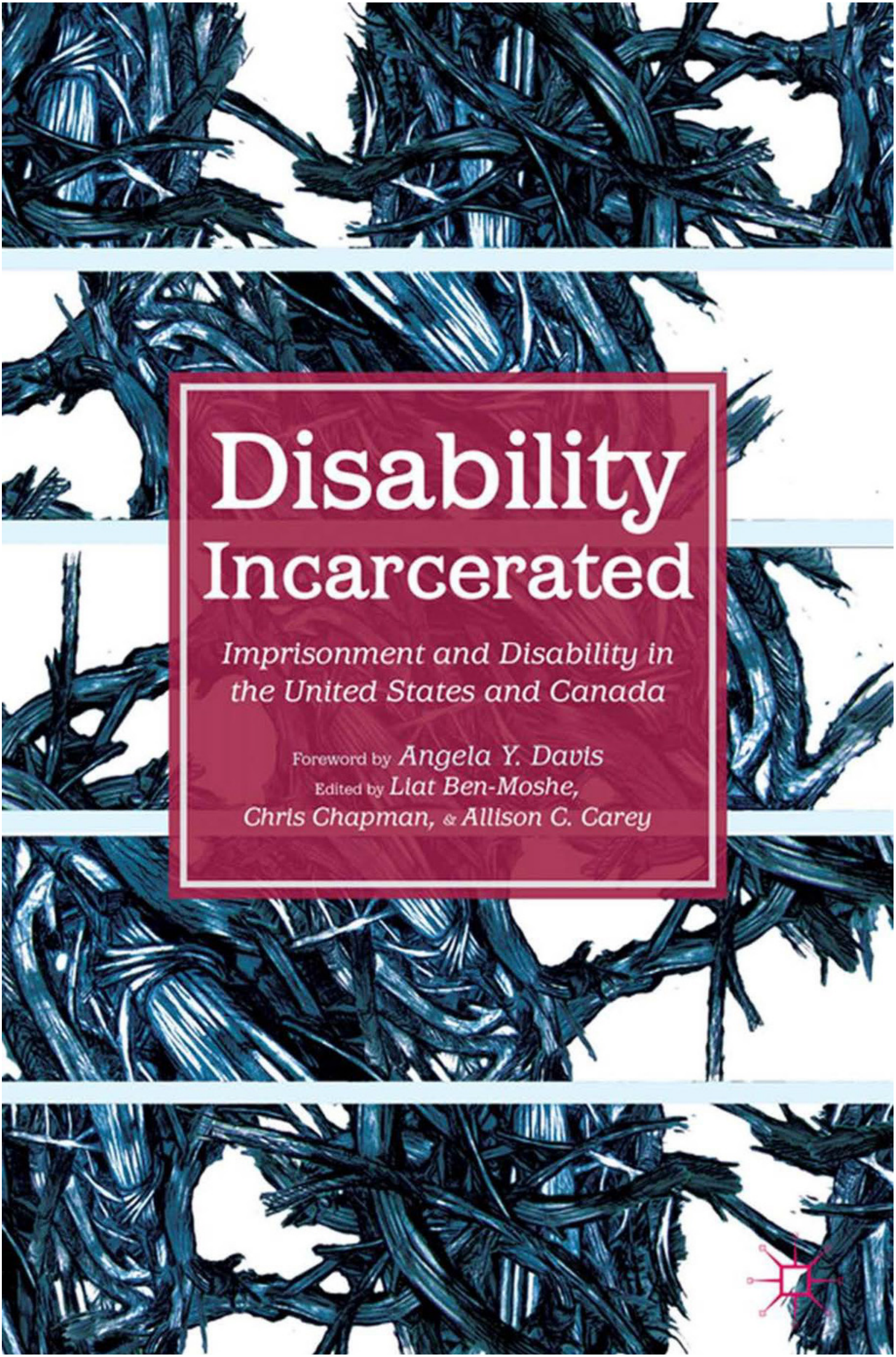

Disability Incarcerated

Imprisonment and Disability in the United States and Canada

Foreword by *Angela Y. Davis*

Edited by *Liat Ben-Moshe, Chris Chapman, & Allison C. Carey*

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It Can't Be Fixed Because It's Not Broken: Racism and Disability in the Prison Industrial Complex

Syrus Ware, Joan Ruzsa, and Giselle Dias

Introduction

Prisons[1] are dangerous places, especially if you are racialized and disabled. Because of the ways that prisons are constructed, imagined, and maintained, rampant ableism and racism affect the daily lives of many prisoners. In this chapter, we explore how disability and experiences of racialization are constructed throughout the Prison Industrial Complex (PIC)[2] within the Canadian context (Turtle Island). Further, we contend that colonization, racism, and ableism are inherent to the functioning of the penal system. The PIC is based on a set of interests created and maintained to support capitalism, patriarchy, imperialism, colonialism, racism, ableism, and white supremacy. It acts as a form of social control for the rich and powerful. As such, it benefits politicians, governments, big businesses, developers, law enforcement, and the nonprofit industrial complex. Angela Davis (2003) explains,

> To deliver up bodies destined for profitable punishment, the political economy of prisons relies on racialized assumptions of criminality—such as images of Black welfare mothers reproducing criminal children—and on racist practices in arrest, conviction, and sentencing patterns. Colored bodies constitute the main human raw material in this vast experiment to disappear the major social problems of our time. Once the aura of magic is stripped away from the imprisonment solution, what is revealed is racism, class bias, and the parasitic seduction of capitalist profit. The prison industrial system materially and morally impoverishes its inhabitants and devours the social wealth needed to address the very problems that have led to spiraling numbers of prisoners. (55)

Disabled people,[3] racialized people, and disabled People of Color experience prison in unique ways. In this chapter, we assert that the PIC reinforces colonialism,

racism, and ableism, and this leads to targeted policing, criminalization, and higher incarceration rates of People of Color, people with disabilities, and People of Color with disabilities. The PIC criminalizes the experience of disability and creates new experiences of disability both within prison and after people get out. With the introduction of new crime legislation, Canada is moving toward mass incarceration, which will only exacerbate colonialism, racism, and disabilities within the PIC. In our view, these systems are not broken, they function as extensions of racist and genocidal policies and practices that seek to criminalize and imprison Indigenous and racialized people, and people with disabilities.

In order to understand how this happens, we rely on stories from our work in prisons and other stories collected by prisoners about their experiences of racialization, disability, and prison.[4] We use these stories as our data because it is so rare to actually hear about prisons from prisoners themselves. We also use anecdotal and personal stories because there has been little research conducted about the experiences of race and disability in carceral spaces. Lastly, because there is so little information about this topic, we have had to make many links that have previously not been made. We are committed to making this chapter accessible to a broader audience, including prisoners and ex-prisoners for whom academic language could be alienating or exclusionary.

To expand on our arguments about how the PIC criminalizes experiences of disabilities, we must look at the prison environment itself. We must examine the devastating effects that prison has on people's psyches. Prison is both detrimental for people with disabilities and responsible for creating new experiences of disabilities. For the purpose of this chapter, we are going to focus solely on the prison environment (although we recognize that the PIC is an ever-expanding interest that includes all carceral spaces). In Foucault's (1977) work *Discipline and Punish: The Birth of the Prison*, he speaks to the experience of power and disciplinary mechanisms in prison settings. Prior to the birth of prisons, people who committed an offense were physically punished through torture, hangings, or dismemberment—that is, through bodily punishments. It is argued that penitentiaries were conceived of by the Quakers, who were trying to find more humane ways of treating "offenders," and were built with the intention of prisoners spending time in solitude focused on penance as a form of rehabilitation (see McShane and Williams 2005). Foucault (1977) argues that the shift in the methods of punishment went from punishing people's bodies to punishing their souls.

In the final section of this chapter, we discuss the ways in which the Conservative Government[5] has created legislation that is a move toward mass incarceration in Canada. Currently, our prisons are bursting at the seams. Prisons are overcrowded, which creates tension and violence. With the introduction of Bill C-10, which includes mandatory minimum sentences for drug offenses, we are beginning to see a move toward sky rocketing incarceration rates for drug users (as witnessed in the United States). Although the legislation is geared toward "organized crime," evidence from the United States indicates that this new legislation will mostly affect poor and racialized bodies—especially Black women (Lapidus et al. 2004; Mauer, Potler, and Wolf 1999). Through prisoners' stories, we hear about targeted policing in low-income Black neighborhoods and the system's creation of fear around "gangs" and rising crime rates. In fact, crime rates and the severity of crime in Canada have been decreasing since 1992 (Brennan 2012).

Critical disability theory and critical race studies have done a poor job of making connections in a way that is meaningful for racialized disabled people (Bell

2006; Ejiogu and Ware 2008). Because disability and race are not often considered together in critical disability theorizing and research and because of the lack of research about the experiences of people in prison in general, it is hard to fully understand the ways that race and disability intertwine to create unique experiences for racialized disabled people in prison. We need more research/information into the experiences of these prisoners. In this chapter, we consider the stories of criminalized, racialized, and disabled prisoners, intentionally making a connection between the experience of ableism and racism/colonialism and the PIC. This chapter tells that story. We begin by considering how racism and ableism play out together in the prison system.

Colonialism, Racism, and Ableism within Prison

In Canada (Turtle Island), the PIC has been used as a tool for the ongoing colonization of Indigenous communities. Our goal here is not to create a detailed history of the colonization process in Canada, but to frame the context in which the overincarceration of Indigenous people has become an extension of the colonization process and an integral part of the PIC. We discuss the historical trauma of First Nations, Métis, and Inuit People to help illuminate the Canadian government's process of ethnocide—which can be defined as the deliberate eradication of a people's culture, usually through political power (Aboriginal Healing Foundation 2003).[6] The main form of eradication was through the assassination of Indigenous people. The Aboriginal Healing Foundation (2004) explains, "In 1492, an estimated ninety to one hundred and twelve million Indigenous people lived on the American continent" (12) and goes on to detail that,

> At least until 1918, various epidemics devastated the lives of Indigenous people across the continent, some reaching as far north as Alaska and west to British Columbia. Dobyns (1983) suggests that 90 to 95 per cent of the Indigenous population was wiped out by epidemic disease, warfare, slavery, starvation and complete and utter despair, with most dying within one hundred years of contact. (Cook 1973)

It is not just that there was this attempt to depopulate such a significant proportion of the Indigenous people on Turtle Island, Indigenous people also faced assimilation practices that impeded the possibility of retaining and rebuilding their cultures. The goal of this assimilation strategy was to create a world where there would be almost no means (oral or written) to pass along and explain traditional ceremonies, cultures, or belief systems. The sheer loss of life ensured that there were fewer elders, teachers, warriors, healers, and artists (Aboriginal Healing Foundation 2004). Despite fierce resistance and continued survival, it is important to note that only 5 to 10 percent of that original population of Indigenous people remain alive after five centuries of epidemics, slavery, war, and colonization (Aboriginal Healing Foundation 2004). In the last half century alone, Indigenous people have been sent to residential schools,[7] where they were punished for participation in their cultural practices and where ongoing (and often violent) attempts were made to force them to assimilate into European Christian culture. In the 1960s, Indigenous children were stolen from their homes and placed in non-Indigenous homes, where they were often beaten, verbally abused, and sexually

assaulted (Aboriginal Healing Foundation 2009). John's[8] story lends insight into the reality of these atrocities:

> I am writing this story on behalf of an individual who has been in prison for over 20 years serving a life sentence. As a young Micmac he was often in trouble with the nuns that ran the [residential] school he was sent to. Eventually, because of his inability to conform to the nun's demand of "silence and subservience" they sent him to the psychiatric asylum (prison) at the age of 9. It was at this facility [that he] was raised to adulthood and when he was 21 years old the asylum released him from their custody . . . with a lack of social skills and [the] deep loneliness of a person raised in a psychiatric prison he soon began to use drugs.[9] It was not long after this that in a horrible turn of events . . . someone was found murdered [and he was arrested]. (Collins 2012)

The brutality of the attempted genocide of Indigenous people has had, and continues to have, a disabling affect. This experience of disability is exacerbated by the PIC. In John's story, resistance to being held in the carceral space of the residential school resulted in him being labeled with a psychiatric disability, which led to time in the carceral space of the "asylum," where he experienced social isolation and loneliness. Peter and John's analysis of the story explains the experience of isolation that led to the use of drugs, which contributed to "a horrible turn of events" in which a murder happens. Although it is unclear from John's story if he is responsible for the murder, the story reads as if this is the case. John's story illustrates both a link between colonization and incarceration as well as disability and incarceration. It also shows how acts of resistance to attempted assimilation and colonization force people into the PIC, in its various forms. When Indigenous people attempt to resist ongoing colonization through settling land claims or demands for self-determination (e.g., Mohawk resistance in Kanehsatake/Oka,[10] Tyendinaga,[11] and Caledonia, etc.), they are arrested and put in prison. Indigenous people make up 3 percent of the general population, but 23 percent of the federal prison population (Gebhard 2012; Trevethan and Rastin 2004). In some provinces, those numbers rise to almost 80 percent (Gebhard 2012; Trevethan and Rastin 2004). While these statistics are used by the state to support the fallacy that Indigenous people are more criminal, in reality they reflect the impact of the historical and ongoing colonization and oppression of Indigenous peoples.

In addition to the driving force of colonialism, the PIC is driven by racism. It is not an accident that there is a significant overincarceration of people from racialized communities; the PIC was designed as a form of social control within racialized communities (see Devon 2012). Mark T. Carleton (1971) suggests that the control of racialized bodies through their conversion into active labor units extended beyond the period of slave labor camps in the United States and into the development of the penal system. He states, "The survival of agricultural operations within the penal system into the 1960s suggest that the terms 'convict,' 'slave,' 'Negro,' and 'farm work' have remained unconsciously interchangeable in the mind of institutional Louisiana" (Carleton 1971, 7). As Matthew J. Mancini (1996) further explains, as prisons formed, the concept that prisoners had forfeited their liberty was tied into understandings of slavery; in 1871, the Virginia Supreme Court determined that a convicted offender "has, as a consequence of his crime, not only forfeited his liberty, but all his personal rights except those which the law

in its humanity accords to him. He is for the time being the slave of the state" (as cited in Alexander 2010, 31). Black people are the second most overrepresented population within Canada's PIC, after Indigenous people (Trevethan and Rastin 2004). The Correctional Investigator of Canada recently launched a study to look into the 50 percent spike in the number of Black people in the prison system in the past decade. Despite making up only 2.5 percent of the general population, Black people account for 9 percent of the federal prison population, and in Ontario those numbers jump to 20 percent (Crawford 2011). Provincially, statistics are not kept on racialized communities, and the only race-based statistics that are kept in provincial prisons are for Indigenous people. This lack of statistical information is problematic in that it prevents us from getting a broader numeric-based picture of racism within the PIC. Unfortunately, there has been little systematic research connecting the history of racism and colonialism in Canada to the PIC. It would be important work to trace the relation between the history of slavery and immigration policy and the PIC.

Kevin, a Black prisoner from a marginalized and under-resourced community in Toronto serving time inside a federal prison, writes of his experience of targeted policing in his community. He states,

> We as a group would just be outside hanging out doing absolutely nothing…and the police would…harass or arrest us for things that we did not do. Sometimes this was as regular as…a daily basis for a period of time as if the police had or needed to fill some sort of arrest quota. I'm still dumbfounded as to…why the police would carry on this way, seeing how they are hired to protect and serve the law, not abuse their powers. I personally have been arrested for crimes such as "Assault Police" to "Resist Arrest," "Drug Trafficking," "Drug Possession"…crimes that I am one million percent not guilty of committing. (Dias 2012)

Targeted policing, as in Kevin's story, illustrates how racialized bodies get picked up and then kept in the prison system. Once inside, the intersectional experience of class, race, and gender can keep people from getting out and staying out. The police are the main enforcers of the law, and officers have a great deal of discretion in terms of how they deal with the public.[12] In our experience, this discretion, married with the systemic racism, colonialism, and ableism[13] leads to the targeting and overpolicing of disabled and racialized communities. In Toronto, the police have repeatedly murdered disabled people, in particular, disabled People of Color with mental health issues.[14]

Ableism in the PIC manifests itself in many ways, including the targeting of disabled communities through overpolicing;[15] the physical construction of carceral spaces for nondisabled bodies that do not work well for disabled bodies (something we explore in more detail in a moment); the maintaining of a hostile environment that is designed to affect the mental health of prisoners (Foucault 1977); and so on. This ableism is intrinsically linked to systemic racism and classism. As Eli Clare elaborates,

> Race, class, gender, sexuality, and disability are so integrally tied together. For instance, racism is strengthened and fueled by ableism, by the belief that any body/mind labelled as "stupid" is worthless and expendable. One of the ways racism functions is to define People of Color–particularly, in a

> US context, poor African Americans and Latinos–as stupid, which in turn drives racist unemployment rates, lack of access to education, and incarceration rates. (Fritsch 2009)

Interconnected experiences of racism and ableism affect the lives of racialized disabled people in particular ways. As Clare explains, the ableist assertion that intelligence governs value and usefulness in society is intertwined with characterizations of racialized people as inherently without value because of perceived intelligence, making it all the more complicated for racialized disabled people to be considered valuable in an ableist racist society. This directly affects employability, and lack of employment and access to resources fuels incarceration rates (Reece 2010). The stigma associated with being an ex-prisoner also affects future employability (Reece 2010). It is from this intersectional perspective so clearly articulated by Clare that we come to understand the ways that prisons are intrinsically tied up in the business of race, class, and disability. We now consider the specific experiences of disabled people labeled with mental health diagnoses, living with HIV/AIDS, and experiencing mobility disabilities.

In 2010, a report was released by the Correctional Investigator's Office (an Ombudsman for the federal prison system) to talk about the growing needs of prison populations. Howard Sapers, a Correctional Investigator states,

> Canadian penitentiaries are becoming the largest psychiatric facilities in the country. The Correctional Service of Canada assumes a legal duty of care to provide required mental health services, including clinical treatment and intervention. In failing to meet this legal obligation, too many mentally disordered offenders [sic] are simply being warehoused in federal penitentiaries. This is not effective or safe corrections. (Office of the Correctional Investigator 2010)

Sapers' quote suggests that (1) prisons are being used in lieu of providing supportive services for psychiatric survivors/consumers in the community and that (2) once inside prison, folks labeled with psychiatric disabilities are not receiving health services available to them in the community. Thus, psychiatric survivors/consumers have a higher likelihood of incarceration and, as a result, are less likely to access supportive services.

There is anecdotal evidence of a trend in Canadian prisons of using long-term segregation to isolate people with mental health issues from the rest of the population. Isolating people with mental health issues is cruel and excessively punitive. One documented example of this is the case of Ashley Smith,[16] a young woman who asphyxiated herself in her segregation cell while several guards looked on. The Smith case is one example that demonstrates that people with mental health issues need access to community resources, not incarceration. Unfortunately, cruel and unusual punishment is commonplace in the PIC, part of the essence of its daily functioning. This has dramatic effects on all prisoners. For prisoners who have psychiatric disabilities or are psychiatric survivors, the prison environment exacerbates existing mental health issues.[17]

In addition, a study released by the Correctional Service of Canada[18] in 2010 reported that rates of HIV in prison are 15 times higher than in the community and rates of Hepatitis C (HCV) are up to 39 percent higher, with an infection rate of 31 percent (Zakaria et al. 2010). These are staggering rates of infection and are

due in large part to the CSC's "zero-tolerance policy" on drug use and refusal to introduce a needle exchange program (see Chu 2010). Without proper distribution of harm reduction materials in prison, these numbers will continue to grow. When looking at intersections of disability and prisons, HIV/AIDS and HCV infection rates are essential to the discussion. Overcrowded prisons without proper harm reduction programs will ensure the further transmission of HIV/AIDS and HCV, leading to greater disability in prison and in the community.

In the next section, we examine how prisons further criminalize and punish people with disabilities and create further disability.

Criminalization and Creation of Disability in the PIC

In order to understand how people's health is affected by incarceration, it is important to look at people's relationship to the social determinants of health *before* incarceration. Juha Mikkonen and Dennis Raphael (2010) list 14 factors that shape the health of Canadians in *The Social Determinants of Health: The Canadian Facts*; reading through this list is like reading the story of who is in prison and why they are there. The factors include: poverty; lack of education; unemployment or low-paying employment/poor working conditions; childhood trauma; food insecurity; insecure housing/homelessness; social exclusion; lack of a social safety network; little or no access to health services; Aboriginal status; race; gender; and disability. The last four factors on the list highlight the fact that racism, sexism, and ableism determine people's living conditions and correlate to the communities and identities that are targeted by the police, criminalized, and imprisoned.

Mental and physical health is negatively impacted by one's relationship to the social determinants of health, or lack thereof. This is true in the community, and it is even more painfully apparent in the prison system. According to the Corrections and Conditional Release Act (the legislation that governs the federal prison system),

> 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 . . . The provision of health care under subsection (1) shall conform to professionally accepted standards . . . The Service shall take into consideration an offender's state of health and health care needs (a) in all decisions affecting the offender, including decisions relating to placement, transfer, administrative segregation and disciplinary matters; and (b) in the preparation of the offender for release and the supervision of the offender.[19]

As we have suggested, the service does *not* provide every prisoner with "essential heath care" that "conforms to professionally accepted standards." In order to clearly outline what is covered under the term "health services," the Commissioner's Directive 800[20] lays out what is meant by "essential health services" in more detail:

> Inmates shall have access to screening, referral and treatment services. Essential services shall include a) emergency health care (i.e., delay of the service will endanger the life of the inmate); b) urgent health care (i.e., the condition is likely to deteriorate to an emergency or affect the inmate's ability

> to carry on the activities of daily living); c) mental health care provided in response to disturbances of thought, mood, perception, orientation or memory that significantly impair judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life (this includes the provision of both acute and long-term mental health care services); . . . Inmates shall have reasonable access to other health services (i.e., conditions not outlined above) which may be provided in keeping with community practice (e.g. prenatal care for women). The provision of these services will be subject to the length of time prior to release, operational requirements, etc. . . . In support of essential health services, emphasis will be on health promotion and illness prevention. (Correctional Service of Canada 2011)

These guidelines suggest that the physical and mental health of prisoners are a high priority for the Correctional Service of Canada and that health services are easily accessible and on par with community standards. Yet, research suggests that the reality of access to care is different than what is outlined in these guidelines, particularly for people living with disabilities (Ford and Wobeser 2012; McLay and Silversides 2011; Sapers 2009). In addition, our stories from prisoners in federal prisons in Canada suggest that prisoners are not accessing health care at community standards and that, in fact, the prison environment both exacerbates existing disabilities and creates new ones. Many prisoners who are suffering from serious health issues put in repeated requests over the course of weeks or months before actually getting to see a doctor. We examine access to health care in relation to mental health diagnoses, HIV/AIDS seroconversion,[21] and mobility in prisons.

In terms of psychiatric disabilities, the World Health Organization (2007) states that, "prisons are bad for mental health" because of overcrowding; violence; solitary confinement; lack of privacy; separation from family and friends; lack of meaningful activity; and uncertain futures in terms of housing, work, and relationship. Prisons affect the ways our brains and bodies work, creating experiences that don't fit within social notions of mental "health."[22] Additionally, there is a lack of appropriate health care—especially care for emotional health—in prison, which leads to increased rates of depression and suicide (WHO 2007). When people are in prison, they are fully under the control of the state. This is true in a logistical sense: in that they have lost their physical freedom and are in a government-run facility. It is also true in the sense that their personal agency is taken away. They are told when to wake up, when to eat, when and for how long they can use the phone, when and in what conditions they can see their families, when they can go outside, what they can read, etc. This lack of autonomy extends to almost every aspect of life in prison, and it is done by design in order to erode people's sense of self-efficacy, so that they become compliant (Foucault 1977); this directly affects their mental health. Powerlessness is a result of this experience. The North American Nursing Diagnosis Association recognizes that,

> The environment in which health care is provided can influence the recipient's perception of personal control. Institutional rules and regulations, autocratic caregivers, and social isolation can increase one's sense of powerlessness. (NANDA International 2009, 190)

The creation of the experience of powerlessness is essential to the functioning of the prison environment, and it is highly relevant to the experience of people

with disabilities trying to access health care services in prison. Despite the claims of the Corrections and Conditional Release Act and Commissioner's Directive (Correctional Service of Canada 2011) listed earlier, prisoners experience difficulty accessing needed health care services, receiving adequate and appropriate ongoing treatment in a timely fashion, and being allowed to meaningfully participate in their own plan of care. The impact of this lack of access on mental health is illustrated in a study by Smith et al. (2008). In a series of experiments to determine the effect of powerlessness on cognitive functioning, these researchers found that,

> Assigning someone a certain position can alter their mental skills in a way that confirms their standing. The powerful retain power because of the improved mental processes that it brings about, while impairments in the same processes keep people without power on the bottom rung. These effects make hierarchies incredibly stable, and lead the powerless into what Smith calls "a destiny of dispossession." (Yong 2008)

It is difficult for people to get access to any counselling and mental health services in prison. When people do get access to these supports, they are rarely offered in an ongoing way or over the long term. Anecdotal evidence suggests that some people request counselling because they are struggling acutely, yet have to wait years before they can see someone trained to help. Because all psychiatrists/psychologists available to prisoners work for Correctional Services Canada and because there is no confidentiality or privacy during therapeutic sessions, these sessions may not provide the support needed. It is hard for people to open up about any challenges they are experiencing in prison, particularly because anything they say will end up in their prison file and could potentially be used against them.[23] Knowing that their responses within psychiatric assessments and during counselling sessions could affect their access to release is hugely stressful and affects willingness to disclose challenges and seek assistance.

When people get out of prison, many leave with what has been termed "Post-Incarceration Syndrome" (PICS) (Gorski 2002),[24] which are understandable responses to living in an oppressive, restrictive, violent, and dehumanizing environment.[25] Gorski (2002) defines PICS as a cluster of symptoms that are usually present in prisoners and ex-prisoners caused by long periods of incarceration. Prolonged incarceration where there is a lack of education and no job training or "rehabilitation," coupled with punishment, ensures that people coming out of prison are worse off than when they went into prison. Prisoners who have experienced long periods of time in solitary confinement and significant abuse while in prison are most severely affected. The severity of these symptoms is subject to the person's ability to cope prior to incarceration; the length of time they are in prison and the prison environment itself; the level of abuse a prisoner faces while in prison; the length of time in solitary confinement; and the degree of involvement in education, work, and other programs while inside (Gorski 2012). He outlines the five clusters of the Post-Incarceration Syndrome as:

> a) Institutionalized Personality Traits resulting from the common deprivations of incarceration, a chronic state of learned helplessness in the face of prison authorities, and antisocial defences in dealing with a predatory inmate milieu;
> b) Post Traumatic Stress Disorder (PTSD) from both pre-incarceration trauma

> and trauma experienced within the institution; c) Antisocial Personality Traits (ASPT) developed as a coping response to institutional abuse and a predatory prisoner milieu; d) Social-Sensory Deprivation Syndrome caused by prolonged exposure to solitary confinement that radically restricts social contact and sensory stimulation; e) Substance Use Disorders caused by the use of alcohol and other drugs to manage or escape the Post-Incarceration Syndrome symptoms. Post-Incarceration Syndrome often coexists with substance use disorders and a variety of affective and personality disorders. Our goal is not to pathologize but to name a cluster of symptoms that deeply effects one's ability to navigate the world post incarceration. (Gorski 2012)

Another area of disability that needs to be examined within the prison context is HIV/AIDS, which is prevalent in Canadian prisons. As of 2010, the rates of HIV in federal prisons were 4.6 percent, according to Correctional Service Canada (CSC 2012); this rate is ten times the rate of HIV/AIDS in the community (McLay and Silversides 2011). Hepatitis C rates are also high in prisons. Current estimates suggest that 31 percent of prisoners have Hepatitis C, a rate which is 39 times higher than that of the general population. (Silversides 2010). Research suggests that many prisoners are seroconverting while inside prison (Canadian HIV/AIDS Legal Network 2013). It is impossible to know how many prisoners are seroconverting while in prison because people would need to be tested when they first arrived in prison, after three months of low/no risk activity, and again upon release. Recognizing the stigma and discrimination facing HIV positive prisoners, community advocates do not encourage this kind of testing. Unfortunately, this means that we have no record of the number of people seroconverting *while* in prison. What we do know is that people are engaged in a number of activities, including drug use, unprotected sex, and tattooing, without the necessary harm reduction tools needed for their own personal health. Because of the criminalization of drug users, there are a lot of people who use drugs in prisons without access to the tools they need to use safely.

Because of the presumption that all past drug users are "drug seeking" when they ask for pain medication (C-Change 2001), it is almost impossible for prisoners to access opiate-based medications, even if they had previously been prescribed these same medications by a doctor outside of prison. The lack of proper pain management forces prisoners into a position where they have to self-medicate, sometimes through the use of injection drugs. Much has been written about the prevalence of injection drugs in prison (e.g., Canadian AIDS Society 2012; Wood, Lim, and Kerr 2006), which is fuelled in part because injection drugs can pass through one's system more quickly, making them less detectable on urine-based drug tests. Because of the lack of access to new needles and harm reduction materials that could make injecting drugs safer, this self-medicating to treat pain often leads to the transmission of HIV or Hepatitis C or both (C-Change 2001).

The experiences of prisoners with HIV inside prison are marked by HIV-phobia and ableism. One of our colleagues inside further explains John's experience:

> [As] he started showing signs of the HIV illnesses (sweats, vomiting etc.) the other prisoners and staff became aware of his HIV status. He was fired from his prison job because of it and the instructor was sanctioned for the wrongful dismissal and he was given his job back. However the supervisor was not happy with this and would make a big production of telling everyone

> very loudly that they were not to bother him because he was HIV+ and as such a special case whom no one was allowed to bother. He would say it in a sneering, trouble making way. Eventually that shop instructor found another way to fire him and the game continued. Eventually he was transferred to this prison and he faced the same systemic racism, HIV stigma, ridicule and aggression from guards and prisoners . . . The health care treatment was horrible and the food services were just as bad. His medications were often cut off for no reason and with HIV treatments this can not only make your body resistant to the treatment it also opens you up for additional problems. The food services workers would not provide him with more food even after he had vomited his breakfast, lunch or supper and the man simply had no extra weight to lose. (Collins 2012)

John's story illustrates that prisoners with HIV rarely "have reasonable access to . . . health services" that emphasize "health promotion and illness prevention," as outlined in the Corrections and Conditional Release Act (Government of Canada 1992). By limiting his access to medications, neglecting to provide a stable diet offered at times that worked for someone with nausea and vomiting related to HIV, and fostering an environment that promoted anti-HIV/AIDS sentiment and ableism, the prison did not provide health services in an environment that supported health promotion and illness prevention. In fact, these limitations created a dangerous and hostile environment for John and contributed to his experience of disability.

Further to our discussion on disability in prisons, it is essential that we discuss mobility issues. As an example, Peter Collins, a prisoner at Bath Penitentiary, suffers from a degenerative back condition that leaves him in constant pain. In 2010, CSC was found guilty by the Canadian Human Rights Tribunal (CHRT) of failing to accommodate his disability by forcing him to stand for "count" (a security measure in federal prisons in Canada involving counting prisoners in each range to ensure everyone is present that can take place multiple times a day and that can require standing for long periods of time). Despite the results of the tribunal and direction to provide Peter with an assistive device for walking, the prison failed to give the device to him for several months:

> Discussions between the CHRT and the Warden had included providing me with a cane in order to assist me when forced to stand for protracted periods of time . . . I asked why I was not told about this (since I had been denied a walker when I requested one) . . . he did not answer, but did indicate that all I had to do was ask. So, in fact, I did ask repeatedly. I asked at the hearing verbally, I was advised to put it in a written request, which I did, which was not responded to so I followed up with a verbal request and more written requests, none of which resulted in the production of a cane. I had a lawyer write to the prison (twice), this did not result in the production of a cane. I asked my sister to pay for a cane in the community and have the medical supply store send it to the prison. This did not result in the production of the cane. It was not until members of Parliament wrote to the prison (at the request of members of the community) that the cane was given to me, more than 2 years after the CHC stated during the Tribunal that all I had to do was ask. (Collins 2012)

Peter's story illustrates again that prisoners who require tools to move rarely "have reasonable access to . . . health services." He needs a cane to be able to move around the prison or stand for prolonged periods of time, things he is expected to do as part of his work duty and participation in security counts. His inability to participate fully in work duty or the security counts affect him dramatically, both in terms of access to funds for the canteen and in more serious ways, such as being perceived as uncooperative and even anti-authority—things that are punishable in prison and also affect his release from prison. Peter's story is typical of the experience of disabled people in prison: there is little support or care to help with the experience of physical and mental difference in prison; as a result, the experience of physical or mental difference can be exacerbated and these experiences then become punishable offenses.

Because prison staff is generally untrained and unqualified to identify or understand physical and mental differences, prisoners whose physical bodies, mental states, and health status are labeled as different are often seen as troublemakers and end up being further punished through institutional charges and administrative segregation. Additional punishments often mean that disabled prisoners spend longer periods of time incarcerated.

Given that prison is an oppressive, violent, dehumanizing environment that worsens existing disabilities and creates new ones, what does this mean for prisoners when they are released into the community? Many come out to the same poor living conditions and systemic discrimination they faced before being incarcerated. In fact, the situation may be worse because of the loss of housing, employment, and social supports that can result from imprisonment. Some people will have had their disabilities aggravated by prison conditions. Others may have developed serious health issues while inside, such as HIV or Hepatitis C, or be suffering from psychological trauma as a result of the isolation, loss of agency/autonomy, deprivation, and oppressive nature of the prison environment.

New Legislation: It's Only Going to Get Worse

> My opinion is that many of the new laws in this bill will only affect the lower class individuals and these prison cells will be stocked disproportionately with individuals from intercity communities who have lack of finances with the door to the community openly revolving with other lower income families stuck in a helpless position of having to reside in these Low Income Neighbourhoods to begin with. Not everyone is rich who are born in this country or immigrate to Canada. (Kevin, federal prisoner, cited in Dias 2012)

In 2011, Conservative Prime Minister Steven Harper pushed through an omnibus crime bill called the "Safe Streets and Community Act," also known as Bill C-10. The bill comprised nine separate bills that the government had previously been unable to pass as a minority government. This crime bill was passed despite the fact that the national crime rate has been dropping since 1992 and is at its lowest rate since 1972 (Brennan 2012). Furthermore, the bill was passed without appropriate consultation, against serious recommendations from experts, and against all evidence-based research. Today, Canada is experiencing its highest incarceration rate with prisons bulging at the seams. The result is an increase in prison expansion for

profit and further genocide and racism with particularly disproportionate effects on Indigenous and Black communities. Looking at the United States, mandatory minimums such as are being implemented with this legislation have had a particularly dangerous effect on Black women (Levy-Pounds 2006). We must contextualize Black and Indigenous women's experience within the PIC in Canada. Dr. Rai Reece (2010) points out,

> Critical analysis of feminist criminology and Black women's incarceration ought to explicitly involve discussions of colonialism and imperialism. In retrospect the legacy of colonial conquest connects with the legacy of sociocultural exclusion, racism and citizenship rights for Black women in Canada. Evidence of this is seen in contemporary practices of over-policing, monitoring, and social exclusion in Canada where understandings of race, gender, class, dis/ability and sexuality flow out of colonial relations and structural ideologies. By exploring the divergent tenets of colonialism, specifically the making of Canada as a white settler society, it is evident that the experiences of incarcerated Black women are connected to the historical ways in which racism and racialization were and still are central organizing features. (6)

For the purposes of understanding how this new crime legislation is going to affect Indigenous and Black communities and how it will create disabilities for prisoners, we focus on just one aspect of the crime bill: the Penalties for Organized Drug Crimes Act.[26]

For the first time ever, changes to the Controlled Drugs and Substances Act included new mandatory minimum sentences for trafficking, import/export, and production. Although there has been a consistent war waged on people who use drugs in Canada (see VANDU 1998; Global Commission on Drugs 2012), mandatory minimums will exacerbate the effects of this war. Despite claims that the government is targeting serious drug offenses as part of organized crime, evidence shows that drug laws and enforcement of these laws predominantly target people most marginalized, including those who are poor, Indigenous, or racialized drug users (Mauer and King 2007; Moore and Elkavich 2008).

For the purposes of this chapter, we consider the disabling experience of drug use as disability with the lens of understanding that drug use is not in itself the "problem" but that the War on Drug Users, lack of harm reduction programming, and lack of access to social support for drug users creates disabling experiences for many users.[27] However, we are also aware that people with undiagnosed psychiatric disabilities often use drugs to try and find relief from the ways that society does not allow for differing mental states, such as anxiety and experiences that are labelled as mania, depression, etc. Evidence shows that 30 percent of people living with psychiatric disabilities also use substances, and 53 percent of people who use drugs have also been labelled with "mental health issues" (Mood Disorder Society of Canada 2009). From our collective experience working in prisons and with harm reduction both on the inside and outside in communities, the authors would estimate these statistics to be higher. What we see from research is that there is a correlation between drug use and psychiatric disabilities that needs to be explored when looking at disabilities and prisons. We look to forms of structural violence that both create and reinforce disability and affect drug users' social determinants of health. Intersectional experiences of marginalization affect both tendency to use drugs and access to supports once using drugs. Drug use by women

is often heightened by experiences such as sexual harassment; emotional, physical, and sexual abuse; poverty; racism; and mental illness (see Martin and Macy 2011; Millay et al. 2009; Stevens-Watkins et al. 2012).

As mentioned in the first section, experiences of mental health issues and drug use by Indigenous people can be directly connected to ongoing realities of colonization. The continued relocations of entire communities and the removal of Indigenous children to residential schools and white foster families resulted in disrupted families and communities, which has created a generation of traumatized peoples, along with the perpetuation of both "mental health and substance use issues" through intergenerational effects (Mussell, Cardiff, and White 2004) and eventually lead to higher incarceration rates for Indigenous people. In an excerpt about Alan's life story, Peter Collins explains:

> Alan is an Aboriginal man who identifies as 2-Spirited…In his early childhood he turned to drugs and alcohol as a means to escape the lack of inclusion that is the natural result of entrenched racism and homophobia. Later on as a teenager he was involved in a violent incident in which a man was significantly injured and he was charged with attempted murder. The proceedings were stayed in the sense that he was found Not Criminally Responsible. Under a Governor General's warrant he was committed to a psychiatric prison.
>
> While incarcerated in the psychiatric prison he was, among other things, subjected to sensory deprivation chambers in combination with courses of psychotropic drugs (LSD) all part of the state's experiments on those people considered disposable and without rights. After some years under those conditions he was released to a community-based therapeutic centre. After being a patient there for some time he was given a job as a Peer working in that facility. However, substance use and a lack of meaningful support eventually led to more violence and a sexual encounter resulted in violence and left one man dead. This time he was found to be criminally responsible (which is a questionable state sleight of hand in which the administration of justice views mental health issues as a ploy to avoid the full force of the law). He was sentenced to life in prison with a minimum parole eligibility of 10 years. That was 34 years and three strokes ago. (Collins 2012)

Alan's story illustrates the ways that intersecting experiences of racialization, homophobia, colonization, drug use, and being labelled with psychiatric disabilities affect the way that one's time in carceral spaces is served and the choices available once inside. With the understanding that Indigenous communities and People of Color (especially individuals with intersecting identities) face increased police surveillance and incarceration, we can begin to see how the new Bill C-10 legislation will play out within our communities.

When analyzing the drug trade in particular, it has been suggested that there is a difference between involvement in the drug trade based on one's experience of gender, and that this differentiation is rooted in poverty (Reece 2010). Women, and particularly Black women and Indigenous women, face poverty at much greater levels than men, leading to increased incarceration rates for women as the "war on drugs" rages on (Reece 2010). Research shows that women do not play a central role in the drug trade but act primarily as "small scale carriers, sellers' couriers or

drivers. In many cases, their roles are limited to answering telephones or living in a home used for drug related activities" (Lapidus et al. 2004). Furthermore, when caught, women are less likely than men to give information to the police (Lapidus et al. 2004). As a result, they do not get to take advantage of plea bargains offered by the police to give names of dealers in exchange for reduced prison sentences. The reality of mandatory minimum sentencing means that low-level drug "offenders" receive the mandatory minimum sentence, while many mid-level or higher level drug offenders (the main targets of legislation) avoid long sentences through plea bargains with the crown and get shorter sentences for naming other people in the drug trade (Lapidus et al. 2004).

We need more information about the experiences of racialized women in prison in order to fully understand how they will be affected by the new legislation. Rai Reece (2010) explains that the despite the overrepresentation of Black women in prison in Canada there is little research about their experiences:

> Analysis depicting the configuration of Black women's bodies as central factors in Canadian nation building is undeveloped. In regard to incarceration and detention, the stories of Black women often rest on the periphery of our environments, if not excluded entirely. Much of the written, visual or verbal experiences of incarcerated Black women remains elusive in feminist criminological and theoretical study. In Canada, Black women and women of color in prison are the silent forgotten population. (6)

Because of sexism, racism, and colonialism, women's stories are often silenced; yet, we know that the new mandatory minimum sentencing will have the greatest effect on women. We know this because the effects of the war on drugs on women in particular have been staggering in the United States. In 1980, there were 12,300 women in prison in the United States; in 2002, there were 182,271 (Lapidus et al. 2004; Mauer, Potler, and Wolf 1999). Lapidus et al. (2004) continue: "By 1999, drug offenses accounted for 72% of the female population in federal prisons" (16). Despite the relatively similar patterns of drug use by all women, racialized women (Black women in particular) in the United States are incarcerated at higher rates than their white counterparts. For example, Black women's incarceration for drug related offenses has increased by 800 percent, while white women's incarceration has increased by 400 percent (Lapidus et al. 2004). Chief Justice William Rehnquist of the US Supreme Court has stated,

> There is a respectable body of opinion which believes that these mandatory minimums impose unduly harsh punishment for first time offenders–particularly for "mules" who played only a minor role in a drug distribution scheme. Be that as it may, the mandatory minimums have also led to an inordinate increase in the federal prison population and will require huge expenditures to build new prison space. (as cited in Lapidus et al. 2004, 38)

Overall rates of incarceration have increased significantly since the war on drugs began in the United States. In 1980, there were approximately 40,000 people in prison for drug-related offenses, and by 2003 the number had increased tenfold to almost 450,000, which is equivalent to almost a quarter of all prisoners in the United States (Mauer 2003).

As evidenced in the United States, we have every reason to believe that the new legislation in Canada will lead to further increased rates of incarceration for Black and Indigenous communities, particularly women. Understanding the link between the disabling effects of the criminalization of drugs and drug use leads to a greater understanding of how disability is being criminalized and what that means for mass incarceration in Canada.

Conclusion

The PIC is based on a set of interests created and maintained to support capitalism, patriarchy, imperialism, colonialism, racism, ableism, and white supremacy.

When we begin to see the magnitude of the tentacles of the PIC and how it works to maintain power and control, we begin to understand that it is not a mistake that poor disabled racialized bodies fill these spaces. We need further research regarding the lived experiences of racialized disabled prisoners and how disability plays out inside the PIC in Canada. This research is essential to understanding how to dismantle the PIC in Canada. We need to correlate the ways that intersectional experiences of marginalization are intrinsically connected to the foundation of the PIC and, by doing so, consider how to work together across communities to try to alter this prison state in which we live. It is not a matter of educating politicians and policy makers. We have come to understand that the PIC is not broken, that it can't be fixed or reformed, and that it continues to keep the rich richer and the poor and racialized in prison. It is within this context that we come to see the intersections between all forms of oppression, but specifically the intersections between the PIC, race, and radical disability politics.

In order to change our society to be a place where we all can have access to the right to self-determination and to create communities that are truly safer and more secure built on foundations of social justice and critical politics, we must not work to change the PIC. Instead, we must work to abolish it. As we have illustrated, the tentacles of the PIC stretch out into so many systemic structures in society, including the police system, the education system, housing, health care systems, and more. Thus, what we are advocating for in our will to abolish the PIC is in fact an abolishment of all of these systems—a revolution to bring in a new way of working, loving, and living together that brings a complexity of analysis and an understanding of intersectional realities into its core.

Notes

1. We use the term prison in this context to refer to actual prison structures, as well as other carceral spaces including, but not limited to, immigration detention centers, jails, holding facilities, psychiatric holding spaces, and more. We include consideration of the broader experience of detention in our analysis.
2. The Prison Industrial Complex includes policing (and targeted policing of particular communities), the legal/(in)justice system, carceral spaces, probation periods, release conditions, and other ways that confinement and imprisonment extend into our daily lives before arrest and after release from detention.
3. We use the term disabled intentionally as part of our understanding of the social model of disability and the power in owning disability as a celebrated identity. As Fran Branfield (1999) suggests, "Thus, to claim 'I am disabled' is a political

statement. It is to align oneself with other disabled people in a struggle for equality, inclusion and full citizenship. As a political statement it does not claim that all disabled people's experience of oppression is the same. It certainly does not claim that there is anything natural or inevitable about the way in which people with impairments are disabled. On the contrary, to 'come out' as disabled is to acknowledge that the oppression we experience is a direct consequence of our society's construction and understanding of disability" (399).

4. To better understand how the prison environment affects prisoners, we asked Peter Collins to gather stories of disabled prisoners. Peter Collins has been working as a peer health educator in prison for the past 15 years of his incarceration. During that time, he became an outspoken advocate for the health of prisoners and, in 2008, won the Award for Action on HIV/AIDS and Human Rights given by the Canadian HIV/AIDS Legal Network and Human Rights Watch. Peter has been a tireless activist on many prisoners' rights issues and has been instrumental in the movement to end the PIC. Through Peter's work he has come across hundreds of prisoners with disabilities who have been criminalized, and then further punished within the penal system, because of their disabilities. It is through his work and personal experience fighting against the PIC that he helped gather stories of Indigenous prisoners whose voices would otherwise be lost because of colonization practices. It is unfortunate that some of these stories were not written in the first person or could not be told by the individuals in their oral tradition; however, without Peter's work with these individuals their stories may have been lost, as has been the case with so many others.
5. Canada has three dominant political parties: the Conservative Party, the Liberal Party, and the New Democratic Party. The current Conservative Government represents right-wing, pro-market, Christian values.
6. Although we recognize the many ways in which Indigenous people and Black communities have resisted colonization and racism, we will not be talking about this resistance in great detail in this chapter. We do want to note that this resistance has been a significant and important part of dismantling the PIC.
7. The Aboriginal Healing Foundation (2009) further explains, "The literature pertaining to the effects of residential schools on the health of Aboriginal peoples in Canada is, at best, limited…Kirmayer and colleagues note the implications of the residential school legacy…'The origins of the high rates of mental health [issues] in Aboriginal communities are not hard to discern. Aboriginal peoples in Canada have faced cultural oppression through policies of forced assimilation on the part of Euro-Canadian institutions since the earliest periods of contact' (2003, S16). Particularly notable was the establishment of the residential school system, a result of federal government policy and culmination of a formal partnership between the government and Roman Catholic, United, Anglican, and other churches to educate Aboriginal children. Both church and state had significant roles in the lives of Aboriginal people. Through education, it was thought that Aboriginal children could be integrated into the emerging British Canadian society and imbued with the principles and knowledge required to [assimilate]" (Kirmayer, Simpson, and Cargo 2003) (7).
8. We were asked to change the names in the stories to avoid further punishment of these individuals.
9. We do not conflate drug use with violence. We recognize that the prohibition of drugs is often the cause of violence.
10. See Obomsawin (2000).
11. See Schertow (2008).
12. See, for example, *Introduction to Policing* by Gene L. Scaramella, Steven M. Cox, and William P. McCamey (2011), which states, "For a variety of reasons, a police

officer may decide not to enforce the law. The exercise of discretion involving individual choice and judgment by police officers is a normal, necessary, and desirable part of policing" (100).

13. Elizabeth Cormack (2012) provides an explanation of the history of the role of policing and the powers given to police during the initial period of colonization in Canada. Similarly, the Committee to Stop Targeted Policing (2000) explains that "the police in Canada have a long history of functioning as a tool to control and limit Aboriginal populations" (11). Backhouse (1999) also documents the ways that systemic racism (including within policing) has been an instrumental part of Canadian history.
14. See police treatment of Edmund Yu (City of Toronto Council and Committees 2000) and Otto Vass ("Inquest Begins into Otto Vass Death," *City News Toronto*, October 16, 2006). For the overrepresentation of police shootings of people with mental health issues see Brink et al. (2011). For the differential treatment, and heightened murder rates, of people of color by the police see Jiwani (2002). See also Hils (2012) for an interview with Leroy Moore about his work against police brutality directed toward people of color with disabilities. Also, in the May 2012 edition of "Voices," the Newsletter for the Psychiatric Survivor Archives of Toronto, Don Weitz (2012) outlines a partial list of psychiatric survivors; young men who have been killed by the Toronto police—half of whom were of African descent.
15. Ibid.
16. See Zlomislic (2009).
17. Ibid.
18. Correctional Services Canada administers and maintains the federal prison system in Canada for prisoners serving a sentence of two years or longer.
19. Corrections and Conditional Release Act, S.C. 1992, c. 20. (Can.). http://laws-lois.justice.gc.ca/eng/acts/C-44.6/page-24.html
20. The Commissioner's Directive 800 is a policy concerning health care in federal prisons in Canada.
21. Seroconversion is the process in which a person's HIV status changes from HIV negative to HIV positive through the development of HIV antibodies.
22. We challenge the notion of "mental health" and "mental illness" and instead support the idea that humans have many different emotional experiences and mental states. Terminology that suggests that there is but one valid mental state (one deemed to be "healthy") and several invalid mental states (described as "illnesses") is inherently ableist and contrary to the tremendous work and advocacy against these categorizations by psychiatric survivors, consumers, and so on.
23. Regarding the release of inmate psychiatric information, the Forum on Corrections Research of Correctional Service Canada states, "the duty of confidentiality, which requires openness and honesty between patient and physician, must be balanced against the public interest in the administration of justice" (Correctional Services Canada 2012).
24. See Terrance Gorski, "Post Incarceration Syndrome and Relapse," http://www.tgorski.com/criminal_justice/cjs_pics_&_relapse.htm. Also refer to "Is There a Recognizable Post-Incarceration Syndrome among Released 'Lifers'?" *The International Journal of Law and Psychiatry*.
25. For a critique of the pathologizing of systemically induced responses to experiences of trauma and violence in the context of the "Residential School Syndrome," (but applicable to the "Post-Incarceration Syndrome"), see Chrisjohn and Young (1995).
26. However, it is important to acknowledge that all of these laws combined will have a very significant effect, particularly on racialized communities
27. The authors do not believe that drug use is a disability.

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