say experts see as a systemic problem for mental health professionals working in prisons:

Faced with too few resources and pressured to conform to a security-centric culture, mental health professionals can begin to distance themselves from patients, become especially sceptical of prisoners exhibiting disruptive behaviour, and minimize complaints that later reveal themselves to be true signals of severe psychological distress. Prisoners crying out for help are routinely ignored as “troublemakers” and are pegged as “manipulators” faking distress for attention. [Citing T.A. Kupers, *Treating those Excluded from the SHU*, 12 *Correctional Mental Health Reporter* (2010), pp. 8-10.]²⁰⁶

The ACLU of Colorado praises the Colorado Department of Corrections for collecting

extensive data on its reforms to solitary confinement, and for making information available to the public on its website. Data was collected on therapeutic out-of-cell time for prisoners, success rates of residential treatment programs, and incidents of violence. The ACLU of Colorado recommends that additional data be collected on non-therapeutic time out-of-cell in residential treatment units as well.

Despite the identified areas for improvement, the ACLU of Colorado commends Rick Raemisch, the director of the Colorado Department of Corrections, for becoming a national spokesperson from within the correctional community on reducing solitary confinement and providing mental health care to prisoners.

The Colorado Department of Corrections’ efforts teach us that with legislative reform and proper funding, it is possible to eliminate the use of solitary confinement for prisoners with mental disabilities, and exemplifies the importance of implementing a broad and inclusive definition of mental disability. Colorado’s experience in developing mental health units illustrates the necessity of providing accessible, quality therapy to prisoners, including sufficient opportunities for individual therapy. This example also demonstrates the importance of transparency in the reform process, by publicly providing data and including prisoner advocacy organizations in lengthy review processes.

California

One of the most prominent cases against the use of solitary confinement in the US is the *Ashker v Brown* suit between the California Department of Corrections and Rehabilitation and the Center for Constitutional Rights on behalf of individuals in solitary confinement at Pelican Bay State Prisons, filed in 2009.²⁰⁷ The legal action was part of a larger movement to reform conditions in Special Handling Units (SHUs) in California’s

prisons that was sparked by hunger strikes by thousands of SHU prisoners in 2011 and 2013.²⁰⁸

Settlement in the case was reached on September 1, 2015 and was approved by the Court on January 26, 2016 (the Ashker Settlement). Prior to the settlement, prisoners could be held in solitary confinement at the SHU for more than 15 years.²⁰⁹ Although the Ashker Settlement eliminates solitary confinement sentences of 10 years or more and solitary confinement sentences of indeterminate length, it still allows solitary confinement for up to five years.

The Ashker Settlement also created a new unit, called a Restricted Custody General Population Unit, designed to be an alternative to solitary confinement aimed at returning prisoners to the general population in two years or less. This unit is for prisoners who are found guilty of numerous acts of misconduct, “designed to facilitate positive and meaningful social interactions for prisoners about whom California has serious security concerns, such that they would otherwise be placed in solitary confinement”.²¹⁰

Prisoners in this unit will be given as much time out of their cells as other general population prisoners, will be allowed to move around without constraints and will be allowed contact visits. Prisoners will be given access to educational courses and will attend group activities in small groups. Through programming, prisoners will be encouraged to engage in positive social interaction with other prisoners and correctional staff.²¹¹

The reforms introduced under the Ashker Settlement are still in very early stages. Critics have expressed concern over the fact that data collection and monitoring of the terms of the Ashker Settlement is only scheduled to continue for two years. They argue that the practice of solitary confinement “has historically

been defined by discretion and invisibility, and is therefore hard to investigate, control and reform.”²¹² Monitoring for a short time may allow the practice to retreat behind closed doors again, they argue. Critics are also obviously concerned about the extremely lengthy periods of time that prisoners can still be subjected to solitary confinement in California.

New York City

New York City incarcerates 11,000 people at any time, with 70,000 admissions each year. Thirty-eight percent of prisoners in New York City are identified as having mental illnesses.²¹³

In 2012, the Correctional Health Services of the New York City Department of Health and Mental Hygiene adopted a human rights framework to the New York City jail health mission, which included concerns about the use of solitary confinement and self-harm. A unit called the Clinical Alternative to Punitive Segregation (CAPS) was created as a clinical setting for prisoners with serious mental illnesses who had breached institutional rules. In CAPS, patients were able to participate in a number of therapeutic activities, including psychotherapy, creative art, nursing education groups, individual mental health and medical encounters and community meetings with patients, health and security staff. Prisoners are not locked up in isolation – they are encouraged to interact with others outside of their cells.²¹⁴

The CAPS unit employed four mental health treatment aids, four social workers, a psychologist, a nurse and a half-time psychiatrist. Security and health care staff who wanted to work in CAPS took one week of joint training which emphasised de-escalation and communication.²¹⁵ Staff who worked in the unit engaged with patients in groups and therapeutic activities and engaged regularly with patients who might be experiencing difficulties.²¹⁶

New York City also implemented “Restrictive Housing Units” for prisoners with less serious mental illnesses who received segregation as a punishment for breaking institutional rules. Prisoners in these units were held in solitary confinement with some clinical programming for one to four hours per day. However, researchers found that “[f]or many patients, the reward of moving from one hour out of cell to two hours out of cell is not a qualitative improvement.”²¹⁷

Researchers found that data from these units “reveal that clinical improvements among incarcerated patients with mental illness are linked to less restrictive and more therapeutic approaches.” Prisoners in the CAPS unit had lower rates of self-harm and injury than prisoners with serious mental illnesses held in other, less therapeutic, units. CAPS is being used as a model for the creation of other therapeutic mental health units in New York City.²¹⁸

UNITED KINGDOM

The United Kingdom relied heavily on the use of solitary confinement in the 1970s, largely to deal with the prominence of violence in their prisons. A punitive approach was taken by prison administrators in order to curb the violence. By the 1980s it became clear to officials that the financial cost of solitary confinement was exceedingly high, yet the violence it was meant to reduce was not being impacted.²¹⁹ In fact, violence was increasing and culminated with a prison riot at Manchester’s Strangeway Prison in 1990 where prisoners demanded better conditions. This was soon followed by a series of disturbances at other prisons in England. Prison officials had no choice but to acknowledge that conditions of confinement were actively playing a role in the violence. As a result of these events, a review of the British prison system was conducted

and a report was produced in 1991, which put forward a set of reforms aimed at reducing the use of solitary confinement. The Woolf Report, as it was called, also recommended the implementation of Close Supervision Centres (the Centres).

The Centres are overseen and coordinated as a national system. They are comprised of groups of less than 10 prisoners in individual cells,²²⁰ housing approximately 60 men in total. These men are considered to be the most difficult to manage due to their histories of violence both in the community and within the prison system.²²¹

The Centres are meant to be incentive-based and focus on prisoner engagement. Prisoners are to be provided access to education programs, libraries as well as daily exercise.²²² Meaningful human contact is recognized as a necessity. Care and Management plans set out specific targets for prisoners with the goal of having them gain the skills needed to cascade out of the Centre. The plans address known triggers and self-harm or suicide risk.

The Centres are run on a step-down model where prisoners who show signs of cooperative behaviour may be rewarded with increased freedom and responsibility.²²³ Step-down programs are not ideal, as prisoners should not be deprived increased liberty for being unable to control behaviour while held in isolation.

A 2015 review of the Centres conducted by the Inspectorate of Prisons, an independent government organization, was critical of the lack of external oversight of the admission process that would ensure fairness and proportionality, and the lack of an appeal process for prisoners.²²⁴

The Inspectorate report and prisoner accounts tell a different tale of what the Centres are really like. The Inspectorate report noted that prisoners at one Centre spend only about two to three hours outside of their cells daily and some

were prohibited from socializing with other prisoners on the unit. The report described the conditions of confinement as being repressive and isolating, with many cells having an obstructed view of the outside and exercise yards “generally consisting of dehumanising austere cages”.²²⁵ One prisoner’s family reported to Solitary Watch that he had no meaningful human contact, being limited to only prison guards in riot gear, and that he was almost always locked up 24 hours a day.²²⁶

In addition to these issues, the Centre regime has also faced criticism for holding a high number of people with severe mental illnesses, and sometimes failing to provide them with appropriate treatment.²²⁷

In another 2015 report, commissioned by the UK Prison Reform Trust, entitled *Deep Custody: Segregation Units and Close Supervision Centres in England and Wales*, the authors, Drs. Sharon Shalev and Kimmitt Edgar, conclude that the Centres are not providing enough individualized programs and activities for prisoners. They also note that prisoners are not provided with clear expectations as to how to progress through the Centre.²²⁸

In addition to the Centres, there are also “segregation units” still operating in British prisons. Drs. Shalev and Edgar note that these units “[are] characterized by social isolation, inactivity and increased control of prisoners”.²²⁹ There are various accounts available of prisoners’ experiences in both the Centres and segregation units that show what can happen to good intentions if there is not an accompanying culture shift amongst all prison personnel.

Drs. Shalev and Edgar recommend in their report that segregation must not be prolonged or indefinite and that the focus must be on reintegration and exit strategies. They recommend that prisoners in segregation should be provided more purposeful activities and

more frequent and higher quality of personal contact. They recommend that staff should be selected and trained to ensure positive interactions with prisoners. They recommend that prisoners should not be segregated when they are waiting for transfer to a security hospital or if they are at risk of self-harm, except under truly exceptional circumstances. Alternatives to segregation for prisoners with mental health issues should be provided, as well as better screening for vulnerabilities. They urge prison administrators to improve the treatment of all prisoners in order to reduce the number of voluntarily segregated prisoners, and to work to resolve the underlying reason for the involuntary segregation request. They further call on Independent Monitoring Boards to better understand their role in protecting the rights of segregated prisoners against unjustified placements, and to be better trained on the Mandela Rules on issues including segregation, mental health and the use of force.

While a reduction of violence in the English prison system has been noted as a result of reforms, it is apparent the Centres are not without their problems. Criticism of the Centres illustrates how difficult it is for reforms to be successful and how easy it is for things to fall back into the status quo without a significant change to correctional culture.

Styal prison for women

Between 2002 and 2003, there were six suicides at the Styal prison for women in England. All of these women had a history of drug abuse, and five of the six had mental disabilities and a history of self-harming. The Prison Inspectorate and Coroner had previously warned prison authorities of inadequate mental health and drug treatment programs at the prison, on which the prison authorities failed to act. Following the six deaths, the Prisons and Probation Ombudsman for England and Wales published

reports regarding the systemic problems at Styal, including overuse of segregation for women at risk of suicide.²³⁰

Following these deaths, the segregation unit at Styal was renamed the Care, Support and Reintegration Unit. Women at risk of harming themselves or others were no longer kept in solitary confinement. They were provided mental health support and increased human interaction.²³¹

According to Gina Westaway, a senior prison officer in the Care, Support and Reintegration Unit at Styal, in a 2007 report, the women had many opportunities to be out of their cells interacting with others each day:

What we try to do here is to keep them busy. When I arrived at 7.30, the prisoners were having their breakfast. They are given any medication afterwards, and at nine we start moving them to their education classes or work. The ones who stay in the unit clean their cells or have a bath before going outside to the exercise yard. They have their lunch at about 11.45, and then go back into their rooms. At 1.30 we move them to education or work again, and some go to the calm room, a therapeutic place where they can have their hair or nails done, or just relax. Female prisoners are much more dependent on the staff than male prisoners. The women have specific worries about their children and families and can get quite distressed. They are in their rooms again at four, where they have a radio (and will soon have television). Dinner is at five, and between six and seven they have association time. At eight they are back in their rooms. The job is stressful, but I love it. Sometimes I wonder, looking at the prisoners, why they are here in the first place. Many of them are eventually moved to secure hospitals. They are vulnerable women with a lot of problems.²³²

The number of suicide deaths dramatically decreased after the Styal segregation unit became the Care, Support and Reintegration Unit.²³³

Sadly, Styal continued to be criticized in reports for failing to adequately resource mental health supports.²³⁴ The segregation unit was reinstated and an average of 20 women were segregated each month, including women with complex needs. Staff felt they lacked necessary mental health supports and training to support the women in their care.²³⁵

FORENSIC PSYCHIATRY – SECLUSION ROOMS

The call to end the overuse of solitary confinement in prison has been echoed in the psychiatric community in relation to the use of seclusion rooms for years. In the last 15 years, researchers have shifted their focus away from the use of seclusion and instead have focused on the delivery of treatment “in the context of prevention, reduction, and/or elimination of seclusion.”²³⁶

Seclusion is a physical intervention involving containing a patient in psychiatric crisis in a locked room.²³⁷ This is markedly similar to what we know as solitary confinement in the prison context.

The legitimacy of seclusion rooms came to the forefront when practitioners began to question their therapeutic value. As with solitary confinement, there is no clear evidence that seclusion promotes healing in any form, yet there are strong indicators that it can be harmful to the individual being secluded, as well as the people who are responsible for delivering the intervention.²³⁸

The authors of a 2007 review of the use of seclusion rooms found that programs aimed at reducing or eliminating their use required strong leadership, the monitoring of seclusion episodes, staff education and changes to the therapeutic environment.²³⁹

The American National Association of State Mental Health Program Directors recommends core strategies to reduce seclusion and restraint. A key strategy involves individualized, trauma-informed treatment. This strategy also promotes de-escalation, environmental changes to include comfort and sensory rooms, sensory modulation interventions and treatment designed to teach emotional self-management skills.²⁴⁰

The strategy stresses the importance of staff training and engagement to “create a treatment environment that is less likely to be coercive or trigger conflicts and in this sense is a core primary prevention intervention.”²⁴¹

The reduction of seclusion is widespread in the United States, and several jurisdictions have already eliminated its use entirely.²⁴² In Canada, “a pan-Canadian group sponsored by the Canadian Patient Safety Institute as well as the Mental Health Commission of Canada (2012) recently declared minimization of seclusion to be the standard of care, consistent with a collaborative, recovery-oriented approach.”²⁴³

Given the push in the psychiatric community to abolish the use of seclusion, which arguably has less deleterious effects than solitary confinement, we maintain it is necessary to call for the end of solitary confinement in Canadian prisons.

LEGISLATIVE AND POLICY TRANSFORMATION NEEDED TO ABOLISH THE USE OF SOLITARY CONFINEMENT

Solitary confinement is the extreme end result of a correctional system that views prisoners as less than human and undeserving of dignity. American psychiatrist Dr. Terry Kupers has described how correctional policies, including the use of solitary confinement, can create a “recipe for madness”. Although written in the context of US supermax prisons, the experience of Prisoners’ Legal Services confirms its relevance to the practices associated with solitary confinement in Canada.

The more vehemently correctional staff insist the disturbed prisoner return a food tray, come out of his cell or remove the paper from the cell door so they can see inside, the more passionately the disturbed prisoner shouts: “You’re going to have to come in here and get it (or me)!” The officers go off and assemble an emergency team – several large officers in total body protective gear who, with a plastic shield, are responsible for doing cell extractions of rowdy or recalcitrant prisoners. The emergency team appears at the prisoner’s cell door and the coordinator asks gruffly if the prisoner wants to return the food tray, or do they have to come in and get it? While a more rational prisoner would realize he had no chance of withstanding this kind of overwhelming force, the disturbed prisoner puts up his fists in mock boxing

battle position and yells “Come on in, if you’re tough enough!” The officers barge in all at once, each being responsible for pushing the prisoner against the wall with the shield or grabbing one of his extremities. The prisoner is bruised and hurt, but when a nurse examines the shackled prisoner and asks about injuries he responds that they hardly scratched him.

This kind of “cell extraction,” which occurs in some supermaximum security prisons as often as ten times per week and reminds one of the scenario sociologists of deviance described in 50’s asylums, is not the only outbreak of madness within correctional institutions. Officers in facilities of all levels of security tend to yell at prisoners and tend to threaten prisoners with harsh reprisals if they do not obey orders quickly or thoroughly enough. Prisoners in whom anger has mounted because of the extremity of their situation typically respond in an angry tone, perhaps meeting swearing with swearing. Or they mutilate themselves repeatedly, or they smear faeces or throw excrement at staff. With each angry, bizarre act on the part of prisoners, correctional staff become more harsh and punitive, less interested in listening to the prisoners’ expressed grievances, less concerned about

prisoners' pain and suffering, and more quick to respond to the slightest provocation with overwhelming force.

The recipe for creating madness in our prisons is easy enough to explicate, one merely needs to identify the steps that were taken to reach the current state of affairs. Here is the recipe:

Begin by over-crowding the prisons with unprecedented numbers of drug-users and petty offenders, and make sentences longer across the board.

Dismantle many of the rehabilitation and education programs so prisoners are relatively idle.

Add to the mix a large number of prisoners suffering from serious mental illness.

Obstruct and restrict visiting, thus cutting prisoners off even more from the outside world.

Respond to the enlarging violence and psychosis by segregating a growing proportion of prisoners in isolative settings such as supermaximum security units.

Ignore the many traumas in the pre-incarceration histories of prisoners as well as traumas such as prison rape that take place inside the prisons.

Discount many cases of mental disorder as "malingerers."

Label out-of-control prisoners "psychopaths."

Deny the "malingerers" and "psychopaths" mental health treatment and leave them warehoused in cells within supermaximum security units.

Watch the recidivism rate rise and proclaim the rise a reflection of a new

breed of incorrigible criminals and "superpredators."²⁴⁴

What steps are necessary to take prisons out of this state of madness?

The history of the use of solitary confinement in Canada and British Columbia teaches us that a significant transformation is needed to ensure that prisoners are protected from the abuses associated with the practice. Despite so many recommendations and criticisms, and initiatives to reduce the use of solitary confinement, the practice continues in both jurisdictions, and prisoners continue to suffer and sometimes die.

The Ontario Human Rights Commission calls for the abolition of the use of solitary confinement in Ontario because "[s]o long as segregation remains an option in Ontario's correctional system, the OHRC believes there will not be a sufficient incentive to develop and support alternatives, and segregation will continue to be overused."²⁴⁵

Prisoners' Legal Services echoes this concern. In our view, the culture of corrections needs to change to recognize that most prisoners suffer from past trauma that affects mental health and behaviour. Many suffer from mental disabilities. The response to behavioural difficulties for most prisoners should not be a punitive one. Correctional administrators and staff must take a trauma-informed approach to corrections, ensure that prisoners are treated professionally and with dignity, and are provided treatment when appropriate, in all living units. Specialized mental health units must be created to meet the needs of the numbers of prisoners who would benefit from them.

When it is necessary to separate prisoners from the population, it should be for as short a period of time as necessary within a day, and no prisoner should ever be denied sufficient meaningful human contact each day. Canada

and British Columbia should never engage in the torture or cruel treatment of its prisoners.

To achieve the abolition of solitary confinement in Canada and British Columbia, governments must set out strict requirements to guarantee the rights of prisoners in legislation.

REDUCING THE NUMBER OF PRISONERS IN CUSTODY AND IN HIGH SECURITY

The first step in eliminating the need for solitary confinement goes beyond the correctional realm, to governments, police and the courts, to reduce the number of prisoners held in custody, and to reduce the security level of prisoners when possible.

In addition to eliminating mandatory minimum sentences – which the federal government has committed to doing – provisions of the *Corrections and Conditional Release Act* previously removed by the Harper government that allowed more opportunities for prisoners to serve more of their sentences under community supervision, need to be reinstated.

Governments must work together to reduce the number of prisoners held in pre-trial custody by initiating bail reform.

The expansion of diversion programs should be explored, especially for prisoners with mental disabilities, in order to prevent people from becoming caught in the system and ending up in long-term solitary confinement for what began with a minor offence.

Too many vulnerable prisoners are held in custody for minor offences. Ashley Smith, who experienced behavioural problems from a young age due to her mental disabilities,²⁴⁶ was charged as a youth for disturbing the peace at 14, and

was in and out of youth jail until the age of 17. Her last offence in the community was throwing crab apples at a postal worker. In custody, she was held in solitary confinement, and she was charged for attempting to self-harm, being disruptive and not following staff orders. These in-custody charges resulted in a federal adult sentence, which led to her solitary confinement and her death at the Grand Valley Institution for Women at the age of 19.²⁴⁷

The case of Adam Capay, who spent the last four years in solitary confinement at the Thunder Bay District Jail has recently come to light. Mr. Capay, from the Lac Seul First Nation near Sioux Lookout, was also sent to jail on minor charges. At the age of 19, he was accused of murdering another prisoner while in custody at the Thunder Bay Correctional Centre. Mr. Capay also self-harmed in solitary confinement, and he continues to be held in isolation.²⁴⁸

If prisoners like Ashley Smith and Adam Capay had been provided diversion programs to deal with their minor offences, their further offending might have been prevented by community-based mental health care treatment.

The BC Division of the Canadian Mental Health Association has prepared a review of best practices for diversion of people with mental disorders, based on the understanding that “the offending behaviour of many mentally disordered persons is more appropriately and effectively dealt with through the provision of treatment and support rather than through traditional criminal justice interventions.” They identify opportunities for diversion at the pre-arrest stage by police, pre-trial diversion after arrest, at the post-sentence or plea stage (jail and court based diversion) as well as at the post-incarceration stage through correctional programming and community re-entry diversion. Court-based diversion may include the establishment of specialty mental health courts.²⁴⁹

In addition to these initiatives, Prisoners' Legal Services also calls on the federal government to amend the *Corrections and Conditional Release Regulations* to allow prisoners with mental disabilities to be classified to lower levels of security. Section 18 of the *Regulations* provides that prisoners "requiring a high degree of supervision and control within the penitentiary" must be placed in maximum security. Prisoners' Legal Services has had many clients who were placed in maximum security prisons because they have high "institutional adjustment" needs due to their mental disabilities. Legislation

should be amended to require any prisoners who are considered to have high institutional adjustment needs due to mental disability to be placed in specialized therapeutic units, rather than in maximum security institutions.

By reducing the overall numbers of prisoners, and the numbers of prisoners in high levels of security, the cost of operating prisons will decrease, which can provide the funds for additional mental health supports and services in prisons, eliminating the need for solitary confinement.



PROCEDURAL FAIRNESS AND OVERSIGHT

“The absence of the Rule of Law is most noticeable at the management level, both within the prison and at the Regional and National levels. The Rule of Law has to be imported and integrated, at those levels, from the other partners in the criminal justice enterprise, as there is no evidence that it will emerge spontaneously.”

The Arbour Report

It is time for the governments of Canada and British Columbia to step in to prevent further abuses of prisoners in solitary confinement. If segregation or separate confinement are to continue, they must be subject to independent adjudication and external oversight to ensure that these regimes no longer meet the United Nations’ definition of solitary confinement. Broad legislative overhaul is necessary to ensure that any prisoners held in segregation or separate confinement are not isolated, are provided work, programs or education to keep their minds productively occupied and have adequate levels of meaningful human contact each day. Extensive reporting requirements and independent external inspection of prisons is essential to preventing further abuses. These rules cannot be left to prison administrators in policy – they must become government made law.

As recently as August 9, 2016, the Correctional Service of Canada’s administration of solitary confinement was criticized by the Alberta Court of Queen’s Bench. In *Hamm v Attorney General of Canada (Edmonton Institution)*,²⁵⁰ Justice Veit considered the case of several prisoners placed in administrative segregation at Edmonton Institution on June 28, 2016. The Correctional Service of Canada’s new policy on administrative

segregation came into effect on October 13, 2015. The *Hamm* decision demonstrates that the Correctional Service of Canada’s efforts to address the problems with solitary confinement by policy alone have been insufficient.

Justice Veit found the appropriate level of procedural fairness required for a segregation review is “one which mirrors the safeguards contained in the criminal trial process”.²⁵¹ She found that the Correctional Service of Canada had failed to provide an adequate level of procedural fairness, as it had not dealt at all with the reason for the segregation.²⁵² She found that “[t]he institution has essentially provided conclusions, rather than reasons, for its actions”, and had relied on the wording of the statute rather than on the facts of the case, thereby failing to provide adequate reasons for the decision to continue segregation.²⁵³

Justice Veit found the decision to segregate each of the applicants was unreasonable. In coming to this conclusion, she considered the Mandela Rules as informing the results in a Canadian *habeas corpus* application.²⁵⁴

The Court found that the segregation review process “was intended by Parliament to be a serious, robust, assessment of whether segregation was warranted and inevitable; the Reviews conducted in this case were merely perfunctory.”²⁵⁵

The applicants in *Hamm* were placed in segregation on the basis that they were believed to be planning to assault a guard who had denied them toilet paper and made racist remarks. Justice Veit noted that “[t]here was no investigation by the institution about the underlying basis for the complaints; one solution to the problem may have been to deal with the underlying complaints.”²⁵⁶

Justice Veit also found that because the applicants had mental health issues, it was unreasonable to segregate them without

completing full mental health assessments. She considered the Aboriginal status of the majority of the applicants, and found that it was unreasonable to deny Aboriginal prisoners transparency in relation to a decision to further deprive their liberty.²⁵⁷

The *Hamm* case illustrates that progressive policy change to the administration of segregation is not enough. Legislative amendments are necessary to ensure that prisoners subjected to administrative segregation receive adequate levels of procedural fairness, including, in our view, independent adjudication.

Legislative reform to improve procedural fairness and to provide independent adjudication is also necessary in the British Columbia provincial system. On April 27, 2016, the Ombudsman of Ontario, Paul Dubé, submitted his report “Segregation: not an Isolated Problem” to the Ontario Ministry of Community Safety and Correctional Services’ review of segregation policies. He identified problems with Ontario’s use of segregation similar to those experienced by prisoners held in BC Corrections’ centres. He found that legislation and policy lacked sufficient procedural fairness, and that corrections routinely failed to follow legislation and policy.

Mr. Dubé found that segregation was regularly used to “effectively punish the most ‘difficult’ and vulnerable inmates”, and that segregation was used because prisons did not have the resources needed to accommodate prisoners in more appropriate settings.²⁵⁸

Prisoners held in segregation or separate confinement in Ontario and British Columbia respectively, by legislation retain the rights and privileges of other prisoners. Mr. Dubé noted that many prisoners in Ontario have complained to his office about losing the right to yard, programs and telephone. Similarly in BC, prisoners call Prisoners’ Legal Services with

complaints that they have been denied access to yard time, programs, legal calls or television.

Mr. Dubé also noted that Ontario prisons failed to complete reviews in accordance with law and policy:

Typically, when we attempt to uncover why a segregation placement was confirmed at the institutional level, we find scant documentation recording what information institutional officials considered and virtually no reasons to support the outcome of the review.²⁵⁹

Again, this mirrors the experience of Prisoners’ Legal Services in relation to BC Corrections – separate confinement notification forms provide only one or two paragraphs of “reasons” for the placement, which often merely restate the legislative criteria or cite historical behavioural issues, copied and pasted from previous decisions to continue long-term separate confinement.

As a remedy to Mr. Dubé’s finding that the Ontario Correctional Service failed to follow law and policy “whether deliberately or through inadvertence or neglect”, he recommends legislative changes to ensure an appropriate level of procedural fairness, including independent adjudication of segregation placement decisions.²⁶⁰ He recommends that prisoners have the right to attend an oral hearing within the first five days of placement in segregation before an independent review panel with a representative of the prisoner’s choice. He recommends that prisoners have the right to meet with a “rights advisor”, that duty counsel be provided, and that prisoners must be given enough information to know the case against them. He recommends that hearings be held in a neutral venue outside of the prisoner’s living unit and cell.²⁶¹

The review panel recommended by Mr. Dubé would be required to evaluate the mental and physical health of segregated prisoners, and the decision should take these factors into account.²⁶² The independent review panel would have the power to remove prisoners from segregation and grant broader remedies such as access to programming or privileges, and to recommend investigations and disciplinary proceedings in relation to correctional staff who have been found to have violated segregation law and policy. Importantly, the independent review panel would be subject to the ombudsperson's jurisdiction.

Mr. Dubé found that the Ontario Ministry responsible for corrections needs to document and report information about segregation placements, including prisoners held in segregation in other units, the number of continuous days of segregation, whether prisoners in segregation have mental health or developmental disabilities, when prisoners have met with a health care professional, whether they have a care or treatment plan, as well as data about gender, race, Aboriginal status, and instances of self-harm and deaths in segregation. He recommends that the Ministry should publicly report statistical information annually.²⁶³

The Ontario Human Rights Commission also made submissions to the Ontario Ministry of Community Safety and Correctional Services' segregation review, on February 29, 2016, with a supplementary submission in October 2016. The Ontario Human Rights Commission called for the abolition of solitary confinement, and made recommendations for interim measures to reduce its harmful impact on vulnerable prisoners protected by the *Human Rights Code*, including prisoners with mental disabilities, women, and Black and Indigenous prisoners.

The Ontario Human Rights Commission also recommended independent review and

oversight of segregation placements and healthcare assessments, and procedural fairness rights for prisoners to allow them to challenge segregation placements with legal assistance.

The Ontario Human Rights Commission made its supplementary submissions after the Ministry released statistics on its use of segregation. The Commission noted that in only three-months, over 4,178 people were in segregation, 1,400 of whom were in long enough to constitute torture or cruel, inhuman or degrading treatment under the United Nations' standards, which "signals the internal procedural safeguards are wholly insufficient to address a problem of this magnitude."²⁶⁴

As noted, we have very little data on the rates of incarceration in BC Corrections' facilities. However, if we compare the percentage of prisoners held in segregation in Ontario, based on a snapshot count at a specific time in August 2016 – between six and eight percent – to the number of British Columbia prisoners in segregation or separate confinement *for more than 15 days*, counted at one time in April 2014 – at five percent, the rates appear to be comparable. If we add prisoners held in ESP at one time to that number, the rate is 8.3 percent.²⁶⁵ It is concerning that the rates in British Columbia might be on par with those in Ontario.

The Ontario Human Rights Commission also called on the Ministry to collect data on the use of segregation and its effects on human rights protected groups. It warned that "the failure to collect accurate and reliable data may foreclose a respondent from making a credible defence that it did not discriminate".²⁶⁶

If segregation and separate confinement regimes are to continue, it is time for Canada and British Columbia to implement independent adjudication of these placements, as recommended by Justice Arbour in 1996,

the Task Force on Administrative segregation in 1997, the Correctional Investigator of Canada beginning in 2008 after the death of Ashley Smith, and as required under the 2015 Mandela Rules. Independent adjudication decisions should be final authority, binding on the Correctional Service of Canada and BC Corrections.

Coupled with the independent adjudication of separate confinement placements, British Columbia requires regular external and independent inspections of prisons, as recommended by the BC Ombudsperson this year. The BC Ministry of Public Safety and Solicitor General has accepted the recommendations of the Ombudsperson, and has implemented a more thorough inspections process over the past four years. The role of this independent inspector should be expanded to serve the essential function that the Correctional Investigator serves for Canada – ensuring that what happens behind prison walls is brought to public attention. BC Corrections must also be required to provide statistical data regarding the number and duration of separate confinement placements, information regarding the mental health of prisoners under separate confinement and data in relation to other human rights protected grounds of discrimination.

Both Canada and British Columbia must be required to document and demonstrate that any prisoner held in segregation or separate confinement is provided productive activities and adequate levels of meaningful human contact each day, to prevent mental health deterioration and to enable prisoners to be able to reintegrate into regular living units.

Independent adjudication and oversight, procedural fairness protections and the requirement to provide statistical data on the use of segregation or separate confinement must be set out in law, rather than left to policy. In our view, any provisions that govern the rights

of prisoners in relation to liberty, and the powers of the state to limit liberty rights, must be set out in legislation.

PRISONERS WITH MENTAL HEALTH CONCERNS

“It cannot be acceptable for the most restrictive and depriving form of incarceration legally administered in Canada – one which is otherwise imposed as punishment – to be the default approach in situations where prisoners are sick or in need of protection.”

*Ontario Human Rights Commission*²⁶⁷

Canada and BC Corrections must address the needs of prisoners with mental health issues, first by prohibiting the use of segregation or separate confinement on prisoners with mental disabilities and second, by providing alternative mental health supports for prisoners so that they are able to live successfully with others.

In addition to the United Nations’ Mandela Rules prohibiting the use of solitary confinement for prisoners with mental disabilities, a number of other authorities and bodies have called for this reform, including the Correctional Investigator for Canada²⁶⁸, the Ontario Human Rights Commission, the National Commission on Correctional Health Care²⁶⁹ and the American Public Health Association²⁷⁰.

The American Psychiatric Association recommends avoiding prolonged segregation of prisoners with serious mental illness, and when prisoners with serious mental illnesses are placed in segregation, they be provided programming, recreation and adequate out-of-cell time.²⁷¹ The World Medical Association

urges governments to prohibit segregation if it would adversely affect the medical condition of prisoners with mental illness, and recommends that segregated prisoners be allowed a reasonable amount of regular human contact.²⁷²

The Ontario Ombudsman, Mr. Dubé, recommends that the Ontario Ministry of Community Safety and Correctional Services abolish indefinite solitary confinement and limit all segregation placements to 15 days with an annual limit of 60 days. He recommends that alternative units be developed for prisoners with mental health and developmental disabilities and behavioural problems²⁷³, and that all segregated prisoners receive mental health assessments every 24 hours and an assessment by a physician or psychiatrist before five-day reviews.²⁷⁴

The Ontario Human Rights Commission calls on the Ontario Ministry responsible for corrections to ensure that prisoners with mental disabilities are appropriately accommodated, to the point of undue hardship. The Commission notes that it would be “very difficult” to establish undue hardship on the basis of cost. The Commission submits that the Ministry must assess what alternatives to segregation must be developed, including community-based secure mental health care treatment facilities.²⁷⁵

While calling for the abolition of solitary confinement, the Ontario Human Rights Commission recommends in the interim that strict limits be placed on the use of segregation, and that the Ministry develop and implement alternatives to segregation, adjust staffing models, hiring, screening and training “to ensure that staff with appropriate attitudes and behavioural skills are working with vulnerable prisoner populations”.

The Ontario Human Rights Commission notes in its supplementary submission to the Ontario Ministry of Community Safety and Correctional Services that the St. Lawrence

Valley Correctional and Treatment Centre has low segregation rates, despite housing prisoners with the most serious mental disabilities. It attributes its success in keeping segregation rates low to the centre’s use of single-cell accommodation and the numerous treatment options available.²⁷⁶

The American National Alliance on Mental Illness also supports mental health alternatives to solitary confinement, including individual and group therapy, regular access to psychiatrists, substance abuse counselling, specialized psychiatric service units, discharge planning, and community re-entry assistance.²⁷⁷

As discussed earlier in this report, Canadian prisoners face significant levels of mental health concerns. It is estimated that 50 percent of male prisoners and 62 percent of female prisoners require further mental health evaluation at intake. With such high levels of psychiatric care needs, high numbers of prisoners with psychological, emotional and behavioural issues (including those at risk of suicide or self-harm), and high rates of prisoners who are intellectually and behaviourally low functioning, there is a great need for many more therapeutic living units to address the specific needs of each prisoner population.

Although both the Correctional Service of Canada and BC Corrections have implemented mental health care units, these units do not provide anywhere near the number of beds needed to meet the needs of prisoners with mental disabilities. For example, the mental health unit at the British Columbia Surrey Pretrial Services Centre can provide up to 50 beds (double-bunked), while the centre has a total of approximately 600 prisoners. The federal Fraser Valley Institution for women has a capacity of 112, while its Structured Living Environment can house only up to 12 women. With 70 percent of women prisoners having a history of sexual abuse and 85 percent having a

history of physical abuse, 12 beds is not enough to help the vast majority of women prisoners with traumatic histories.

The Correctional Service of Canada's implementation of 150 psychiatric beds and 628 intermediate-level care beds is hardly adequate to address the mental health needs of more than half the total number of prisoners in federal custody with identified mental health issues. In our view, at least half of the living units in federal and provincial prisons should be therapeutic units, geared toward addressing the specific mental health needs of prisoners. In the federal system, that would represent approximately 7,500 beds nationally. BC Corrections would need to provide approximately 1,200 beds across the province.

In 2010, Psychologist Dr. Margo Rivera wrote a report for the Correctional Service of Canada entitled "Segregation Is Our Prison Within The Prison" in which an external review board was tasked with examining the use of long-term segregation and the placement of prisoners with mental health concerns in segregation. Dr. Rivera's report is an excellent study of the practical ways that the Correctional Service of Canada could dramatically reduce its reliance on solitary confinement and provide services to prisoners with mental health concerns that would prevent them from being placed in solitary confinement.

The external review board studied the experiences of 78 men held in long-term segregation (over 60 days, with an average stay of 144 days) at five medium-security federal prisons and six federal women prisoners held in long-term segregation (over 30 days). The external review board interviewed 143 Correctional Service of Canada staff members at all levels, as well as staff of the Correctional Investigator.²⁷⁸

Dr. Rivera recommended that the practice of solving a wide range of management problems within federal institutions by placing prisoners who are seen to be in trouble or causing trouble in solitary confinement must be challenged. She asserted that in order to do this, policy change, staff re-training and effective leadership will be necessary.²⁷⁹

Prisoners' Legal Services adopts many of the recommendations made by Dr. Rivera in her report.

MENTAL HEALTH SUPPORT

Dr. Rivera noted that the shortage of psychologists in many federal institutions meant that it was difficult for the Correctional Service of Canada to provide more than psychological assessments and crisis management.²⁸⁰ Her external review board's interviews with prisoners revealed that very few of them with mental health concerns received regular individual counselling and many did not trust psychologists not to use what they might say in counselling against them.²⁸¹

According to a psychiatrist interviewed by the external review board:

Most of the offenders I see have abuse histories, attachment problems, and lots of experience of trauma. I am here once a week, and I see 26 men, mostly for medication review. They need meds, but they need therapy more than meds. They need supportive therapy on a regular basis, which we know works well for addictions as well as other psychological problems. They could use behavioural counsellors and skill-building groups like they have in the women's institutions, groups to teach them how to manage and understand their emotions.²⁸²

Dr. Rivera recommended increasing the level of mental health interventions in the prisoner population before prisoners act out and are placed in segregation.

Dr. Rivera discussed the need for services for prisoners at risk of suicide or self-harm, and noted that the Correctional Service of Canada was implementing the pilot Complex Needs Program in the Pacific Region at the time, which turned out to be unsuccessful. Staff interviewed for the report also felt that suicidal prisoners should not be housed in segregation units, but should be housed in health care areas.²⁸³ Dr. Rivera concluded that “[o]nly well-trained and experienced staff are capable of meeting the challenge of offering compassionate and effective care and treatment to these complex individuals”, who require a “non-punitive” and “evidence-based treatment” approach.²⁸⁴

For women who suffer with severe psychological, emotional and behavioural issues, Dr. Rivera recommended either new units with specialized services and highly trained staff at each women’s institution, or an additional institution as an alternative to long-term segregation. The Canadian Association of Elizabeth Fry Societies does not support the creation of an additional institution for high needs women, but advocates for transfers to community-based mental health services under s. 29 of the *Corrections and Conditional Release Act*. Prisoners’ Legal Services supports this approach, which would allow women to remain close to their home communities while receiving the psychological and psychiatric care they need in a non-punitive, therapeutic environment.

Dr. Rivera also discussed the need for services for prisoners with mental health issues who do not qualify for psychiatric hospital care. The implementation of the Intermediate Mental Health Care Units by the Correctional Service of Canada seem to follow some of her recommendations, however, they have not been

adequately resourced, especially in the Pacific Region. Prisoners’ Legal Services still receives calls from clients with serious mental health issues who are transferred from the Pacific Institution’s Regional Treatment Centre to Kent Institution, where they will likely end up in solitary confinement due to behaviour caused by their mental disabilities.

Dr. Rivera interviewed Correctional Service of Canada staff who expressed a need for units to provide ongoing care for prisoners “who are intellectually and behaviourally low functioning, have foetal alcohol spectrum disorder, brain injuries, or impaired communication and relationship problems”.²⁸⁵

Dr. Rivera also identified a need for medical and psychological treatment for prisoners with situational conditions, including anxiety, depression and sleep disturbances.²⁸⁶

The Rivera Report recommended that rehabilitation, special-needs or complex needs units be established in every institution to decrease the number of vulnerable prisoners placed in solitary confinement, and that intermediate care programs be established for prisoners with chronic psychiatric problems, personality disorders, brain injury, low cognitive functioning or who engage in self-harm.²⁸⁷

The Correctional Service of Canada and BC Corrections can learn from the Colorado Department of Corrections, discussed above, and ensure that mental health services are provided to all prisoners, even those who seem resistant to treatment, or who appear to be “malingering”. According to Dr. Kupers:

While “malingering” does occur in prison, staff need to understand its roots in the severe deprivations prisoners experience. Before questioning whether a prisoner is really hearing bona fide voices, or is really intent on committing suicide, staff need to ask themselves what has driven the prisoner

to the point of contemplating his or her own demise, or what pain is causing him or her to exaggerate symptoms. In other words, to the extent that malingering is an issue, it is a symptom that requires attention.

Attention to antisocial personality disorder and psychopathy can be useful in helping shape individualized therapeutic interventions. But to the extent the diagnosis of an “Axis II Disorder” or psychopathy leads clinicians to give up on helping a dysfunctional prisoner, that diagnosis needs to be downplayed while a more effective intervention is sought. In other words, we need to stop blaming the victim’s innate “badness” for failed interventions, and we need to try harder.²⁸⁸

Staff at men’s institutions reported to Dr. Rivera’s review board that alternative units have been tried at various institutions, but they

eventually failed when the resource level was reduced and consequently their effectiveness undermined, but they emphasised how helpful these ranges had been in providing the extra attention and interventions that were able to keep vulnerable offenders from acting out in such a way that they wound up on segregation status.

The transition units in the men’s institutions were originally created specifically to assist in the gradual transfer of inmates from segregation to general population. During their on-site visits, the [external review board] noted that these units rarely had a framework for transferring the inmates back to general population, that there were very few services or programs offered in most of them, and that intervention staff did not often interact with the inmates in most of the transition units.²⁸⁹

Dr. Rivera reported that special needs units have been highly successful, but they tend to become

under-resourced, “watered down and then closed down”.²⁹⁰

The Intermediate Mental Health Care Units introduced by the Correctional Service of Canada and the more informal mental health care units in place at various BC Corrections’ centres are a step in the right direction. However, without adequate and secure funding, these units are unlikely to be successful in the long-term. The number of beds available in these units is also insufficient.

Prisoners’ Legal Services recommends that specialized therapeutic units be developed at each federal and provincial prison to address the unique needs of prisoners with a broad spectrum of psychiatric and psychological needs, including those with developmental disabilities and brain injuries, prisoners with situational psychological conditions, prisoners who need trauma counselling, and those with personality disorders that would benefit from treatment. The number of beds available must be equal to the number of prisoners who have these needs. This will require federal and provincial governments to legislate an ongoing increase in funding to the Correctional Service of Canada and BC Corrections so that these units can be properly and stably resourced.

Prisoners’ Legal Services also recommends that the Correctional Service of Canada and BC Corrections establish specialized mental health therapeutic centres in cities that have universities with medical and psychological programs, and develop partnerships with them in order to ensure that mental health programs are in line with current best practices, and that these centres do not face difficulties with recruitment and retention of quality mental health staff.

STAFFING

“The prison administration shall provide for the careful selection of every grade of the personnel, since it is on their integrity, humanity, professional capacity and personal suitability for the work that the proper administration of prisons depends.”

Rule 74 (1), the Mandela Rules

Dr. Rivera received reports from prisoners that some correctional officers are viewed as “negative, sarcastic, and unwilling to respond to offenders’ needs.”²⁹¹ Prisoners reported that they understood that if they “act like a jerk, the guards act like a jerk back”. Prisoners’ Legal Services has been told by one member of management at a federal institution that correctional officers are “only human” when they respond inappropriately to a prisoner who complains about them in an abusive manner. Dr. Rivera expressed the opinion that correctional officers are trained and contracted to respond professionally to prisoners, “even when their behaviours are annoying, frightening, or upsetting”, and that being dismissive or confrontational only serves to aggravate conflict. She recommended that segregation staff selection, training, supervision and evaluation be reviewed and enhanced.²⁹²

The Rivera Report emphasized the importance of ensuring there is a stable, high calibre of staff working in segregation units who are trained in conflict-diffusion skills and who use professional, respectful, encouraging and empowering communication with prisoners housed there.²⁹³ Staff working in segregation units should be a dedicated roster selected on the basis of interest, skills and attitude, rather than on seniority.²⁹⁴

Dr. Rivera recommended that staff be trained “in conflict-diffusion skills, teaching correctional officers how to allow offenders to back down and yet save face, rather than becoming involved in unnecessary power struggles.”²⁹⁵ She recommended that staff be evaluated for their “demonstrated functioning regarding professional, respectful, encouraging, and empowering communication with offenders in segregation”.²⁹⁶

The American National Alliance on Mental Illness also recommends that correctional officers be trained on how to respond to prisoners experiencing psychiatric crises in a way the de-escalates, rather than escalates the crises.²⁹⁷

In 2009, after the police-involved Taser death of Robert Dziekanski at the Vancouver Airport, an inquiry was held, led by Justice Thomas Braidwood. As a result of the report produced by Justice Braidwood, British Columbia created the Crisis Intervention and De-escalation Standard, which emphasizes “crisis intervention and de-escalation” training for police officers by establishing rapport with the person in crisis, facilitating communication and engaging in solution building.²⁹⁸

De-escalation training involves training officers to feel less threatened when they are confronted with an emotionally disturbed person. Experts believe that officers who feel less threatened in such a situation “will be more likely to try such alternative tactics as containment of the subject, increasing physical distance and time, dialogue or disengagement.”²⁹⁹

As stated by Paul Dubé, Ombudsman of Ontario:

Screaming repetitive stuff doesn’t always work, especially with someone who is actually mentally ill. But if time, barriers [and] safety for the officer allow to slow it all down, then that training can come into play...³⁰⁰

The Correctional Investigator is critical of the Correctional Service of Canada for treating self-injurious behaviour as a security issue, rather than a mental health issue. He noted in his 2015-2016 Annual Report that policy allows situations to escalate quickly into the use of inflammatory agents, physical handling, the use of restraints, disciplinary charges or solitary confinement. He advocates for a non-security focused approach to prisoners in crisis:

An alternative response model would direct security staff to adopt a primary support role (i.e. ensuring everyone's safety) while the actual intervention, carried out by mental health professional(s), focuses on assisting the self-injurious offender. In correspondence to the Office, CSC stated that they "...share the OCI's concerns regarding mentally ill inmates and the use of force." Punishing people for behaviours and emotions that they may not be able to regulate or control does not indicate that CSC shares the Office's concerns. That is the point of trying a different model and approach to managing self-injurious incidents in a prison setting. That is what the jury at the Ashley Smith inquest recommended and it is what CSC should do.³⁰¹

British Columbia prisoner accounts also indicate that BC Corrections adopts a security focused response to prisoners in mental health crisis.

Prisoners' Legal Services recommends that de-escalation training be a central part of all federal and provincial correctional officer training, and refresher courses should be required every three years. All correctional officers should be trained in conflict-diffusion skills and should be hired and promoted based on their ability to be professional, respectful, encouraging and empowering of prisoners, both in segregation or separate confinement units, and in all living units in order to prevent prisoners from being segregated.

Prisoners' Legal Services recommends that the Correctional Service of Canada and BC Corrections change their policies on how to respond to security incidents involving a prisoner in physical or mental health distress to a medical or mental-health response, with security staff present but not intervening unless necessary to prevent imminent harm.

INCREASE USE OF DYNAMIC SECURITY

An aggressive security response to a prisoner who disobeys a direction or who is rude to correctional staff only serves to escalate minor incidents into the use of emergency response teams, uses of force, and ultimately solitary confinement.

Dynamic security is aimed at creating an atmosphere of positive staff-prisoner relationships rather than a harsh and austere environment. It requires correctional officers to communicate professionally and respectfully with prisoners, and to treat them fairly.³⁰² Dynamic security allows prisoners to feel comfortable when approaching staff before problems escalate.³⁰³

In 2001, a Correctional Service of Canada Task Force on Security was convened and produced a report aimed at improving staff and prisoner interactions, and promoting safe reintegration. The authors noted that no other element played such an important role in maintaining the safety and security of institutions as dynamic security: "The review of security incidents has reflected repeatedly that problems in institutions occur when there is little positive interaction between staff and inmates."³⁰⁴

In her report, Dr. Rivera noted that management at all institutions were attempting to promote the use of dynamic security, where correctional

officers would interact and engage with prisoners, encourage positive behaviour, respond to requests and maintain respectful, calm and constructive communication with prisoners at all times, “rather than [engaging in] confrontation and power struggles”. However, she notes that staff reported that dynamic security was being used less often, possibly due to the Union of Canadian Correctional Officers’ influence, which promotes the use of static security over dynamic security.³⁰⁵

Dr. Rivera was of the view that many of the segregated medium-security prisoners interviewed in her study would have functioned well in a medium-security living unit if all institutional staff helped them to “manage their emotions, control their behaviours, and make substantial changes to how they relate to other people.” In her view, this would result in better outcomes for prisoners and public safety than keeping them in long-term segregation.³⁰⁶

Some direct supervision prisons in the United States provide an example of institutions successfully employing dynamic security. These prisons are organized into small, decentralized living units, with staff working in direct contact with prisoners, rather than in control rooms or towers – comparative research has shown this kind of facility reduces levels of assaults and other serious incidents, which contributes to settings that are less stressful and more agreeable to counselling and rehabilitation programs.³⁰⁷

Prisoners’ Legal Services recommends that the Correctional Service of Canada and BC Corrections, as well as the unions for federal and provincial correctional officers, promote the evidence-based value of dynamic security over static security.

Prisoners’ Legal Services recommends that federal and provincial correctional administrators be required to report to external

oversight bodies on all segregation or separate confinement placements and all use of force incidents. This reporting should include a consideration of how the use of dynamic security principles could have avoided the segregation, separate confinement or use of force.

MEDIATION AND SHORT-TERM CELL LOCK-UP

Dr. Rivera recommended that prior to segregating a prisoner, mediation should be attempted to address aggressive behaviour.³⁰⁸ She suggested a procedure that would require the involvement of interventions staff, such as a psychologist, mental health nurse, chaplain or Elder, who the prisoner knows, to have to agree to the segregation before admission. Prisoners could be locked in their cells or another cell for a short duration until it is determined that segregation is not necessary or until formal admission takes place.³⁰⁹

Dr. Rivera noted that in women’s corrections, “time-out” is used successfully for women experiencing stress to address behaviour before it escalates to the point that a segregation placement is considered necessary.³¹⁰

Dr. Rivera recommended that segregation placements be made only for serious behaviours that endanger life, and that other issues be dealt with while the prisoner remains in the prisoner population.³¹¹

Prisoners’ Legal Services recommends that governments introduce regulations that require mediation to be used as a first resort to addressing aggressive behaviour, whenever possible.

Prisoners’ Legal Services recommends that short-term cell lock up be used as an alternative to segregation or separate confinement when a

prisoner requires a cooling-off period. Cell lock-up should never be for more than a few hours, and must be for the shortest amount of time necessary.

WORK, PROGRAMS AND EDUCATION

The Rivera Report advocated for more opportunities for segregated prisoners to work, to leave their unit for social interaction, to access programming and education, and to access television. In it, Dr. Rivera recommended the implementation of Behavioural Counsellors to create behaviour-changing programs for men similar to the way Dialectical Behavioural Therapy has been used in women's institutions.³¹²

Prisoners' Legal Services recommends that if segregation and separate confinement are to continue to be used, prisoners must be provided opportunities for productive engagement, including work, programs and education. All prisoners should have access to television and sufficient hours of meaningful human interaction each day, including access to behavioural therapy.

VOLUNTARY SEGREGATION

The population of prisoners who are classified as being voluntarily segregated is diverse and includes prisoners who are at risk of violence from other prisoners because of *inter alia*, drug debts, gang rivalries, or being viewed as informants. However, a significant part of this population includes prisoners who suffer from low intellectual functioning, brain injury or less severe mental health problems that makes getting along with other prisoners difficult.

In her report, Dr. Rivera discussed the issue of prisoners who are in segregation "voluntarily". Prisoners who do not feel safe in the prison population may be placed in segregation voluntarily, because there are no alternative units in which they could feel safe. Dr. Rivera noted that many Correctional Service of Canada staff felt that segregation should not be made too comfortable, or prisoners will not want to leave.³¹³ Prisoners' Legal Services has heard this concern expressed as well, and saw a period of time when the Correctional Service of Canada was attempting to make life uncomfortable for voluntary prisoners in segregation by withholding "privileges" such as television and personal effects.

Dr. Rivera described a "sheltered unit" that was established at Stony Mountain Institution for prisoners at risk of segregation who were unable to integrate into the population because they preferred to be alone in their cells, were low functioning or had habits that others found annoying or offensive. The sheltered unit provided opportunities for prisoners to engage socially and to learn social skills. Staff would teach social skills to prisoners and encourage loners to join with others to eat meals or play games.³¹⁴

Dr. Rivera concluded that it is likely that one of the reasons there are so fewer women in long-term segregation than men is that they receive "significantly more mental health services and correctional programming" which "help them deal with the difficulties that caused the segregation placements".³¹⁵ She recommended that prisoners in voluntary segregation be given "maximum resources" to allow them to be productive and avoid mental health problems.³¹⁶

The Ontario Human Rights Commission's supplementary submission to the Ontario minister responsible for correctional services also noted:

that almost 300 of the segregation placements were made based on prisoner requests. That any prisoners, likely motivated by fear for their personal safety in the general population, would request being housed in conditions as harsh as segregation suggests few meaningful alternatives to segregation or mental health treatment options are actually being made available.

Prisoners' Legal Services recommends that prisoners in voluntary segregation or separate confinement be offered additional mental health supports, and be offered placement in a unit specifically designed for prisoners who have difficulty interacting socially with others, to be staffed by correctional officers and mental health professionals skilled at encouraging positive social interaction.

TRAUMA-INFORMED CORRECTIONS

“When a person’s escalated behaviour is understood as a result of trauma, it makes little sense to respond to that behaviour with an intervention that patients say is traumatic in and of itself, and which they perceive to be coercive, shameful, humiliating, punitive and alienating.”³¹⁷

Secure Rooms and Seclusion Standards & Guidelines

It is recognized that women prisoners are a particularly vulnerable group due to their extensive trauma histories, their victimization and the prevalence of mental health issues among them.³¹⁸ The Canadian Association of the Elizabeth Fry Societies reports that federally sentenced women have the highest rates of childhood sexual abuse, commonly incestuous,

violent, and extended over a long period of time, usually by men.³¹⁹ They are also more likely to be re-victimized.³²⁰

In a 2013 paper entitled “Life History Models of Female Offending: The Roles of Serious Mental Illness and Trauma in Women’s Pathways to Jail”, the researchers cite numerous studies that illustrate the high levels of exposure to trauma among women and girls who are incarcerated.³²¹ Neurobiological changes have been shown to occur as a result of exposure to trauma and can lead to emotional and cognitive impairments that often manifest in behaviour that contributes to criminality, such as poor self-regulation and anger.³²² Poor self-regulation and anger can easily result in behaviour that leads to placement in solitary confinement, unless the behaviour is understood to be a symptom of trauma and is responded to with compassion.

The link between traumatic experiences and subsequent mental health issues is also widely recognized. The Correctional Service of Canada’s own research, in a report entitled “Mental health needs of federal women offenders”, indicates that the percentage of women admitted to federal custody with a mental illness has “significantly increased” since the early 2000s.³²³ The researchers who conducted the report found that among the sample of 88 federally incarcerated women who participated in the study, 94 percent “had experienced symptoms consistent with a lifetime diagnosis of a psychiatric disorder”³²⁴ and 85 percent had experienced symptoms of more than one disorder. The most prevalent disorders were post-traumatic stress disorder at 52 percent, major depressive episodes at 69 percent and antisocial personality disorder at 83 percent.³²⁵

The rates of trauma experienced by male prisoners has not been as widely studied as it has for women, though research in the United States suggests that the rates of trauma are also high among male prisoners. Dr. Terry

Kupers' research reveals that "prisoners, on average, have suffered from a lifetime of severe traumas, including the domestic violence they witnessed or fell victim to as children, the violence and deaths they saw on the streets and the violence they experienced as adults prior to incarceration. (Kupers, 2005) Then, as convicts, they experience new traumas, including beatings, sexual assaults and time in solitary confinement."³²⁶ In a study conducted in 2012 by Nancy Wolff and Jing Shi on childhood and adult trauma and their criminogenic impact on adults, the researchers found that there are elevated rates of trauma among the incarcerated population. They assert that it is imperative to screen incarcerated men for trauma-related disorders such as post-traumatic stress disorder and to provide trauma-informed treatment for them.³²⁷

More research is needed to determine how prevalent trauma is among men in Canadian prisons. Prisoners' Legal Services has observed anecdotally that many of our male clients have had past traumatic experiences, including in childhood.

All prisoners who have a history of trauma would benefit from a trauma-informed approach to corrections. Trauma-informed treatment focuses on maintaining a patient's dignity and safety through the recognition that people who experience trauma can react to its impact in various ways. In the context of prisoners, this includes actions that led to their criminality.³²⁸

Researchers Niki Miller and Lisa Najavits describe the need for trauma-informed care in the prison system. They argue that a trauma-informed approach to prison care, combined with interventions designed to address trauma symptoms, will reduce potential harm to both prisoners and correctional staff, which in turn could reduce mental health and security costs for institutions.³²⁹ It is reasonable to assume that a trauma-informed approach would result in less

reliance on solitary confinement as a response to behavioural problems.

Ms. Miller and Dr. Najavits assert that correctional staff who are familiar with trauma, its symptoms and how men and women respond to it, will be better prepared to deal with the various reactions prisoners can have in situations that trigger trauma related responses.³³⁰

Trauma-informed care within prisons aims to "identify trauma and its symptoms among prisoners, train staff to understand the impact of trauma, minimize the risk of re-traumatization, maintain sensitivity to triggers of trauma, and identify how traumatic dynamics may, without intent, repeatedly play out in prisons."³³¹

In the United States, some institutions have begun to enhance staff training on trauma, and include programs for prisoners to learn techniques to respond effectively to their trauma symptoms. Staff are trained on ways to reduce triggers, stabilize prisoners who are in distress by de-escalating situations and to avoid measures that may repeat aspects of past abuse, such as isolation. They are finding that this approach creates safer institutions and greater job satisfaction.³³²

Trauma informed treatment also recognizes that "people at risk of or experiencing seclusion are particularly vulnerable and require interventions that take their specific histories and individual needs into account."³³³ Staff must be trained to respond to prisoners with empathy, understanding that the behaviour these prisoners are displaying is an involuntary response to particular triggers.³³⁴

Prisoners' Legal Services recommends that all staff who work with male and female prisoners be trained extensively in trauma-informed care, and that a trauma-informed approach be implemented in all federal and provincial prisons.

THE ROLE OF MEDICAL PROFESSIONALS IN PRISONS

The Mandela Rules include provisions that relate to health care professionals working in prisons.³⁵⁶ These include the following obligations:

- Doctors and other health care professionals must abide by the same ethical and professional standards when treating prisoners as would apply to patients in the community, including “[a]n absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment” (Rule 32);
- Doctors must report to the warden if they consider that a prisoner’s physical or mental health has been or will be injuriously affected by continued imprisonment or a condition of imprisonment (including solitary confinement) (Rule 33);
- Health care professionals who become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment must document and report it to the competent medical, administrative or judicial authority (Rule 34);
- Doctors must regularly inspect and advise the warden on conditions of confinement (Rule 35);
- Health care professionals must not play any role in imposing disciplinary sanctions or other restrictive measures (such as solitary confinement) (Rule 46);
- Health care staff must pay particular attention to the health of prisoners in solitary confinement, visit them on a daily basis and provide prompt medical assistance and treatment upon request of prisoners or staff (Rule 46);

- Health care staff must immediately report to the director any adverse effects of restrictive measures on the physical or mental health of prisoners and advise the director if they consider it necessary to terminate or alter the restrictive measures (Rule 46); and
- Health care staff must have the authority to review and recommend changes to the solitary confinement of prisoners to ensure it does not exacerbate a medical condition or mental or physical disability of the prisoner (Rule 46).

The Mandela Rules also provide that only the responsible health-care professional can make clinical decisions, and they cannot be overruled or ignored by non-medical prison staff (Rule 27).

Other bodies have called for similar reforms. The World Medical Association urges national medical associations and governments to adopt schemes that would require authorities to take account of prisoners’ health and medical conditions, regularly re-evaluate and document prisoners’ conditions, and immediately remove prisoners from segregation if they suffer adverse health consequences in isolation.³⁵⁷ The World Medical Association’s Guidelines for medical doctors affirm that prison physicians are “ethically obligated to refrain from countenancing, condoning, participating in, or facilitating torture or other forms of cruel, inhuman, or degrading treatment.”³⁵⁸

The American National Commission on Correctional Health Care takes the position that correctional health professionals should not condone or participate in cruel, inhuman or degrading treatment of prisoners, and if systems do not conform to international standards, health care staff should advocate to establish policies prohibiting the use of solitary confinement for youth and prisoners with mental illness and limiting its use to less than 15 days for all others.³⁵⁹ The American Public Health Association has recommended that people

should only be segregated for medical reasons upon the direction of a physician, and must be in the least restrictive environment for the shortest duration possible.³⁶⁰

In October 2015, Prisoners' Legal Services wrote to federal and British Columbia medical regulatory bodies and associations³⁶¹ asking them to develop guidelines for medical practitioners who work in prisons to comply with the sections of the Mandela Rules that apply to health care providers. Specifically, Prisoners' Legal Services requested that these bodies clarify that health care professionals who work in prisons must not play any role in approving prisoners to be held in solitary confinement, must report to the warden whenever they consider a prisoners' physical or mental health at risk by continued solitary confinement, 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.

To date, none of the bodies and associations contacted have committed to developing such guidelines for their members.

Nor has Correctional Service of Canada policy adequately incorporated the standards contained in the Mandela Rules. Prior to recent changes, policy merely required 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 stated 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 behaviours at the time of the assessment."³⁶²

Recent changes to Correctional Service of Canada policy are an improvement, but still fall short of compliance with the Mandela Rules. Now, normally before admission to segregation, the Correctional Service of Canada must consider whether referral to mental health services (acute psychiatric hospital care, intermediation mental health care or primary care) is an appropriate alternative.³⁶³ The warden is required to consider mental health care needs when deciding whether to maintain segregation or release a prisoner from segregation.³⁶⁴ If there are health care concerns that would preclude continued placement in administrative segregation, there must be a plan to address the issues. Where a mental health professional determines that a prisoner has "significant mental health issues which would require referral for mental health services...it must be identified and a plan initiated to provide this level of care".³⁶⁵

A health care professional, normally a nurse, is to visit the prisoner in person upon admission to segregation "to determine physical health care needs and mental health concerns, including risk of suicide or self-injury." Prisoners are to be visited daily by a nurse or other health professional, and referred to mental health services if there are mental health concerns. Before the five-day review, a mental health professional is to provide written comments on "any mental health issues that may impact the offender's segregation status" and how needs can be accommodated. This assessment is not typically based on an in-person assessment. At least once in the first 25 days and every 60 days thereafter, a mental health professional or staff under supervision is to assess and report on segregated prisoners' mental health status, with an emphasis on risk of self-injury or suicide, and consider a referral for mental health services. This assessment is to include a file review and interview, but the interview is not required to be in private. If mental health follow-up is required,

the assessor must share concerns with the appropriate staff members, which can include a recommendation for a change of placement. If a referral for mental health services is made at the 25-day or 60-day assessment, the referral should include an opinion on whether mental health issues will be exacerbated by continued segregation.³⁶⁶

The policy does not explicitly require health care staff to oppose placing prisoners with mental disabilities in segregation, to immediately report any adverse effects of solitary confinement, or to advise if they consider it necessary to terminate solitary confinement. The first assessment by a mental health professional is at the five-day review, but this is not usually based on an in-person assessment. How can a mental health professional comment accurately on mental health issues that may impact segregation status without meeting the prisoner? Policy does not require a mental health professional to report if a prisoner's mental health will be impacted until the 25-day review, and 60-day reviews thereafter. These time frames are well past the 15 days when solitary confinement becomes torture or cruel, inhuman or degrading treatment under United Nations' standards.

These policies do not prohibit health care professionals from playing any role in approving prisoners to be held in solitary confinement – rather, they require a health care provider to be a member of the segregation review board.³⁶⁷ Without limiting the use of solitary confinement to less than 15 days, and prohibiting its use on prisoners with mental disabilities, any decision to maintain segregation in these circumstances is a violation of the Mandela Rules.

The Correctional Investigator is critical of the policy involving health care professionals in segregation review boards: "It seems improper for health care workers to be involved in the decision to maintain an offender in

administrative segregation while maintaining a therapeutic relationship with that inmate".³⁶⁸

The policy also falls short by not requiring health care professionals to report the use of solitary confinement on prisoners with mental disabilities or solitary confinement for 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.

There is evidence in case law that the Correctional Service of Canada's new segregation policies are not always effective in preventing prisoners with serious mental disabilities from being held in long-term solitary confinement. In the *Hamm* decision, discussed above, a psychiatrist from another federal institution had previously assessed Mr. Hamm's medical records and concluded that he suffered from bi-polar disorder, which constituted a "severe and persistent mental illness."³⁶⁹ However, a psychologist at Edmonton Institution concluded that

[w]hile major mental disorder related to his mood has been considered in the past, more recently it does not appear that this diagnosis remains supported...Although Mr. Hamm is currently receiving pharmacological therapy to address his emotional regulation difficulties, the most significant health domain is likely dysfunctional personality traits. Based on this review, there is no evidence to suggest mental health concerns should preclude Mr. Hamm's placement in segregation at this time.³⁷⁰

In the case of another of the applicants in *Hamm*, despite having a history of suicidal ideation and behaviour, and receiving psychotropic medications which were only discontinued due to allegations of diversion, the institutional psychologist determined that, "there is no evidence to suggest mental health

concern would preclude Mr. Tobin's placement in segregation and there do not appear to be any mental health needs which will require accommodation while segregated."³⁷¹

Justice Veit concluded that given their mental health issues, it was unreasonable to place the applicants in segregation without a full mental health assessment.³⁷²

Prisoners' Legal Services' 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 they believe routinely rubber stamp their continued solitary confinement.

For example, in the case of a certified prisoner client who had been in solitary confinement for approximately seven weeks, the mental health professional's review indicated 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 was held in solitary confinement for over a year.

A psychiatrist discharged a client of Prisoners' Legal Services 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. Solitary confinement is known to increase the risk of self-harm or suicide – in our view it is never an appropriate response to self-harm.

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.³⁷³

We have had provincial clients remain in solitary confinement for months on end, and frequent reports of certified prisoners held in solitary confinement.

The Correctional Investigator of Canada expressed concern in his latest Annual Report that "there is a pervading feeling of 'mission creep,' co-optation of health care workers in service of operational interests at the potential expense of patient needs". He recommends that the Correctional Service of Canada consult with professional licencing bodies "to ensure that operational policies do not conflict with or undermine the standards, autonomy and ethics of professional health care workers in corrections".³⁷⁴

Prisoners' Legal Services recommends that federal and provincial medical regulatory bodies and associations develop guidelines for medical practitioners who work in prisons to comply with the sections of the Mandela Rules that apply to health care providers. Specifically, guidelines should stipulate that health care professionals who work in prisons must not play any role in approving prisoners to be held in solitary confinement, must report to the warden if they consider a prisoner's physical or mental health is at risk by continued solitary confinement, and must report the use of solitary confinement on prisoners with mental disabilities or solitary

confinement of 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.

Prisoners' Legal Services also recommends that the Correctional Service of Canada and BC Corrections amend their policies related to medical professionals to be in accordance with the Mandela Rules.



SOLITARY CONFINEMENT OF YOUTH

American research indicates that up to 70 percent of youth in custody have at least one mental disability,³³⁵ and the psychological harm caused by the solitary confinement of young people can exacerbate pre-existing mental illness and increase the likelihood of drug abuse.³³⁶ Another American study shows that 30 percent of youth in custody have learning disabilities and 45 percent have attention deficit problems.³³⁷ Solitary confinement for youth is particularly damaging because young people are still developing. Dr. Craig Haney states: “you put them in a situation where they have nothing to rely on but their own, underdeveloped internal mechanisms, but you are making it impossible for them to develop a healthy functioning adult social identity.”³³⁸

The United Nations’ Convention on the Rights of the Child strictly forbids the solitary confinement of people under the age of 18.³³⁹ The UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan Méndez, believes that the solitary confinement of youth for any duration is cruel, inhuman or degrading treatment and violates the International Covenant on Civil and Political Rights and the Convention against Torture. He recommends that states abolish the use of solitary confinement for youths.³⁴⁰

According to the Statistics Canada Youth Correctional Statistics in Canada Report, 2013-14 (the Youth Report), there has been a steady decline in the number of youths in custody in

Canada over the past several years. For the 2013-14 year, the average daily rate of youth involved in correctional services was 63 per 10,000 youth population. This was a reduction of 9 percent from 2012-13 and 25 percent from five years earlier.³⁴¹

According to the Youth Report, the majority of youth involved with the youth correctional system were being supervised in the community rather than in custody. In 2013-2014, for the nine reporting jurisdictions, 90 percent of the 9,458 youths being supervised on an average day were being supervised in the community.³⁴²

As is the pattern with the adult prison population, Indigenous youth are overrepresented in the youth prison population in Canada, with 41 percent of youth admissions to youth correctional centres being Indigenous, while representing only seven percent of the youth population in 2013-14.³⁴³

In British Columbia, the rates of youth incarceration have also dramatically decreased since 1994-1995, when the average number of youth in custody was 405, to an average of 64 youth in custody in 2015-2016. British Columbia went from having a higher rate of youth in custody per capita than the national average, to a lower rate than the national average. British Columbia also has higher rates of youth diversion than the national average, at 66 percent in 2015. Youth custody rates have declined so significantly due to decreased crime rates, enhanced police diversion, more

integrated services, enhanced community based alternatives to custody, changes to the *Youth Criminal Justice Act* and a change to the youth justice system culture.³⁴⁴

The *Youth Criminal Justice Act* provides direction to those in charge of youth aged 12 to 17 years involved with the justice system. The *Youth Criminal Justice Act* states that the principle of “the least restrictive measures” is to be used in achieving its purposes, but it is silent on the explicit use of solitary confinement.³⁴⁵

According to s 13 of the British Columbia *Youth Custody Regulation*, a youth cannot be separately confined for more than 72 hours without the approval of the Executive Director, Youth Custody Services.³⁴⁶ A staff member must explain to the youth the reason for the placement for separate confinement within four hours of the placement.³⁴⁷ Youth held in separate confinement are usually not held in isolation – they are usually held in a separate confinement unit with other youth, and are not generally locked in their cells for extended periods of time each day. However, without a prohibition on the practice of solitary confinement, youth are at risk of being held in extended periods of isolation.

In November of 2015, a British Columbia teen launched a legal challenge against the province regarding the four months he spent in solitary confinement.³⁴⁸ The teen alleged he suffered from both an intellectual impairment and a severe behavioural disorder.³⁴⁹ Although the teen spent the maximum 72 hours in solitary confinement, he was not returned to his regular living unit upon release. He was sent to a new living unit where he lived alone for four months, in isolation.³⁵⁰

Since 2010, former Professor of Social Work at the University of Manitoba Stephen de Groot has developed and implemented the relationship and strength based approach at the

St. Lawrence Youth Association, a justice facility near Kingston, Ontario.³⁵¹ The relationship and strength based approach to youth detention focuses on teaching youth how to emotionally and socially self-regulate.³⁵² Diane Irwin, Executive Director at the St. Lawrence Youth Association reports that although it has taken almost two years to fully adopt, the institution is seeing success.³⁵³ Youth are more comfortable in custody and staff report that their job is easier.³⁵⁴ Although solitary confinement is used in extreme situations, the frequency and duration has significantly decreased.³⁵⁵

Through anecdotal evidence, Prisoners’ Legal Services believes that the use of solitary confinement for youth in British Columbia is reasonably rare, but we are concerned that if it is used, there is no strong legislative or administrative direction for the practice, leaving the opportunity for its use to be abused.

RECOMMENDATIONS

1. We recommend that Canada and British Columbia prohibit the use of solitary confinement by statute. Legislation should require that when it is necessary to separate a prisoner from the population, it should be for as short a period of time as necessary within one day, and no prisoner should ever be denied sufficient meaningful human contact each day. Canada and British Columbia should never engage in the torture or cruel treatment of its prisoners.
2. We recommend that Canada and British Columbia legislatively prohibit the use of segregation or separate confinement on prisoners with mental disabilities and youth under the age of 21.
3. We recommend that Canada and British Columbia amend legislation to prohibit the use of segregation as a penalty for a breach of an institutional rule.
4. We recommend that British Columbia repeal s. 24 of the *Correction Act Regulation*, which allows prisoners to be held in segregation pending a disciplinary hearing.
5. If segregation and separate confinement are to continue to be used, federal and provincial prisoners must be afforded the statutory right to procedural fairness, including the right to an oral hearing of the evidence, legal representation of the prisoner's choice, and independent adjudication of segregation or separate confinement placements. Independent adjudicators must have the authority to remove prisoners from segregation or separate confinement, order access to programs or privileges, and recommend investigations and disciplinary proceedings against correctional staff who have violated law and policy. Independent adjudicators must be subject to the jurisdiction of the Correctional Investigator (federal) or the Investigation and Standards Office (BC provincial).
6. If segregation and separate confinement are to continue to be used, we recommend that Canada and British Columbia institute legislative time limits of 15 days continuous placement, with an annual limit of 30 days.
7. If segregation and separate confinement are to continue to be used, we recommend that Canada and British Columbia legislate for the external oversight of these placements to ensure that prisoners are not isolated, are provided opportunities to keep their minds productively occupied and have adequate levels of meaningful human contact each day.

8. We recommend that any segregated prisoners have as much human contact as possible with people from outside the institution, as well as with programming, religious and medical staff. Small groups of prisoners should be allowed to socialize if there are no serious safety concerns, such as for religious ceremonies, programs or in the yard. Prisoners in segregation should be provided access to counselling and behavioural therapy, programs, school, work and religious or community support.
9. We recommend that psychological services be offered to prisoners in segregation or separate confinement in a private area rather than only through the cell door.
10. We recommend that all segregated prisoners have access to television and personal effects within one day.
11. We recommend that any prisoners held in segregation or separate confinement never be double-bunked.
12. We recommend that legislation be introduced to ensure that prisoners on suicide watch are not housed in segregation units, and are provided adequate mental health resources and sufficient meaningful human contact.
13. We recommend that any staff who behave inappropriately in relation to segregated prisoners or who fail to provide segregated prisoners with daily access to showers, telephones, cleaning supplies and a separate hour of daily exercise be disciplined and removed from working with vulnerable prisoners.
14. We recommend that that prisoners held in segregation or separate confinement be provided access to request and complaint forms, that they receive a copy of all requests, complaints and grievances submitted, and that they are responded to within reasonable legislative or policy based timeframes.
15. We recommend that the Correctional Service of Canada and BC Corrections be required by law to document and report information about segregation, separate confinement and ESP placements, including the number of prisoners held under any of these regimes, the number of continuous days held in each of these regimes, the total number of days in these regimes for a prisoner in the year, whether prisoners have mental health needs, and data about gender, race, Aboriginal status, and instances of self-harm and deaths in segregation. This information should be publicly reported annually.
16. We recommend that the Correctional Service of Canada and BC Corrections be required by law to document and report publicly the number of hours prisoners held in segregation, separate confinement, ESP or specialized therapeutic units are out of their cells, including time out of cells receiving therapeutic services.
17. We recommend that federal and provincial correctional administrators be required to report to external oversight bodies on all segregation or separate confinement placements and all use of force incidents, and reporting should include a consideration of how the use of dynamic security principles could have avoided the segregation, separate confinement or use of force.

18. We recommend that BC Corrections be required to publicly report all non-natural deaths, including by suicide, murder, overdose and accident, and whether or not these deaths occurred in segregation, separate confinement or ESP, on an annual basis, similar to what is reported federally.
19. We recommend that British Columbia prisons be subject to regular external and independent inspections, as recommended by the BC Ombudsperson, and that this role be expanded to report publicly on BC Corrections' use of solitary confinement and other conditions of confinement, similar to the role of the federal Correctional Investigator.
20. We recommend that Canada and British Columbia fund the Correctional Service of Canada and BC Corrections sufficiently to provide at least half of the beds in each prison as therapeutic living units, on an ongoing basis. Legislation should specify that the number of therapeutic beds available must be sufficient to meet the mental health needs of the number of prisoners who are identified as having mental health needs.
21. We recommend that the definition of prisoners with mental health needs be broad and inclusive of prisoners with a spectrum of psychiatric and non-psychiatric needs, including developmental disabilities, brain injuries, depression, anxiety, insomnia, learning disabilities, attention deficit hyperactivity disorder, post-traumatic stress disorder, antisocial or borderline personality disorders, and prisoners who would benefit from trauma counselling. The definition of mental health needs should include prisoners who, regardless of diagnosis, demonstrate significant functional impairment within the correctional environment.
22. We recommend that specialized therapeutic units be developed at each federal and provincial prison to address the unique needs of prisoners with mental health needs, as defined above. These units should be adequately funded so that they can be staffed with mental health professionals including nurses, social workers, counsellors, psychologists and psychiatrists as appropriate.
23. We recommend that specialized mental health units adopt a policy and philosophy to work with prisoners despite non-compliance or resistance to therapy.
24. We recommend that specialized mental health units not be considered transitional units, but that prisoners be permitted to stay in these units as long as they are benefiting from a therapeutic environment.
25. We recommend that prisoners in specialized mental health units be offered at least 10 hours of out-of-cell therapeutic time per week, including opportunities for individual therapy. If refusal rates climb above 25 percent, additional individual therapy opportunities should be offered to maintain refusal rates below 25 percent.
26. We recommend that the federal government amend the *Corrections and Conditional Release Regulations* by removing the requirement that prisoners "requiring a high degree of supervision and control within the penitentiary" must be placed in maximum security. The regulation should instead provide that prisoners who require a high degree of supervision and control within the penitentiary, due to mental health problems, be placed in specialized mental health units that are able to meet their unique mental health needs.

27. We recommend that the Correctional Service of Canada and BC Corrections establish specialized mental health therapeutic centres in cities that have universities with medical and psychological programs, and develop partnerships with them in order to ensure that mental health programs are in line with current best practices, and that these centres do not face difficulties with recruitment and retention of quality professional staff. Mental health professionals in these centres should have oversight of the mental health units at each institution.
28. We recommend that federal and provincial prisoners with high mental health needs that cannot be met within institutions be transferred to community-based mental health services. We recommend that such transfers be used when appropriate for women prisoners to ensure that they receive the care they need close to home communities.
29. We recommend that de-escalation training and conflict-diffusion skills be a central part of all correctional officer training, and refresher courses should be required every three years.
30. We recommend that all correctional officers should be hired and promoted based on their ability to be professional, respectful, encouraging and empowering of prisoners, both in segregation or separate confinement units, and in all living units, in order to prevent prisoners from being segregated. Staff found to have behaved unprofessionally toward prisoners should be disciplined.
31. We recommend that the Correctional Service of Canada and BC Corrections change their policies on how to respond to security incidents involving a prisoner in physical or mental health distress to a medical or mental-health response, with security staff present but not intervening unless necessary to prevent imminent harm.
32. We recommend that all staff who work with male and female prisoners be trained extensively in trauma-informed care, and that a trauma-informed approach be implemented in all federal and provincial prisons.
33. We recommend that the Correctional Service of Canada and BC Corrections, as well as the unions for federal and provincial correctional officers, promote the evidence-based value of dynamic security.
34. We recommend that governments introduce regulations that require mediation to be used as a first resort to address aggressive behaviour, whenever possible.
35. We recommend that short-term cell lock-up be used as an alternative to segregation or separate confinement when a prisoner requires a cooling-off period. Cell lock-up should never be for more than a few hours.
36. We recommend that any prisoners in voluntary segregation or separate confinement due to mental health problems be offered additional mental health supports, and offered placement in a unit specifically designed for prisoners who have difficulty interacting socially with others, to be staffed by correctional officers and mental health professionals skilled at encouraging positive social interaction.

37. We recommend that federal and provincial medical regulatory bodies and associations develop guidelines for medical practitioners who work in prisons to comply with the sections of the Mandela Rules that apply to health care providers. Specifically, guidelines should stipulate that health care professionals who work in prisons must not play any role in approving prisoners to be held in solitary confinement, must report to the warden if they consider a prisoner's physical or mental health is at risk by continued solitary confinement, and must report the use of solitary confinement on prisoners with mental disabilities or solitary confinement of 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.
38. We recommend that Canada, British Columbia, the Correctional Service of Canada and BC Corrections amend their laws and policies related to medical professionals to be in accordance with the Mandela Rules.
39. We recommend that the federal and British Columbia ministries responsible for corrections include mental health experts and key stakeholders, including Prisoners' Legal Services, to be involved in the transformation of segregation and separate confinement, and mental health strategies, and to be open and transparent during that process. This process should include a review period over a number of years, to allow failures to be reconsidered and developed into successes.

ENDNOTES

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- 5 Méndez Report, *supra* note 2 at ¶ 25.
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- 13 Nancy Wolff, Jing Shi, and Jane A. Siegel, “Patterns of Victimization Among Male and Female Inmates: Evidence of an Enduring Legacy” (2009) *Violence Vict.* 24(4) at 469-484 [Wolff, “Patterns of Victimization Among Male and Female Inmates”]. Online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3793850/>.
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55 Michael Jackson, *Justice Behind the Walls* (Vancouver: Douglas & McIntyre, 2002) [Jackson, *Justice Behind the Walls*] at 291. Online: <http://justicebehindthewalls.net/>.

56 See *McCann v Canada* [1976] 1 FC No 570, where the court declared that conditions in the segregation unit of the British Columbia Penitentiary amounted to cruel and unusual treatment or punishment, contrary to the *Canadian Bill of Rights*. However, no time limits were imposed and nor was there an order for independent adjudication of segregation decisions as the petitioners sought.

57 Jackson, *Prisoners of Isolation*, *supra* note 36 at 62-63.

58 Jackson, *Justice Behind the Walls*, *supra* note 55 at 296.

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68 *Ibid* at 81-82.

69 *Ibid* at 71, 105 and 135. Justice Arbour’s preferred model would permit the institutional head to segregate a prisoner for up to three days to diffuse an immediate incident. After three days, a documented review would take place. If further segregation was contemplated, the administrative review could provide for a maximum of 30 days in segregation, no more than twice in a calendar year, with the effect that a prisoner could not be made to spend more than 60 non-consecutive days annually in segregation. After 30 days, or if the total days served in segregation during that year already approached 60, the institution would have to apply other options, such as transfer, placement in a mental health unit, or forms of intensive supervision, all involving interaction with the general population. If these options proved unavailable, or if the Correctional Service thought that a longer period of segregation was required, it would have to apply to a court for this determination.

Failing a willingness to put segregation under judicial supervision, Justice Arbour recommended that segregation decisions be made initially at the institutional level, but that they be subject to confirmation within five days by an independent adjudicator who should be a lawyer and who would be required to give reasons for a decision to maintain segregation. Thereafter, segregation reviews with an independent adjudicator would be conducted every 30 days.

70 *Ibid* at 162.

71 *Ibid* at 99.

72 *Task Force Report on Administrative Segregation – Commitment to Legal Compliance, Fair Decisions and Effective Results* (March 1997) [“Task Force Report on Administrative Segregation”] at 7 and 18.

73 The Correctional Investigator is mandated by Part III of the *CCRA* as an Ombudsman for federal prisoners. The primary function of the Office is to investigate and bring resolution to individual prisoner’s complaints. The Office also has a responsibility to review and make recommendations on the Correctional Service’s policies and procedures associated with the areas of individual complaints to ensure that systemic areas of concern are identified and appropriately addressed.

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