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Chair

Mr. Garry Breitkreuz

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● (1115)

[*English*]

Mr. James Livingston (Researcher, Mental Health and Addiction Services, Forensic Psychiatric Services Commission of British Columbia): Thank you very much.

Good morning, Mr. Chairman and members of the committee.

It's an honour to have this opportunity to speak to you today about mental health and addiction services in correctional settings. My name is James Livingston, and I'm a researcher with the Forensic Psychiatric Services Commission of B.C. Mental Health and Addiction Services. The Forensic Psychiatric Services Commission is a multi-site provincial health organization in British Columbia that provides specialized hospital and community-based assessment, treatment, and clinical case management services to adults with mental illness who are involved with the criminal justice system. I'm also a PhD candidate in the School of Criminology at Simon Fraser University.

When individuals with mental health and substance use problems are detained, imprisoned, or are supervised in the community, opportunities arise for detecting untreated illness, reducing suffering, and improving quality of life. Too often this opportunity is missed.

Earlier this year I was commissioned by the International Centre for Criminal Law Reform and Criminal Justice Policy to undertake a study of international standards and best practices in relation to the provision of mental health and substance use services in correctional settings, including jails, prisons, and community-based corrections. The centre is an independent international institute based in Vancouver, British Columbia, with a mandate to promote the rule of law, democracy, human rights, and good governance in criminal law and the administration of criminal justice domestically, regionally, and globally.

The research I undertook involved an extensive review of published and unpublished literature and a synthesis of the standards and guidelines contained in over 200 relevant documents. The preliminary findings of this review were refined through consultation with a small group of prominent experts in forensic mental health and addiction services.

I would like to spend my time providing you with an overview of our findings, which are detailed in a report entitled *Mental Health and Substance Use Services in Correctional Settings: A Review of Minimum Standards and Best Practices*. This report has been published and is available on the website of the International Centre for Criminal Law Reform and Criminal Justice Policy.

Our review revealed that published standards and best practices regarding correctional mental health and substance use services generally cluster around five service themes, including screening and assessment, treatment, suicide prevention and management, transitional services and supports, and community-based services and supports. For each of these themes, both best practices and minimum standards are identified and discussed in our report.

For the committee's purpose today, I will focus on the minimum standards that were identified in our research. Minimum standards are conceptualized as the policies, procedures, and practices that have been identified as essential for addressing mental health and substance use problems in correctional settings. Generally, these standards are formulated on the basis of legal and ethical considerations, particularly those that concern human rights.

The first service theme identified by our report relates to screening and assessment. Published guidelines and standards unanimously assert that providing systematic mental health and substance use screening and assessment in jails and prisons is a necessary, essential service. Our review identified five minimum standards in this area—for instance, training all staff members who work with inmates to recognize and respond to mental health and substance use problems, and screening all inmates upon arrival at correctional facilities to identify emergent and urgent mental health and substance use problems.

The second service theme is treatment, which involves providing services and supports to individuals with mental health and substance use problems in order to decrease disability, decrease human suffering, maximize the ability for individuals to participate in correctional programs, and create safe environments for those who live, work, and visit jails and prisons. With respect to treatment, our review suggests eight minimum standards, such as providing inmates who have mental health and substance use problems with access to the same level and standard of care available to individuals in the community, and ensuring that written, individualized treatment plans are created and regularly reviewed for inmates with mental health and substance use problems.

The third service theme is suicide prevention and management. On account of the high rates of suicide in jails and prisons, organizations have made considerable efforts developing comprehensive guidelines, standards, and programs to prevent and manage inmate suicide.

Regardless of the size or nature of the facility, all jails and prisons should establish adequate suicide prevention and management programs. Our analysis of the literature suggests six minimum standards in this area—for example, training all staff members who work with inmates to recognize verbal and behavioural cues that indicate potential suicide, and how to intervene, and housing potentially suicidal inmates in safe environments that maximize interactions with staff and others and minimize experiences of isolation.

The next service theme involves transitional services and supports. For inmates with mental health and substance use problems, the transition between custody and community can be acutely stressful, psychologically distressing, and disruptive to their recovery and treatment. Our review has identified three minimum standards in this area, such as providing inmates who have mental health and substance use problems with written transition plans that identify available and appropriate community resources prior to their transfer or release from prison or jail, and ensuring that inmates with mental health and substance use problems who require continued pharmacological treatment are provided with a sufficient supply of medication that can last at least until they are able to see a community health service provider.

The final service theme identified by our review relates to community-based services and supports. The community corrections system has a significant role to play in ensuring that probationers and parolees have access to appropriate mental health and substance use services. Our review suggests five minimum standards in this area, including screening all probationers and parolees to identify emergent and urgent mental health and substance use problems, including potential suicidality, and ensuring that probationers and parolees with mental health and substance use problems have access to the same level and standard of care available to individuals in the community who are not involved with the criminal justice system.

In closing, we recognize there is no single blueprint for creating a correctional mental health and substance use service system. Implementation of minimum standards and best practices should be flexible, varying according the types of settings and population, as well as other contextual factors, such as geography and resources. However, the conceptual framework and the minimum standards and best practices outlined in our report provide a useful guide to inform decision-making concerning mental health and substance use services in correctional settings. Currently, the minimum standards described within our report are being considered for adoption by correctional authorities throughout Canada in order to assess the strengths and gaps of their systems in providing mental health and substance use services.

Thank you for this opportunity to share our work. Should the members of the committee be interested in learning more about the best practices and minimum standards described within our report, I can provide additional examples and elaborate on the process we undertook in our research.

I look forward to your questions and wish you all the best with this important study.

Thank you.

● (1120)

The Chair (Mr. Garry Breitkreuz (Yorkton—Melville, CPC)): Thank you very much. I appreciate that outline of your research on the correctional mental health and substance use services.

Our next witness is Mr. Frank Sirotich, from the Canadian Mental Health Association. Go ahead, sir.

Dr. Frank Sirotich (Program Director, Community Support Services, Canadian Mental Health Association): Good morning. Thank you.

I am very pleased to be here today, and I'd like to thank you all for the opportunity to speak with you on the very important issue of addressing mental illness and addictions within the federal correctional system.

I will begin by briefly providing sorne background about the Canadian Mental Health Association, followed by an overview of community-based mental health services that have been funded within Ontario to address mental health needs of individuals within the provincial criminal justice and correctional systems. These initiatives may have some applicability within the federal correctional context. I will conclude by identifying broad recommendations pertaining to reintegration strategies for mentally ill offenders through the provision of specific services and cross-sector planning and coordination.

The Canadian Mental Health Association is a nationwide charitable organization that promotes the mental health of all persons and supports the resilience and recovery of people experiencing mental illness. It strives to achieve this objective through research, through the provision of public policy advice to government, through public education and mental health promotion campaigns for the community, and through community support services to men and women with serious mental illness. Each year it provides direct services to more than 100,000 individuals through the combined efforts of more than 10,000 staff and volunteers across Canada in 135 communities.

At CMHA's Toronto branch, as well as at a large number of branches across the country, we have a variety of services that operate at the interface of the mental health and criminal justice systems. I should add that many other community mental health agencies also provide services specifically targeting persons with mental illness and criminal justice involvement.

Within Ontario these mental health and justice services are organized across juncture points within the criminal justice, correctional, and forensic mental health systems. These services are aimed at reducing the involvement of persons with serious mental illness in the criminal justice system.

First among these services are prevention or pre-charge diversion programs, to which police can refer an individual for linkage to mental health services when the police believe the individual has a mental illness and that the person is at risk of coming into conflict with the criminal justice system or may have committed a minor public nuisance offence. The individual may be referred to treatment services in lieu of criminal arrest.

Second, there are court diversion initiatives, including mental health courts, which link mentally ill accused to treatment services. Criminal prosecution is stayed when the individual is successfully linked to mental health and addiction services. These court-based programs also assist in developing bail release plans and service care plans, which may be incorporated into probation orders for the remand population.

Third, we provide release-from-custody programs through which mental health workers within detention centres develop discharge plans for individuals pending their release to promote their successful reintegration into the community.

Fourth, we also provide intensive case management services dedicated to persons with justice involvement. These case management services include specialized programs targeted at persons with concurrent disorders—that is, a mental illness and an addiction—and/or a dual diagnosis, which is a mental illness and a developmental disability.

Included along this continuum of specialized community support programs are forensic assertive community treatment teams, which are mobile multidisciplinary teams that include psychiatrists, nurses, social workers, vocational specialists, addiction workers, and case managers. These forensic ACT teams work to reintegrate mentally ill offenders who are under the purview of Ontario Review Board pursuant to a finding of not criminally responsible due to mental disorder.

In addition to these community support programs and court-based and custody-based services, a continuum of residential services were also developed. These include short-term residential beds, often referred to as safe beds. These residential programs provide 24-hour on-site support for up to 30 days and provide interim housing pending linkage to longer-term housing. In addition, there is dedicated long-term supportive housing, with different levels of support that range from independent to 24-hour on-site support. There are also transitional rehabilitative programs that provide high-support housing and case management to individuals transitioning from the Ontario Review Board system to community mental health services.

In order to coordinate these services, both across program areas and across sectors, local and regional committees and a provincial human service and justice coordinating committee were established. These coordinating committees were established in response to a recognized need to coordinate resources and services and to plan more effectively for people with serious mental illness, developmental disability, acquired brain injury, and/or drug and alcohol problems who are in conflict with the law or at significant risk of coming into contact with the criminal justice system.

● (1125)

These committees are a joint collaboration between the ministries of the Attorney General, Community and Social Services, Child and Youth Services, Health and Long-term Care, and Community Safety and Correctional Services and various community mental health and addictions organizations.

Some elements in the continuum of services, such as forensic ACT teams, transitional and long-term housing programs, and specialized case management services, may have direct relevance to the federal correctional system. Moreover, these coordinating bodies may provide a vehicle for intergovernmental planning and coordination of services for individuals who are transitioning from the federal correctional system to community-based services. Conceivably, they could be replicated in other jurisdictions. Increased collaboration between the federal correctional and provincial health and justice systems is necessary to ensure continuity of care.

However, though these services may be transferable to the federal corrections population, it is important to recognize that these services alone may not he adequate. We currently do not have an adequate program infrastructure to address the complex range of needs of this population. Moreover, there is limited capacity among existing services to meet the needs of the federal correctional population. New investments are needed to build community capacity to provide adequate services for federal offenders who have serious mental illness. Moreover, such services would need to be evidence-based and targeted at criminogenic needs that predispose a person to recidivism, such as substance abuse, antisocial attitudes, and anger management problems. They also need to target the social determinants of health, such as having adequate housing and opportunities for employment.

Moreover, it is recommended that funding for the evaluation of new programming be included in any investment in the development of services. Building an ongoing infrastructure for research and development is necessary to ascertain more effective solutions and to ensure accountability for fiscal investments.

In sum, enhancing community capacity through the development of an infrastructure of specialized, evidence-based programming that addresses the complex needs of offenders who have mental illnesses and/or addictions, and coordinating with provincial and local human service and justice providers to enhance service continuity, will serve to lower the risk of recidivism, increase public safety, and improve the quality of life of persons with mental illness who are re-integrating into society from the federal correctional system.

Thank you for this opportunity to speak on some of efforts of community mental health organizations to address the needs of persons in the criminal justice and correctional systems who have mental illness and to outline potential strategies this committee may consider in its deliberations.

The Chair: Thank you very much, sir, for that presentation. I appreciate it.

We'll now go to Ms. Gail Czukar, from the Centre for Addiction and Mental Health. Welcome to our committee. You may give your presentation.

Ms. Gail Czukar (Executive Vice-President, Policy, Education and Health Promotion, Centre for Addiction and Mental Health): Thank you. I too would like to thank you very much for the opportunity to appear before this committee.

CAMH, the Centre for Addiction and Mental Health, is the largest mental health and addictions facility in Canada. We're a teaching hospital fully affiliated with the University of Toronto, with central clinical and research facilities. We also have 26 locations around the province. We serve 20,000 unique individuals annually and we have a staff of about 2,700 people including 200 full-time psychiatrists.

CAMH operates in-patient facilities in downtown Toronto. About 30% of our beds—170 in total—are forensic mental health beds. We house clients within our forensic mental health program who have been referred to CAMH for psychiatric assessment, and some are on pre-trial treatment orders. The majority of the forensic mental health clients are people who the courts have concluded cannot be held criminally responsible on account of their mental disorder or are unfit to stand trial under part XX.1 of the Criminal Code.

These clients fall under the jurisdiction of the Ontario Review Board. Most of CAMH's review board clients live in the community, but we're responsible for monitoring and treating them according to the terms of the review board orders.

Stigma is a huge barrier to treatment and support. The vast majority of incarcerated individuals with mental illness or addiction are in federal or provincial correctional facilities, not in the forensic mental health system. Your committee has already heard testimony about the prevalence of mental illness and addiction within federal correctional facilities, as well as estimates of those who are able to access treatment and those who aren't.

I won't repeat those numbers, but it's important for the committee to know that all across Canada, across settings as diverse as prisons, schools, workplaces, and city streets, a large percentage of people who need treatment and support for their mental health or substance use problems don't get the help they need.

As is the case in federal correctional facilities, there's no single explanation for this gap in service. We know people often don't seek help or choose not to accept help that's offered, but we also know there's an overall lack of system capacity. Both of my co-presenters today have spoken to that.

While mental health and addictions account for roughly 13% of death, disability, and illness, it receives only 5% of Canadian public health care expenditure. All of these problems have their roots in stigma. We continue to see mental health and addiction problems as frightening, threatening, and shameful.

CAMH has addressed stigma in various ways, but the Mental Health Commission of Canada is very committed to addressing stigma. The commission has done extensive research on how best to confront stigma, and this research has led them to launch some highly targeted initiatives customized to particular audiences and settings.

There are anti-stigma initiatives that have been evaluated and proven to have an impact. One of those is offered by my own organization. I encourage your committee to connect with the work of the Mental Health Commission and explore the most effective ways to address stigma in the correctional culture among both staff and prisoners.

Mental health and substance use problems are complex. The roots of these problems defy simple explanation and the paths to recovery are diverse. These problems are, above all, health problems. And our focus must be on finding the most effective treatment and support to help individuals to heal, to take greater control over their lives, and ultimately, to be successfully integrated or reintegrated into the community.

The groundbreaking 2006 report of the Senate, *Out of the Shadows at Last*, recommended that the standard of care for mental health within correctional institutions should be raised to the equivalent of non-offenders in the community. This is a worthy objective and one that your committee may want to endorse.

The best treatment within correctional facilities must be rooted in the lives and experiences of the individual. For CAMH and many other addiction providers, this means that we offer health services and supports to people with substance use problems who are still using drugs, including illegal drugs.

Health interventions that do not require cessation of use as a precondition are sometimes referred to as harm reduction, and those interventions often generate considerable controversy. But I would say that the single most important test that harm reduction measures must meet is whether they make people healthier.

● (1130)

Initiatives such as needle exchange programs have been evaluated and proven to reduce the transmission of infectious disease. I believe that the decision about needle exchange programs should be based on the best available evidence about its impact on the health of the prison population.

Connecting to community resources post-incarceration is also important. Regardless of the type of treatment, connecting to community resources upon release from prison can be challenging. Federal inmates who are released on parole continue to receive services funded by Correctional Service Canada, often through community agencies providing contractual services. CAMH has a small program of this type, funded by CSC.

There is no question that continuity of care—particularly once the warrant has expired—is a challenge. Like everyone else, people released from custody must navigate a system of care that can be confusing and is often poorly coordinated, but they carry the additional disadvantage of an extra label. Ontario, and likely other provincial-territorial jurisdictions, struggle to develop the most effective way of connecting people to services. We know that effective, responsive case management can help solve this problem. But case management requires system capacity. Simply put, you have to have services that the case manager can connect to.

In its draft national strategy document, the Mental Health Commission reports that only one-third of people living with a mental health problem or illness get access to services and supports, and that the situation is worse for populations in rural and remote communities. One of the commission's recommendations is that there be “robust and well-coordinated monitoring of mental health status and measuring of performance”. Federal and provincial governments should be working together to monitor the ability of those leaving correctional facilities to gain access to appropriate treatments and supports.

In conclusion, I would say that the Mental Health Commission is developing a national strategy on mental health. A broad-based group that was convened by the Canadian Centre on Substance Abuse—of which I was part as a member of the Canadian Executive Council on Addictions, and which CAMH participated in—has developed recommendations for a national addictions strategy. One of the messages of both plans is the need for services to be seamlessly integrated across institutions, sectors, and settings to meet the needs of individuals.

This is a challenge for all of us who work in mental health and addictions care. It is of course particularly challenging for people emerging from correctional facilities who are likely to have both serious problems and inadequate connection to communities and the services they offer.

We have much work to do to develop services in correctional facilities that meet the needs of prisoners and that offer the continuum of care that we know can work. Canadians across all sectors must find ways to meet the growing demands of people with mental health and addiction problems. The growing demand for mental health and addiction services can be celebrated as testimony to lower levels of stigma and a far greater awareness of the impact of these problems. Meeting this demand will require both greater investment and greater integration of mental health and addictions supports and services with all health services.

Thank you for your attention. I’d be happy to answer questions.

● (1135)

The Chair: Thank you very much. I appreciate your presentations.

We'll move immediately to the Liberal Party. Mr. Holland.

Mr. Mark Holland (Ajax—Pickering, Lib.): Thank you, Mr. Chair.

Thank you to the witnesses.

Maybe I could begin by talking about where our correctional system is today and the trajectory of where it's going.

I had the opportunity of being at the Grand Valley facility and to be in the cell in solitary confinement where Ashley Smith had passed away after more than eleven months in solitary confinement. She was an individual who was never diagnosed as having a mental health issue, but clearly did.

The report of the correctional investigator on that I think was disturbing, not because Ashley was so badly failed, although that was a great tragedy, but because the correctional investigator said this was symptomatic of what's happening generally. Ashley's story is unfolding every day in many prisons right across the country, and we are fundamentally failing in our approach to how we deal with mental health issues in our prison facilities.

Two days ago we had Dr. Jones before this committee, who's the executive director of the John Howard Society of Canada. His statement on the approach that's being taken right now, taken by the government, said it contradicts evidence, logic, effectiveness, history, justice, and humanity.

I'm wondering about your reflections on where we are right now. Do you agree that the current approach being taken in corrections is ineffective and, frankly, inhumane?

Ms. Gail Czukar: I don't work in prisons, and I can't really comment on that. I think what we know is that people who are in prisons and have mental illnesses identified, have addiction problems identified, not all of them are getting the help they need. From my reading of some of the testimony before this committee and some of the reports, it sounds like maybe half of the people who are identified with mental health problems—and these tend to be fairly serious mental health problems—get the help they need. So there's clearly a need for a lot more services.

I understand there's also a problem with the level of remuneration for staff, so it's hard to hold good staff. We're all facing that problem in the health field. If you're paying 40% less than the competition, you're going to have a very hard time having good staff in those facilities. We do know that there's a shortage of good services, and that on the addictions side in particular, most of the investments recently have been in interdiction and trying to prevent drugs from getting into prisons rather than trying to address the demand side of the question in terms of treating people's addictions. That's not uncommon in drug policy around the world today, but it's not, in the long run, an effective strategy. Sooner or later you have to address the demand question and help people with their addictions.

● (1140)

Mr. Mark Holland: One of the concerns that has been raised is that most of the way that more serious mental health prisoners are dealt with is through solitary confinement because they don't have the resources to be able to deal with them in a facility. First, would you agree that the approach of putting somebody who has mental health issues in solitary confinement would exacerbate their problem? It's probably one of the worst ways to deal with that issue. Second, given the fact that in a lot of situations these individuals are being released directly out of solitary confinement back into the general population, not only is it bad for them, but it's bad for society, because obviously, if they're coming directly out of solitary confinement into communities, these are not individuals who are likely to have been rehabilitated.

Mr. James Livingston: I'm fairly novice as to the current state of operations of our correctional system and what's happening on the ground, so my comments are really limited to my understanding of the research and literature.

Back to your question about ineffective and inhumane, it's obvious from the literature that not providing people with mental health and substance use services who need them is inconsistent with minimum standards that are endorsed by the World Health Organization, the United Nations, and many international and national correctional organizations. So I would refer you to those documents, but I can't say how they map against our current system.

Mr. Mark Holland: I think it's now becoming more widely accepted that mental health concerns and addiction concerns are intertwined; they're more often than not inseparable, they're very much linked, and they can't be treated in isolation. I'm wondering if you would agree with that and what your thoughts on that are.

Ms. Gail Czukar: I would just address that, and since we are the Centre for Addiction and Mental Health, say that they are intertwined. We serve many people with concurrent disorders. They're not always seen together. The key is to have the most appropriate services for people, so you have to have accurate assessments of whether the person has only a mental illness, only an addiction problem, or both together. Where both together are assessed, they do need to be treated together. We don't have a good record of that in our system generally, so I wouldn't expect that it would be significantly different in correctional facilities.

We do find in our forensic programs that we have a higher representation of people with concurrent disorders than in the normal population of people who use mental health services. Substance use problems, I understand from your previous testimony, are about 80% in correctional facilities, so it's very likely you're going to find a pretty high percentage of concurrent disorders.

Mr. Mark Holland: There is testimony before this committee that around 12% of the prison population is facing a serious mental health issue, but we heard from Dr. Jones two days ago, whose comments were that this is probably understated and that the concerns you've just talked about, about the concurrence, mean that percentage might actually be much higher. Would you agree with that?

● (1145)

Ms. Gail Czukar: My understanding is the 12% to 20% estimate is for people who've been diagnosed with a serious mental illness at intake, and it doesn't take into account people who might have a more moderate problem and it doesn't take into account people who become ill while they're in prison. It seems like, given the conditions that someone's in—separated from family and support and in a very different kind of environment with high discipline and so on—they would be vulnerable and probably come in vulnerable, to some extent, to developing mental health problems. So it's probably an underestimate, yes.

The Chair: I'll have to cut it off there and move over to the Bloc Québécois now.

Monsieur Ménard, please.

[*Translation*]

Mr. Serge Ménard (Marc-Aurèle-Fortin, BQ): Thank you.

Has anyone among you ever visited a prison or been in a prison to offer professional services?

[*English*]

Dr. Frank Sirotich: I can respond. I have not done that at a penitentiary, but at a local remand centre, yes, sir.

Mr. James Livingston: No. As I stated earlier, I'm a researcher, so I don't provide clinical service.

[*Translation*]

Mr. Serge Ménard: Do you believe that a prison environment is conducive to the treatment of mental illness?

[*English*]

Dr. Frank Sirotich: It would depend on what the illness is. Certainly in terms of treatment, there are facilities that have special needs units, though they seem to be woefully resourced, at least at the provincial level. Again, I couldn't speak about at the federal level.

I think what would be key is that you have the treatment resources, further to what Mr. Livingston was indicating, that are comparable, that would be available in a community context so that you have adequate addiction services, adequate psychiatric resources for psycho-pharmacological intervention, but one of the difficulties in local remand centres is often those services aren't available.

In terms of the term “dead time”, it's often applied to that context because such services aren't available.

[*Translation*]

Mr. Serge Ménard: Do I err in thinking that the kinds of resources you are talking about are almost non-existent in Canadian correctional institutions?

For instance, what do you think of the fact that the Commissioner of Corrections was asked about the annual cost for keeping an inmate in a Canadian prison? The cost is $101,000 of which only 2% is devoted to programs while the balance is for accommodation and security.

Do you believe that the Canadian correctional system has, at this time, the necessary resources to treat mental illnesses?

[*English*]

Dr. Frank Sirotich: I couldn't speak to the actual figures. Again, the context from which I'm coming at it is really local remand centres or detention centres, which certainly, from my experience, from what I've seen, are woefully under-resourced.

[*Translation*]

Mr. Serge Ménard: If this was compared to institutions or centres which are treating addictions outside of prisons, even if it might be a residential centre…

Have you heard of Portage in Quebec? It is a government organization inspired by the New York model.

[*English*]

Dr. Frank Sirotich: I'm sorry, sir, I'm not familiar with that model.

[*Translation*]

Mr. Serge Ménard: Maybe others—

[*English*]

Mr. James Livingston: Yes, I'm familiar with it.

Was there a question? I'm sorry.

[*Translation*]

Mr. Serge Ménard: This first question was only to know if you knew of them.

Do you think that this is a good model for treating addictions?

[*English*]

Mr. James Livingston: It's been shown in the literature to be a best practice.

[*Translation*]

Mr. Serge Ménard: Yes, very well.

We may contrast the experience of Portage and that of Matsqui that you are surely familiar with.

Could you elaborate on how the two compare with each other and help us to decide if we should favour one over the other?

● (1150)

[*English*]

Mr. James Livingston: I'm familiar with Matsqui and Portage, but I'm not aware of the comparison you're speaking about.

[*Translation*]

Mr. Serge Ménard: All right.

Are you familiar with the Joliette Penitentiary for Women?

You seem to indicate that you are.

[*English*]

Mr. James Livingston: Yes.

[*Translation*]

Mr. Serge Ménard: When it was built, it received prizes for its architectural design. It was specifically designed to make that environment more humane, to facilitate the rehabilitation of inmates.

Could you tell us about this environment? Do you think that in fact the sought-after results were obtained in regards to the treatment of inmates, or do you have other information in the documentation you have on this subject?

[*English*]

Mr. James Livingston: No.

[*Translation*]

Mr. Serge Ménard: I believe that Ms. Czukar—

[*English*]

Ms. Gail Czukar: I'm not aware of the literature either, but I think the question you're trying to get at is whether the kind of environment provided in a correctional facility is amenable to helping people with their mental health and addiction problems, and whether that's the appropriate place for people to be, or would they be better off in hospitals or in other kinds of treatment places. Is that your question?

[*Translation*]

Mr. Serge Ménard: In fact, is it documented that large prisons can offer these services because they might be a little more specialized or that, on the contrary, prisons should be kept to a smaller size?

[*English*]

Mr. James Livingston: Regarding that question, my familiarity is with the literature. I don't think it directly answers that question, but it does recognize that mental health and addiction services are delivered differently to different sized jails and prisons. The issues of the services you provide to a jail population, because of their shorter term of incarceration and their sometimes unpredictable release, would be different from a federal correctional population, where their release is more predictable and they're often incarcerated for longer periods of time. Therefore, their attachment to community-based services and supports, family members, and social networks are often limited because of the amount of time they spend in custody.

I don't know if that answers your question directly.

[*Translation*]

Mr. Serge Ménard: In any case, it is very difficult to provide answers to specific questions in that area.

Staff training is very important. What prior education should they require of applicants for a position in correctional institutions?

[*English*]

Ms. Gail Czukar: My understanding is the Correctional Service already employs a number of psychologists and people with psychological training, but doesn't have many vacancies in those positions—trainers in assessment and testing, who assist people with their counselling and other kinds of programs; psychiatrists who assess needs for medication, for treatment, and those sorts of things; and social workers, people like that, to help clients in those areas. I think there's been some discussion, and certainly case managers are very helpful in terms of the transition out of the facility and back to the community, but as I said, if there aren't the services in the community for people, then having case managers doesn't help.

In terms of the services to be provided within the correctional facilities, on the mental health side those would be some of the people, and addiction counsellors as well to assist with addicted clients.

The Chair: Thank you very much.

[*Translation*]

Mr. Serge Ménard: I will give others a chance to ask questions.

[*English*]

The Chair: Thank you very much.

We'll go over to the NDP now. We'll have Mr. Davies, please, for seven minutes.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you for being here today. It's very helpful.

What are the most common mental illnesses you would find in a federal prison? I would ask you, also, to separate them by men and women.

● (1155)

Mr. James Livingston: I think the question is twofold. What the most common detected mental illnesses are is one question. What the common underlying, undetected mental illnesses are would be another question. With my familiarity with the literature, I can't separate it by men and women, although the profiles would be much different.

The correctional system tends to concentrate on more severe types of mental illness in terms of their identification, which would be schizophrenia and other psychotic disorders. The less severe depression and anxiety disorders might not be picked up on the radar in terms of the screening and assessment, perhaps because of a lack of available services to address those underlying problems. I can't give you exact figures for that particular question. I'm sorry.

Mr. Don Davies: Through my amateur research, it's my understanding that substance abuse is actually listed in the DSM-IV and is in itself a mental illness. When we separate substance abuse from other forms of mental illness, we don't mean to say that they're not all mental illnesses. But it's helpful to have that dichotomy, because they have different treatment plans, and I suppose that they indicate themselves differently.

Do you believe there is a linkage between those mental illnesses, whether they're detected or not, and the committing of the crimes for which those people are in jail?

Dr. Frank Sirotich: Certainly with regard to substance abuse, the literature would indicate that there is a connection with substance abuse. It is a criminogenic risk factor in terms of recidivism. The literature on psychosis and psychotic symptoms has been mixed.

More recently, actually, there was a meta-analysis that was undertaken that seemed to suggest that psychotic symptoms, such as "threat/control-override" delusions, a belief that somebody is going to harm the individual or that their mind or body is being controlled by another being or source, could increase the person's risk, although not substantially.

Ms. Gail Czukar: Certainly the evidence is clear that people with mental health problems are not more violent than the general population in general. It is important to remember that, because while we are talking about great need in the correctional system for services for people with mental illness and addiction problems, I think that saying they are there because of those problems is a dangerous way to go. Then we conflate two things.

On this question, I think we really have to separate mental illness and substance use. Many people are in the correctional system because of their substance use, which may or may not be an addiction issue. We know that alcohol is implicated in many crimes in the sense that violence tends to result from alcohol. Alcohol causes huge social problems, which is one of the reasons the CAMH does a lot of work on alcohol policy and lowering blood alcohol levels and those kinds of things.

We know that there is a great connection between alcohol, violence, and people being in correctional facilities. There are other people who are there because of the consequence of their drug use. So it may not be a violence issue. It tends to be people on harder drugs, who have stolen to support those habits. They're not as prevalent as alcohol-related problems. When it comes to mental illness, I would not say that mental illness causes people to be criminal.

Mr. Don Davies: Don't misunderstand me; I wasn't meaning to suggest that mental illness is a cause. You made a linkage to violence. That was not in my mind at all.

What I'm trying to find out is whether there is a link between underlying mental health issues: anxiety, depression, paranoia, feelings of insecurity, all the way down to things such as post-traumatic stress disorder, which I know is epidemic in women's institutions, as well as FASD, which I know is not mental illness but is something that I think lessens impulse control. In a lot of cases, are those some of the underlying contributors to why that person is in prison?

The reason I ask that is because it would seem to me, then, that if we are not accurately diagnosing and treating those issues in the corrections system, are we doing what we can to reduce the recidivism of those people when they come out? If there's no linkage, then I guess we don't have to diagnose or treat them in prison, do we, because there is no linkage. But I happen to believe there is.

That is what I was getting at. I wonder if that helps flesh it out, and I would invite any comment on that.

● (1200)

Mr. James Livingston: My comment as a student of criminology and sociology is that your question is very complex and it sort of hinges on the social determinants of both mental illness and crime, which are very related. Poverty, marginalization as such, living in impoverished neighbourhoods, and those sorts of things are related to both of those problems.

But going back to your question about increasing recidivism because of the lack of mental health services in correctional settings —if I could paraphrase it—not providing people with mental health and substance abuse treatment is detrimental to their participation in correctional programs that are focused on reducing those sorts of things you talk about.

We know that by providing people with mental health treatment they're able to better participate in the programs that are specifically designed for recidivism in correctional settings.

Mr. Don Davies: Okay. I have two quick questions, and we will keep the answers brief.

Did I understand you correctly, Ms. Czukar, that corrections is paying 40% less to professionals in the corrections system than in the market in general?

Ms. Gail Czukar: I read in some of the previous hearings an example where someone was being paid, I think, $88,000 and was hired by another organization that was paying them $118,000. I am not sure if my math exactly adds up, but it's almost that.

Mr. Don Davies: That jibes, because in August and September I toured nine institutions in British Columbia, clustered in the Fraser Valley. There were vacancies all over the place for psychologists, occupational therapists, and substance abuse counsellors, because they just cannot attract them.

My last question is on 12-step programs. I found that there was a real lack of 12-step program presence in every institution I was in. There seem to be some barriers to that, because inmates are not necessarily the best population in which to conduct 12-step member-based programs.

Do you have any comment on ways to get the community involved in our prisons to help expose those prisoners to 12-step programs, which seem to have a lot of success?

Dr. Frank Sirotich: No, not specifically on 12-step programs, but there are models with regard to mental health services.

When people are under an Ontario Review Board order and they are transitioning into the community, the community providers actually will go into the forensic hospitals and work collaboratively with the hospital staff there so that there is greater continuity when the person transitions into the community.

Presumably, there could be parallels. That's with mental health. I could see parallels certainly being applied to an addictions context.

The Chair: We'll go to Mr. Rathgeber now, for seven minutes, please.

Mr. Brent Rathgeber (Edmonton—St. Albert, CPC): Thank you, Mr. Chair.

Thank you to all the witnesses for your interesting presentations.

Dr. Czukar, in response to a question that Mr. Holland posed to you, did I hear you correctly that your estimation or research had indicated only 12% of the Canadian prison population suffers from some form of mental illness?

Ms. Gail Czukar: No, those are not my figures. Those are the figures that I believe were presented here by previous witnesses. So I don't have any source for that, but I have read some of the previous testimony.

Mr. Brent Rathgeber: That number appears low to me. I have heard estimates as high as 30%, but I suppose it depends how you define mental illness.

Does anybody know what exactly is included in that 12% figure? Is that as minor as manageable depression, or does it only include serious anti-social behaviour types of illnesses?

Mr. James Livingston: Depending on the population you're looking at, the country you're looking at, and the definition of mental illness or mental disorder, the figures range from 5% to 70% within the literature. And that is not just within a Canadian context.

Meta-analysis has generally ballparked the number from reviewing international studies at around 8% to 12%. I can't provide you with the inclusion criteria for how they defined mental illness within that 8% to 12%, but I can certainly provide research references for that.

● (1205)

Mr. Brent Rathgeber: So we're clear, is the 8% to 12% among those involved in criminal activity, or is that in the population generally?

Mr. James Livingston: That's in prison populations. It also depends on how you define a prison population, because internationally it's defined quite differently.

Mr. Brent Rathgeber: That's not significantly higher than in the general population. I've read reports that indicate almost 10% of the population suffer from some form of depression.

Ms. Gail Czukar: I think a serious mental illness, a psychosis, in the general population is 1% to 3%. Depression is much broader.

The figures generally are that one in five people in Canada will have a mental illness or substance abuse problem in their lifetime. That's a fairly well-accepted figure. In Ontario, I believe it's one in four.

It's somewhere between 3% and 20%. We're probably not the ones in a position to help you with the criteria for the way the Correctional Service is deciding who has a serious mental illness. The 12% to 20% is what I've heard the correctional officials give you.

Mr. Brent Rathgeber: Thank you. I think that underscores the importance of my point about what is being defined as mental illness when we float these figures.

Dr. Livingston, with respect to your model and best practices, how realistic is it that mental health issues can be treated in the prison system? As you know, the prison system is highly regimented, highly regulated; there are rules upon rules. Society generally has not been particularly successful in treating mental illness, so how realistic are these best practices and this conceptual framework you refer to? How realistic will its success be in the highly structured system of corrections?

Mr. James Livingston: I definitely take your point. The correctional environment is certainly difficult for delivering mental health and substance abuse services because of the inherent tensions within the environment.

Having said that, others have done it, and there are innovative models. Within the last few years, the U.K. has developed a different model for providing services to prison populations. They've taken the responsibility away from prison authorities, and the National Health Service now provides prison-based mental health services.

There are innovative models for doing it, and it's being done in other jurisdictions.

Mr. Brent Rathgeber: We have a couple of minutes. Can you tell me about some of those innovative models? What is happening in the corrections system in Britain that has been successful in treating mental illness inside prison walls?

Mr. James Livingston: There are innovative models from the U. S. as well, so it's not just the U.K. There are psychiatric in-reach teams, in which mental health service providers go to prisons to provide services.

There are people called trans-agency coordinators. They are responsible for coordinating and funding services between corrections and mental health environments. It's someone who is sort of a “boundary spanner”, administratively.

There are also cross-training programs between correctional staff and mental health staff so they build up mutual respect and learn different skills in different environments.

This is all detailed in the report I mentioned. There are innovative models throughout the U.S., and other jurisdictions as well.

Mr. Brent Rathgeber: Thank you. I'll read up on this.

With regard to my last question, can addictions and mental health issues be treated concurrently, or does one have to get addictions under control before entertaining mental health treatment?

● (1210)

Mr. James Livingston: I will briefly address that.

I'm not a clinician, so I couldn't tell you, based on a clinical view. The research supports integrated concurrent disorders treatment as a best practice and so supports dealing with both problems at the same time. I don't know sequentially how that happens in practice clinically, but it's certainly a best practice, and the national treatment strategy that was identified by my colleague certainly endorses such an approach for people who have concurrent disorders.

Mr. Brent Rathgeber: Dr. Czukar, in the 30 seconds I have left, do you have anything to add?

Ms. Gail Czukar: I feel very honoured, but I am not a doctor. I just want to be clear. I am a lawyer and a psychologist.

I would say it's very important to treat addictions and mental illness together. The addiction is frequently a kind of symptom of the illness, so expecting someone to get their addiction under control without addressing the underlying mental health problem or the underlying trauma, or those kinds of needs, isn't going to work.

Mr. Brent Rathgeber: Thank you very much, all of you.

The Chair: Thank you.

The analyst has just pointed out to me that in the Sampson report of 2007, they report that 12% of men and 26% of women offenders are identified as having very serious mental health problems.

We will now go over to the Liberal Party again. Mr. Oliphant, please, for five minutes.

Mr. Robert Oliphant (Don Valley West, Lib.): Thank you, Mr. Chair.

Thank you, all three, for being here, especially Ms. Czukar. I think today's a big day in your organization, with the closing of the 1001 campus, a campus I've actually spent many hours at. I think it's great you're here today. I hope you get back in time. You won't, but it's a big day in the life of your organization.

I also want to thank Dr. Sirotich for your work in your organization. Often the prison populations are forgotten in mainstream studies about everything, whether it's income security, education, whatever. Your organization has kept the prison population on the radar within the broader mental health field, and that's very much appreciated.

I don't know the work of Mr. Livingston, but I'm now learning about it, and I think there is some interesting modelling for the federal system that we can take from B.C.

I want to make sure I'm getting some points, because my time is limited.

What I am hearing overall is this. Both from what you've written in the past and what you've said today, you have made six points: an emphasis on crime reduction with a concentration on the social determinants of both health and crime behaviour; an assessment diagnosis model that is appropriate for all people within the criminal justice system; diversion processes including court and other diversion processes to get people out of the penitentiary system earlier; a continuum of care, which begins right from arrest and remand all the way through sentencing to release; capacity-building, both on the infrastructure and the programs as well as on professionals and caregivers; risk reduction models that should be incorporated into the prison population, not left out; and upon release, community programs and integration and continuing care.

That's what I'm hearing. First, is there something major I'm missing in what you're presenting today?

Ms. Gail Czukar: I didn't hear you mention treatment in the facilities—

Mr. Robert Oliphant: Continuum of care. I should have added it to the treatment.

Ms. Gail Czukar: Okay. I think that's extremely important.

You mentioned diversion, but we haven't really talked about this very much. Diversion, prior to people getting into any involvement with the criminal justice system, is obviously what we would be most concerned with, because as soon as someone is involved in the criminal justice system—whether it's at the provincial level, the kind of court support work that Frank has been very involved in, and others—we have added a whole lot of problems to that person's life as well as significant costs to the system. So a well-resourced system of mental health and addiction services generally is what's going to help with all of the things that you've mentioned: assessment, diagnosis, continuum, capacity-building, risk reduction. That's really the best answer to a number of these things.

● (1215)

Mr. Robert Oliphant: And that is different from the viewpoint of the Sampson report. One of its focuses on mental health has to do with a reward and punishment system for people within an already stretched system, in which I would say we don't have the capacity or the professionals, but we also haven't figured out how to get people assessed and in treatment.

I'd like some comments on your understanding of a reward and punishment system for people who engage in treatment versus mandatory programs and the human rights issues that go with them.

The Chair: You have one minute to briefly respond.

Mr. Robert Oliphant: We're going to have to have lunch some time.

Ms. Gail Czukar: Oh.

Well, maybe I'll start, but I'm sure my colleagues have something to say about this.

You're contrasting a reward and punishment system with mandatory...?

Mr. Robert Oliphant: With mandatory...or a third alternative that maybe this committee needs to understand. I believe CMHA has questioned some of the stuff around reward and punishment, but I don't know what the theories are, what the research is with respect to treatment options.

Ms. Gail Czukar: You're talking about compulsory treatment?

Mr. Robert Oliphant: About compulsory treatment, yes.

The Chair: Let's have a 30-second answer.

Ms. Gail Czukar: There is no easy answer to that. We know that treatment that is non-coerced tends to be more effective, tends to help people if they recognize that they have a problem and want help with it.

That having been said, there are provisions in the law, of course, for treatment without consent under very limited circumstances. In the code, it's in order to make someone fit to stand trial, and those are the only circumstances in Ontario in which you can treat someone, under the law, without their consent. It's a basic human rights issue.

Mr. Robert Oliphant: Is health, though, also a human right?

The Chair: We're way over time. I'm sorry; we'll have to go over to Mr. McColeman. You should have started with that question.

Mr. McColeman, please.

Mr. Phil McColeman (Brant, CPC): Thank you, Chair.

Thank you very much for coming today. It is a great learning experience to hear from experts such as yourselves. I'm looking forward to reading the report that you, Dr. Livingston, have put together.

You mentioned in your opening comments the suicidal tendencies of people with mental illness. Are there any hard statistics around the rate of attempted suicide or suicides in our correctional facilities?

Mr. James Livingston: I'm sure there are, but they don't come to mind right now. The research generally recognizes the elevated risk among prisoners of suicide and self-harm—behaviours that have been covered in my report as well—and attempted suicides; however, the figures escape me currently.

Mr. Phil McColeman: Okay, but they are part of your report and outlined?

Mr. James Livingston: The bodies of research from which I've mentioned that elevated risk are outlined in the report.

Mr. Phil McColeman: Okay.

From your comments, Ms. Czukar, regarding the community-based programs and the stigmatism around mental illness, it appears to me that our society in general has a much larger role to play in treatment and the destigmatization of people with mental illness, first; and then concerning those who have that combined with conviction for criminal activities.

In your work, do you have ways to assist at the community level? I would think that in some ways the result—someone moving to criminal activity—might be avoided.

Ms. Gail Czukar: I wouldn't want to identify mental illness with criminal activity in quite that way.

I think, though, that it's important to distinguish between stigma on the part of the general public, say, and those who work in hospitals, who work in facilities, and so on. We know from research that unfortunately people who work in the system, health workers, are among the worst stigmatizers around. We actually have programs —we have a program called “Beyond the Label”—that we do with people who work in the system.

In the correctional facilities, it's much worse. It's a huge stigma for correctional workers to talk about their own mental health and their own mental illness and the difficulties they might be having, let alone their attitude towards prisoners. When we talk about stigma, it's important to start with ourselves and with the people we are trying to take care of first, because stigma on the part of people who are working in the system, whether it's the correctional system or the health system, translates pretty directly into self-stigma on the part of people who need help or people who are in prison.

I don't want to take more time on this, but I can't emphasize enough the importance of dealing with stigma with respect to prison officials and prison workers as well as inmates. That would be a very important place to start.

● (1220)

Mr. Phil McColeman: About the question of the vacancies we have among the professional people involved in our correctional system, do you believe there are enough people wanting to work in the system? If the remuneration were comparable, let's say, to another offering somewhere out there, do you think these jobs would be taken, or do you believe that you have to actually pay someone a premium to work in a prison system?

Mr. James Livingston: I'll talk just generally about that as well. This is also related to stigma, and health professionals feel the stigma. I work in the Forensic Psychiatric Services Commission in B.C., and the stigma inherent among forensic psychologists and forensic nurses dealing with this particular population is very difficult, from the standpoint of recruitment and hiring practices.

I can't be more specific about that, but if the committee wants to know a little more about stigma, I've been doing stigma research for the past four years for people on compulsory community treatment in B.C. and in the forensic psychiatric system, and certainly among the health professionals it's a big issue as well.

Mr. Phil McColeman: It strikes me, thinking very simplistically, that we have job openings here, and there's a reason why they're not being filled. Is the reason money, or are there other reasons? Perhaps that stigma factor is much larger than we really know.

Mr. James Livingston: I can't say specifically, but I can tell you that delivering treatment to people who want to be treated is easier than delivering treatment to people who don't want to be treated. That's certainly a factor as well.

Mr. Phil McColeman: I appreciate those comments. Those are things we'll need to focus on as we study this issue, in terms of how we staff up and recruit the proper people. It will be interesting to talk to officials as we visit institutions.

Thank you.

The Chair: Your time is up.

Ms. Mourani, please.

[*Translation*]

Mrs. Maria Mourani (Ahuntsic, BQ): Thank you, Mr. Chair.

I thank all our witnesses. I have a few short questions.

We considered many very theoretical points today. Yet, I am a very down-to-earth person, so I would like to bring the discussion down to the level of mortals.

Mr. Livingston, you spoke of a security environment with minimal isolation. I must admit that having worked in prisons, I have trouble seeing how we could do that. If you have a suggestion, it would be welcomed.

[*English*]

Mr. James Livingston: Generally, the guidelines suggest that you don't isolate someone without contact with people when you're trying to prevent and manage suicide. So if you're talking specifically about suicide, the level of risk should indicate the level of supervision that somebody receives.

The literature is very clear that isolating someone who is at potential risk for suicide is a contributor to the completed suicide. So staff interaction every 15 minutes, or every five minutes, and not replacing direct and meaningful staff interaction with technology, such as cameras, or with other correctional inmates who often serve as companions—

[*Translation*]

Mrs. Maria Mourani: Have you observed this in prisons?

[*English*]

Mr. James Livingston: No, it's not from direct experience; it's from the literature, which is very rich. There has been a lot of work done in developing minimum standards in this particular area and studying the effectiveness of what approaches work well. This has been identified in the research and is unanimously supported by a range of international standards.

● (1225)

[*Translation*]

Mrs. Maria Mourani: If I am not mistaken, these are minimal standards, but it does not mean that they are already enforced. It might be that they are already implemented in our prisons as we speak. Is that right?

[*English*]

Mr. James Livingston: Yes, they could be. My report just outlines them. They could be already applied.

And it might be of interest to the committee that I'm aware that a recent federal-territorial-provincial committee on prisons and mental health has had a look at my report and has built it into a self-assessment guide to measure and monitor their system across Canada. It might be of interest to follow that up a little bit.

[*Translation*]

Mrs. Maria Mourani: At this time, Correctional Service Canada has a very specific management program for persons who are put into isolation. From the time a person is placed in isolation not only is she in her own cell—there are never two people in the same cell —, but a guard is present who makes rounds about every ten minutes. Furthermore, a corrections officer must make a daily evaluation of the inmate's condition.

I thought at first that you were talking theoretically, but it is possible that this is actually going on in prisons in Canada. That is my understanding. This would be the ideal situation, but you cannot tell us if it is not already implemented in some federal institutions.

[*English*]

Mr. James Livingston: No. As I said, I'm a novice in terms of what's happening on the ground, and I'm not an expert. I'm an expert on very little, especially having to do with the operations of corrections.

[*Translation*]

Mrs. Maria Mourani: My question is for Ms. Czukar. We were talking about conducting a diagnostic assessment of inmates. Have you heard of the Regional Reception Centre, in Quebec?

[*English*]

Ms. Gail Czukar: No, I don't know the specific reception centres. I know that there are, I think, five of them across the country and so on, but I don't know specific ones, no.

[*Translation*]

Mrs. Maria Mourani: Most federal penitentiaries have an intake process for inmates. An assessment is made of all inmates and they are directed to one or another prison depending on their security risk and their program needs.

Have you heard of the Regional Mental Health Centre, in Quebec?

Ms. Gail Czukar: No.

Mrs. Maria Mourani: I was listening to what you were saying and I have the impression that nothing or very little is going on at the present time in Correctional Service Canada. I referred to the Regional Mental Health Centre. The same facility exists in Kingston. This is really focussed on mental health. We find there psychologists, psychiatrists, social workers, parole officers, security officers, all these multidisciplinary teams.

Did you look into the federal prisons to see if these services were offered or not?

[*English*]

Ms. Gail Czukar: My understanding is that there is a great deal already provided, but that it's insufficient.

[*Translation*]

Mrs. Maria Mourani: Insufficient, agreed.

[*English*]

Ms. Gail Czukar: There are not enough of these services, and I understand that the testimony before this committee has been that about half of the people who are in serious need of services are not receiving them. So I'm not saying there's nothing happening, but from what others have told you who do know the system, it sounds like a lot of people aren't getting what they need.

[*Translation*]

Mrs. Maria Mourani: I have another question.

[*English*]

The Chair: You're actually out of time, but go ahead.

[*Translation*]

Mrs. Maria Mourani: I will be brief.

Earlier, you made a very important point: the link between mental health and violence. In your work, have you seen people with mental health problems capable of committing crimes due to psychotic hallucinations, and who are violent? What do we do with these people?

[*English*]

Ms. Gail Czukar: Yes, that does happen. And I think a lot of those people are the people we were talking about in prison. I think we've said that it can very well lead to someone being in the system. It's not always the case, and some of the people you find there are like that and some aren't.

The Chair: Thank you.

We'll go over to the government side now. Ms. Glover, please, for five minutes.

Mrs. Shelly Glover (Saint Boniface, CPC): Thank you very much, Mr. Chair.

I want to welcome our witnesses here today. I take a tremendous interest in this area, and I have a few questions, but I'd like to start with Dr. Livingston's statement. You said, and it's not verbatim but very close, that treating those who want to be treated is easier than treating those who don't want to be treated.

The reason I take such an interest in that statement is because in my home province, we had the terrible tragedy of Mr. Li's events on a Greyhound bus where Tim McLean was in fact murdered and beheaded, and a number of other things occurred following his death. In that case specifically, Mr. Li was found not criminally responsible. However, we are all aware that physically he was responsible for this terrible crime.

In addressing your statement, I'm wondering if you ever feel that there are times or occasions when you believe that incarcerating people who don't want treatment in fact is essential for the interest of the public and for the interest of the individual. Can you comment on that?

● (1230)

Mr. James Livingston: Yes, and maybe I can provide you with a little bit of context around that statement. Like I said, I've been researching stigma for people who are legally mandated to attend treatment services in the community throughout B.C. and more specifically in Vancouver, including the downtown east side.

The difficulty with getting people to take psychiatric treatments when they don't want to, when their agency and choice are perhaps not respected around treatment issues, and when they are required to attend treatment appointments when they don't want to, is that it makes it very difficult to set out a course of treatment for these individuals.

Not only that, but their experiences with the mental health system —and that's what I research—aren't positive because of the coercive techniques that are used to have them comply with treatment. Their outcomes might be great in terms of clinical outcomes, but in terms of their experiences with the system, it's a whole different ball game. And it affects their future treatment and willingness to engage in treatment as well.

Mrs. Shelly Glover: Do you mean in the general population or in the prison system?

Mr. James Livingston: I follow two groups of people. One of them is in the general population. They are a civil mental health population who are on what some people call a community treatment order; in B.C., it's an extended leave. They are civilly committed to hospital and discharged to the community, but they are still required to attend treatment services.

The other half of my sample is a forensic psychiatric population. They're not an inmate population. They're not mentally disordered offenders; they're mentally disordered accused persons. They've all been found not criminally responsible on account of mental disorder. They spent some time at our forensic psychiatric hospital, were discharged to the community, and are now receiving compulsory community mental health treatment under the sections following section 672 in the Criminal Code. It's a conditional discharge.

Many of them have had histories of being inmates in the past, but I'm not specifically following an inmate population.

Mrs. Shelly Glover: Do you believe that some of those clients you deal with pose a significant threat to the public and perhaps at times to themselves if they don't get their treatment, and that sometimes incarceration is an alternative to ensure the safety of both the general public and themselves?

Mr. James Livingston: I wouldn't say so specifically about my population, because once again, it's not an offender population, but is placing people in a correctional institution an alternative? Yes, it's an alternative. There are other alternatives as well. I don't think it's the only alternative.

Mrs. Shelly Glover: I agree. I'm just asking if you think it is ever essential to do that.

Mr. James Livingston: It is, most definitely. Incarceration and a correctional system exist to protect the public, as well as to respect human rights and for general purposes of deterrence. There are a lot of sentencing principles in play here. One of them has to be that there is that sort of alternative for people who commit serious violent offences.

Mrs. Shelly Glover: Very good. Thank you.

Ms. Gail Czukar: The thing you're talking about is actually something that's the subject of the Ontario Mental Health Act. It's the mental health act that allows people to be committed to psychiatric treatment if they are a danger to themselves or others. We incarcerate people in correctional facilities when they've been convicted of a crime, so it's a separate matter. We don't convict them and incarcerate them in order to treat them against their will.

Mrs. Shelly Glover: I agree with that. We don't always incarcerate them in prisons, either. There are other forms of institutions where they are held, and it's potentially to protect their safety and the safety of the public.

I wanted to address you, Doctor. I have a great respect for a fellow by the name of Jonathan Garwood in my home province, who works in the same agency that you're presently working in. We've spoken a few times about traditional teachings. My mother is a Métis woman; I am a Métis woman. She worked at the jail for kids in Manitoba and brought many of the traditional teachings to the jail.

I'm curious to know your view on whether the traditional teachings are helpful. Are there any documented cases in which they were actually helpful or effective in helping to treat people who were diagnosed with mental illness or addiction in the prison population? What, if any, effects are there?

● (1235)

Dr. Frank Sirotich: I'm afraid I'm not aware of any.

More broadly, some of the recommendations within the literature talk about tailoring services to a person's particular cultural background, whatever it may be, so it's specific to that. It's tailoring the service to that cultural background. It really applies within the criminological literature to the notion of the responsivity principle. Whatever the treatment is, it has to be tailored to the needs of the person so that it's actually effective, but I don't know specifics. I can't actually—

Mrs. Shelly Glover: Does anyone else have any experience with traditional teachings and its impacts, if any, on treatment?

Ms. Gail Czukar: We offer aboriginal services. We work quite extensively in that area, and I agree with what my colleague Mr. Sirotich has said, which is that it's important to be culturally sensitive. Traditional teachings may well communicate with people we can't reach any other way, so I think they're important. I'm just not sure what's behind your question.

Mrs. Shelly Glover: I'll answer that very quickly.

The Chair: Please be very brief.

Mrs. Shelly Glover: I actually tutored for the Native Brotherhood in Stony Mountain Penitentiary in the late 1980s. I found that having traditional teachings before commencing studies and those kinds of things had an impact. I also spent 19 years policing and saw how traditional teachings sometimes did affect the way we saw behaviour among the people we dealt with. That's why I wondered about your experiences.

Thank you.

The Chair: Mr. Kania, please.

Mr. Andrew Kania (Brampton West, Lib.): Dr. Livingston, you did mention the U.K., but I'm going to first quote from page 23 of your report. You say:

> England and Wales has recently adopted an innovative model for ensuring that health authorities uphold their responsibility of providing treatment services and supports to inmates with mental health and substance use problems.... Limited evidence suggests that this approach improves standards of care.

You may be aware that we are travelling to London in a couple of weeks. On behalf of the committee, can you please advise us as to what you are aware of specifically with respect to this system, what has worked, what has not worked, and what other ideas you may have to change it?

Mr. James Livingston: Thank you for the question.

The problem that this particular "solution" addresses is a system-level problem with creating parallel correctional mental health services with other community-based services. Who pays for it? Who's responsible for it? This solution places the onus and responsibility on health for addressing prisoners' mental health and addictions issues.

Inmate mental health and addictions is a community health problem. It's a public health problem, and I think this innovative model not only shifts the direction, authority, and responsibility towards those who are fully capable of providing the service but also it allows for an expansion of the continuity of care for people who manage the rest of the system. So it's a system-level innovation in terms of how to manage and fund prison-based mental health services.

Specifically, I wouldn't know what you should be attending to, and I'm very happy to hear that you're travelling there to hear their experiences. I know it's a fairly recent thing, so they might be going through some growing pains. I look forward to reading about what you find.

Mr. Andrew Kania: Are you currently aware of any problem areas for their system, or as a separate question, is there something in particular that's better about their system than ours, other than what you've said?

Mr. James Livingston: No.

Mr. Andrew Kania: Okay.

The Chair: Ms. Czukar, did you want to respond?

Ms. Gail Czukar: I've had experience, not in London but in Birmingham, visiting a prison there, where a unit was operated by the local mental health trust. Their experience was that they found it very difficult to deliver the services properly because the mental health treatment unit was located in a new part of the prison that was accessible to people with physical problems. So while it was supposed to be a 34-bed mental health unit, at least half those beds were occupied by people with physical health problems. They weren't really qualified to treat those people, but that was the only place they could get anything, any kind of help with their problems. They just found that the prison culture was not conducive to their being able to deliver their services in the way they needed to, so it wasn't being particularly effective.

Plus, it was a prison for about 1,400, mostly young men. They had 34 beds, about half of which were occupied by people with mental health problems, and that was way, way, way too few for that population. So they had a big problem.

● (1240)

Mr. Andrew Kania: Ms. Czukar, you made a comment about the creation of mental health problems in prisons. So how is that occurring specifically, and what should be done to avoid that?

Ms. Gail Czukar: I mean, we've established that I don't have the on-the-ground experience that some members of your committee do. The conditions in prisons, where you have a lot of people living together, you have isolation from support systems and so on—the hallmarks of large institutions—as well as the correctional culture would suggest that there are going to be mental health problems. Those are the kinds of conditions that would produce those problems in many people, but would exacerbate problems that someone might come with already, if they were already depressed or anxious or had any kind of past experience with trauma, in particular, or psychosis. So those kinds of conditions are very likely to create mental health problems.

Mr. Andrew Kania: Okay, so what should we do about that?

Ms. Gail Czukar: Partly, to the extent it's possible, change the culture, deal with the stigma of both correctional officers and other inmates about what it means to have a mental health problem. I think we're starting to address some of that issue in the society generally. It would be nice to see that translate into correctional cultures. It would be good to offer the treatment to the people who need it and assist them with their problems.

The Chair: We're really out of time, so just very briefly. It's 5:35.

Mr. Andrew Kania: Dr. Jones indicated approximately 80% of the prison population suffer from some form of mental illness or concurrent disorder. Do you all agree with that statistic?

Ms. Gail Czukar: I've heard that 80% have substance use issues and could well have some kind of underlying mental illness. I don't accept that they're always exactly the same together, but a very high percentage have substance use problems.

The Chair: Mr. Norlock, please, for five minutes.

Mr. Rick Norlock (Northumberland—Quinte West, CPC): I thank the witnesses very much for coming today.

We've learned much so far, but as with learning much, it increases the number of questions you may have.

I was very interested in the line of questioning from Mr. Kania and your response with regard to stigmatization. You're 100% correct. There is stigma to mental illness out there. You will know that the government did fund a national organization and part of that funding has gone to increased advertising on TV, where we see some relatively famous personalities talking about mental illness and that it's okay to say you suffer from some form of mental illness. I think every single one of us in this room has a relative or a close friend who has had treatment for mental illness and may very well continue to do so. I think we all relate to that.

Coming from a police background in Ontario, I was very interested in the Mental Health Act, the grounds for arrest, etc. I think you referred to training. Would the three of you not recommend that before this committee makes any recommendations we need to know what training correctional officers have in recognizing and dealing with people who have mental illness? I wonder if you're aware of what kind of training they may have, if any.

● (1245)

Ms. Gail Czukar: I'm not aware of what training they currently get, but in general it would certainly be a good idea to increase their capacity to deal with people who have problems and to manage behaviour in ways that are helpful rather than unhelpful to people.

Dr. Frank Sirotich: I would agree. I think it also makes sense in terms of obtaining a baseline for what training is currently on the ground, then ascertaining from there what the gaps are, and once you have the gaps, how best to address them.

Mr. Rick Norlock: Thank you.

You would recommend that before this committee was to make any recommendations we'd have to interview Correctional Service of Canada with a view to seeing what kind of training is available.

I guess we need to go to an organization that might make recommendations.

Do you know of any organizations that might wish to attend these committee hearings that we could subpoena as witnesses? We could provide them with a training manual, or the numbers of hours and training curriculum, and then they could come back and make some recommendations.

Mr. James Livingston: There are two streams here. There's training available for correctional officers, but clinical staff also provide mental health services.

Your statement not to move forward until we know the training of correctional officers is blurring the issue, with respect. You can still develop specialized mental health services for people who are legally and professionally competent to deliver those services while you train your correctional officers in how to identify the suicidal and how to identify mental illness. Your correctional officers are not necessarily going to be providing your mental services. It's going to be people who have graduate degrees, who are trained to do so.

To your other point, regarding anyone who would be interested, the report I wrote was commissioned by a centre called the International Centre for Criminal Law Reform and Criminal Justice Policy. It is an independent organization. I know they're interested in doing further work in this area. They're Vancouver-based, although they work internationally. I think they're affiliated with the UN. I could give you the contact information and I'm sure they'd be interested.

Mr. Rick Norlock: Thank you. Would you provide that to the clerk, please?

Mr. James Livingston: Yes, no problem.

Mr. Rick Norlock: Thank you.

Do I have any time left?

The Chair: You have a minute.

Mr. Rick Norlock: When I made reference to training, I wasn't referring to the training of Correctional Service officers to treat mental illness. What I was suggesting is to be more sensitive to stigmatization—in other words, to dissuade the tendency to stigmatize, and at the same time have the sensitivity to recognize certain indices of mental illness, or perhaps sensitivity to someone who may want to commit suicide or maybe somebody who is taking some kind of drug. In other words, you really don't expect to see drugs in prison—although we know they're there—but the best way is to intervene and see where a person is at risk or may be consuming and therefore be there to help them. That's what I was referring to.

I think we need to see what the training is and then use some comparisons when we go elsewhere to see what kind of training their people get. That's what I was looking at.

Ms. Gail Czukar: I think that's really important. It's always important to give people better tools to do their jobs, and this would be one of them, both on the stigma front—the recognition front you're talking about—and sensitivity. And there's no question that increasing all of the Correctional Service officers' capacities to recognize problems and have some elementary skills about how to deal with that would be good.

We do capacity-building work in many countries of the world, actually, with primary health-care providers and others. And it is possible to provide short courses even in therapy, and so on. So you do need people who are trained to do this, but we can also increase the capacity of people at the front line. It's very important.

Mr. Rick Norlock: Thank you.

The Chair: Okay. We've gone through our list and Mr. Oliphant has indicated he still has a supplementary question.

Does anybody else want to ask any questions after Mr. Oliphant? Would you like to, Mr. Davies? The Bloc would actually have first opportunity, but if you want.... Okay.

Mr. Oliphant, please.

● (1250)

Mr. Robert Oliphant: Thank you.

Going back to where I left off, for a moment I want us to imagine that we have full capacity in terms of bricks and mortar, the government gets a heart and we have full capacity in terms of trained professionals, and we have a centre for excellence within Canada on mental health and addictions within the prison population.

I think there would still be barriers to treatment. I wonder if you have thoughts on what those barriers are. They may be legislative; they may be the nature of mental illness and addiction itself, they may be socio-cultural, or maybe something else I don't know. In that perfect world with those facilities, what are the barriers, and do you have any ideas as to how we could address them?

Ms. Gail Czukar: At the risk of sounding like a broken record, I would say that the primary barrier is still stigma. It's still whether people seek treatment or not, and whether people who are around them are willing to recognize it also. So you're hypothesizing that we have all of the capacity, but not necessarily receptivity.

The other thing I would say is that barriers exist around social determinants. And we face this in hospitals all the time. We may do a perfect job of treating someone and stabilizing their illness, but if they're then going back to a very bad living situation or they're going back to no employment.... And of course we know that people who have been in psychiatric institutions have a much higher rate of unemployment. I'm sure it's very high among people coming out of correctional facilities as well. If we don't take care of the social determinants—people's connections to their communities, decent housing, income, and those sorts of things—those are going to minimize the effects of treatment very quickly.

Dr. Frank Sirotich: Just following up on that, if there aren't the adequate resources in the community so persons being discharged.... If you have a five-star treatment facility within the prison system but there isn't a mechanism or there isn't the capacity and the appropriate resources in the community when they come out, then in terms of that transition and the person's success, some of the gains that have been made could be lost.

Mr. James Livingston: In the utopia you've built, I'd also like to see health literacy, as people might not know they're experiencing symptoms of mental illness. That's a separate issue from stigma. So it's a matter of having people, the inmate population, being more mental health literate about what's available for good treatment—because there are good treatments out there—and attending to symptoms and those sorts of things.

Mr. Robert Oliphant: So it's their “normal”. In fact, they have become normalized.

I think Ms. Glover was very helpful, in that we have a disproportionate aboriginal population in our prison system. There is no morality, I don't believe, attached to that. I think it is socio-cultural and I think it has to do with many oppressions and many socio-cultural problems. It seems to me that's a barrier as well. You're the witness, I'm not, but it seems to me that Ms. Glover has pointed out some pretty important stuff.

Whether it's Poundmaker's Lodge Treatment Centre in Alberta, or other things, it seems to me that we're going to need more help from you experts on how to do this, whether you're willing to do that work in your organizations.

Mr. James Livingston: I would just echo that as well. We're focusing on mental health and substance use, and that's what my report does, but this is within a holistic environment where people have HIV/AIDS and other forms of diseases, dental diseases and what not. So considering mental health and addictions as part of a holistic health problem is very useful in addressing this.

The interrelationships between other health conditions and the social determinants of housing and other forms of marginalization, and attending to diversity and intersections of diversity, whether they be gender, culture, sexuality, or what not, are all very, very important.

Mr. Robert Oliphant: Thank you.

The Chair: Mr. Davies, please.

Mr. Don Davies: I respect very much the discussion around stigma. I think it's been mentioned a lot in this discussion here, and I think it has its place, particularly in the general population.

But I also want to shift the focus a bit, because when I've spoken with a lot of inmates over the last several months, to be quite frank with you, I didn't detect a real stigma barrier, nor did I detect that when I spoke with the professionals working in prisons. What I heard from the inmates was that they did recognize they had problems and wanted access to treatment, and couldn't get it.

From the professionals, what I heard repeatedly—it didn't matter which institution I went to—was that there was inadequate diagnosis. When people are entering the federal corrections system, the professionals are saying that what's really needed is front-line, accurate, and comprehensive diagnosis at that point so people can be identified and get treatment.

So if wasn't necessarily for lack of people wanting to say they have a problem, although I'm sure that's prevalent and I'm not denying it. But I'm just wondering what you think about that in terms of the diagnostic resources in our system, and whether we should be putting more focus on them.

● (1255)

Mr. James Livingston: I can certainly speak to that, being a stigma researcher. I think you raise a really important point. The fact that someone has a mental illness does not mean they're stigmatized. They're perhaps diagnosed with a stigmatizing condition, but the literature reveals there's a range: people can fall along a stigma continuum, ranging from feeling empowered to feeling indifferent.

The fact that someone is using mental health services or is diagnosed with a mental illness does not mean they experience stigma. In my own research, as I described earlier, to my surprise, only 11% of my population has high experiences, quantitatively measured, on internalized stigma measures. So there's a great range of experiences when it comes to stigma.

Often, when we talk about stigma, it's being used very atheoretically in current culture, without attending to the complexity of the issue, as well as the range of people's personal experiences. So I take your point regarding the range of experiences. It's certainly reflected in the research literature around stigma and in my own research and experience as well.

Ms. Gail Czukar: I think you were also asking if we need to have sufficient resources for assessment, diagnosis, and identification of people, who can then get access to services, because if you're not identified as needing those services, you're not going to get access to them.

So, absolutely, having good assessment is key. We spend a lot of time developing assessment tools that assess both substance use and mental illness, so it's key that we have those. I don't know what the current resources are in the system for this, but if that's what you're hearing from inmates, it would certainly merit following up.

The Chair: Okay, thank you very much.

Ms. Glover, can you wrap this up?

Mrs. Shelly Glover: This is going to be a quick question, and it's actually directed to you, Ms. Czukar.

We talked a lot about the stigma associated with the professionals as well. So I just want to add a question as to the availability of professionals, because, as was indicated, there are vacancies that haven't been filled. There was one explanation that it may be related to the pay scale, and another explanation was there is some stigma associated with that. But we have a national problem with the shortage of nurses graduating, for example.

Does this affect this problem? Is there in fact a shortage of mental health professionals or health professionals in the forensics area to fill those vacancies, which might also explain why those vacancies exist?

Ms. Gail Czukar: I think I did say there are human resource problems in the health system generally for everyone, and we know these are going to increase over the next five to ten years as a lot of people retire—or maybe fewer people are going to retire sooner now. But certainly building the capacity of the system and training people to work in hospitals, community services, and with this population is a high priority. It has to be done. Specific forensic training that addresses criminogenic needs, as well as the health needs of people in the system, is also seriously needed.

Mrs. Shelly Glover: Thank you.

And I want to thank you, Mr. Livingston. I found your work very interesting. I know that I made an announcement in my riding of Saint Boniface about funding to study or to do research at the St. Boniface General Hospital Research Centre on the link between mental health and addiction, and so on.

I congratulate all of you for your work, and encourage you to continue and work with us to help solve this.

● (1300)

The Chair: Thank you very much. We're wrapping up just on time.

I want to thank the witnesses. This has been a very good session. You've really added a lot to our knowledge base, and we appreciate that very, very much. So thank you once again.

This meeting stands adjourned.

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