

THE “PROBLEM OF HEALTH CARE” IN CANADA’S FEDERAL PRISONS

THE “PROBLEM OF HEALTH CARE” IN CANADA’S FEDERAL PRISONS

By Eilish Scallan, B.Sc. (Psychology)

**A Thesis Submitted to the School of Graduate Studies in Partial Fulfilment
of the Requirements for the Degree of Master of Science (M.Sc.) Global Health**

McMaster University © Copyright by Eilish Scallan, March 2018

McMaster University MASTER OF SCIENCE (2018) Hamilton, Ontario (Global Health)

TITLE: The “Problem of Health Care” in Canada’s Federal Prisons

AUTHOR: Eilish Scallan, B.Sc. Psychology (Queen’s University)

SUPERVISOR: Dr. Fiona Kouyoumdjian

COMMITTEE MEMBER: Dr. Kari Lancaster

NUMBER OF PAGES: x, 63

LAY ABSTRACT

The United Nations states that “prisoners should enjoy the same standards of health care that are available in the community.” Despite this, persons in custody around the world continue to experience barriers to care and face unique health challenges. In Canada, the health of persons in federal custody is governed by the *Corrections and Conditional Release Act*. This legislation states that Correctional Services must provide “essential health care” and “reasonable access to non-essential mental health care” to inmates. Without clear definition, the interpretation of which services are “essential” is left to the discretion of correctional authorities, and as a result access and quality of care are significantly reduced in Canada’s prisons when compared to the broader community. This thesis applied Carol Bacchi’s “What’s the Problem Represented to Be” analytical framework to examine how “health care” is uniquely represented as a “problem” for Canada’s federal prison population, and the concerning inequities that are produced by this representation.

ABSTRACT:

Background: The United Nations states that “prisoners should enjoy the same standards of health care that are available in the community.” However, persons in custody continue to face barriers to care worldwide. The health of persons in federal custody in Canada is governed by the *Corrections and Conditional Release Act* (CCRA), which states that Correctional Services Canada is responsible for the provision of “essential health care” to all inmates. In the absence of concrete definition, these “essential” services provided in Canadian federal prisons often fall below standard. More research is needed into how “health care” is represented as a problem in Canada’s federal prisons, and the impact on the incarcerated population.

Methodology: Carol Bacchi’s “What’s the Problem Represented to Be?” (WPR) (Bacchi, 2009) framework was applied to the CCRA with a specific focus on health care. Questions one, three, and five of the WPR approach were applied, respectively, in order to analyze how the “problem” of “health care” is represented, how this particular representation came about, and the effects of this representation on the health of persons in custody.

Findings: In applying the WPR approach to the CCRA, three main themes emerged. First, the notion of what services are constituted as “essential” in the context of federal prisons is more limited compared to the broader community. Second, the creation of the CCRA involved a great deal of discussion around the rights of persons in custody versus

the protection of society, a dichotomy that has significant bearings on the treatment of those in prison. Third, this representation has negative effects on the health of those in custody.

Conclusion: The representation of health care in the CCRA has negative effects on the health of persons in custody. Greater attention must be paid to these inequities in health care provision in order to meet UN standards.

Keywords: Prison Health, Essential Health Care, Carol Bacchi, Inequity

ACKNOWLEDGMENTS

I would like to express my sincere gratitude to my supervisor, Dr. Fiona Kouyoumdjian, and committee member, Dr. Kari Lancaster. Dr. Kouyoumdjian has been a wonderful role model, as a champion of equitable health care provision and believer in this project. In teaching me how to think about problems differently, Dr. Lancaster has continued to challenge my critical thinking and supported my growth as an academic all the way from Australia. Thank you both for your support and encouragement – I've been very fortunate to learn from you.

I would also like to thank the Queen Elizabeth Scholarship Program and the McMaster Health Forum for providing support as I travelled to Australia to learn about strengthening health systems. I extend my warmest thanks to Dr. Carla Treloar, my mentor at the Centre for Social Research in Health, for encouraging me to think outside the box. Furthermore, I would like to thank the McMaster Global Health program for providing such exciting opportunities to learn and grow.

My warmest gratitude goes to my family and friends for their unwavering support and encouragement as I navigated this project. A special thank you to Amanda, a true social justice warrior.

Finally, I would like to extend my gratitude to the health advocates, scholars, story-tellers, critics, and champions, both inside and outside of prisons, whose work has inspired change in our health system.

Table of Contents

Chapter I: Introduction	1
1.1: Thesis Goals and Structure	1
Chapter II: Background	3
2.1: Global Precedents for Health in Prisons	3
2.2: Health Status of Prisoners: The Canadian Context	3
2.3: The Canadian Context	5
2.4: The Corrections and Conditional Release Act	7
2.5: Problematizing Health Behind Bars	9
Chapter III: Methodology	11
3.1: “What’s the Problem Represented to Be?”	11
3.2: Theoretical Underpinnings	12
3.3: Questions and Definitions	13
3.4: Application to Health Policy	16
Chapter IV: Analysis	18
4.1: Introduction	18
4.2: Federal Institutions and “Essential Health Care” (Question 1)	19
4.3: Health of Persons in Federal Custody vs. Protection of Society (Question 3)	23
4.4: Health and the “Offender” vs. Health and the “Citizen” (Question 5)	33
4.5: Self-Reflection	40
Chapter V: Case Study: Harm Reduction in Federal Prisons	42
5.1: Tertiary and Secondary HCV Prevention	44
5.1: Primary HCV Prevention	46
5.3: “Deadly Disregard”: Effects of Political Power on Discursive Effects	49
Chapter VI: Conclusion	51
6.1: Key Themes	51
6.2: Considerations	53
References	56

LIST OF TABLES AND FIGURES:

Table 1: Bacchi's WPR Approach

LIST OF ABBREVIATIONS AND SYMBOLS:

UN – United Nations
WHO – World Health Organization
HIV – Human Immunodeficiency Virus
HCV – Hepatitis C virus
CSC – Correctional Services Canada
CHA – Canada Health Act
CCRA – Corrections and Conditional Release Act
WPR – “What’s the Problem Represented to Be?”
CBA – Canadian Bar Association
DAA – Direct-Acting Antiviral
PWID – People who inject drugs
NSP – Needle and Syringe Program
PNSP – Prison-based Needle and Syringe Program

Declaration of Academic Achievement

All research presented in this document was conducted and written by Eilish Scallan, recognizing the contributions from Dr. Fiona Kouyoumdjian and Dr. Kari Lancaster who provided insight and guided analysis.

CHAPTER I: INTRODUCTION

“It is said that no one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens, but its lowest ones.”

- Nelson Mandela (United Nations, 2018)

-

The United Nations' (UN) Nelson Mandela Rules assert that prisoners should have access to the same health services as the general community. Formerly the *Basic Principles for the Treatment of Prisoners* (United Nations General Assembly, 2015), these rules establish a global precedent that persons in custody retain their fundamental human rights. These standards were first adopted by the UN in 1955 and have undergone considerable growth and development in the years since (United Nations, 2018). Despite this precedent, health in prisons remains a global challenge and striking threat to human rights.

1.1 Thesis Goals and Structure

The current thesis aims to examine the state of health care provision in Canada's federal prisons by critically analyzing the legislation defining care, the *Corrections and Conditional Release Act* (Corrections and Conditional Release Act, 1992). In analyzing the ways in which health is represented as a problem in this document, this work aims to explore the historical underpinnings and lived effects of this representation.

The first chapter of this thesis serves as an entry point into the discussion of human rights in prison, with emphasis being placed on the right to health care equal to that of the greater community. The second chapter will provide context for the global

health crisis occurring in prisons. The health status of persons in Canada's federal prisons will be emphasized, and legislation of interest will be presented. The third chapter will discuss the methodology and analytical framework applied in the current thesis, explaining the basis for this approach and the questions that will be addressed. The fourth chapter delves into analysis, with attention being drawn to a historical analysis of the *Corrections and Conditional Release Act* and the effects of its representation of health care. Following, the fifth chapter will turn to a case study of hepatitis C virus prevention in Canada's federal prisons, to provide context to the analysis. This thesis will conclude with a reflection on the main themes of this work, and a consideration of limitations and future directions for research.

CHAPTER II: BACKGROUND

2.1 Global Precedents

The Mandela Rules state that “prisoners should enjoy the same standards of health care that are available in the community” (United Nations General Assembly, 2015). The principles laid out by the United Nations (UN) have been supported and reiterated by the World Health Organization (WHO). In their report *Prisons and Health* (Enggist, Møller, Galea, & Udesen, 2014) the WHO builds on the assertion that after revoking liberties, a state must take on the responsibility to provide health care to its incarcerated population. This report asserts that in order to provide care, it is essential to understand and address the health needs of the incarcerated population on a both a systemic and individual level. Prisons house the most marginalized populations of a society. The health status of persons in prison is worse than that of the broader community, a reality that positions prisons as centres in which health is both a pressing challenge and a unique opportunity. Institutions have the potential to serve as places in which the health needs of hard-to-reach populations can be identified and addressed (Kouyoumdjian, Schuler, Matheson, & Hwang, 2016; Møller, Gatherer, Jürgens, Stöver, & Nikogosian, 2007).

2.2 The Health Status of Prisoners

Despite global precedents, persons in custody continue to experience barriers to care, and the challenge of health providing adequate health care remains in prisons globally. It is estimated that more than 11 million people are imprisoned worldwide, and the burden of illness falls disproportionately on this population (Fazel & Baillargeon, 2011; Walmsley, 2015). A number of determinants place persons in custody at higher risk

of disease. A number of these factors are intrinsic to time in custody. For instance, overcrowding contributes to tuberculosis rates that are 10 to 100 times higher than those of the general community. The deprivation and dislocation associated with imprisonment deepen psychological and physical distress among the incarcerated population (De Viggiani, 2007). In this sense, prison acts as a form of “double punishment” (Sim, 1990). A number of factors that are present before a person enters custody pose heightened risk when continued in prison. Risk behaviours, such as needle-sharing and unprotected sex, contribute to higher rates of infectious disease such as human immunodeficiency virus (HIV) and hepatitis C virus (HCV) (Zakaria, Borgatta, & Thompson, 2010). The widespread inadequacy of harm reduction resources in prisons amplifies the risk of these activities (Chu & Peddle, 2010; Kouyoumdjian & McIsaac, 2015). For instance, very few prisons in the world offer needle and syringe programs, despite their proven effectiveness in reducing disease and linking people to health services in the broader community (Chu & Peddle, 2010). Mental illness is common among persons entering custody, with higher rates of post-traumatic stress disorder, drug dependence, and histories of severe trauma and abuse compared to the broader population (Driessen, Schroeder, Widmann, von Schonfeld, & Schneider, 2006; Fazel & Baillargeon, 2011). Taken together, the structural determinants of prison health combine with existing health problems to position prisons as the ultimate “antithesis” to health and wellbeing (De Viggiani, 2007).

There has been a great deal of discussion on the health care inequities faced by persons in custody. With more than 30 million people traveling through the prison system each year, the concerning health status of persons in custody demands action (Kinner,

Forsyth, & Williams, 2013). Given the differences in prison governance that exist between countries and jurisdictions, it is useful to examine the health of persons in custody on a smaller scale. As such, this chapter will now turn to the Canadian context, in order to understand health in Canada's prisons and the forms of governance that regulate this health.

2.3 The Canadian Context

In Canada, there are more than 250,000 admissions to correctional facilities each year. On any given day, there are over 14,000 persons in federal custody (Reitano, 2017). Canada's prisons house some of the country's most marginalized groups and addressing the unique health needs of this population requires an understanding of their histories and lived experiences. There is a significant overrepresentation of Indigenous people in prisons – while Indigenous persons comprise less than 5% of Canada's population, this group makes up 26.4% of the federal inmate population (Zinger, 2017). Many Indigenous persons suffered in residential schools, and continue to carry this “history of disadvantage” into prison as they experience more time in segregation and face higher levels of security compared to non-Indigenous inmates (Zinger, 2016). The number of women in federal custody increased by nearly 30% between 2007 and 2017, representing the fastest growing population behind bars. Histories of physical, emotional, and sexual abuse are common among women in custody (Correctional Service Canada, 2017b). The majority of women report living with mental health problems, an issue that is amplified in the prison setting (Zinger, 2017). Many persons report using drugs in the recent past before they were admitted to custody, and continue to use drugs in prison (Kouyoumdjian

et al., 2016; Sapers, 2015). Higher rates of substance use and mental health disorders are met with a severe lack of resources in prison, leaving inmates to struggle (Stall, 2013a). This struggle is reflected in high rates of self-injury and suicide in Canada's prisons (Kouyoumdjian et al., 2016).

In entering the correctional system in Canada, a person first enters the provincial or territorial system while awaiting sentencing ("remand") or if sentenced to less than two years. Sentences of two years or less are served in the provincial or territorial system. As a result, the provision of health care in these facilities remains the vested responsibility of the jurisdictional government regulating health. While this authority differs between provinces and territories, the health care provision for inmates in these institutions remains governed by the *Canada Health Act*. Despite this, health care delivery in provincial prisons falls short of the UN-declared obligations (Kouyoumdjian et al., 2016). Overcrowding and a significant deficit of rehabilitative resources contribute to the health care crisis within Canada's provincial and territorial institutions (Public Services Foundation of Canada, 2015).

Persons 18 years and older who are sentenced to two years or longer are transferred to the federal correctional system. There are approximately 15,000 persons in federal custody at any given time, with the rate of federal admissions having increased in recent years (Reitano, 2017). Upon entering a federal institution, persons become the responsibility of the Correctional Service of Canada (CSC). The *Canada Health Act* no longer applies to health care in this setting. Rather, the *Corrections and Conditional Release Act* is the legislation outlining the provision of health care in federal prisons. As

with provincial institutions, access to care is significantly reduced within federal institutions when compared to the broader community, while at the same time risk of infectious disease and violence increase (Kouyoumdjian & McIsaac, 2015; Miller, 2013a). This paradox positions health as a critical concern for persons housed in both the federal and provincial arms of Canada’s prison system.

This thesis will focus on the provision of health to persons incarcerated in Canadian federal prisons in order to interrogate how “health” is uniquely defined for this population. Given that the legislation outlining health care provision in the federal setting differs from the broader Canadian population, this thesis aims to explore how the representation of health in this legislation works to produce effects for persons in federal custody. In the following sections, the legislative context of prison health care in Canada will be described, followed by a critical analysis of how health care is constructed in this context.

2.4 The Corrections and Conditional Release Act

The *Canada Health Act* (CHA) sets the standard for health provision in Canada (Canada Health Act, 1985). The CHA establishes a foundation for health provision built on public administration, comprehensiveness, universality, portability, and accessibility, and provides the means through which the federal government can hold provincial and territorial governments responsible for quality care provision. However, this Act does not govern the health of Indigenous persons living on reserves and persons in federal prisons; the health of these groups are governed by the *Indian Act* and the *Corrections and Conditional Release Act*, respectively (Corrections and Conditional Release Act, 1992;

The Indian Act, 1985). While provincial/territorial institutions are obligated to meet the conditions of the CHA, federal facilities are not.

The Corrections and Conditional Release Act (CCRA) guides the governance of federal institutions by CSC. This Act arose from the 1986 Correctional Law Review Project, a project conducted by the Solicitor General Canada which aimed to promote fairness and justice for Canada's incarcerated population. In conducting public consultations with a range of stakeholders, this review advocated for continuity and consistency within the Canadian system of justice as it operates in prisons. Central to this advocacy was the notion that the standards of health for the incarcerated population must be equal to the standards governing the health of the broader community (Working Group of the Correctional Law Review, 1988).

The release of the CCRA in 1992 was met with a mixed response. The publication of this Act signaled a movement towards a more balanced system of reform and justice, by recognizing the rights of persons in custody and creating legally binding provisions for decision-making processes that affect this population. However, the Act did not reflect many of the recommendations from the Correctional Law Review Project, which were aimed at strengthening the protection of persons in custody. Chief among these oversights was the failure to expand the role of independent bodies in law enforcement. This process of independent review is crucial to the fair assessment of inmate grievances, and this expansion would have contributed to fairness within the system by monitoring authority (Canadian Bar Association, 1999; Working Group of the Correctional Law Review, 1988).

The main objective of the CCRA is to “contribute to the respect of the law and the maintenance of a just, peaceful, and safe society” (Corrections and Conditional Release Act, 1992). This objective provides insight into the grounding purpose of corrections in Canada, which is the protection of society. In building ideas of justice on the foundation of this priority, other important factors, such as the rehabilitation of persons in custody, have less significance.

2.5 Problematizing Health Behind Bars

The current chapter aims to explore the governance of health in Canada’s federal prisons by analyzing how “health care” is represented as a “problem” within the CCRA. To undertake this analysis, this chapter will draw on poststructural approaches to policy analysis, and in particular the work of policy theorist Carol Bacchi (Bacchi, 2009; Bacchi & Goodwin, 2016). Applying this approach, which is outlined in greater detail below, this paper will focus on sections 86-88 of the CCRA, which detail health provision in federal institutions. Specifically, attention will be drawn to Section 86, which outlines the Obligations of Service held by Correctional Service Canada in the provision of health:

86 (1) The Service shall provide every inmate with

(a) essential health care; and

(b) reasonable access to non-essential mental health care that will contribute to the inmate’s rehabilitation and successful reintegration into the community (Corrections and Conditional Release Act, 1992).

The services deemed to be “essential” are at the discretion of CSC. In contrast to the primary objective of the CHA which is to “protect, promote and restore the physical and mental well-being of residents of Canada” (Canada Health Act, 1985), the CCRA

places emphasis on the maintenance of “essential” health care, a notion which is deserving of critical attention. The legislation suggests that any “non-essential” care is provided to persons who will be re-entering the broader community, and does not specify that such care should be extended to persons who are not being released to the community. One effect of this law is that it inherently delegitimizes the health of people serving life sentences in Canada’s federal prisons, a population that accounted for 23% of all incarcerated persons in 2016 (Correctional Service Canada, 2017a). This representation of health will serve as an entry point for analysis, serving as a window through which the problematization of health behind bars can be critically analyzed.

Chapter III: Methodology

3.1 “What’s the Problem Represented to Be?”

The current paper applies Carol Bacchi’s “What’s the Problem Represented to Be?” (WPR) approach to policy analysis, in order to critically examine the way in which “health” is represented as a problem in the CCRA. In her book “Analysing Policy” (2009), Bacchi outlines a tool for analysis that fundamentally questions the way problems are represented in policy. The WPR approach to policy analysis rests upon the idea that our proposed actions signal what we believe to be the “problem.” For instance, if a policy aims to combat the underrepresentation of women in positions of power by creating tailored training programs in the workplace, then it is implied that the “problem” is a lack of adequate training. This problem representation silences other possibilities, including the systemic barriers that may stand in the way of women succeeding in some settings. In this sense, policies are productive – they give shape to problem representations that “do not imitate reality but are the practices through which things take on meaning and value” (Shapiro, 1988). The WPR approach builds upon this notion that problems are produced rather than fixed entities.

The WPR approach has multiple goals: to reflect on how we are governed, how this governing occurs, how we are produced as subjects within this framework, and the implications of these processes (Bacchi, 2009). At the core of these processes of governance is the concept of “problematization”, a key tenet of the WPR approach. Problematization examines how ideas are represented as “problems”, a process that

results in the oversimplification of the range of factors that contribute to an issue (Bacchi, 2009). It is this oversimplification that the WPR approach aims to unpack. By acknowledging the problem representations that are embedded in policies, it is possible to critically interrogate modes of governing – and in doing so, discussion is shifted from the act of “problem-solving” to “problem-questioning” (Bacchi, 2009, p. xvii).

3.2 Theoretical Underpinnings

The WPR approach draws on a number of theoretical resources. The approach incorporates the influence of social construction theory and ontological politics (Mol, 1999), which maintain that many things, such as knowledge, are socially produced. Studies of government are reflected in the emphasis on governing practices seen in the WPR approach. These forms of governing include the state and other groups such as experts, professionals, social workers, and academics (Bacchi, 2009). The WPR approach places significant emphasis on the lived effects of the problem representations that are embedded in policy, a reflection of feminist body theory. Policies shape realities, and the effects of this must be interrogated.

Poststructural theory lays a great deal of the groundwork for the WPR approach, through its reference to the contestable nature of reality and its emphasis on the politics involved in assigning meaning to practices. The influence of Michel Foucault resonates in the theories of Carol Bacchi, as can particularly be seen in the study of problematization. In critically analyzing governance, Foucault explores the lived effects stemming from produced knowledges. On his studies of problematization, Foucault asserts:

When I say that I am studying the “problematization” of madness, crime, or sexuality, it is not a way of denying the reality of such phenomena. On the contrary, I have tried to show that it was precisely some real existent in the world which was the target of social regulation at a given moment. The question I raise is this one: How and why were very different things in the world gathered together, characterized, analyzed, and treated as, for example, ‘mental illness’? What are the elements which are relevant for a given ‘problematization’? ... The problematization is an ‘answer’ to a concrete situation which is real. (Foucault, 1985, p. 115)

Bacchi’s WPR approach builds on Foucault’s poststructural theories by applying a lens of problematization to a range of texts, including policies and legislation. A WPR analysis broadens Foucault’s approach to problematizations. While Foucault often sought to analyze “crisis” moments, where shifts in practices or policies occur, the WPR approach considers *all* policy proposals to contain inherent problematizations (Bacchi, 2012; Foucault, 1985).

3.3 Questions and Definitions

The WPR approach is designed to be an adaptable tool for policy analysis. Six questions and one self-reflective step comprise a framework that can either be applied systematically or as an integrated analysis. These questions are as follows (Table 1):

1. What’s the problem (e.g. of “gender inequality”, “drug use/abuse”, “economic development”, “global warming”, “childhood obesity”, “irregular migration”, etc.) represented to be in a specific policy?
2. What deep-seated presuppositions or assumptions underlie this representation of the “problem”?

3. How has this representation of the “problem” come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the “problem” be conceptualized differently?
5. What effects (discursive, subjective, lived) are produced by this representation of the “problem”?
6. How and where has this representation of the “problem” been produced, disseminated and defended? How has it been and/or how can it be disrupted and replaced?
7. Apply this list of questions to your own problem representations. (Bacchi & Goodwin, 2016)

These questions can be applied to a select document in order to interrogate the effects of problem representations within a text. Question 1 signals a starting point to analysis, clarifying the problem representations that are inherent within a policy or proposal. Question 2 calls for a reflection on the underlying assumptions that contribute to this representation. As an exercise in Foucauldian archaeology, this question prompts an examination of the thoughts behind problematizations. A discourse analysis examining the binaries, key concepts, and categories that are inherent in a given policy or proposal facilitates the process of identifying assumptions. Question 3 can be considered a historical analysis, as the researcher interrogates how this problem representation emerged. This question has two primary objectives: to reflect on historical developments, and to recognize that problem representations exist and change over time and space, under changing influences. Question 4 acknowledges the limitations of

problematizations, through a careful analysis of the gaps and silences that are left by particular representations. Question 5 calls for a critical examination of the effects of problem representations, which often benefit some groups and harm others. The analysis of three main types of effects guide this question: discursive effects, which follow from limits on thoughts and speech; subjectification effects, which follow from ways in which people are positioned in a problem; and lived effects, which describe the impact of a problem representation on life and death. Finally, question 6 presents an analysis of how a particular problem representation is conveyed to the public. This question necessitates consideration of how a particular representation becomes dominant, and can include questioning the role of media (Bacchi, 2009; Bletsas & Beasley, 2012).

A complete study of problematization necessarily includes reflection on the self. The position of the researcher in a WPR analysis comes with a set of beliefs, assumptions, and intentions that influence the study of problem representations. In light of this, self-problematization is built into the WPR approach – Bacchi encourages the applications of all questions to one’s own biases (Bacchi, 2009). A WPR analysis “radicalizes our sense of the contingency of our dearest biases and most accepted necessities, thereby opening up a space for change” (Flynn, 2005, p. 33). In this sense, applying a critical lens to one’s own thoughts lays the foundation for reflection and growth, and the WPR approach moves from a series of declarations to an exercise in critical reflexivity (Bacchi & Goodwin, 2016).

3.4 Application to Health Policy

The WPR approach has applications across a range of disciplines. For instance, researchers in the field of Australian drug policy have applied this approach to interrogate representations of drug “problems”, “recovery” and “addiction” in law and policy, and in doing so have shed light on the potentially damaging effects of this discourse (Lancaster, Duke, & Ritter, 2015; Lancaster, Seear, & Treloar, 2015; Seear & Fraser, 2014). Further, researchers in the field of education policy have applied this approach to analyze “problems” of educational disadvantages and reimagine methods of teaching (Goodwin, 2011; McInerney, 2007; Salter, 2013). Indeed, the WPR approach can be applied across fields and subjects.

Of particular interest to the current paper is the poststructural approach to health policy outlined in “Analysing Policy” (2009) and “Poststructural Policy Analysis” (2016). Bacchi stipulates that the meaning of “health” changes based on time and space and is influenced by norms and values. In conducting a poststructural analysis of health policy, it is necessary to examine how policies constitute “health care” as a particular kind of problem, and the effects that stem from this representation. Fundamental to this analysis are multiple and different constitutions of “health;” for example, as a biomedical “problem” or a social “problem” – the former focusing on absence of disease, the latter emphasizing a broader sense of wellbeing. Tracing the effects of these different constitutions of “health,” it becomes possible to interrogate how people are produced as either passive or active subjects of their own health. It is from this starting point that the

current paper will build, in order to examine the problem of “health” within Canada’s federal prisons, and how persons in custody are produced as particular kinds of health subjects.

Chapter IV: Analysis

4.1 Introduction

The problem representation of “health” is unique for Canada’s federally incarcerated population. In this section, the WPR approach will be applied to section 86 of the *Corrections and Conditional Release Act*, which deals with the obligations of healthcare provision within federal institutions. Definitions, standards, and other contextual guidelines for health provision are provided in sections 85 and 87-89. However, I chose to focus on section 86 of the Act as it directly details the legal obligations for the delivery of healthcare to persons in custody. This analysis will unpack the inherent assumptions, silences, and lived effects of problematizations of “health” in this context. Further, by placing the CCRA in conversation with the *Canada Health Act* at various points, analysis of differing problematizations of health and different subject positions can be conducted. The law reflects the ever-changing values of a society, and so the current analysis will provide valuable insight into how persons in custody are perceived at this time in Canada (Seear & Fraser, 2014).

As Bacchi (2009) advises, the WPR approach can be conducted systematically or as an integrated analysis. The current paper will adopt the former approach, selecting specific questions in order to delve deeper into chosen issues. Using questions 1, 3, 5 and 7 of the WPR approach as a guiding tool, this analysis will explore how the problem of health is represented to be in the CCRA, how this representation has come about, and the effects that are produced by this representation of the problem. In applying these

questions, three themes emerge from the text, each applying to a respective question in the WPR framework: (1) federal institutions and “essential health care;” (2) health of persons in federal custody vs. the protection of society; and (3) health and the “offender” vs. health and the “citizen.” Following an in-depth exploration of these key themes, I will conduct a critical self-reflection in accordance with Step 7 of the WPR approach.

4.2 Federal Institutions and “Essential Health Care”

The WPR approach begins with a policy intervention – in this case, a piece of legislation – and works backwards in order to reveal how the issue is being conceptualized. While health is discussed in sections 85-89 of the CCRA, section 86 speaks directly to the obligations of service that CSC is bound to meet (as listed in Chapter II).

Examining what is proposed as a health intervention indicates how the problem of health is being conceptualized by CSC. In focusing first on subsection (a) of section 86 of the CCRA, the labelling of care as “essential” implies that health issues are being addressed out of necessity. Further, the labelling of some aspects of care as “essential” implies that other parts of care are non-essential. This notion fundamentally undermines the WHO’s definition of health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 2018). Quality of health care provision varies widely across federal institutions, often falling below the standards that would be acceptable in the broader community (Miller, 2013b). In a setting where the spread of infectious disease is heightened, there is no increase in health services to mirror need (Miller, 2013a). The ambiguity in what services

are “essential” contributes to striking inconsistencies in the quality and quantity of care across institutions (Miller, 2013b). These inadequacies indicate that the constitution of “essential” varies based on institution and may fail to meet the basic health needs of persons in custody. This representation lends itself strongly to the biomedical paradigm of health, which is focused on the absence of disease, rather than promoting wellness more broadly including factors such as shelter, education, income, food, and stability (Bacchi, 2009). The biomedical paradigm of health is largely curative in nature, as a provider responds to the immediate needs of the patient. Health can also be seen as necessary for the maintenance of order and control – conditions that are seen as absolute requirement within a correctional facility. In order to successfully govern and “police” a population, the population must be healthy (Bacchi, 2009; Turner, 1997). The exclusion of certain resources that are seen as key to the broader community, such as needle exchange programs, also suggests that the constitution of “essential” is built on moral grounds. The lack of clarity on the difference between “essential” and non-essential suggests that the provision of health services may be partly limited by a moral judgment on what the prison population, a highly stigmatized group, deserves.

The lack of clarity between “essential” and non-essential health care has implications for mental health provision in federal prisons as well. As previously stated, the CCRA stipulates that CSC must provide “essential health care, including medical, dental and mental health care, and reasonable access to nonessential mental health care that will contribute to the inmate’s rehabilitation and successful reintegration into the community” (Corrections and Conditional Release Act, 1992). However, given the

psychological stressors of prison and the extensive histories of trauma reported by most persons in custody (De Viggiani, 2007; Driessen et al., 2006; Fazel & Baillargeon, 2011), to paint mental health provision as “non-essential” is a dangerous generalization. The burden of mental illness in Canada’s prisons is estimated to be three times that of the general population, and the conditions of prison further contribute to the development of problems (Stall, 2013b). To separate mental health from physical health is an alarming oversight given the histories of people in custody. Further, the description of mental health services in the CCRA suggests that rehabilitative services are only deserved by those persons who will at some point be “reintegrated” into the community. This distinction draws a line between health and wellbeing, with the latter only being afforded to those who will enter the general population again at some point.

As previously mentioned, the representation of non-essential services as support for community reintegration inherently delegitimizes the health of persons who are serving life sentences in federal institutions – a group that accounted for 23% of the incarcerated population in 2016 (Correctional Service Canada, 2017a). The use of language in this portion of the Act invokes a particular subject, one who is not worthy of health beyond the essential. However, this representation also works to produce a responsabilized subject who is expected to achieve a certain standard of health to be able to “re-enter” a society from which they have been excluded from. In unpacking this problematization, a paradox becomes clear – while persons in custody are dependent on the sub-standard health care resources deemed necessary within institutions, they are also expected to achieve exemplary health in order to succeed in the community upon release.

This paradox suggests that when it comes to health, persons in custody may be set up to fail. Modern health provision hinges on the neo-liberal notion that people are autonomous decision-makers in their own health. The difficulty that persons in custody face in accessing health services positions them to “fail the test of neoliberalism,” and in doing so positions them to face further stigma and recidivism (Moore & Fraser, 2006; Olver, Stockdale, & Wormith, 2011). While CSC has devised strategies to improve mental health among persons in custody, internal review has found many of these commitments to be nonspecific, unmeasurable, or unachievable (Correctional Service Canada - Internal Audit Sector, 2015). a

The CCRA remains the sole legal document holding CSC accountable for its governance of health in prisons. Its broad and nondescript terminology places the health of the incarcerated population at the discretion of CSC and institutional authorities, as well as individual health providers. Bacchi (2009) asserts that problem representations can be identified within a given text by examining how funding is allocated. For the 2017-2018 fiscal year, CSC has a budget exceeding \$2.3 billion. Of this, less than 10% is budgeted for mental and physical health services (The Honourable Ralph Goodale, 2016). In contrast, health care is the largest budget item in provinces across Canada, accounting for 43.2% of program spending in Ontario in 2016 (Barua, Palacios, & Emes, 2017). This supports the notion that “essential” health services in prisons are limited than those services provided to the general community. Given that poor access to health services constitutes the most frequent complaint by persons in custody (Zinger, 2017), the negative effects of this problematization of health behind bars must be explored.

4.3 Health of Persons in Federal Custody vs. the Protection of Society

The purpose of question 3 in the WPR approach is to examine the historical processes and discourses that shaped a particular problem representation. The goals of this question are two-fold: to examine specific developments, and to challenge the notion that problem representations are fixed and stable by identifying moments of key decisions. In interrogating these moments, it becomes possible to understand how an issue could have been conceptualized differently. This exercise in Foucauldian genealogy sheds light on the persons in power who define issues and determine their representation (Bacchi, 2009). In order to highlight how the representation of health in Canada's federal prisons came to be one of biomedical necessity, it is necessary to conduct a broad historical analysis of the CCRA. The following section will examine the development of the CCRA from 1977, when changes in Canadian prisons laws began to take place, to the publication of the Act in 1992. Following this, certain discourses will be explored in order to present how the problem of prison health has changed over time and space.

There is a long history of criminal justice in Canada, and the examination of key decisions along the path of time narrows the current lens of analysis. Canada's first *Penitentiary Act* was published in 1834 and set a new standard for imprisonment practices in the country. While crime was previously dealt with through corporal punishment, the *Penitentiary Act* heralded a new age of thinking. Marked by the opening of the Kingston Penitentiary, prisons became places where criminals were sent to be "reformed" through hard labour and moral reeducation (Coleman & Miner, 2013).

However, a Royal Commission in 1848 found that the treatment of persons in the Kingston Penitentiary was “barbarous and inhumane.” This report signaled the first major call for reform in the way persons were treated in custody, calling for equality and accountability within the justice system (Jackson, 2002). To date, meeting this standard remains a pressing challenge.

Historical Analysis

1977: Report of the Parliamentary Sub-Committee on the Penitentiary in Canada

The Report of the Parliamentary Sub-Committee in 1977 showed that conditions in the prison system had remained relatively stagnant since the Royal Commission deemed the behaviour of authority unacceptable in 1848. Courts in Canada displayed a reluctance to interfere with the administrative dealings of prison authorities, negatively impacting on the rights of persons in custody (Canadian Bar Association, 1999). Pointing to this marked absence of justice from penitentiaries, the committee advocated for two major changes: first, that the Rule of Law must prevail in prison; and second, that there be clear rules and guidelines in place to maintain justice behind bars (Canadian Bar Association, 1999).

1980: Supreme Court Rulings

The expanded role of the court envisaged by the Parliamentary Sub-Committee did not immediately take hold. However, a landmark ruling in the Supreme Court of Canada three years later demonstrated that the courts were prepared to respond to these

calls. The case of *Martineau vs. Matsqui Institution Inmate Disciplinary Board* marked a turning point for criminal justice in Canada. Robert Thomas Martineau was sentenced to 15 days of solitary confinement by the Disciplinary Board after committing the “flagrant or serious” offence of engaging sexually with another inmate inside a cell. Ultimately, the Court found that the Board had breached the rights of the inmates by failing to provide fair and just proceedings. This decision set the stage for judicial reform in Canada’s prisons by necessarily expanding the rights of persons in custody beyond the discretion of disciplinary boards (Jackson, 2002; *Martineau vs. Matsqui Institution*, 1980). In the years following this ruling, the courts continued to uphold the concept of “residual liberty” being held by persons in custody. This concept maintains that following a person’s entry into prison and the deprivation of their general liberty, they still hold rights pertaining to the nature of their incarceration, such as the nature of discipline and segregation (Jackson, 2002; *Martineau vs. Matsqui Institution*, 1980). Following this, any deprivation or violation of these rights in relation to imprisonment could be – and were – challenged in court (Canadian Bar Association, 1999).

1986-1988: Correctional Law Review Project

The *Canadian Charter of Rights and Freedoms* was introduced into Canadian society in 1982 and signaled major progress in fostering a culture of respect and justice in the country. It also signaled a major milestone for justice in Canada’s correctional facilities, as it further supported the rights of persons in prison to uphold their liberties in court (Jackson, 2002). To further advocate for the civil liberties of persons in custody, the

Correctional Law Review Project was initiated by the Solicitor General Secretariat, which gives guidance to corrections in Canada and contributes to a “peaceful society” (Derworiz, 2006). With representation from CSC, the National Parole Board, and the Department of Justice, this review published a series of papers exploring the interests of criminal justice and civil liberties in the age of the Charter (Canadian Bar Association, 1999). Given the ambiguity of the Charter, further legislative provisions were necessary to clarify the limitations on rights that exist within the context of corrections (Working Group of the Correctional Law Review, 1988).

Between June of 1986 and February of 1988, the Correctional Law Review Project conducted public consultations and published nine papers that would ultimately inform the CCRA. Of particular relevance to this thesis were the fifth working paper, “Correctional Authority and Inmate Rights,” and the ninth working paper, “Mental Health Services for Penitentiary Inmates.” Remarking on the health rights of persons in custody, these papers remarked that the “standard of health care for inmates shall be the same as for the general population” (Working Group of the Correctional Law Review, 1988, p. 243). Defining expectations for health standards within Canadian prisons shaped the CCRA. Here, it becomes possible to examine the successes and shortcomings of the Act in a historical context.

1992: The Corrections and Conditional Release Act

The CCRA was ultimately presented as a compilation and refinement of the Correctional Law Review Project Working Papers. Given the extensive consultations and

input from a range of stakeholders, the CCRA promised to provide dramatic reform to the previous *Penitentiary Act*. However, when the Act was released by Justice Canada and Solicitor General Canada, the immediate reaction was mixed. The Canadian Bar Association (CBA), which had engaged extensively in Working Paper consultations, concluded:

The proposed *Corrections Act* and draft regulations have diluted, and in some cases eviscerated, the Correctional Law Review proposals. In our opinion, the Correctional Law Review proposals constitute a necessary, although not entirely sufficient, blueprint for law reform. The proposed *Corrections Act* and draft regulations fall below the minimum threshold for law reform and are therefore unacceptable. (Canadian Bar Association, 1999, p. 13)

Despite its shortcomings, the CCRA marked a major advance in criminal law reform, as many previous guidelines became bound by law and thus enforceable in courts. Many celebrated the major advances that were made for the rights of persons in custody (Jackson, 2002). However, the initial review of the CBA shed light on a lingering truth – providing just treatment to criminals and promoting rehabilitation were still not considered equal priorities. To this day, the protection of society remains the primary concern in the CCRA. It is here that “health” emerges as a problem of order and control, more so than a problem of rehabilitation and wellbeing.

Discourse Analysis

Following this examination of the historical events leading to the development of the CCRA, it is important to examine the key discourses that contributed to this development. This analysis lends itself to the argument that problem representations are

neither fixed nor stable and change over time depending on changing dominant discourses. In reviewing the history of the CCRA, the collision of many discourses becomes evident. However, the suggestions of the Correctional Law Review Project and the resulting CCRA provide a key intersection of dialogues. Working Papers five and nine specifically represent the critical calls for health reform in Canada's prisons, while the resulting CCRA represents the ultimate interests of the dominant discourses at the time. The discrepancies between these dialogues indicate the voices of power that ultimately shaped the current representation of health in Canada's federal institutions.

The Correctional Law Review project consolidated a range of interests to inform its proposal for law reform. These interests included those of provincial and territorial jurisdictions, churches, academics, professionals, parole authorities, and persons with lived experience in custody. As previously mentioned, the project was headed by the Solicitor General Secretariat, joined by representatives from CSC, the National Parole Board, and the Department of Justice. This team was ultimately responsible for carrying out consultations and presenting the recommendations for legislation to the federal government (MacPhail, 1999).

Working Paper No. 5 and Working Paper No. 9

The fifth working paper of the Correctional Law Review Project, entitled "Correctional Authority and Inmate Rights" (Working Group of the Correctional Law Review, 1988) was published in 1987. The fifth paper aimed to discuss the rights of persons in custody, and how authority in prison must work to respect these rights. The

result of consultations was a list of proposals for inclusion in emerging legislation, dealing with rights regarding segregation, disciplinary processes, transfer, and access to health services. In addressing inmate rights across the system, this paper fundamentally asserts that inmates retain the rights of all members of society with the exception of those that must be necessarily removed in prison. Elaborating on this, the writers assert:

In effect, the “retained rights” principle means that it is not giving rights to inmates which requires justification, but rather it is *restricting* them which does. Undoubtedly, some individual rights of inmates, such as liberty, must be limited by the nature of incarceration, in the same way that the rights of non-inmates in open society must be limited in certain situations. The important point, however, is that it is limitations on inmate rights which must be justified, and that the only justifiable limitations are those that are necessary to achieve a legitimate correctional goal, and that are the least restrictive possible. (Working Group of the Correctional Law Review, 1988, p. 172)

The focus of the fifth paper does not stop at the prison gates - attention is called to the fact that society has a responsibility to respond to these rights. In advocating for the continuity of personal rights and freedoms, ideas of incarceration here are less dichotomous than the ideas reflected in the CCRA.

The ninth Working Paper, entitled “Mental Health Services for Penitentiary Inmates,” deals directly with the rights of persons in custody in relation to mental health care. Published in 1988, this paper paints a picture of the nature of mental health in Canada’s prisons, and advocates for enhanced services. This paper applies the term “mental health services” widely, using it to encompass a range of access points including medical doctors, nurses, psychologists and chaplaincy personnel. Pointing to the high concentration of persons affected by mental health problems in prison, the writers of this

Working Paper argue that inmates have a fundamental right to access care in the age of the *Charter*.

Conflicting Principles: Working Papers vs. CCRA

By examining the recommendations for health in the Working Papers compared to their reflection in the legislation, it becomes possible to note points of division and departure in discourse. The fifth working paper of the Correctional Law Review Project specifically explores health as it relates to individual rights as an inmate. The Working Paper stipulates that “the standard of health care for inmates shall be the same as for the general population” (Working Group of the Correctional Law Review, 1988, p. 243), a notion that has been further reiterated by the UN and WHO, through the Nelson Mandela Rules (United Nations General Assembly, 2015). This concept is not articulated in the CCRA – rather than asserting that standards must be equal to the community, the Act states that health care must conform to professionally accepted standards, leaving room for interpretation (Corrections and Conditional Release Act, 1992). This may suggest that care is delivered at a minimum acceptable standard, and not at a standard that is optimal or tailored to the needs of the incarcerated population. In terms of mental health service provision, the ninth Working Paper deals specifically with the rights of inmates in relation to mental health services. This paper paints a picture of urgency, as it asserts that federal institutions are in “serious need of mental health services” (Working Group of the Correctional Law Review, 1988, p. 431). In asserting that the need for mental health services far outweighs the level of provision, this paper calls for robust mental health

programs that meet the unique needs of persons in custody. This depiction of mental health services directly opposes the CCRA’s description of some components of mental health care as “non-essential” in nature.

The underlying sentiment of the Correctional Law Review Project Working Papers is that persons in custody retain their necessary rights. As previously cited, in prison it is not necessary to justify a person’s rights, but rather to justify the *removal* of these rights (Working Group of the Correctional Law Review, 1988, p. 172). The CCRA does not reflect this sentiment. Rather, in relation to health, the Act holds that health services beyond the essential are somewhat of a privilege. In keeping with discourse analysis, it is necessary to examine the dominant discourses in an attempt to understand the shifting emphasis from Working Papers to the enacted legislation. The CCRA was initially presented to the Parliament of Canada in 1991 as Bill C-36. When introduced in 1991, Solicitor General Doug Lewis reiterated the fundamental principle of corrections in Canada: that the protection of society comes before all. In defining the purpose of the eventual Act, Hon. Doug Lewis professed:

The interpretation of this one important principle is this – if the release of an offender threatens society, the offender will not be released. The government wants to get a message to two groups. First of all, the government wants to assure the public that from this point forward they, instead of the offenders, will get the benefit of the doubt. The government also wants to send a strong message to all those who work in the parole and prison system that law-abiding citizens come first and that at no time should public safety be put in jeopardy. (Lewis, n.d.)

Here, there is a marked division between the rights of persons in custody and the protection of society, with the latter achieving greater emphasis and weight. Despite the

calls for reform and justice in the Working Papers, the CCRA ultimately places its emphasis on punishment and imprisonment rather than rehabilitation (Canadian Bar Association, 1999).

Protection of Society

Despite the marked differences in principles demonstrated by the Working Papers and the resulting CCRA, there are commonalities. In examining the discourse surrounding the treatment of persons in custody, significant emphasis is placed in the Working Papers on rehabilitating those inmates who will be reentering society. Describing the fundamental purpose of robust mental health services in federal institutions, Working Paper number 9 asserts that “the objectives are reliable programs and treatments of benefit to the inmate and, ultimately, to society” (Working Group of the Correctional Law Review, 1988, p. 444). Similarly, in advocating for inmate rights, Working Paper number 5 consistently cites the ultimate goal of reintegration into society as a motivator. While this goal does indeed apply to a high number of federally incarcerated persons, there are also a number of inmates who are serving life sentences and will never “reintegrate” with the broader population. This underlying goal of the CCRA serves to alienate this population and further remove them from their liberties, painting them as removed from society. Attention must be paid to the subtle dichotomies that are drawn in the discourses of both the Working Papers and the CCRA – ultimately, these discourses suggest that the interests of the society are a priority.

4.4 Health and the “Offender” vs. Health and the “Citizen”

The fifth question in the WPR approach examines what effects are produced by a specific problem representation. This question provides a means by which policies can be assessed, noting three types of overlapping effects: discursive effects, subjectification effects, and lived effects. Discursive effects are reflected in the limits placed on thought and speech by a particular problem representation. The way in which a problem is represented necessarily limits how it can be conceptualized, silencing other viewpoints and voices. Subjectification effects describe the way that persons are represented within a particular problem. Key to this is the notion that governments elicit subjectivities, but they do not determine them – subjectivities can change over time and space. Finally, lived effects observe the real-life consequences of problem representations. The way in which a problem is represented shapes the lives of affected persons.

At this point in analysis, it is useful to place the CCRA in conversation with the *Canada Health Act* (CHA), in order to highlight the differences in effects produced by representations of health among the incarcerated and general populations. The CHA received Royal Assent in 1984, and outlines the requirements for health provision by the provinces to Canada’s general population. This Act is the foundation upon which the federal government holds provinces and territories accountable for health provision – while provinces and territories are responsible for the provision of services, the federal government can intervene by providing finances to jurisdictions if certain standards are met. These standards for health insurance and service provision are public administration,

comprehensiveness, universality, portability, and accessibility. Health services must be publicly administered on a non-profit basis, and all services that are “medically necessary” must be insured. Access to health insurance must be universal for all residents, and benefits must follow a citizen who temporarily leaves the province or territory. All persons must be able to access health services free of discrimination and other barriers (Canada Health Act, 1985; Madore, 2005).

Discursive Effects

While the CHA is largely an Act of economic and fiscal nature, it also serves the purpose of setting a standard for health care within the country. Health insurance in Canada is largely public, meaning that health risks are pooled among the population with everyone contributing according to their respective income. This emphasis on transferring resources from the rich to the poor fosters a sense of public responsibility for health. The depiction of health in the CHA heavily emphasizes a social paradigm, in which health is a product of environmental and social influences (Bacchi, 2009). The CHA asserts:

That Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease (Canada Health Act, 1985, p. 1).

The CHA indicates that the individual endeavor of a healthy lifestyle is essential to wellbeing, and is supported by a person’s community and resources. Health is largely an issue of personal responsibility, operating within a health system that promotes

wellbeing and protects against disease. As it stands, this understanding closes off consideration of the systemic barriers to health faced by certain citizens. For instance, populations including refugees, people who inject drugs, and Indigenous persons not living on reserve have unique health needs, and experience widespread barriers to care (Adelson, 2005; McKeary & Newbold, 2010). By framing the problem as one of responsibility on the part of the individual, this representation limits thinking to those who are in a position to take on this responsibility and who do not face barriers in accessing services.

Exploring the representation of health in the CHA, and the discursive effects that result, serves to highlight how health operates in the CCRA. Fundamentally, the fact that the CHA does not apply to persons in federal prison makes access to health a matter of one's legal standing. The discourse of "responsibility" cuts across problem representations in the CHA and the CCRA, with shifting emphases placed on the responsibility of the citizen and the state to cooperate in achieving health goals. However, once a citizen enters a federal institution, the state no longer carries the responsibility to "promote physical and mental health and [protect] against disease" (Canada Health Act, 1985, p. 1). Rather, the understanding of health becomes limited to concepts of either "essential" care or "non-essential mental health" care (Corrections and Conditional Release Act, 1992). Suddenly, the responsibility for maintenance of health beyond the essential is placed largely on the shoulders of persons in custody – a population already experiencing limitations on their rights and freedoms. This representation closes off a consideration of the state's responsibility, which should arguably be heightened given the

restrictions being placed on persons in custody. The reciprocity principle speaks to the ethics of power, stipulating that when burdens are placed on a population for the good of society, then society must be prepared to provide a form of compensation (Harris & Holm, 1995; Upshur, 2002). In this context, it could be argued that the state has a responsibility to provide exceptional healthcare within federal institutions, given that persons in custody lack the freedom to pursue health independently. However, it is difficult to draw attention to these challenges given the discursive construction of the CCRA.

Subjectification Effects

In reflecting on the subjectification effects of policies, Bacchi (2009) asserts that the policies create political subjects by positioning people within problems. The social relationships that are formed by policies and legislation result from the discourse surrounding them, and members of society take up a certain position within these relationships. It is from this position that people make sense of themselves, the world, and the political issue at hand. Foucault's notion of "dividing practices" (Foucault, 1982, p. 208) points to the way in which people are placed in opposition by the subjectification effects of policies. As an example of this, Bacchi cites the social dichotomies of "problem gamblers" versus "recreational gamblers" and "binge drinkers" versus "socially responsible drinkers" (Bacchi, 2009, p. 16). These oppositions serve to create a minority group that bears the burden of responsibility for the "problem."

Competing representations of health within the CCRA and the CHA serve to

create dichotomies between the “citizen” and the “offender,” and the type of care to which each is entitled. The CHA produces the concept of the citizen who takes an active role in their own health. This responsibility is supported by the state, which has an equal responsibility to provide public, comprehensive, universal, portable, and accessible care for all. As previously mentioned, the CHA is largely an economic framework for federal transfers of funding to support provincial health care in Canada. Its emphasis on the pooling of risks between the healthy and unhealthy highlights the underlying belief that both the state and its citizens have a duty to contribute to overall health by sharing resources. However, this balance of ownership is not always equal. Canada’s politics have tended toward neoliberalism in the post-war years, a form of governance that shifts ownership away from governments and onto individuals (Harvey, 2007). In terms of healthcare, neoliberal government agendas have further shifted the responsibility of health onto the individual, as citizens are seen as autonomous and rational units that determine their own wellbeing. In this context, citizens are responsibilized subjects for whom poor health is a personal failing (Ilcan, 2009; Moore & Fraser, 2006). As an example, current attempts to reduce obesity rates among children in Canada point to the necessity of physical activity and responsibility on the part of parents/guardians to uphold a healthy lifestyle. While seemingly uncontentious, this policy inherently places the “obesity epidemic” on the shoulders of families, without drawing attention to structural factors that impact health (Alexander & Coveney, 2013; Bacchi & Goodwin, 2016).

The responsibilization of Canadian citizens under the CHA poses a range of possibilities and challenges, and silences a discussion of the systemic barriers faced by

marginalized populations in accessing care. However, the current chapter focuses on how this subjectification contrasts with that of the person in custody, in order to emphasize the problem of health in Canada's prisons. In contrast to the responsible citizen, the CCRA – and the accompanying discourse that contributed to its creation – form the subject as an “offender” who has necessarily sacrificed their rights in entering a federal institution. Expectations for health are markedly different between persons in custody and persons in the broader community. For instance, while mental health is portrayed as necessary for wellbeing in the general population, it may be “nonessential” for persons in custody. Representing these services as optional allows their provision by the CSC to be seen as benevolent or even extraneous, reinforcing the power relations that exist between inmates and the state. Further, the development of an “us versus them” attitude has resounding negative consequences on an inmate's ability to access care, as they are often categorized as “attention seeking and drug seeking” (Miller, 2013b, p. E250).

There is a further dichotomy drawn between incarcerated subjects, which deepens the power relations that exist within these health legislations. As noted previously, the CCRA addresses the need for mental health services by persons who will be reintegrated into the general community. This discourse reiterates that prisons are places of punishment, rather than rehabilitation, by dismissing certain persons from the narrative. Further, this subjectification reiterates the foundational principle of the CCRA – that prisons exist for the protection of society. It is only when the worlds of prison and the community come into contact that consideration is given to the needs of those behind bars.

Lived Effects

As Bacchi (2009) affirms, “how problems are represented directly affects people’s lives” (Bacchi, 2009, p. 17). The representation of health in both the CHA and the CCRA are unique, and both have lived effects. In the CHA, people are painted as consumers of health. The strong emphasis on personal responsibility assumes that people must take action to meet the expectations of health outlined by society. This inherently silences people who are not in an equal position to take on this responsibility, or who face barriers in access to care. Race, income, gender, sexuality, and immigrant status are all factors that can contribute to difficulties in accessing and receiving care in Canada (Lasser, Himmelstein, & Woolhandler, 2006). People who end up in Canada’s federal institutions often represent those populations who struggle to access care in the first place.

The representation of health within Canada’s federal prisons has further damaging effects on persons in custody. The dichotomies drawn between those in the community and those behind bars leads to an implicit acceptance for lower standards of care within institutions. Inmates are seen as “others,” who are more highly regarded if their reintegration into the community is imminent. As has been explored, this may have deleterious effects on the health status of prisoners. Prison itself may expose people to a range of illnesses and communicable diseases, including HCV, HIV and tuberculosis, and the harsh environment contributes to mental illness and suffering (De Viggiani, 2007; Flegel & Bouchard, 2013; Kouyoumdjian et al., 2016). Until the problem of health in prisons is reframed as an opportunity for intervention and rehabilitation, persons in

custody will continue to face the consequences of poor access to care.

4.5 Self-Reflection

At this final point in the analysis, I will apply Bacchi's WPR approach to my own problem representations. Bacchi stipulates that the act of self-problematization is key, given that everyone is uniquely situated in history and culture. This act of reflexivity problematizes our own thought processes, and shifts the WPR approach beyond observation into a rigorous activity in thought (Bacchi, 2012; Bacchi & Goodwin, 2016).

In reflecting on the three questions of focus in this thesis, I am aware that my lens of analysis is shaped by the construction of health that I have developed in my studies. As a student of Global Health, I am encouraged to approach problems holistically and empathetically, considering outcomes across a number of variables. As such, my construction of health is wholesome and inclusive, and aligns with the notion that in order to be healthy, one must enjoy a broader sense of wellbeing rather than a simple absence of disease. This schema draws my attentions to questions 1, 3, and 5 of Bacchi's approach – I am interested in subjects for whom this construction differs, how it differs, and the lived effects of this difference.

I must also be aware and critical of my position in the neoliberal context. As a responsabilized subject in my own health, I am privileged to be able to engage with this responsibility and pursue health goals (Ilcan, 2009). I do not face similar barriers to care as the persons I write about, though I strive to understand their situation. For persons in

custody, the constitution of “health” in legislation is inherently different than the general population. This constitution invokes a subject who is both a responsabilized subject in health, and also a criminal – similar to the ways in which PWID are perceived when accessing NSPs (Lancaster, Seear, et al., 2015). Further, my position as a Canadian carries with it a great deal of privilege that I must be aware of. As a citizen of a wealthy country with a well-funded public health system, I am able to critically analyze health provision and access from a relatively comfortable vantage point.

Chapter V: Case Study – Hepatitis C Virus in Canada’s Federal Prisons

This chapter will turn to a case study of hepatitis C virus (HCV) in Canada’s federal prisons in order to further explore the effects stemming from the present problem representation of health. Question 5 of the WPR approach (“What effects are produced by this representation of the ‘problem’”) will be applied, with a specific focus on the lived effects on the lives of persons in federal custody.

The health crises occurring within the walls of Canada’s federal institutions can be closely analyzed through an examination of HCV rates and treatments. HCV is a blood-borne virus, positioning the sharing of injection equipment a major risk factor for the disease. A looming public threat in Canada, there are 250,000 people with current infection (Remis, 2008). Many people infected with HCV will develop chronic infection, which can lead to cirrhosis and liver disease (Canadian Liver Foundation, 2017). However, HCV is now a curable condition – recent advances in treatment have placed this disease within reach of elimination (World Health Organization, 2016b). While past interferon-based therapies often resulted in adverse side effects such as fever, nausea and depression, newer direct-acting antiviral treatments (DAAs) offer a more tolerable and effective alternative (Banerjee & Reddy, 2016; Manns et al., 2001).

The WHO aims to eliminate HCV by 2030. This goal has been placed in reach following the development of highly effective DAA treatments (World Health Organization, 2016a). There is a disproportionate burden of HCV on the incarcerated population, and prisons are key sites for intervention (World Health Organization,

2016a). According to the literature, an estimated one in nine Canadians infected with HCV spend time in either federal or provincial and territorial correctional facilities each year (Kouyoumdjian & McIsaac, 2015). This uniquely positions prisons as possible centres for prevention and treatment of HCV. In order to meet the WHO goal of elimination, emphasis must be placed on preventing transmission and treating existing infection. Specifically, this elimination goal hinges on a global “treatment as prevention” effort, in which high-risk populations are screened and linked to treatment and care (Grebely, Matthews, Lloyd, & Dore, 2013).

The burden of HCV infection on Canada’s federal system is significant, with 24% of inmates having been infected or exposed to the virus. With such a large proportion of the prison population being affected by HCV, the health services deemed to be “essential” have significant effects on the lives of all persons in custody. In order to treat and prevent a disease, effort must be made to provide primary, secondary, and tertiary prevention measures (Kouyoumdjian & McIsaac, 2015). CSC has made significant strides towards a treatment as prevention approach, given significant budget increases for HCV treatments and a renewed emphasis on treating persons in custody regardless of the severity of their disease (Fletcher, 2017). However, emphasis on “essential” services continues to position secondary and tertiary measures of HCV treatment and prevention ahead of primary measures, resulting in harmful lived effects for the incarcerated population. These effects will be explored through an examination of the tertiary, secondary, and primary prevention efforts that are framed as “essential” in Canada’s federal prisons.

5.1 Secondary and Tertiary HCV Prevention

The prison setting poses a unique challenge for HCV testing and treatment. The widespread imprisonment of people who engage in injection drug use and needle-sharing results in a high number of people at risk within prisons (Chu & Peddle, 2010). If a person enters an institution without previous infection and they engage in risk behaviours, they are at heightened risk of HCV acquisition within the facility (Kouyoumdjian & McIsaac, 2015). These factors position HCV as an urgent matter within prison walls. Secondary and tertiary prevention efforts in prison are carried out through systematic screening and treatment. In order to track and monitor rates of HCV, CSC provides systematic screening for HCV in all federal facilities (Kouyoumdjian & McIsaac, 2015). However, while inmates may test positive for the virus, follow-up and treatment are another issue. HCV is a curative condition, but access to treatment has historically proven to be a major barrier in the corrections setting. Prior to 2017, HCV treatment was limited to inmates who were found to have advanced liver disease (Marshall et al., 2016). While those with earlier stages of disease were assessed on a case-by-case basis, those with more serious disease were given priority treatment. Given the expense of DAAs, inadequate funding left many inmates untreated. The difficulty in accessing treatment was compounded by insufficient program abilities, and limited access to specialists within the prison setting (Marshall et al., 2016; Webster, 2012a).

While surveillance, reporting, and follow-up of inmates who test positive for the virus were found to have diminished dramatically in recent years (Webster, 2015), recent

changes may signal a new era in HCV treatment within federal prisons. The 2017-18 budget for HCV treatment in federal prisons is \$16.5 million, nearly four times greater than the budget in 2010. In contrast to previous guidelines, persons in custody may now access treatment before their liver fibrosis progresses to a certain severity (Fletcher, 2017). This means that over 1000 persons in custody may start on HCV treatment this year, a marked increase from past years (Webster, 2017). This is a promising development and suggests that the treatment of HCV has emerged as an “essential” health treatment on the CSC agenda.

The representation of HCV treatment as “essential” will have significant effects on persons in custody. Reframing this problem as one of equitable access will work to paint the incarcerated population as subjects worthy of prompt and efficacious treatment. Discourse will shift towards a model of care emphasizing population health, which will benefit not only persons testing positive for HCV, but all members of the prison population. The lived effects of this representation may be promising, as limits to treatment have been lifted and a certain degree of suffering is no longer a qualification. However, in order to adequately address the health risk of HCV within prisons, greater effort must be dedicated towards primary prevention methods in this setting. It is possible that the discourse surround the newfound promise of DAA treatments has silenced important conversations about primary prevention.

While screening and treatment may have positive effects on population health, the discourse around these efforts merits deeper consideration. It is possible that competing

problematizations are at play – on one hand, persons in custody may be represented as subjects who are worthy of treatment. However, limiting discourse to secondary and tertiary measures of prevention suggests that persons in custody are not quite worthy of the primary prevention measures that the broader community can access. Despite evidence indicating the efficacy of harm reduction services in both the broader community and in prisons globally, many of these services remain unavailable in Canadian prisons. Resistance on the part of the federal government to implement these programs has negative lived effects on persons in custody who remain at risk of transmission or reinfection (Fletcher, 2017). These effects are further explored below.

5.2 Primary HCV Prevention

An understanding of population behaviour and environmental factors can contribute to primary prevention models that limit transmission of the HCV virus (Mateu-Gelabert et al., 2007). Without primary prevention measures that address transmission of the virus, re-infection rates are high, placing a significant burden on individuals and the incarcerated population (Farley, Truong, Horvath, Nguyen, & Shum, 2012; Webster, 2012a). While enhanced HCV treatment in federal prisons should be celebrated, attention must be drawn to the shortcomings in primary prevention.

Given the blood-borne nature of HCV, the burden of this disease rests heavily on the shoulders of PWID. Across Canada, a number of NSPs operate to prevent the transmission of blood-borne viruses through the provision of clean needles and injection equipment to PWID. These harm reduction strategies have been supported by federal and

provincial governments, and advocated for by the international laws that guarantee health care without discrimination for PWID (Bailey et al., 2007). NSPs often serve as a resource for further health services, and have been found to be effective in the prevention of disease as well as in linking clients to other forms of care (Strike et al., 2006).

The benefits of these harm reduction programs do not stop at the prison gates – on the contrary, they have proven to be of key importance in a particularly high-risk setting (Kouyoumdjian & McIsaac, 2015). Needle-sharing in prison is a major contributing factor to HCV infection (Canadian HIV/AIDS Legal Network, 2017). To combat this, more than 60 prisons worldwide have introduced prison-based needle and syringe programs (PNSPs), sites where clean injecting materials can be received and exchanged. The outcomes of these services have been consistently positive: drug overdoses have been reduced, people have received adequate care and referral to further services, and risk of infectious disease has been reduced. Further, there has been no increase in the negative outcomes often cited by critics of the service, such as increased drug use and needles being used as weapons within prisons (Chu & Peddle, 2010).

Given the positive health outcomes of NSPs, as well as global evidence for the efficacy of PNSPs, it seems logical that these services would be included under the umbrella of “essential” health care in prison. However, Canada offers no such programs inside any of its prisons. In fact, the main harm reduction resource provided by CSC is bleach, intended for the sanitation of contaminated syringes. However, the WHO has stated that this strategy is not supported by evidence, and that the use of bleach is second-

line to NSPs (Correctional Service Canada, 2015; World Health Organization, 2007). The representation of adequate harm reduction services as non-essential in the context of federal prisons has a number of effects. Limiting access within prisons to services that would otherwise be available in the community paints persons in custody as unworthy of adequate care. Underpinning this representation may be a persistent discourse that the incarcerated population is inherently untrustworthy and undeserving of adequate health care. This limits the ways in which primary prevention can be considered in the context of prisons (Lancaster, Seear, et al., 2015). While advances in secondary and tertiary prevention have shifted discourse towards population health, stopping the efforts at primary prevention limits this progress.

True population health hinges on access to clean needles (Chu & Peddle, 2010). Without this access, persons in custody are at risk of HCV transmission, re-infection, and injection-site abscesses. Like community-based NSPs, PNSPs have been found to reduce needle-sharing, overdoses and deaths, while increasing referrals to drug treatment programs (Fletcher, 2017). Persons in custody must navigate these risks when there are limited harm reduction measures at hand. The process of obtaining clean needles requires participation in the prison economy, where persons in custody face threats of violence and extreme prices in order to access materials that are provided for free in the broader community (Treloar, McCredie, & Lloyd, 2016). Adequate harm reduction resources, particularly PNSPs, must be represented as “essential” within Canada’s prisons in order to address these detrimental effects.

5.3 “Deadly Disregard”: Effects of Political Power on Discursive Effects

In considering the effects of inadequate harm reduction services in Canada’s prisons, it is useful to consider the ways in which progress can be made. This chapter now turns to a historical example of innovation in the past, in order to examine how discourse is shaped by the circulating power in politics. The view of standard harm reduction resources as non-essential in the prison setting has been demonstrated in past initiatives. In 2005, CSC and the Public Health Agency of Canada launched the “Safer Tattooing Practices Pilot Initiative” (Correctional Services Canada, 2009). This intervention, a partnership between the prison and healthcare system, provided education and instruction on safe and sterile tattooing procedures. Inmate tattoo artists were given access to safe equipment and were trained on infection control. Despite positive health outcomes, the project was shut down early by federal Public Safety Minister Stockwell Day who, despite objection from the public health community, claimed that the project was not “demonstrably effective” (Kondro, 2007).

The failure of the Safer Tattooing Practices Pilot Initiative was not due to inadequate evidence – its discontinuation is a prime example of the dominating voices that represent the problem of health care within the correctional setting. The same political voices that shaped the representation of health in the CCRA continue to influence the implementation of programs in this setting. The government’s refusal to implement PNSPs in federal prisons has been described as a “deadly disregard,” as political voices continue to overpower the wealth of evidence supporting these harm

reduction measures (Elliott, 2007; Webster, 2012b). Circulating political power often interferes with hard-earned progress for health services in prisons, signaling that a paradigm shift must be achieved at the highest levels in order to resolve these inequities behind bars (Watson, 2014).

CHAPTER VI: CONCLUSIONS

In the 26 years since the establishment of the CCRA, our understanding of prison health care inequities has developed substantially. However, there has been limited progress in addressing and resolving these inequities. In the current thesis, three key themes emerged from the WPR analysis of the CCRA. In reiterating these themes and considering their role in current health issues, limitations and future directions will be considered.

6.1 Key Themes

In applying the WPR analysis to the CCRA, three key themes emerged. First, there are significant differences in what services are considered to be “essential” in federal prisons versus the broader community. Second, there is a conflict between value placed in the health of persons in custody and the protection of society. Third, there are significant effects stemming from the ways in which persons in custody are represented as consumers of health.

This thesis argued that “essential health care” may differ significantly between institutions and compared to the broader community. The lack of a concrete definition regarding “essential” services has negative bearings on both physical and mental health service provision. Federal prisons should operate as sites for health intervention and promotion, but in order to achieve this, there must be a clear definition on what facets of care are “essential.” Given the significant burden of mental illness within Canada’s

prisons, this definition of essential should be extended to include a range of mental health services that improve the quality of life of all persons. Fundamentally, health care provision behind prison walls should emphasize equity – in order to ensure this, a clear and encompassing definition is imperative.

An examination of the historical processes and discourses that shaped the current problem representation revealed a recurring conflict: that of the health of persons in federal custody versus the protection of society. The protection of society emerged as a common theme in this analysis. Reintegration into society is commonly cited as a motivator for mental health care in prisons, and benefits to society were commonly claimed in the discourses leading up to the development of the CCRA. Underpinning the spirit of corrections in Canada is the principle of public safety. In order to focus on the adequacy of health care in prisons, there must be a separation between the concerns of society and the rights of those behind bars.

In comparing the *Canada Health Act* and the *Corrections and Conditional Release Act*, two distinct enactments of health emerge in this analysis. Health in the CHA is constituted as broad sense of wellbeing, emphasizing the prevention of disease and promotion of physical and mental health. In contrast, health in the CCRA hinges on the provision of “essential” health services and “non-essential mental health” care. This thesis argues that creating this division between the “citizen” and the “offender” has serious lived effects for those in custody. Framing health in prisons as a problem of the bare essentials silences the possibilities of intervention, harm reduction, and health

promotion. Until this dichotomy is dissolved and the problem of health in prisons is reframed as an opportunity, persons in custody will continue to suffer.

6.2 Considerations

The current thesis was limited to a focus on health care provision within federal prisons, but barriers to care are salient within the provincial and territorial system as well. In the provincial/territorial system, HCV treatment may be inaccessible (Kouyoumdjian & McIsaac, 2015). As overcrowding builds in the system, persons in need of mental health and addictions treatment struggle to access services (Public Services Foundation of Canada, 2015). Persons in custody face significant challenges in accessing opioid agonist treatments, even when these treatments have been prescribed (Kouyoumdjian, Patel, To, Kiefer, & Regenstreif, 2018). Widespread inequities must be challenged through identifying the unique barriers that exist within both federal and provincial/territorial prison systems. A holistic approach to health care reform must be taken by stakeholders when advocating for change. The model of health advocated for by the current thesis is one of wellbeing, and this model necessitates an inclusive framework for change.

This thesis did not gather qualitative evidence from stakeholders, including policy makers, health care professionals, persons in custody, and correctional authorities. Future work should focus on gathering evidence of the effects of these problem representations in the legislation by hearing from affected persons directly. Change necessitates the coordinated efforts of many people, and research reflecting the experiences and opinions of all stakeholders would contribute positively to these efforts.

Stepping inside Canada’s federal prisons, a striking public health challenge is revealed. The health of persons in custody remains a threat to human rights and dignity in this country. The description of “essential health care” in the CCRA leaves too much room for interpretation, and this lack of definition has negative effects on the lives of some of Canada’s most marginalized populations. A shift of emphasis to a holistic and proactive model of care will require a broadened understanding of “essential” services, and an interest in change at a systemic level. If these steps can be taken, public health and human rights in Canada will be changed for the better.

Table 1. Carol Bacchi’s “What’s the Problem Represented to Be?” Approach

Question 1: What’s the problem (e.g. of “gender inequality”, “drug use/abuse”, “economic development”, “global warming”, “childhood obesity”, “irregular migration”, etc.) represented to be in a specific policy or policies?

Question 2: What deep-seated presuppositions or assumptions (conceptual logics) underlie this representation of the “problem” (*problem representation*)?

Question 3: How has this representation of the “problem” come about?

Question 4: What is left unproblematic in this problem representation? Where are the silences? Can the “problem” be conceptualized differently?

Question 5: What effects (discursive, subjectification, lived) are produced by this representation of the “problem”?

Question 6: How and where has this representation of the “problem” been produced, disseminated and defended? How has it been and/or how can it be disrupted and replaced?

Step 7: Apply this list of questions to your own problem representations.

Adapted from: C. Bacchi and S. Goodwin (2016) *Poststructural Policy Analysis: A Guide to Practice*. New York: Palgrave Macmillan, p. 20.

References

- Adelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*, S45–S61.
- Alexander, S. A., & Coveney, J. (2013). A critical discourse analysis of Canadian and Australian public health recommendations promoting physical activity to children. *Health Sociology Review*, 22(4), 353–364.
- Bacchi, C. (2009). *Analysing Policy*. Sydney: Pearson Higher Education AU.
- Bacchi, C. (2012). Why Study Problematizations? Making Politics Visible. *Open Journal of Political Science*, 2(1), 1–8. <https://doi.org/10.4236/ojps.2012.21001>
- Bacchi, C., & Goodwin, S. (2016). *Poststructural policy analysis: A guide to practice*. Springer.
- Bailey, D., Balian, R., Cavalieri, W., Fairburn, S., Findlay, L., Hemsley, C., ... Wilson, S. (2007). *Sticking Points: Barriers to Access to Needle and Syringe Programs in Canada*. Public Health Agency of Canada. Retrieved from www.aidslaw.ca
- Banerjee, D., & Reddy, K. R. (2016). Safety and tolerability of direct-acting anti-viral agents in the new era of hepatitis C therapy. *Alimentary Pharmacology & Therapeutics*, 43(6), 674–696.
- Barua, B., Palacios, M., & Emes, J. (2017). *The Sustainability of Health Care Spending in Canada 2017*. Fraser Institute. Vancouver. <https://doi.org/10.1017/CBO9781107415324.004>
- Bletsas, A., & Beasley, C. (2012). *Engaging with Carol Bacchi: Strategic interventions and exchanges*. University of Adelaide Press.
- Canada Health Act. RSC 1985, c C-6 (1985).
- Canadian Bar Association. (1999). *Corrections & Conditional Release Act Review*. Retrieved from <https://www.cba.org/CMSPages/GetFile.aspx?guid=763c1b4e-f69a-4919-a799-b45d35bebf0d>
- Canadian HIV/AIDS Legal Network. (2017). *Prison Needle and Syringe Programs: Policy Brief*. Retrieved from <http://www.aidslaw.ca/site/prison-needle-and-syringe-programs-policy-brief/?lang=en>
- Canadian Liver Foundation. (2017). Hepatitis C. Retrieved February 16, 2018, from <https://www.liver.ca/patients-caregivers/liver-diseases/hepatitis-c/>

- Chu, H., & Peddle, K. (2010). Under the Skin: A people's case for Prison Needle and Syringe Programs. Retrieved from <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1990>
- Coleman, E. J., & Miner, M. (2013). *Sex Offender Treatment: Accomplishments, Challenges and Future Directions*. Routledge.
- Correctional Service Canada. (2015). Bleach Distribution: Guidelines. Retrieved February 18, 2018, from <http://www.csc-scc.gc.ca/politiques-et-lois/800-6-gl-eng.shtml>
- Correctional Service Canada. (2017a). *CSC Statistics - Key facts and figures*. Retrieved from <http://www.csc-scc.gc.ca/publications/092/005007-3024-eng.pdf>
- Correctional Service Canada. (2017b). *Gender Responsive Corrections for Women in Canada: The Road to Successful Reintegration*. Retrieved from <http://www.csc-scc.gc.ca/women/002002-0005-en.shtml>
- Correctional Service Canada - Internal Audit Sector. (2015). *Review of Mental Health Commitments*. Retrieved from <http://www.csc-scc.gc.ca/publications/005007-2535-eng.shtml>
- Correctional Services Canada. (2009). Correctional Service Canada's Safer Tattooing Practices Pilot Initiative. Retrieved February 18, 2018, from <http://www.csc-scc.gc.ca/text/pa/ev-tattooing-394-2-39/index-eng.shtml>
- Corrections and Conditional Release Act. SC 1992 c 20 (1992). Retrieved from <http://laws-lois.justice.gc.ca/eng/acts/C-44.6/>
- De Viggiani, N. (2007). Unhealthy prisons: exploring structural determinants of prison health. *Sociology of Health & Illness*, 29(1), 115–135.
- Derworiz, C. (2006). Department of Solicitor General. Retrieved February 16, 2018, from <http://www.thecanadianencyclopedia.ca/en/article/department-of-solicitor-general/>
- Driessen, M., Schroeder, T., Widmann, B., von Schonfeld, C., & Schneider, F. (2006). Childhood trauma, psychiatric disorders, and criminal behavior in prisoners in Germany: a comparative study in incarcerated women and men. *Journal of Clinical Psychiatry*, 67(10), 1486–1492.
- Elliott, R. (2007). Deadly disregard: government refusal to implement evidence-based measures to prevent HIV and hepatitis C virus infection in prisons. *Canadian Medical Association Journal*, 177(3), 262–264.
- Enggist, S., Møller, L., Galea, G., & Udesen, C. (2014). *Prisons and Health*.

Copenhagen.

- Farley, J., Truong, A., Horvath, G., Nguyen, T., & Shum, W. (2012). Re-infection of hepatitis C virus infection in HIV/HCV co-infected inmates of correctional institutions, Canada. *Journal of the International AIDS Society*, 15(S4), 1.
- Fazel, S., & Baillargeon, J. (2011). The health of prisoners. *The Lancet*, 377(9769), 956–965. [https://doi.org/https://doi.org/10.1016/S0140-6736\(10\)61053-7](https://doi.org/https://doi.org/10.1016/S0140-6736(10)61053-7)
- Flegel, K., & Bouchard, F. (2013). Let us get prison health care out of jail. *Cmaj*, 185(4), 281. <https://doi.org/10.1503/cmaj.130149>
- Fletcher, A. (2017). *Access to HCV Treatment in Federal Institutions*. Toronto. Retrieved from <http://ctac.ca/wp-content/uploads/2018/01/Access-to-Treatment-in-Federal-Institutions-Web-1.pdf>
- Flynn, T. (2005). Foucault's Mapping of History. In e Cambridge Companion to Foucault, ed. G. Gutting, 29–48. Cambridge: Cambridge University Press.
- Foucault, M. (1982). The subject and power. *Critical Inquiry*, 8(4), 777–795.
- Foucault, M. (1985). *Discourse and Truth: The Problematization of Parrhesia*. (J. Pearson, Ed.). Northwestern University, Evanston/Illinois.
- Goodwin, S. (2011). Analysing Policy as Discourse: Methodological Advances in Policy Analysis. In *Methodological Choice and Design* (pp. 167–180). Springer.
- Grebely, J., Matthews, G. V, Lloyd, A. R., & Dore, G. J. (2013). Elimination of hepatitis C virus infection among people who inject drugs through treatment as prevention: feasibility and future requirements. *Clinical Infectious Diseases*, 57(7), 1014–1020.
- Harris, J., & Holm, S. (1995). Is there a moral obligation not to infect others? *BMJ: British Medical Journal*, 311(7014), 1215.
- Harvey, D. (2007). *A brief history of neoliberalism*. Oxford University Press, USA.
- Ilean, S. (2009). Privatizing responsibility: Public sector reform under neoliberal government. *Canadian Review of Sociology/Revue Canadienne de Sociologie*, 46(3), 207–234.
- Jackson, M. (2002). *Justice behind the walls: human rights in Canadian prisons*. Douglas & McIntyre. Retrieved from <https://books.google.ca/books?id=P8hLAQAAIAAJ>
- Kinner, S. A., Forsyth, S., & Williams, G. (2013). Systematic review of record linkage studies of mortality in ex-prisoners: why (good) methods matter. *Addiction*, 108(1), 38–49.

- Kondro, W. (2007). Prison tattoo program wasn't given enough time. *Canadian Medical Association Journal*, 176(3), 307–308.
- Kouyoumdjian, F., & McIsaac, K. (2015). Persons in correctional facilities in Canada: A key population for hepatitis C prevention and control. *Canadian Journal of Public Health*, 106(6), e454–e456. <https://doi.org/10.17269/CJPH.106.5132>
- Kouyoumdjian, F., Patel, A., To, M., Kiefer, L., & Regenstreif, L. (2018). Physician prescribing of opioid agonist treatments in provincial correctional facilities in Ontario, Canada: A survey. *PloS One*, 13(2), e0192431.
- Kouyoumdjian, F., Schuler, A., Matheson, F. I., & Hwang, S. W. (2016). Health status of prisoners in Canada. *Canadian Family Physician*, 62(3), 215–222.
- Lancaster, K., Duke, K., & Ritter, A. (2015). Producing the “problem of drugs”: A cross national-comparison of “recovery” discourse in two Australian and British reports. *International Journal of Drug Policy*, 26(7), 617–625. <https://doi.org/10.1016/j.drugpo.2015.04.006>
- Lancaster, K., Seear, K., & Treloar, C. (2015). Laws prohibiting peer distribution of injecting equipment in Australia: A critical analysis of their effects. *International Journal of Drug Policy*, 26(12), 1198–1206. <https://doi.org/10.1016/j.drugpo.2015.05.014>
- Lasser, K. E., Himmelstein, D. U., & Woolhandler, S. (2006). Access to care, health status, and health disparities in the United States and Canada: results of a cross-national population-based survey. *American Journal of Public Health*, 96(7), 1300–1307.
- Lewis, D. (1991, Nov. 4). “Corrections and Conditional Release Act.” Canada. Parliament. House of Commons. Edited Hansard. 34th Parliament, 2nd session. Retrieved from <http://parl.canadiana.ca/>
- MacPhail, A. (1999). The Development of Corrections and Conditional Release Act. In *Unpublished paper presented at the Changing Punishment at the Turn of the Century: Finding a Common Ground Conference*.
- Madore, O. (2005). *The Canada Health Act: Overview and Options*. Parliamentary Information and Research Service.
- Manns, M. P., McHutchison, J. G., Gordon, S. C., Rustgi, V. K., Shiffman, M., Reindollar, R., ... Albrecht, J. K. (2001). Peginterferon alfa-2b plus ribavirin compared with interferon alfa-2b plus ribavirin for initial treatment of chronic hepatitis C: a randomised trial. *The Lancet*, 358(9286), 958–965.

- Marshall, A. D., Saeed, S., Barrett, L., Cooper, C. L., Treloar, C., Bruneau, J., ... Grebely, J. (2016). Restrictions for reimbursement of direct-acting antiviral treatment for hepatitis C virus infection in Canada: a descriptive study. *Canadian Medical Association Journal Open*, 4(4), E605–E614. <https://doi.org/10.9778/cmajo.20160008>
- Martineau vs. Matsqui Institution. (1980) 1 SCR 602, 1979 CanLII 184 (SCC) (1980). Retrieved from <https://www.canlii.org/en/ca/scc/doc/1979/1979canlii184/1979canlii184.html>
- Mateu-Gelabert, P., Treloar, C., Calatayud, V. A., Sandoval, M., Zurián, J. C. V., Maher, L., ... Friedman, S. R. (2007). How can hepatitis C be prevented in the long term? *International Journal of Drug Policy*, 18(5), 338–340.
- McInerney, P. (2007). The ethics of problem representation in public education policy: From educational disadvantage to individual deficits. *Policy and Society*, 26(3), 85–98.
- McKeary, M., & Newbold, B. (2010). Barriers to care: The challenges for Canadian refugees and their health care providers. *Journal of Refugee Studies*, 23(4), 523–545.
- Miller, A. (2013a). Health and hard time. *Canadian Medical Association Journal*, 185(3), E139–E140. <https://doi.org/10.1503/cmaj.109-4389>
- Miller, A. (2013b). Prison health care inequality. *Canadian Medical Association Journal*, 185(6), E249 LP-E250. Retrieved from <http://www.cmaj.ca/content/185/6/E249.abstract>
- Mol, A. (1999). Ontological politics. A word and some questions. *The Sociological Review*, 47(1_suppl), 74–89.
- Møller, L., Gatherer, A., Jürgens, R., Stöver, H., & Nikogosian, H. (2007). *Health in prisons: a WHO guide to the essentials in prison health*. WHO Regional Office Europe.
- Moore, D., & Fraser, S. (2006). Putting at risk what we know: Reflecting on the drug-using subject in harm reduction and its political implications. *Social Science & Medicine*, 62(12), 3035–3047. <https://doi.org/https://doi.org/10.1016/j.socscimed.2005.11.067>
- Olver, M. E., Stockdale, K. C., & Wormith, J. S. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting and Clinical Psychology*, 79(1), 6.
- Public Services Foundation of Canada. (2015). *Crisis in Correctional Services:*

Overcrowding and inmates with mental health problems in provincial correctional facilities.

- Reitano, J. (2017). *Adult correctional statistics in Canada, 2015/2016*. Juristat: Canadian Centre for Justice Statistics. Ottawa.
- Remis, R. S. (2008). *A Study to Characterize the Epidemiology of Hepatitis C Infection in Canada, 2002*. Hepatitis C Prevention, Support and Research Program, Public Health Agency of Canada. Retrieved from http://publications.gc.ca/collections/collection_2009/aspc-phac/HP40-31-2008E.pdf
- Salter, P. (2013). The problem in policy: Representations of Asia literacy in Australian education for the Asian century. *Asian Studies Review*, 37(1), 3–23.
- Sapers, H. (2015). Annual Report of the Office of the Correctional Investigator 2014-2015. Retrieved from <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20142015-eng.pdf>
- Seear, K., & Fraser, S. (2014). The addict as victim: Producing the “problem” of addiction in Australian victims of crime compensation laws. *International Journal of Drug Policy*, 25(5), 826–835. <https://doi.org/10.1016/j.drugpo.2014.02.016>
- Shapiro, M. J. (1988). *The politics of representation: Writing practices in biography, photography, and policy analysis*. University of Wisconsin Press.
- Sim, J. (1990). *Medical power in prisons: the prison medical service in England 1774-1989*. Milton Keynes [England] ; Philadelphia: Open University Press. Retrieved from <file://catalog.hathitrust.org/Record/004512409>
- Stall, N. (2013a). Agony behind bars.PDF. *Canadian Medical Association Journal*, 185(3), 202–204. Retrieved from <https://doi.org/10.1503/cmaj>
- Stall, N. (2013b). Imprisoning the mentally ill.PDF. *Canadian Medical Association Journal*, 185(3), 201–203.
- Strike, C., Leonard, L., Millson, M., Anstice, S., Berkeley, N., & Medd, E. (2006). *Ontario Needle Exchange Programs : Best Practice Recommendations*. Toronto. Retrieved from http://www.ohrdp.ca/wp-content/uploads/pdf/Best_Practices_Report.pdf
- The Honourable Ralph Goodale. (2016). *2016-2017 Report on Plans and Priorities (RPP)*. Correctional Services Canada. Retrieved from <http://www.csc-scc.gc.ca/publications/092/005007-2604-eng.pdf>
- The Indian Act. R.S.C., 1985, c. 1-5 (1985). Retrieved from <http://canlii.ca/t/52fln>

- Treloar, C., McCredie, L., & Lloyd, A. R. (2016). The prison economy of needles and syringes: what opportunities exist for blood borne virus risk reduction when prices are so high? *PloS One*, *11*(9), e0162399.
- Turner, B. S. (1997). From governmentality to risk: Some reflections on Foucault's contribution to medical sociology. *Foucault, Health and Medicine*, ix–xxi.
- United Nations. (2018). Nelson Mandela Rules. Retrieved February 27, 2018, from <http://www.un.org/en/events/mandeladay/rules.shtml>
- United Nations General Assembly. (2015). United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), *A/RES/70/1*(September), 1–33. <https://doi.org/E/CN.15/2015/L.6/Rev.1>
- Upshur, R. E. G. (2002). Principles for the justification of public health intervention. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique*, 101–103.
- Walmsley, R. (2015). *World Prison Population List*. Institute for Criminal Policy Research. Retrieved from <https://books.google.ca/books?id=sXOQAQAACAAJ>
- Watson, T. M. (2014). The politics of harm reduction in federal prisons. *International Journal of Drug Policy*, *25*(5), 916–923.
- Webster, P. (2012a). Prison Puzzle: treating hepatitis C. *Canadian Medical Association Journal*, *184*(9), 1017–1018. <https://doi.org/10.1503/cmaj.1070017>
- Webster, P. (2012b). The redlining of harm reduction programs. *Canadian Medical Association Journal*, *184*(1), E21–E22.
- Webster, P. (2015). Federal inmates treated for hep C drop 29%. *Canadian Medical Association Journal*, *187*(18), 1345–1346. <https://doi.org/10.1503/cmaj.109-5181>
- Webster, P. (2017). Dramatic budget increase for hepatitis treatment in federal prisons. *Canadian Medical Association Journal*, *189*(32), E1052. <https://doi.org/10.1503/cmaj.1095468>
- Working Group of the Correctional Law Review. (1988). *Influences on Canadian Correctional Reform: Working Papers of the Correctional Law Review 1986 to 1988*. Solicitor General Canada. Retrieved from <https://books.google.ca/books?id=zQuLOWAACAAJ>
- World Health Organization. (2007). *Effectiveness of Interventions To Address HIV in Prisons*. Geneva. Retrieved from http://www.who.int/hiv/idu/OMS_E4Acomprehensive_WEB.pdf

- World Health Organization. (2016a). *Global Health Sector Strategy on Viral Hepatitis 2016-2021: Towards Ending Viral Hepatitis*. Geneva: World Health Organization.
- World Health Organization. (2016b). *Global health sector strategy on viral hepatitis 2016–2021*. 2016. Geneva. Retrieved from <http://apps.who.int/iris/bitstream/10665/246177/1/WHO-HIV-2016.06-eng.pdf?ua=1>
- World Health Organization. (2018). Constitution of WHO: Principles. Retrieved February 13, 2018, from <http://www.who.int/about/mission/en/>
- Zakaria, D., Borgatta, F., & Thompson, J. M. (2010). *A Comparison of Drug-related and Sexual Risk-behaviours in the Community and Prison for Canadian Federal Inmates*. Correctional Service of Canada.
- Zinger, I. (2016). *Annual Report of the Office of the Correctional Investigator 2016-2017*. Retrieved from <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20162017-eng.pdf>
- Zinger, I. (2017). *Annual Report of the Office of the Correctional Investigator 2016-2017*. <https://doi.org/10.1108/ijppm.2004.07953dab.003>