

Telepsychiatry and mental health equity in correctional facilities: Legal opportunities and challenges

Dimitri Patrinos

Volume 28, Number 2, 2023

Rencontres. Regards croisés sur la justice

URI: <https://id.erudit.org/iderudit/1105663ar>

DOI: <https://doi.org/10.7202/1105663ar>

[See table of contents](#)

Publisher(s)

Centre de recherche en droit public Université de Montréal

ISSN

1480-1787 (digital)

[Explore this journal](#)

Cite this article

Patrinos, D. (2023). Telepsychiatry and mental health equity in correctional facilities: Legal opportunities and challenges. *Lex Electronica*, 28(2), 39–57. <https://doi.org/10.7202/1105663ar>

Article abstract

Lack of access to mental health care in Canadian correctional facilities is a serious and longstanding issue. Telepsychiatry, which entails the usage of information and communications technologies to provide remote mental health care to patients, has been demonstrated to be an effective model of mental health care provision in correctional facilities. The right to health care, including mental health care, of inmates is recognized in both international and domestic law. However, mental health conditions remain suboptimal in Canadian correctional facilities and are far below the standards which exist in the general community, leading to significant mental health disparities for inmates. Telepsychiatry can be viewed as a vector for increasing mental health equity in the correctional system and provides a promising opportunity for correctional facilities to meet their legal obligations to provide inmates with health care, including mental health care. This article explores the legal frameworks governing the provision of mental health care services in Canadian correctional facilities and highlights the role telepsychiatry can play in the fulfillment of these legal frameworks. It also explores the legal challenges facing the implementation of telepsychiatry in correctional facilities. Ultimately, despite these challenges, it argues that telepsychiatry should be more widely implemented in correctional facilities to ensure mental health equity for inmates.

© Dimitri Patrinos, 2023



This document is protected by copyright law. Use of the services of Érudit (including reproduction) is subject to its terms and conditions, which can be viewed online.

<https://apropos.erudit.org/en/users/policy-on-use/>

érudit

This article is disseminated and preserved by Érudit.

Érudit is a non-profit inter-university consortium of the Université de Montréal, Université Laval, and the Université du Québec à Montréal. Its mission is to promote and disseminate research.

<https://www.erudit.org/en/>

TELEPSYCHIATRY AND MENTAL HEALTH EQUITY IN CORRECTIONAL FACILITIES: LEGAL OPPORTUNITIES AND CHALLENGES

Dimitri PATRINOS¹⁹

¹⁹ LL.M. Candidate, McGill University, Faculty of Law. Email: dimitri.patrinos@mcgill.ca.

ABSTRACT

Lack of access to mental health care in Canadian correctional facilities is a serious and longstanding issue. Telepsychiatry, which entails the usage of information and communications technologies to provide remote mental health care to patients, has been demonstrated to be an effective model of mental health care provision in correctional facilities. The right to health care, including mental health care, of inmates is recognized in both international and domestic law. However, mental health conditions remain suboptimal in Canadian correctional facilities and are far below the standards which exist in the general community, leading to significant mental health disparities for inmates. Telepsychiatry can be viewed as a vector for increasing mental health equity in the correctional system and provides a promising opportunity for correctional facilities to meet their legal obligations to provide inmates with health care, including mental health care. This article explores the legal frameworks governing the provision of mental health care services in Canadian correctional facilities and highlights the role telepsychiatry can play in the fulfillment of these legal frameworks. It also explores the legal challenges facing the implementation of telepsychiatry in correctional facilities. Ultimately, despite these challenges, it argues that telepsychiatry should be more widely implemented in correctional facilities to ensure mental health equity for inmates.

RÉSUMÉ

Le manque d'accès aux soins de santé mentale dans les établissements correctionnels canadiens est un problème grave et de longue date. La télépsychiatrie, qui consiste à utiliser les technologies de l'information et des communications pour fournir des soins de santé mentale à distance aux patients, s'est avérée être un modèle efficace de prestation de soins de santé mentale dans les établissements correctionnels. Le droit des détenus aux soins de santé, y compris aux soins de santé mentale, est reconnu dans le droit international et national. Cependant, les conditions de santé mentale restent sous-optimales dans les établissements correctionnels canadiens et sont bien en deçà des normes qui existent dans la communauté générale, ce qui entraîne des disparités importantes en matière de santé mentale pour les détenus. La télépsychiatrie peut être considérée comme un vecteur d'amélioration de l'équité en matière de santé mentale dans le système correctionnel et offre une occasion prometteuse aux établissements correctionnels de respecter leurs obligations légales de fournir aux détenus des soins de santé, y compris des soins de santé mentale. Cet article explore les cadres juridiques régissant la prestation de services de soins de santé mentale dans les établissements correctionnels canadiens et souligne le rôle que la télépsychiatrie peut jouer dans l'accomplissement de ces obligations juridiques. Il explore également les défis juridiques auxquels est confrontée la mise en œuvre de la télépsychiatrie dans les établissements correctionnels. En fin de compte, malgré ces défis, l'article soutient que la télépsychiatrie devrait être plus largement mise en œuvre dans les établissements correctionnels afin d'assurer l'équité en matière de santé mentale pour les détenus.

INTRODUCTION

[1] The mental health of inmates in the criminal justice system is a serious and longstanding issue (Gray et al., 2008, p. 412 ; Kouyoumdjian et al., 2016, p. 217). Recent Canadian judicial rulings on the use of solitary confinement in correctional facilities have highlighted the critical state of mental health in these institutions (*British Columbia Civil Liberties Association v Canada (Attorney General)*, 2018 ; *Corporation of the Canadian Civil Liberties Association v Her Majesty the Queen*, 2017). Mental health in the criminal justice system has also been recently identified as a “renewed area of focus” in the Mental Health Commission of Canada’s 2019-2021 mandate from Health Canada (Mental Health Commission of Canada, 2020, p. 1). Lack of access to mental health care, in particular, has long been highlighted as a major contributing factor to the high prevalence of mental health conditions in correctional facilities (World Health Organization, 2005, p. 1).

[2] Telehealth is also an issue that has been receiving much attention in recent years, partly spurred by the onset of the COVID-19 pandemic, which has resulted in the increased implementation of telehealth in the health care system. Consisting in the provision of health care through the use of information and communications technologies, telehealth has been noted to promote equitable access to health care, especially for hard-to-reach and underserved populations and communities (Hoffman, 2020, p. 2; Blake et al., 2021, p. 410; Lévesque & Knoppers, 2019, p. 81; Shore, 2015, p. 469). Though it had been in existence long before, the use of telehealth has increased significantly since the beginning of the COVID-19 pandemic and is expected to play an increasingly important role in the future of health care. Such is the increasing prevalence of telehealth, that two Canadian provinces – Québec and Newfoundland and Labrador – have provided legislative definitions of this mode of health care delivery (*Act respecting health services and social services*, CQLR c S-4.2, s. 108.1 ; *Medical Regulations*, NLR 38/15, s. 2(1)(aa)).

[3] As a subset of telehealth, telepsychiatry (also referred to as “telemental health”) refers to the use of information and communications technologies to provide remote mental health care to patients (Kaftarian, 2019, p. 2 ; Shore, 2015, p. 469). As with telehealth more generally, telepsychiatry has been noted to provide equitable access to mental health services and enhanced quality of care, while also being cost-effective (Cowan et al., 2019, p. 2510). Indeed, the literature reports comparable positive health outcomes for telepsychiatry versus in-person care across various patient populations and for various mental health disorders (Cowan et al., 2019, p. 2510). In particular, telepsychiatry has been noted to be an effective model of mental health care in the correctional system (Cowan et al., 2019, p. 2519 ; Deslich et al., 2013, p. 3 ; Kaftarian, 2019, p. 2).

[4] This is important given that access to mental health care (and, indeed, health care more generally) is limited in correctional facilities compared to the general population (Miller, 2013, p. 249), despite the fact that both international and Canadian law require that inmates benefit from health care standards comparable to those in the general population. This is particularly critical given the higher rate of mental health issues

among inmates compared to the general population – a rate that continues to increase (Kaftarian, 2019, p. 2). While this higher prevalence can be attributed to a number of factors, inadequate access to mental health care services remains a serious issue in correctional facilities. Consequently, models that can help overcome these barriers to access are necessary to improve mental health outcomes for inmates, address existing disparities, and promote mental health equity in correctional facilities. The implementation of telepsychiatry represents one such model.

[5] Accordingly, in this article I discuss how the implementation of telepsychiatry can promote mental health equity for inmates by increasing access to mental health care services in correctional facilities. In the first part, I describe the current state of mental health care in the Canadian correctional system, highlighting many of the issues facing inmates. In the second part, I outline the legal obligations that correctional facilities owe inmates concerning the provision of mental health care services, under both international and Canadian law. In the third part, I demonstrate how the implementation of telepsychiatry represents a promising avenue for the fulfillment of these legal obligations. In particular, I will discuss how telepsychiatry constitutes an opportunity for correctional facilities to fulfill their duties to provide mental health care to inmates, in accordance with prescribed legal norms. In the final part of this article, I discuss some of the legal challenges facing the implementation of telepsychiatry in correctional facilities. More specifically, I discuss how the negative rights-based approach that Canadian law appears to endorse in health care matters may be a significant obstacle in the implementation of telepsychiatry in the correctional system.

MENTAL HEALTH CARE IN CORRECTIONAL FACILITIES

[6] Inequitable and inadequate mental health care in correctional facilities is a serious global issue (McLeod et al., 2020; Scallan et al., 2021, p. 4). The quality of mental health care provided to inmates in the Canadian correctional system is suboptimal compared to the general population and varies greatly across facilities (Miller, 2013, p. 249). This is particularly serious, given that inmates use health care services more than any other population (Iftene & Manson, 2013, p. 887). The substandard quality of mental health care provided to inmates, in particular, is a serious issue given that the prevalence of mental health disorders among incarcerated individuals is higher than in the general population (Fazel et al., 2016, p. 871).

[7] Indeed, it is estimated that 73% of federally incarcerated men and 79% of federally incarcerated women meet the criteria for a current mental health disorder (Mental Health Commission of Canada, 2020, p. 1). Moreover, an estimated 12% of federally incarcerated men and 17% of federally incarcerated women meet the criteria for a current major mental illness, such as bipolar, major depressive, and psychotic disorders (Mental Health Commission of Canada, 2020, p. 1). Suicide and self-harm rates are high in correctional facilities, with 1 in 5 inmates having attempted suicide during incarceration (Fazel et al., 2016, p. 872 ; Kouyoumdjian et al., 2016, p. 217). Within the federal correctional system, the suicide rate is seven times higher than in the general population (Centre for Addiction and Mental Health, 2013, p. 9). There is also an overrepresentation of marginalized communities in the correctional system, including

indigenous peoples, who account for less than 5% of the Canadian population, yet constitute more than a quarter of the federal incarceration population (Boyer et al., 2019, p. 29 ; Zinger, 2017).

[8] Numerous factors explain the disproportionately high rate of mental health conditions in correctional facilities, including systemic factors such as structural poverty and institutionalized racism (Centre for Addiction and Mental Health, 2013, p. 4). Compared to the general population, inmates are more likely to have pre-existing histories with substance abuse, traumatic experiences, and posttraumatic stress disorder (Scallan et al., 2021, p. 4). According to both the World Health Organization and the United Nations Commission on Human Rights, these individuals are often incarcerated rather than treated for their mental health conditions or substance abuse problems (Hunt & United Nations Commission on Human Rights, 2005, para 11; World Health Organization, 2005, p. 1). During incarceration, aggravating factors such as isolation, overcrowding, and exposure to violence often exacerbate existing mental health issues (Boyer et al., 2019, p. 30; Iftene & Manson, 2013, p. 887). Recent judicial decisions have also highlighted the psychological harm caused by solitary confinement in correctional facilities (*British Columbia Civil Liberties Association v Canada (Attorney General)*, 2018 ; *Corporation of the Canadian Civil Liberties Association v Her Majesty the Queen*, 2017). Lack of access to optimal mental health care only reinforces existing inequities, continuing the trend of negative health outcomes for inmates. In order to address these inequities, it is important to first determine the legal frameworks which govern the provision of mental health care services in correctional facilities.

CURRENT LEGAL FRAMEWORKS

[9] The right to health care for inmates, including mental health care, is entrenched in both international and national law. Legal norms require correctional facilities to provide inmates with certain standards of mental health care. In the following section, I examine how international legal documents, domestic legislation and the common law address these rights and obligations.

INTERNATIONAL LAW

[10] International legal instruments recognize that inmates have a right to the highest attainable level of health care that meets the same standards as those in the general community. This right is enshrined in various documents, most notably in the *United Nations Standard Minimum Rules for the Treatment of Prisoners*. Also known as “the Nelson Mandela Rules”, the *United Nations Standard Minimum Rules for the Treatment of Prisoners* recognize that inmates should enjoy the “same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status” (Rule 24). The Rules further elaborate that correctional facilities should implement health care services that evaluate, promote, protect, and improve the physical *and mental health* of inmates (Rule 25(1), *my emphasis*). These services should be provided by “sufficient qualified personnel acting in full clinical independence and shall encompass sufficient expertise in psychology and psychiatry” (Rule 25(2)). The general right to receive health care which meets the same standards as the general community is also provided for in

the United Nations' *Basic Principles for the Treatment of Prisoners*, which state that inmates shall "have access to the health services available in the country without discrimination on the grounds of their legal situation" (art. 9).

[11] In addition, various legal instruments have been adopted concerning specific inmate populations, such as the *United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders* ("the Bangkok Rules") and the *United Nations Rules for the Protection of Juveniles Deprived of their Liberty*, which both contain health care-related provisions. Moreover, inmates retain the human rights and fundamental freedoms set out in the *Universal Declaration of Human Rights* and the *International Covenant on Economic, Social and Cultural Rights*. These include the rights to medical care and necessary social services (*Universal Declaration of Human Rights*, 1948, art. 25(1)) and to the enjoyment of the highest attainable standard of physical and mental health (*International Covenant on Economic, Social and Cultural Rights*, 1966, art. 12(1)).

[12] While these instruments are not legally binding and do not contain actionable legal rights per se, they nonetheless affirm the principle that inmates should benefit from health care, including mental health care, at comparable standards to those available to the general public (Iftene & Manson, 2013, p. 886). Indeed, international legal instruments "solidify a rights-based approach" that can help promote the objective of an "equality-based health care approach" in the Canadian correctional system (Boyer et al., 2019, p. 57). Moreover, courts have relied on international legal norms in recent judicial decisions regarding the use of solitary confinement in correctional facilities and its negative effects on inmates' mental health (Webster, 2019, p. 567). Consequently, the principles entrenched in international legal instruments should provide interpretive guidance on how health care-related rights under Canadian law should be viewed and enforced.

CANADIAN LEGISLATION

[13] In Canada, the administration of correctional facilities is shared between the federal, provincial and territorial governments. Individuals sentenced to imprisonment for terms of two years or more are incarcerated in federal correctional facilities, called penitentiaries (*Criminal Code*, RSC 1985, c C-46, s. 743.1(1)), whereas those sentenced to terms of imprisonment of less than two years serve out their sentences in provincial or territorial prisons (*Criminal Code*, RSC 1985 c C-46. s. 743.1(2)). Jurisdiction over the health care provided to inmates therefore depends on the type of correctional facility. At the federal level, the Correctional Service of Canada (CSC) is responsible for the provision of health care services in penitentiaries. Health care in provincial and territorial systems is overseen by the provincial and territorial governments (Kouyoumdjian et al., 2016, p. 216 ; Scallan et al., 2021, p. 5).

[14] Central to the distinction between the mental health care provided in federal versus provincial and territorial correctional facilities is the applicability of the *Canada Health Act* (*CHA*) (RSC 1985, c C-6, s. 2). The *CHA* sets the standards for the federal financial contributions to the provincial and territorial health insurance programs, based on the following criteria: public administration, comprehensiveness, universality, portability, and accessibility (*CHA*, s. 7). Inmates in federal penitentiaries, however, are excluded from

the *CHA* and are not covered by the provincial and territorial health care systems (s. 2). Instead, they are governed by the *Corrections and Conditional Release Act (CCRA)*, which vests responsibility over the care and custody of inmates in federal penitentiaries to the CSC (SC 1992, c 20, s. 5). Health care in provincial and territorial correctional facilities remains governed by the *CHA* and is under the jurisdiction of the provincial and territorial governments. Consequently, health care in federal correctional facilities is governed separately, not only from provincial and territorial correctional facilities, but from the general Canadian public as well. Given this unique distinction, I will focus specifically on the legislative framework governing the provision of mental health care services in federal penitentiaries.

[15] Under the *CCRA*, the CSC has the obligation to provide inmates with both essential health care and reasonable access to non-essential health care (s. 86(1)). In both circumstances, the provision of health care to inmates must conform to professionally accepted standards (s. 86(2)). The *CCRA* defines health care as “medical care, dental care and *mental health care*, provided by registered health care professionals” (s. 85, *emphasis is mine*). Furthermore, mental health care is defined as the “care of a disorder of thought, mood, perception, orientation or memory that significantly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life” (s. 85). The *CCRA*, however, does not define or describe what constitutes “professionally accepted standards” (see e.g., *Simons et al v Minister of Public Safety et al*, 2020 at para 27). Similarly, the *CCRA* does not establish standards for distinguishing between essential and non-essential health care (see e.g., *Brewer v Her Majesty the Queen*, 2020 at para 15). Instead, these standards are set out in guidelines and directives established by the CSC (Correctional Service Canada, 2015). Consequently, deciding what constitutes essential versus non-essential health care is context-specific and discretionary (Scallan et al., 2021, pp. 8-9). The lack of standardization or uniformity in what constitutes essential health care has contributed to the variability of health care services provided across federal penitentiaries, reinforcing existing inequities and barriers to optimal mental health care (Scallan et al., 2021, p. 9). This has important consequences for the quality and quantity of mental health care services available in federal penitentiaries (Scallan et al., 2021, p. 10).

COMMON LAW

[16] In addition to the legal obligations laid out in the *CCRA*, courts have recognized various duties owed by correctional facilities towards inmates, which supplement those outlined in the relevant legislation. Indeed, Canadian courts have long recognized the general common law duty of prison authorities to take “reasonable care” for the health and safety of inmates (*Timm v Canada*, 1965 at para 18 ; *Scott v Canada*, 1985 at para 39 ; *Sutherland v Canada*, 2003 at para 65 ; *MacLean v The Queen*, 1973, p. 7 ; *Oswald v Canada*, 1997 at para 59 ; *Bastarache v Canada*, 2003 at para 23 ; *Levasseur v Canada*, 2004 at para 71).

[17] This general duty has been elaborated and nuanced in numerous other decisions. In *Steele v Ontario*, for instance, the Ontario Court of Justice (General Division) recognized the duty of correctional systems to ensure that inmates receive adequate medical care and attention for their health and well-being while in detention (para 3). In *Lavoie v Canada*, the Ontario Superior Court of Justice recognized the duty to provide

appropriate medical care as part of correctional facilities' general duty of care towards inmates (para 13, *my emphasis*). While these cases do not specifically address the provision of mental health services in correctional facilities and deal rather with the issue of medical care more generally, they are indicative of the general types of duties owed toward inmates. Indeed, the mental health and well-being of inmates should fall within the purview of the medical care that is owed to them, as is recognized in international legal instruments and the *CCRA*.

LEGAL OPPORTUNITIES FOR TELE PSYCHIATRY IN CORRECTIONAL FACILITIES

[18] It is clear from this review of international and national legal norms that inmates have a right to receive adequate mental health care, despite the fact that, in reality, the quality of care received falls very short of prescribed standards. Telepsychiatry should be viewed as a manner of fulfilling these disparities, by helping to provide greater and more equitable access to mental health care services. As already noted, several authors have highlighted the potential for telehealth to overcome barriers to access health care services (Hoffman, 2020, p. 2; Blake et al., 2021, p. 410; Lévesque & Knoppers, 2019, p. 81; Shore, 2015, p. 469). Telepsychiatry should therefore be provided to inmates and should be strongly considered in health care reform efforts in correctional facilities.

[19] Indeed, a 2014 research report by the CSC described telehealth as a “promising practice”, with the potential to improve the delivery of health services to inmates, particularly mental health services (Correctional Service Canada, 2014). However, telehealth has yet to receive any form of widespread implementation or attention within the Canadian correctional system, though the CSC has committed to increasing adoption of telehealth services since the onset of the COVID-19 pandemic (Correctional Service Canada, 2020). Nonetheless, evidence shows that uptake of telehealth services in Canadian correctional facilities has been slow (Sethuram et al., 2022). This represents a missed opportunity, given the many benefits telehealth and telepsychiatry, more specifically, offer for the improvement of mental health care services in correctional facilities. Given the increasing attention and adoption of telehealth since the COVID-19 pandemic, expansion of telehealth services, including telepsychiatry, in Canadian correctional facilities should be made a priority moving forward.

[20] Access to mental health services among the general Canadian population is limited, caused in part by shortages of mental health professionals, long wait times, and geographic and demographic inequities (Moroz et al., 2020, p. 283). Access to these services is even more limited in correctional facilities, a fact further compounded by the higher prevalence of poor mental health among prisoners compared to the general population (Centre for Addiction and Mental Health, 2013). Telepsychiatry has been shown to be a cost-effective solution that can help improve overall access to mental health services, especially for underserved and hard-to-reach populations, including inmates (Kaftarian, 2019, p. 7 ; Langarizadeh et al., 2017, p. 244) For one, it allows health care practitioners to more readily reach and remain connected with these populations. Inmates very often lack access to health care providers, especially

specialized practitioners, due to geographical and cost barriers (Jeremy & Badowski, 2017, p. 1). Security-related concerns have also been raised as a barrier to access health care services in correctional facilities (Deslich et al., 2013, p. 7). Telepsychiatry provides the opportunity to address many of these barriers, closing the parity gap between the level of care inmates receive and that which exists within the general community.

[21] Importantly, the Mental Health Commission of Canada, in its efforts to guide reforms in the provision of mental health services in correctional facilities, has set out a list of guiding principles to support the mental health of individuals within the criminal justice system: (1) human rights, social justice and health equity frameworks; (2) recovery-oriented principles ; and, (3) health care parity (Mental Health Commission of Canada, 2020, pp. 3-4). The issue of health care parity, in particular, is a pressing one and one in which telepsychiatry offers many potential benefits, as described above. The Mental Health Commission of Canada in particular emphasizes that the level of mental health care offered in correctional facilities should be equivalent to those that exist within the general community (Mental Health Commission of Canada, 2020, p. 3).

[22] It is unquestionable that legal norms require correctional facilities to provide inmates with a standard of mental health care that is comparable to that of the general community (Iftene & Manson, 2013, p. 886). The actual level of care provided fails to meet these standards, however. Telepsychiatry represents an untapped opportunity to provide the level of care to inmates that is required by legal norms, both national and international. It should therefore figure within future mental health care reforms in correctional facilities and be viewed as a vector toward the fulfillment of the legal obligations of correctional facilities and as a vector toward mental health equity for inmates. However, as will be demonstrated in the following section, there are challenges from a legal perspective in ensuring the implementation of telepsychiatry in correctional facilities. In particular, one key challenge on the legal front is how the law views the right to health care. In the next section, we will see that the law itself cannot be used as a tool to enforce the implementation of telepsychiatry in correctional facilities, despite its opportunities and benefits.

LEGAL CHALLENGES IN THE IMPLEMENTATION OF TELE PSYCHIATRY IN CORRECTIONAL FACILITIES

[23] As already demonstrated, telepsychiatry can help address many of the barriers facing the provision of mental health care services in correctional facilities. Accordingly, it can help ensure parity and equity in the provision of mental health care services. Despite this untapped potential, greater implementation of telepsychiatry in correctional facilities will mainly depend upon non-legal, policy factors such as resource allocation and budgetary restraints.

[24] While the fulfillment of correctional facilities' legal obligations and the opportunity for inmates to benefit from the level of mental health care they are owed are both critical, these reasons can only serve as an impetus for the implementation of telepsychiatry in correctional facilities. Alone, they cannot be used to compel the implementation of

telepsychiatry. Indeed, the way the law views health rights in Canada is largely restrictive and, in general, the law cannot be used to enforce a positive duty on the part of governmental institutions to enforce these rights (Thomas & Flood, 2015, p. 58).

[25] Unlike other countries, Canada's constitution, specifically the *Canadian Charter of Rights and Freedoms* (hereafter the *Charter*) does not explicitly enshrine a general, positive right to health care, which requires the State to ensure access to health care services (Flood & Chen, p. 484; Jackman, 2010, p. 4 ; Régis & Savard, 2010, p. 280). Provincial legislation in certain cases, however, does provide for a right to health care services (Régis & Savard, 2010, p. 281). Québec's *Act respecting health services and social services* (CQLR c S-4.2), for instance, provides for a right to receive health services and social services "with continuity and in a personalized and safe manner" (ss. 5, 13). At the same time, the Act imposes specific obligations on institutions with respect to the supply and delivery of these services (s. 101). The right to receive these services, however, is not absolute (Régis & Savard, 2010, p. 282). It is limited to services that are "scientifically, humanly and socially appropriate" (s. 5) and that feature "within the framework of the legislative and regulatory provisions relating to the organizational and operational structure of the institution and within the limits of the human, material and financial resources at its disposal" (s. 13). Indeed, health and social services institutions have the discretion to determine the services they will provide, within the scope of the missions of the centres they operate and the resources at their disposal (s. 105). Therefore, while there is a right under the *Act* to receive health care services, this right is not absolute and is subject to various limitations.

[26] The discretionary nature of what constitutes essential versus non-essential health care in the *CCRA*, as well as which particular services are deemed "essential", falls within a similar framework. These legal frameworks greatly limit the actionability of health care-related rights in Canada. While the implementation of telepsychiatry can be proposed as a potential avenue toward the fulfillment of the mental health care-related obligations in correctional facilities, the legal conception of the right to health care is limitative. This may therefore limit how the obligations in the *CCRA*, as well as applicable international legal norms and common law duties, are viewed and put into action. Jurisprudence on the *Charter* relating to access to health care is informative in this regard.

[27] As previously mentioned, the Charter does not provide for a "freestanding positive right to health care" (Flood & Chen, 2010, p. 484). Nonetheless, two sections of the *Charter*, sections 7 and 15(1), have been invoked in cases involving health rights. In the majority of successful *Charter*-based health rights litigation, negative rights rather than positive rights to health care have been obtained (Flood & Chen, 2010, p. 494). While positive rights recognize the duty of the government to provide certain health care services, negative rights can be used to require that "government laws or policies acting as barriers to the consumption of health care be removed" (Thomas & Flood, 2015, p. 78).

[28] Section 7 of the *Charter* guarantees the right to life, liberty and personal security, as well as the "right not to be deprived thereof except in accordance with the principles of fundamental justice". Though some legal scholars have argued that this provision may

be interpreted as including a positive right to accessible health care services (see e.g., Jackman, 2006, p. 373; Sossin, 2005, p. 178), this interpretation has found little success with courts (Flood & Chen, 2010, p. 486). Indeed, while the Supreme Court of Canada did open the door to the possibility of section 7 being interpreted one day to “include positive obligations” in *Gosselin v Quebec (Attorney General)* (para 82), subsequent case law has not upheld this interpretation (see e.g., *Chaoulli v Quebec (Attorney General)*, 2005 ; *Flora v Ontario Health Insurance Plan*, 2008). Rather, section 7 has instead been interpreted as protecting negative rights, removing barriers that prevent access to certain health care services (Thomas & Flood, 2015, p. 67). For example, section 7 has successfully been invoked to challenge restrictions on access to abortion services (*R v Morgentaler*, 1988) and access to safe injection sites (*Canada (Attorney General) v. PHS Community Services Society*, 2011).

[29] Section 15(1) of the *Charter* provides a constitutional guarantee of equality and prohibits state actions or legislations that discriminate on the basis of race, national or ethnic origin, colour, religion, sex, age, mental or physical disability, or analogous grounds that have been identified by the courts (*R v Kapp*, 2008 at para 25). Accordingly, the main purpose of section 15(1) is to “ensure that when governments choose to enact benefits or burdens, they do so on a non-discriminatory basis” (*Auton (Guardian ad litem of) v British Columbia (AG)*, 2004 at para 28). From a health rights perspective, section 15(1) may be invoked where a government makes certain health care services available to one group of the population but not others, and the unequal treatment violates the dignity of those to whom the services were not made available (Flood & Chen, 2010, p. 487).

[30] While section 15(1) has not been found to uphold positive rights to access health care services, it may nonetheless serve to compel governments to remove access barriers to certain health care services, again demonstrating a negative rights conception. Such an approach was successful in *Eldridge v British Columbia (Attorney General)*, where the Supreme Court of Canada found that the provincial government's decision not to fund sign language interpreting services as an insured benefit under the provincial health insurance plan contravened section 15(1) of the *Charter*. The Court found that the lack of sign language interpreting services affected the quality of deaf patients' communications with their health care providers, which the Court considered an “integral part of the provision of medical services” (para 69).

[31] This approach was not successful, however, in *Auton (Guardian ad litem of) v British Columbia (AG)*, where it was argued that the provincial government's failure to fund Applied Behavioral Analysis (ABA/IBI), a novel form of therapy for autistic children, constituted a violation of the children's equality rights under section 15(1). While the reasoning in the *Auton* case is complex, the Supreme Court of Canada ultimately found that the government's decision not to fund the ABA/IBI therapy did not contravene section 15(1) of the *Charter*. In *Eldridge*, the case revolved around equal access to medical services that were already provided by the provincial government. The government's failure to provide sign language interpreters as an insured benefit constituted a barrier for deaf patients to access these services. In *Auton*, however, the plaintiffs sought a new benefit that was not conferred by the law (para 38).

[32] In short, *Charter*-based health rights litigation has generally shown a negative-rights based approach to health care rights in Canada, where courts are reticent to enforce public obligations upon governments related to the provision of health care services. Rather, courts have conceptualized health rights through a negative rights lens, invalidating legislation or government policies which hinder access to health care services where inconsistent with the *Charter*.

[33] It is clear from this overview of health rights-based litigation that the law cannot be used to enforce or compel the implementation of a specific health care service. In the case of telepsychiatry in correctional facilities, while there is an obligation on the part of correctional facilities to provide health care services to inmates (including mental health care), as well as a corollary right to health care for inmates (including mental health care), these rights and obligations cannot be used to compel correctional facilities to implement telepsychiatry, despite its ability to improve mental health equity for inmates. Nevertheless, these obligations and associated rights can serve as an impetus and should be used to argue in favour of the implementation of telepsychiatry as a way of addressing some of the barriers that have created and perpetuated mental health inequities in correctional facilities.

[34] Ultimately, though, as is the case for the majority of health care services, the increased implementation of telepsychiatry in correctional facilities will largely be a matter of public policy, based on resource allocation and budgetary restrictions, among other factors. Indeed, Canadian courts have recognized the difficulty with which resources are allocated by governments and policymakers, and the tension between financial cost and potential benefits in the health care sphere has long been an important topic of discussion (Ries, 2011, p. 649). Nonetheless, the severity and urgency of the current state of mental health conditions and lack of access to proper mental health care in correctional facilities warrants increased attention from governmental and policymaking institutions. Telepsychiatry should receive strong consideration as a manner of increasing access to mental health care services in correctional facilities, helping these institutions fulfill their legal obligations toward inmates, who do not receive the level of mental health care which they are owed under existing legal norms. In this manner, existing mental health disparities can be addressed and inmates may benefit from significantly improved levels of care.

CONCLUSION

[35] Inmates have a right to receive mental health care services at comparable standards to those available to the general public. Correctional facilities have corresponding legal obligations to ensure these services are made available to inmates in their custody. While these rights and obligations are enshrined in both international and national legal norms, access to mental health care services is severely limited in correctional facilities, where mental health conditions are poor, creating significant disparities and inequities. Telepsychiatry can improve access to mental health care services during incarceration and should be more widely implemented in correctional facilities to ensure mental health equity for inmates, an underserved and vulnerable population. Implementing telepsychiatry can help fulfill these obligations and ensure inmates benefit from their health care rights. While there may be significant challenges

in the implementation of telepsychiatry in correctional facilities, its untapped potential in ensuring mental health equity for inmates should not be unduly overlooked.

BIBLIOGRAPHY

International documents

International Covenant on Economic, Social and Cultural Rights, GA Res 2200A (XXI), UNGAOR, 1966, 16 December 1966.

United Nations Standard Minimum Rules for the Treatment of Prisoners, UNGAOR, 70th session, annex, A/RES/70/175.

United Nations' Basic Principles for the Treatment of Prisoners, UNGAOR, 45th session, annex, A/RES/45/111.

United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders, UNGAOR, 65th session, annex, A/C.3/65/L.5.

United Nations Rules for the Protection of Juveniles Deprived of their Liberty, UNGAOR, 45th session, annex, A/RES/45/113.

Universal Declaration of Human Rights, GA Res 217A (III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810 (1948).

Legislation

Act respecting health services and social services, CQLR c S-4.2.

Canada Health Act, RSC 1985, c C-6.

Canadian Charter of Rights and Freedoms, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982 (UK)*, 1982, c 11.

Corrections and Conditional Release Act, SC 1992, c 20.

Criminal Code, RSC 1985, c C-46.

Medical Regulations, NLR 38/15.

Jurisprudence

Auton (Guardian ad litem of) v British Columbia (AG), 2004 SCC 78, [2004] 3 SCR 657.

Bastarache v Canada, 2003 FC 1463.

Brewer v Her Majesty the Queen, 2020 NSSC 308.

British Columbia Civil Liberties Association v Canada (Attorney General), 2018 BCSC 62.

Canada (Attorney General) v. PHS Community Services Society, 2011 SCC 44, [2011] 3 SCR 134.

Chaoulli v Quebec (Attorney General), 2005 SCC 35, [2005] 1 SCR 791.

Corporation of the Canadian Civil Liberties Association v Her Majesty the Queen, 2017 ONSC 7491.

Eldridge v British Columbia (Attorney General), [1997] 3 S.C.R. 624, 151 DLR (4th) 577.

Flora v Ontario Health Insurance Plan, 2008 ONCA 538.

Gosselin v Quebec (Attorney General), 2002 SCC 84, [2002] 4 SCR 429.

Lavoie v Canada, [2008] O.J. No. 4564.

Levasseur v Canada, 2004 FC 976.

MacLean v The Queen, [1973] S.C.R. 2, 27 DLR (3d) 365.

Oswald v Canada, 1997 CanLII 16271 (FC), [1997] F.C.J. No. 203.

R v Kapp, 2008 SCC 41, [2008] 2 SCR 483.

R v Morgentaler, [1988] 1 SCR 30, 44 DLR (4th) 385.

Scott v Canada, [1985] F.C.J. No. 35, [1985] A.C.F. no 3.

Simons et al v Minister of Public Safety et al, 2020 ONSC 1431.

Steele v Ontario, [1993] O.J. No. 2010, 42 A.C.W.S. (3d) 562.

Sutherland v Canada, 2003 FC 1516.

Timm v Canada, [1965] 1 Ex. C.R. 174.

Secondary materials : Monographs

Gray, John E., Shone, Margaret A. & Peter F. Liddle, *Canadian Mental Health Law and Policy*, 2nd ed, (Markham: LexisNexis, 2008).

Secondary materials : Book chapters

Ries, Nola M. "Charter Challenges" in Jocelyn Downie, Timothy Caulfield & Colleen M. Flood, eds., *Canadian Health Law and Policy*, 4th ed. (Markham: LexisNexis, 2011) 615.

Sossin, Lorne, "Towards a Two-Tier Constitution? The Poverty of Health Rights" in Colleen M. Flood, Kent Roach & Lorne Sossin, eds., *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 161.

Secondary materials : Articles

Blake, Hassanatu et al, "Beyond COVID-19: The State of Telehealth Equity and Best Practices in Underserved Populations" (2021) 49:3 J Law Med & Ethics 410.

Boyer, Yvonne *et al*, "First Nations, Métis, and Inuit Prisoners' Rights to Health within the Prison System: Missed Opportunities" (2019) 13:1 McGill JL & Health 27.

Cowan, Kirsten E., "Barriers to Use of Telepsychiatry: Clinicians as Gatekeepers" (2019) 94:12 Mayo Clinic Proceedings 2510.

Deslich, Stacie *et al*, "Telepsychiatry in the 21st Century: Transforming Healthcare with Technology" (2013) 10 Perspectives in Health Information Management 1.

Edge, Chantal *et al*, "Improving care quality with prison telemedicine: The effects of context and multiplicity on successful implementation and use" (2021) 27:6 J Telemedicine & Telecare 325.

Fazel, Seena *et al*, "Mental health of prisoners: prevalence, adverse outcomes, and interventions" (2016) 3:9 The Lancet Psychiatry 871.

Flood, Colleen M. & Y.Y. Brandon Chen, "Charter Rights & Health Care Funding: A Typology of Canadian Health Rights Litigation" (2010) 19:3 Ann Health L 494.

Hoffman, David A., "Increasing access to care: telehealth during COVID-19" (2020) 7:1 JL & Biosciences 1.

Iftene, Adelina & Allan Manson, "Recent crime legislation and the challenge for prison health care" (2013) 185:10 CMAJ 886.

Jackman, Martha, "Charter Review as a Health Care Accountability Mechanism in Canada" (2010) 18 Health LJ 1.

Jackman, Martha, "The Last Line of Defence for [Which] Citizens: Accountability, Equality, and the Right to Health in Chaoulli" (2006) 44:2 Osgoode Hall LJ 349.

Kaftarian, Edward, "Lessons Learned in Prison and Jail-Based Telepsychiatry" (2019) 21:15 Current Psychiatry Reports 1.

Kouyoumdjian, Fiona *et al*, "Health status of prisoners in Canada" (2016) 62:3 Can Fam Phys 215.

Langarizadeh, Mostafa et al, “Telemental Health Care, an Effective Alternative to Conventional Mental Care: a Systematic Review” (2017) 25:4 Acta Medica Informatica 240.

Lévesque, Emmanuelle & Bartha Maria Knoppers, “La télésanté au Québec: quel est l’encadrement prévu pour la consultation vidéo?” (2019) 49:1 RDUS 77.

McLeod, Katherine E. et al, “Global Prison Health Care Governance and Health Equity: A Critical Lack of Evidence” (2020) 110:3 Am J Public Health 303.

Miller, Adam, “Prison Health Care Inequality” (2013) 185:6 CMAJ 249.

Moroz, Nicolas et al, “Mental health services in Canada: Barriers and cost-effective solutions to increase access” (2020) 33:6 Healthcare Management Forum 282.

Régis, Catherine & Anne-Marie Savard, “L’accès aux soins et aux médicaments au Québec; entre l’idéal et la réalité” (2010) 40 RDUS 269.

Scallan, Eilish, Lancaster, Kari & Fiona Kouyoumdjian, “The “problem” of health: An analysis of health care provision in Canada’s federal prisons” (2019) 25:1 Health 3.

Sethuram, Claire et al, “Electronic consultation in correctional facilities worldwide: a scoping review” (2022) 12:8 BMJ Open 055049.

Shore, Jay, “The evolution and history of telepsychiatry and its impact on psychiatric care: Current implications for psychiatrists and psychiatric organizations” (2015) 27:6 Int Rev Psychiatry 469.

Thomas, Bryan & Colleen M. Flood, “Putting Health To Rights: A Canadian View on Global Trends in Litigating Health Care Rights” (2015) 1:1 CJCCL 49.

Webster, Paul, “Canadian prisons face new legal challenges over mental health” (2019) 6:7 The Lancet Psychiatry 567.

Young, Jeremy D. & Melissa E. Badowski, “Telehealth: Increasing Access to High Quality Care by Expanding the Role of Technology in Correctional Medicine” (2017) 6:2 J Clin Med 1.

Electronic sources

Centre for Addiction and Mental Health, “Mental Health and Criminal Justice Policy Framework” (2013), online (pdf): <www.camh.ca/-/media/files/pdfs---public-policy-submissions/mh_criminal_justice_policy_framework-pdf.pdf>.

Correctional Service Canada, “Commissioner’s Directive: Health Services” (27 April 2015), online: *Government of Canada* < <https://www.csc-scc.gc.ca/politiques-et-lois/800-cd-eng.shtml>>.

Correctional Service Canada, “COVID-19 preparedness and plans in federal corrections: June 25, 2020” (25 June 2020), online: *Government of Canada* <<https://www.canada.ca/en/correctional-service/campaigns/covid-19/plans-preparation/update-june-2020.html>>.

Correctional Service Canada, “Using Telemedicine with Offenders: A Promising Practice” (10 February 2014), online: *Government of Canada* <<https://www.csc-scc.gc.ca/research/005008-rr13-01-eng.shtml>>.

Durcan, Graham & Jan Cees Zwemstra, “Mental health in prison” (2014), online (pdf): *Prisons and Health, World Health Organization, Regional Office for Europe* <https://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf>.

Hunt, Paul & United Nations Commission on Human Rights, “Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health” (2 February 2005), online (pdf): United Nations <<https://digitallibrary.un.org/record/540651?ln=en>>.

Mental Health Commission of Canada, “Mental Health and the Criminal Justice System: ‘What We Heard’ (Evidence Summary Report)” (2020), online: *Mental Health Commission of Canada* <https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2020-08/mental_health_and_the_law_evidence_summary_report_eng.pdf>.

World Health Organization, “Information Sheet: Mental Health and Prisons” (2005), online (pdf): *World Health Organization* <https://www.euro.who.int/__data/assets/pdf_file/0007/98989/WHO_ICRC_InfoSht_MNH_Prisons.pdf>.

Zinger, Ivan “Annual Report of the Office of the Correctional Investigator 2016–2017” (28 June 2017), online: *Office of the Correctional Investigator* <<http://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20162017-eng.aspx>>.