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Chair

Mr. Garry Breitkreuz

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● (1110)

[*English*]

The Chair (Mr. Garry Breitkreuz (Yorkton—Melville, CPC)): I'd like to bring this meeting to order.

This is the Standing Committee on Public Safety and National Security, meeting number 43, and we're continuing our study of federal corrections: mental health and addictions.

Today we welcome Mr. Glenn Thompson, secretary of the board of the Mental Health Commission of Canada.

Welcome, sir, to our committee. We look forward to the input you will have.

The usual practice is to allow you an opening statement. You're the only witness today. If you need more than 10 minutes, I'm sure the committee would allow for that.

Do you have a statement prepared?

Mr. Glenn Thompson (Secretary of the Board, Mental Health Commission of Canada): I do, Mr. Chair, and I'm very happy to have that opportunity. I believe the members will have a copy of what I'm going to be saying as well. If they happen to want to follow along or refer back to it as we go along today, they'll be able to do that.

I want to say, first of all, that you've been very patient with us at the Mental Health Commission because you've invited us to come here, three of us. Mr. Préfontaine has worked very hard to try to get the three of us here. Judge Ted Ormston, who is the chair of one of our advisory committees, our chief operating officer, and I as secretary of the board were intending to come along. We haven't been able to find a date that you had and was possible for us. But I'll just say to you that if you have further interest after this meeting, Mr. Chair and members of the committee, in hearing more from us, I'm sure those other people will be able to make time for you individually, collectively, or however you'd like to do it. So thank you for inviting us.

I want to move right along, and I want to situate my remarks—as you would expect me to do, I think, since I'm from the Mental Health Commission—about mental health and addiction care for federally incarcerated offenders in the context of the work of the Mental Health Commission of Canada.

The MHCC, as I'll refer to it as a short form, had its origins in the report tabled by the Standing Committee on Social Affairs, Science and Technology. That report was tabled in May 2006 and was prepared under the leadership of someone many of you will know, the Honourable Michael Kirby, and his deputy chair for that committee, Dr. Wilbert Keon.

Appropriately titled “Out of the Shadows at Last”, this was the first ever—it's hard to believe for somebody like me who has worked in correctional services since 1960 and in the mental health field—comprehensive study of mental health, mental illness, and addiction services in Canada. Many of you may have seen that report. If you haven't, it's that thick. It's well worth referring to. It has a specific section referring to the federally incarcerated offender group and the work of the Correctional Service of Canada, which would be helpful.

Their process in that committee, the Senate committee, was to make proposals that would transform the systems and services provided for persons living with a mental illness and/or addictive behaviours in Canada. Some of you will know that about 60% of the people who have a mental illness also have a substance abuse problem. So the crossover is very high.

One of the 118 recommendations in that report proposed the creation of a Mental Health Commission. The purpose of this national, not federal, commission was to provide a body empowered to accelerate the development and implementation of effective solutions and to maintain a needed national focus on mental health issues. Again, if any of you know Michael Kirby, you'll know he makes it his business to keep a focus on whatever task he is given. In all of the activities of the commission, we strive to be a catalyst for change. So that's our byword. In the federal budget of March 2007, the federal government announced the creation and funding of a Mental Health Commission with Michael Kirby as its chair.

The commission was asked to focus on certain specific tasks. They are the development of a mental health strategy for Canada, the development of a knowledge exchange centre for this field, and the creation and implementation of a 10-year anti-stigma/anti-discrimination program. And then subsequently, the federal government asked the commission to establish a five-year research/demonstration project for homeless mentally ill persons situated in five cities in Canada. Some of you will be familiar with that activity, which is very much under way at the moment.

The commission itself has a 10-year life, so it will run on longer than do those demonstration projects in homelessness.

The commission has just published a phase one report concerning the mental health strategy. It is the product of an extensive consultation across Canada. All of you as members, I think, have received it. It's the product of an extensive consultation across Canada to determine what should be included in a national strategy.

Entitled *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada*, this report provides a comprehensive, high-level platform for the next stage of development and consultation. This second phase will present the "how"—what should be in the strategy for Canada for mental health and justice, for example, the whole justice field. So this second phase is going to work on the "how" of the transformation, is expected to be completed by late 2011.

For example, it will include what are eight distinct advisory committees, such as the one chaired by Judge Ted Ormston. Judge Ted Ormston will provide what the public government bodies, our staff, and those various persons, perhaps you yourselves, believe should be in sections of the report. It's certainly going to deal with the widest possible range of mental health and addiction matters, from children and youth to seniors, to addicted persons, to those who fall into the criminal justice system.

I trust that committee members will have that report. Mr. Préfontaine indicates that you received it.

The *Toward Recovery and Well-Being* report could be useful to this committee as you perhaps consider the value of a national mental health and substance abuse strategy for the Correctional Service of Canada. We believe that such a strategy could be useful in providing a sound framework for determining funding priorities, program development, and change within the Correctional Service of Canada. We encourage that if they do, or you do, recommend that they undertake having a national strategy for corrections, it be integrated with the national strategy that the Mental Health Commission is developing. It makes sense to have sub-strategies, if I can put it that way, across Canada. The last thing we need in this poor old mental health and criminal justice field is more fragmentation. We've got plenty of that.

Just as the general mental health and addiction service system is poorly integrated and with many challenges as clients move through it—maybe you have relatives, as almost all of us do, who have moved through the mental health system—we know how fragmented it is, so also is the criminal justice system faced with similar obstacles, but ones that are often even more substantial. A mental health strategy for the Correctional Service of Canada could be a good start.

Stigma, and the discrimination that emanates from it, is a hurdle that Canadians must overcome if the mental health and addiction service is to function to best effect. The commission's Opening Minds program was recently launched, and the campaign that goes with it is absolutely essential in raising public awareness about stigma and its impacts. Most of us who work at the Mental Health Commission don't think that the changes we're involved in and helping to promote are going to get very far unless there is a reduction in the stigma and discrimination against people in corrections.

Just as stigma is a large issue to overcome with the general public, the stigma and fear that attaches to criminal behaviour when combined with mental illness is a much greater challenge. It's our view that any program to transform mental health and addictions care for the Correctional Service of Canada will need to be accompanied by an anti-stigma program directed at staff and other inmates, as well as the general public.

You might be interested to know that the stigma program, the general one that we're operating, is focusing first on the area of stigmatization of youth and also the stigmatization of mentally ill people within the health care system. Our vice-chair, Dr. David Goldbloom, a very well-known doctor in Canada, a psychiatrist, would be the first to say that patients who come to hospitals for general care face a tremendous amount of discrimination from all levels of staff within the system. All of us have grown up with this kind of sense of apprehension about what to do about the mentally ill, and physicians aren't any different. They get relatively little training. For general practitioners in this area, when someone appears who has a mental illness, it's very difficult to know what to do, and to do it in a short time. If you have a broken arm, they're much more adroit at handling that.

So training and retraining will be vital aspects of system and service delivery transformation for mental health and addictions in the criminal justice system. We believe that a robust knowledge transfer and exchange program should accompany this training for it to have the most widespread and highest impact.

● (1115)

I know from my past work in the mental health field that the Community Living agency in Ontario, a very large agency devoted to helping people who are developmentally challenged, has a marvellous and very expensive website that people who are staff in institutions can go to and refer to documents written by other staff who write in layperson's language so that people can understand it, whether it's in the middle of the night or in the middle of the day when they're trying to find something out.

There are literally thousands of people who work in correctional services and the criminal justice system in Canada. We need to give them easier access to information that will help them do their work. The Mental Health Commission is not a traditional service agency. Its central methodology is to establish research demonstration projects, often in partnership with other agencies, in a wide variety of sectors as we search, or help others search, for better ways to structure the system and to provide service.

My personal experience with correctional services over the years has been that the system has shifted from one set of programs and beliefs to another without ever having sufficient research to know what has had the best effect. I watched it for twenty years while I was in the correctional services department in Ontario, and we went from industrial farms to treatment to educational programs. It was whatever the government of the day or the staff of the day thought might work best, but it was very poorly researched. That's been the history of correctional services in Canada.

Your committee, I think, has an opportunity to suggest that research demonstration projects become a key component of any major changes that may be instituted within the Correctional Service of Canada. For those persons faced with a serious mental illness under the responsibility of CSC, there are regional treatment centres. I'm sure you know about them, and I think you visited one of them just recently. However, we think it would be helpful to have an intermediate-level mental health facility for persons who've responded to treatment in the RTCs, one or the other of them, so that they're not shunted directly back into the regular criminal justice population of correctional services.

There needs to be some intermediate level. A coherent strategy for those affected by mental health and addictions would afford an opportunity to build on the changes begun at the regional treatment centre in an intermediate environment with more support and with access to continued but less intensive treatment. Indeed, it might be beneficial for persons with a mental illness or a serious substance abuse issue to go to that kind of intermediate facility before discharge to the community, whether they come from the regional treatment centre or whether they come from a general correctional institution. It would provide a place to get people who have a mental health or substance abuse problem or both to be readied in a better way for the outside world.

If you look at it from a public safety point of view, it might very well make them less difficult, less dangerous, and less likely to reoffend, and certainly there would be an improvement in their care.

I think that kind of intermediate-level facility would provide an excellent opportunity as well for a demonstration project with rigorous research as a component of it, so we'd recommend that kind of facility, but we really wouldn't be strongly in favour of it unless it was heavily researched to see if it really does pay off. Between 2004 and 2008 in Ontario, the mental health services saw an increase of $220 million in their budgets. This still represented a decline in the proportion of the health care dollars spent on these vital services in Ontario.

In that same period, the spending on services for those with substance abuse issues in Ontario saw very little increase at all. While mental health systems have been studied exhaustively and in spite of thoughtful recommendations, governments have usually chosen to put their health care dollar elsewhere.

● (1120)

The Chair: Excuse me. Do you mind if I interrupt?

Mr. Glenn Thompson: Not at all.

The Chair: We have your presentation here, and we have only about an hour left. Perhaps we could ask questions at this point.

Mr. Glenn Thompson: Sure. That's fine with me.

The Chair: Would you mind wrapping up in the next minute or so?

Mr. Glenn Thompson: That's just fine.

The Chair: Okay. It's been over 15 minutes already.

Mr. Glenn Thompson: Okay. I'll wind up.

I think the last thing I want to say, then, is that strengthening the community sector so that it can handle many more minor offenders with mental illness and substance abuse issues, whether they are diverted from the courts or released from periods in the Correctional Service of Canada, is an absolute requirement if these troubled individuals are to stabilize successfully out of institutional care.

I recommend strongly to you that you look not just at institutional programs but at the correctional services programs that the federal service provides out in the community. Agencies such as St. Leonard's Society and Operation Springboard in Toronto, which I know well, are excellent examples of agencies that can support people once they come back into the community.

We're very pleased to be here with you to represent the commission, and I'm more than pleased, Mr. Chair, to engage in conversation. Thanks a lot.

The Chair: Thank you very much for your presentation.

We'll immediately go over to the official opposition. Mr. Holland, go ahead.

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

Thank you very much, Mr. Thompson, for appearing before the committee today.

One of the things we've heard again and again, particularly from the correctional investigator, but also from a number of witnesses, is that our prison system is really being used to warehouse the mentally ill. And prisons, as they're currently structured, are a poor place to get somebody better.

You mentioned in your presentation the importance of early intervention and of catching problems before they escalate. Can you talk about two things? First, how do you feel that's working right now? How good a job do you think we're doing right now catching people early and making sure they don't begin to walk a dark path?

Second, from your personal reflections or experiences in the organization you represent, what impact does a stay in prison have on somebody who has a mental disability?

● (1125)

Mr. Glenn Thompson: To take the second part of your question first, I'd say that the impact on anyone with a mental illness who's put in a custody situation is not likely to be a good one at all. Any correctional services agency in the world is faced with a tremendous challenge if a person is admitted who also has a serious mental illness. That person shouldn't be in the general correctional population. The correctional officers aren't trained to deal with those people. The institutional environment isn't a good one in which to deal with them, either.

While I was in correctional services in Ontario, we developed some separate institutions for those persons, such as the regional treatment centres. The Ontario Correctional Institute in Brampton is an example of that type of institution. If those people are in a correctional service institution, they need to be handled separately.

The best thing to do, if it's possible, is to get those people diverted when their first mental illness appears, before they are ever into a correctional services mode at all and before they've ever broken the law. As I indicated in my presentation, we're spending less on mental health care than we were several years ago in Ontario, and that's true across Canada. If we're not spending much, and we're not intervening at the time people are usually seen to be developing mental illnesses—at high-school age or in very early adulthood—time passes, and people often engage in the criminal justice system. Then departments like the Correctional Services of Canada are left to try to figure out what on earth to do and how to back out of the kind of tremendous deterioration that has likely occurred over that period of time. We need to intervene earlier and better. There are all sorts of programs available now that are being tried in some jurisdictions. They're not free. Schools, agencies, and communities have to work together to get those programs in place.

The diversion programs that have begun to happen in the last five years are absolutely terrific in getting that minor offender—who more often than not is somebody who got caught up in some illegal event because of his or her mental illness and kicked in a window or something stupid like that—diverted by the police, the crown attorney, or the court over to a mental health agency. That is happening very frequently now across Ontario and probably elsewhere in Canada. We would very much support that kind of program.

The head of one of the advisory committees for the Mental Health Commission, Steve Lurie of the Canadian Mental Health Association in Toronto, says they are receiving all sorts of people from the Toronto court system in that way. Also important is that they're using the backup service of the Centre for Addiction and Mental Health in Toronto when someone's mental health condition deteriorates beyond their ability to handle it. Just passing somebody off to a mental health agency isn't enough; there needs to be a coherent kind of system out there, or the person will be in difficulty.

Mr. Mark Holland: You mentioned jurisdictions that you felt were doing early intervention well. Can you talk about what those jurisdictions are? Specifically, what types of interventions are working. What do those interventions look like?

Second, I wonder if you could perhaps address the fact that the approach to somebody who commits a minor crime is often that you have to be tough on them; you have to give them a tough sentence and teach them a lesson. What I'm hearing you say is that if you do that with somebody who is facing a mental illness, you're going to create a much more serious problem that has much more additional cost. Eventually that person will get out and will probably commit a more serious crime.

Would that be a fair assessment?

Mr. Glenn Thompson: Yes, I'd say so. The important thing is to recognize the serious mental illness at the earliest possible stage and do something about it.

A few years ago when a study was done in Canada, we found that people with a mental illness who are at high school age usually see their general practitioner five times over the course of two years before the diagnosis is made. A psychiatrist would tell us—if David Goldbloom was here—that a tremendous opportunity is lost in that period of time to get involved in positive treatment. So intervening early and diverting early is the answer for people when they are minor offenders. Don't let them get to the next stage if you can avoid it.

It's not always going to be avoidable. There are always going to be people with a serious mental illness in the Correctional Service of Canada and in provincial services, but we could reduce that dramatically. It's beginning to be done. The Canadian Mental Health Association in Toronto and Peel are good examples of diversion programs.

It requires the courts, the police—I know that some of you have police experience in your backgrounds—the judges, and the community agencies to all be engaged in partnership or it doesn't work. And staff have to be trained to handle this kind of clientele.

● (1130)

The Chair: Okay.

We'll move over now to the Bloc Québécois.

Ms. Mourani.

[*Translation*]

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

Thank you, Mr. Thompson, for being here today.

I have two questions to ask. First of all, in relation to what you've just said. Recently we have met with people who have some knowledge of the mental health and drug treatment courts. I have noticed that these courts mainly deal with minor offences. For a more serious crime, people are referred to regular courts. Yet, whether people commit major or minor crimes, when they have mental health problems, they have mental health problems, period.

Do you believe these famous mental health and drug treatment courts should also deal with more serious offenders and refer to specialized hospitals where there is greater security rather than to Corrections?

[*English*]

Mr. Glenn Thompson: I think it might be a pity at this early stage of the development of mental health courts to have them try to deal with all comers, the most difficult kind of person. If someone has committed a murder and they have a serious mental illness, they're going to have to be handled in a very high security environment as they likely are a dangerous person. So there's no getting away from the fact that, for public safety and for deterrence, some people are going to be in a very secure facility. The general court system needs to learn how to handle those people rather than expecting all courts, all mental health courts, to become the refuge for everyone who appears who has a mental illness. So I wouldn't recommend having the mental health courts at this stage of their development try to do that.

But the general court system needs to have—and it's a must that they have—much more ability to call upon psychiatric assistance when they're making sentences and making recommendations for where the person will be placed. And then, of course, the provincial system or the federal system has to have the adequate assessment process right at the beginning of a person's entry into their system to know where to put them, to know what kind of care to engage them in.

I might just say, because I was involved in the provincial system for 20 years, that all of these people come from somewhere to the Correctional Service of Canada. They don't come from the courts directly there. They're always in a provincial institution for some period of time. If those institutions aren't dealing adequately with them—and most often they're not—then we've lost a tremendous distance with those individuals before they ever get to Correctional Service of Canada.

So just imagine that I have a serious mental illness and I'm in Toronto Jail. I spend a year there waiting for my trial and processing. Who knows what happens to me in terms of my mental health condition, but it's not likely to get better during that period of time.

So fixing the services for mentally ill and substance abuse persons in the federal system isn't enough. We have to fix it for the whole of the correctional system, and I guess I would say we need to see it as an integrated system.

[*Translation*]

Mrs. Maria Mourani: There is one thing I do not understand, Mr. Thompson. You say that people with mental health conditions are not likely to get better in jail. From what I've understood about mental health courts they proceed to a type of diversion, so that these people may access tailored resources. So, why not refer them to mental health courts? Is it a funding issue?

● (1135)

[*English*]

Mr. Glenn Thompson: I would say that it's a numbers issue. The number of mentally ill people who have committed serious crimes is probably quite large in Canada. If that were to happen, the courts we have at the moment would be absolutely swamped tomorrow, and they wouldn't be doing the job they're now doing to divert the minor offender who has a mental illness. It's not that we don't need improved services to assess and refer people with a serious offence; it's that the mental health courts, as they exist now, would be swamped.

[*Translation*]

Mrs. Maria Mourani: In another vein, you spoke a great deal of having a national strategy, earlier on. It came up a number of times in your presentation. But mental health, in fact health in general, is a provincial area of jurisdiction, not federal.

We went to Oslo and the United Kingdom. I believe you have a good knowledge of their systems. People with mental health problems who have committed offences are dealt with by the health care system. Of course the provincial-federal issue does not exist over there.

The major question I'm asking but to which no one seems to have responded to date, perhaps you will be able to, is the following: while respecting provincial areas of jurisdiction in mental health and addictions, how can we implement, here in Canada, a system like what exists in Oslo, for instance, which I found very interesting?

[*English*]

Mr. Glenn Thompson: The mental health strategy that we contemplate has to be built to attract the buy-in of the provinces, the funder of the health care system. Our chair, Michael Kirby, and the members of our board are working hard to keep the federal, provincial, and territorial governments engaged. That's why we have five representatives from provinces on our board of directors. Four of them are deputy ministers.

So you're absolutely right: having that buy-in is an imperative for us. We're lucky to have the Deputy Minister of Health Canada on our board. Not through any work of mine but through work of others, there's been a good design for connecting the work of this national strategy, making it a Canada-wide affair that has the engagement of funders at all levels.

[*Translation*]

Mrs. Maria Mourani: I am a person—

[*English*]

The Chair: We'll have to wrap it up. Just briefly, please.

[*Translation*]

Mrs. Maria Mourani: I am a very down-to-earth woman. Let us put aside concepts of a national strategy and focus rather on the daily operations in custodial settings. Federal penitentiaries, for instance, must currently manage the Corrections and Conditional Release Act. Given the various provincial health care laws, they find themselves caught somewhere between a rock and a hard place.

Do you believe the federal government should allow for provincial health care laws to be applied in federal penitentiaries and reimburse the provinces afterwards? What exactly should be done? That is my final question.

[*English*]

The Chair: Please be brief.

Mr. Glenn Thompson: I think that's a good subject for the next phase of the national strategy. I don't mean to duck the question, but there has been a debate for as long as I've been around the system, for the last 50 years, about how much the provincial health care apparatuses should be engaged with the federal offender populations. In my opinion, the provinces' health care systems should be more engaged with these people.

● (1140)

The Chair: Thank you very much.

Mr. Davies, please.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chairman.

Thank you, Mr. Thompson, for your very well laid out presentation.

My first question is this. In your presentation you say that your personal experience with correctional services over the years has been that the system has shifted from one set of programs and beliefs to another, without sufficient research to ever know what has the best effect. I wonder if you can tell our committee if there's anything that stands out to you that has had a good effect, something positive in the system that we might use as an example to build on in terms of helping with the mental health and substance abuse issue.

Mr. Glenn Thompson: I would say to you that thinking about offenders as though they're just one particular type of person is like thinking about criminal justice programs as though there is one that will suit all. I've watched this in correctional services in Ontario. When I joined in 1960 we had industrial farms all over the place and some adult training centres. Then we shifted to educational programming. Then we shifted—I'm a social worker—to a therapeutic type of programming. We have moved in recent years, sadly, in my view, to a much more custodial kind of program, very overcrowded and so on.

Each of those types of programs can work for various types of offenders, in my view. So there's no one shoe that fits all of the offender population at all, any more than there is one shoe that fits all of the kinds of mental illnesses that exist and the severity of them. The person with a minor depression is an entirely different person to deal with than a person with a severe psychiatric condition like schizophrenia. So one has to have a very diverse kind of program, and the federal service has tried very hard to do that over the years, I think. It's a tall order to do it.

I've seen at an adult training centre that we had in Brampton—and this will date me—in 1969, where 80% of the people who went into that adult training centre never came back. I did my research and my social work degree on that centre. All of the residents I saw were people who had come from Hungary as new immigrants and had got into trouble with the law here. So 80% of them went out and never came back again, so it had a very high success rate, that particular kind of program for a particular kind of group. If we'd sent a group of people there who were mentally ill and had committed a murder, it wouldn't have worked.

The psychiatric hospital I worked at in England had a therapeutic community model that had been invented in the Second World War for post-traumatic syndrome, then called shell shock. It was used for that population of men, and perhaps some women at that time. By the time I got there, it dealt with people who were called delinquent psychopaths. We had people transferred in from correctional institutions and psychiatric hospitals all over England, and they were in a mess. The research that was done there, carefully done, showed that a third of the people made a very significant improvement. They felt—the people who came there and the staff—that these people were at the end of the line. A third got better, if you want to put it that way, a third were helped significantly, and for a third it didn't work at all.

That program was very intensive and very unusual because the patient population participated in it extensively. There were no drugs. Everything happened in groups. It was very, very unusual. The federal Correctional Service of Canada tried therapeutic community programming at Springhill a few years ago. It has some strengths for some kinds of populations. It won't work for everybody.

Mr. Don Davies: To summarize, it sounds like what you're saying is that we need to have, in our federal correction system, a diverse range of programs to deal with mental health effectively, ranging from vocational programs to prison farms to therapeutic aspects.

Is it your view that we are doing that presently in the system?

Mr. Glenn Thompson: I don't think anybody would say that the Correctional Service of Canada or any of the provincial services have the diversity of programs and the ability to put people in them in the right level of custody, which is another serious problem when you're running correctional programs. Neither is the diversity there nor the ability to house people with the right kind of staff at the right time. Training is a terrific kind of requirement in these types of facilities. You can't just start a therapeutic community program tomorrow and hope it's going to work.

The answer, unfortunately, has to be no, I think.

● (1145)

Mr. Don Davies: I want to touch on something you haven't spoken about, and I wonder if you have a view on it.

There may be some disagreement on this committee, but it appears to some of us that we've been using segregation as one tool for placing difficult-to-manage prisoners. Maybe we all feel there's a role for segregation in some cases, but there's a concern that as the number of mentally ill inmates grows in our prison population, some of them are being put into segregation.

I wonder if you have any comments to help us understand that issue.

Mr. Glenn Thompson: I just reflect back on experiences I had when I was a correctional services superintendent—or warden, as the federal system calls them. I used to laugh and say I got same-day service from the psychiatric system at the time. My physician would send a mentally ill person over to a psychiatric hospital and they'd be back the same day, because the psychiatric hospital would say, “We don't have the security to handle those people. Why on earth are you sending them to us?” So that's a good example of the health care system at that time not being ready to handle those most difficult people—neither are they today, for the most part.

In fact, in psychiatric circles I think you'd find people saying that we really don't have psychiatric methods to handle many of these people. Obviously there's something wrong with them, and we don't have a good prescription for them these days.

So correctional staff—wardens and senior staff in institutions—end up putting people in segregation who have no business there, because they don't know what else to do with them. I think that's the serious problem. Then when you put somebody in that state in a secure cell with nothing around them, they're not going to get better, for sure.

The Chair: Your time is up. Do you have a brief supplementary?

Mr. Don Davies: Do you have any suggestions on what we could do with those people?

Mr. Glenn Thompson: Sure. I'd get them out of the regular population and into a psychiatric centre run by CSC with enough security to handle them. Some people won't respond to that well, but better there than slog away under the supervision of some poor warden, senior staff, and correctional officers who are trying to look after this person and know very well it isn't going to work.

The Chair: Thank you very much.

We'll go over to the government side now.

Mr. Norlock, please.

Mr. Rick Norlock (Northumberland—Quinte West, CPC): Thank you very much, Mr. Thompson, for your attendance here. I can already see something positive coming from your attendance here, just because you've given us clear direction as to where we need to start. You have to crawl before you walk, sort of thing. I'm glad you use the progressive approach.

Near the end of your testimony—I don't find anything humorous about this—you said you had same-day service. My background is policing in Ontario, and occasionally we would have someone put on a form 1. Because of my northern location, we'd occasionally send them to a local facility to be assessed. Often they would be back in the community even before we were back. So we had same-day service also. That's not a complaint; it's just the reality. And I understand the complexity.

You started by talking about the stigmatization of people with mental illnesses, not only in the community at large but in the very institutions where people with mental illnesses go for treatment, and in correctional services. Since we're charged with the specific area here of correctional services, could you suggest a program that you're aware of—perhaps from a provincial perspective, which is your background—that might not be in existence in the Correctional Service of Canada and that this committee could recommend?

● (1150)

Mr. Glenn Thompson: I'd hearken back to a program that the Federal Bureau of Prisons had in place in the U.S. some years ago. I don't know what they're doing these days. They took all of their new recruits—and it didn't matter whether you were a psychiatrist or a correctional officer, or whatever you were—to one or other of the two or three settings they had at the time, and they had a training program for them all in the same place. It didn't matter what your job was going to be; what mattered was that they had an opportunity with you to assure you of the way that the correctional services there, the Federal Bureau of Prisons, wanted you to operate.

From the point of view of having a good start for anybody who begins in the program, in the work area that we're talking about, I think that's one way to do it. Then you're not just left with somebody who has been hired from some other field altogether, started as a correctional officer yesterday, begins in that institution, likely is put on the job too soon in most jurisdictions, and doesn't have enough background and experience. In terms of much more training at the beginning of a person's experience, we can learn at lot from police services in this regard.

I know from my experience at the Canadian Mental Health Association that one of our people there who had a serious mental illness was working as a trainer with the police in Toronto and had, it seemed to me, a very effective relationship with them. He thought his life had been saved by police persons many times, and I think it had. His approach wasn't to be critical; he was just saying, here's what it feels like if you're in a psychotic condition and a group of policemen are coming to get you from somewhere and you're acting very strangely. Here's what it feels like. Here's what I saw. This person had very good recall of what had happened to him. He was more than grateful to the police. That kind of training is something that most correctional services haven't taken time to provide.

So I'd put a lot of stock in training, and retraining.

And then I mentioned in the remarks I made at the start the need for some sort of ability to get something online these days electronically for the correctional services staff that they can refer to any time, on the job or even in their home environment, training materials that are electronically available. People don't remember everything from a two-week course or a three-month course, or whatever it might be, and they need to refer back and think about it as their experience goes along. Today, they maybe had to supervise a person who had a schizophrenic condition. They may want to go and think about that and read about it and find out more about what other people have learned to do in that kind of situation.

Mr. Rick Norlock: Thank you very much for that.

What I'd like to see us talk about on the committee in our recommendations is, one, how do we not get these types of persons in our maximum security prisons, or even medium, for that matter? How can we divert them after they've committed a crime?

You mentioned in response to one of the questions that some of them may have committed such a serious crime that there needs to be a certain level of security that may not be in existence currently. I'm referring to, of course, our experience in Saskatoon, where they basically have switched the institution from a prison to a hospital. They treat their people more like patients rather than inmates. And we saw quite a diversity.

So if you could, in as succinct a way as possible—and I know that can be different, but just hit on the key notes—talk about once they're in the court system, how we can divert them to the proper location. The practical part that we're dealing with here, as a country, is that we're heading into deficit, as is the rest of the industrialized world, or the whole world almost, so we may be prepared to put some funding in, but maybe somewhere along the line here today you could talk about maybe reallocating funds from things that don't work to things that do, and you could comment on that. And then perhaps you could comment on what do we do with people afterwards. You've already talked about that a bit, and you mentioned two places, one in Toronto, Operation Springboard, and the St. Leonard's Society.

So I wonder if you could talk about that.

● (1155)

The Chair: We're out of time, but I'm going to take the liberty to let you give an answer to that.

Mr. Glenn Thompson: You saw the facility in Saskatoon. There's one nearby here, in Brockville, which I'd recommend you have a look at as well. The Royal Ottawa Hospital runs it; it is a provincial institution. Correctional officers run the security side; therapeutic staff—Ottawa Hospital staff—run the inside. It works for people.

I know a person who, in a psychiatric condition, murdered his child and was placed in that facility by the courts. He has responded well to treatment, and I had contact with him while I was in the Canadian Mental Health Association. The other day he sent me an e-mail and said he had his release. He's been out in the community, back living with his family. He's now fully out of custody, as it were—out of supervision.

It has worked for this person. If we had put him in a regular facility and had him sit there for 20 years, what would we have had at the end of the day? He is back with his family; he is working; he is making a life for himself and his family. So I'd have a look at that kind of facility. You just saw one that is similar.

We need an intermediate facility. We need to connect whatever is put into existence in institutions—that variety we spoke about earlier, which Mr. Davies was dealing with—out to the community as well. The person who is in whatever facility it is or whatever kind of program it is has to go to some facility that connects to it out in the community. It can't just be a complete sort of chop, from one kind of program to another.

St. Leonard's has handled all sorts of complex persons over the years, and so has Operation Springboard. They are two good examples of organizations that know what they are doing, in my opinion, in terms of handling people in the community who are difficult and, some people would say, sometimes dangerous, I suppose.

The Chair: Thank you very much.

We'll go over to Mr. Kania now, please, for five minutes.

Mr. Andrew Kania (Brampton West, Lib.): Thank you, Mr. Chair.

Sir, here is a quotation from your presentation:

> Many young persons with early symptoms of mental illness are overlooked while years go by and their illness becomes much more difficult to treat. Some of these individuals are certain to end up in trouble with the law as young adults.

I perfectly agree. Part of what we have discovered is that a great proportion of persons who are incarcerated have these difficulties. From my perspective concerning our report, the first part of it, in my view, should be prevention, because if you can prevent people from committing crimes by curing their mental difficulties or their addictions—which was the other part of it, though I won't ask you about that—obviously we are doing something in advance to keep the prison population down and to help people.

I'd like you to be very practical and specific, if possible. I have seen this pamphlet and I know you have done good work. What should we be doing on a very practical basis to try to prevent this? Is it as simple as having psychiatrists or somebody go into schools? What ideas have you come up with to try to prevent this at an early stage?

Mr. Glenn Thompson: It certainly isn't simple, and there's no uniform way to do it.

For example, yesterday I attended a meeting in Toronto, where agencies that are dealing with the Somali community, the Caribbean community, and the Tamil community are working with a different approach from just straight individual mental health or psychological care for individuals. They are trying to connect the community into it, to do it in a way that connects to the spiritual beliefs of these folks and to their community. Many of the newcomers to Canada have very strong family connections, very strong spiritual connections. They may also get into trouble with the law; they may also have a mental illness. One has to develop a program that connects all of those dots, I think.

That's what this group of staff are trying to do. It's a very interesting set of programs that's being researched. These are people who are meeting midway through a project to assess it. I was there listening attentively, as a Mental Health Commission person. There are examples of programs like this, which are going to be preventative.

I think we need to do much more with our newcomers to Canada who have come from traumatic situations. Some of the people I was in the room with yesterday have lived lives in other countries, before they came here, that I would never imagine. If we don't do something better than we're doing at the moment with many of those people, some of them are going to fall off the train. They're going to end up in the hands of the Correctional Service of Canada some time along the line and be in great difficulty, like those Hungarian folks I spoke about whom I was involved with way back in 1959. If those young men hadn't got into that positive program in that institution, they might have very well ended up in serious grief later on. Having a coherent program with many facets is something that simply has to be done, if we're going to be preventative.

The Canadian Mental Health Association and others—the Mood Disorders Association, the Schizophrenia Society—spend most of their time trying to be preventative, trying to educate the community to deal differently with the mentally ill and substance abuse population. We could all learn a lot from the kinds of programs they've had that are working—because they are working, in many cases. They're very weakly funded, for the most part. We have a habit of waiting until people sort of hit us over the head with a serious offence before we act on many of these things.

The gist of your question, I think, is that we should be intervening earlier, and we certainly should. They're doing that in schools—and not just with psychiatrists, I think; many people with less advanced training can do that kind of work in schools and intervene early. In the U.S., you would be much more likely to see a social worker and then a psychologist before you got to see a psychiatrist. In Canada, our habit has been to go in with guns blazing. If you have a psychiatric illness, we often take you to the most highly trained person first. We don't fund psychologists the same way; we don't fund social workers the same way. That's another factor.

● (1200)

The Chair: Be very brief. You're out of time, Mr. Kania.

Mr. Andrew Kania: It's because of the nature of the question.

Do you have something, once again on a practical basis—for example, a 10-point plan—about which you could say to us “enact this, work on this, solve this”. You're here in the Parliament of Canada; there's a lot we can do. I'm looking for those sorts of recommendations to assist with this.

If you can't do it now, is it something you can go back to work on with your people to provide to us?

Mr. Glenn Thompson: Absolutely, yes. I was just going to say that there are others who are much more expert than I am in prevention promotion activities, and lots has been written and said about it that is practically being used and is in place at the moment.

I'd be more than happy to do that, Mr. Chair.

The Chair: Thank you very much.

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

Mr. Phil McColeman (Brant, CPC): Thank you very much, Mr. Thompson, for being here.

In some ways, if I might just say so on a personal level, you've assisted me in conceptualizing some of the things we've seen in terms of the sheer diversity. To my mind, how we will make recommendations coherently around that has been a little bit daunting. You've helped me see that conceptually, and you've outlined a number of very good initiatives.

One of the biggest things we have witnessed is connecting to the community. Some of the successes really revolve around the effectiveness of connection to the community.

One of those areas is connecting to higher-level educational institutions within communities, post-secondary institutions that have specific programming. Because of your vast knowledge and experience, I'd like to ask you this question: in our current curriculums for criminology or the various disciplines, do you think we are churning out—for lack of a better word—graduates with enough specialized education and skills who have an interest in taking these initiatives forward?

● (1205)

Mr. Glenn Thompson: Well, we certainly aren't, that's for sure. We're not turning out enough people.

I would look less at the training of people at the advanced level. Psychiatrists are getting very good training. Psychologists are getting terrific training. Social workers are getting better and better training. We need to look at the next layer down, I think. What about teachers and how diversified their training can be, or people in the schools who can help to intervene in these situations, doing the early intervention kind of stuff? It doesn't have to be a psychiatrist or even a social worker or psychologist. Lots of people can be trained at a basic level to be helpful.

The Mental Health Commission is probably going to take on a program that's been operating in Alberta called Mental Health First Aid. You may never have heard of it, but it's being widely used across the world these days. It was invented in Australia. It's a training program of a very basic sort. It's a kind of CPR for mental health, I'd say. So if you know how to help a person who's having heart difficulty and do mouth-to-mouth respiration, this is the equivalent in mental health terms.

We need to have many more people trained at that kind of simple level without any highfalutin kind of advanced training so they can refer people on and sort them out. There are all kinds of young people in high school. If you have teenagers in your house, you probably wonder some days if they aren't all mentally ill, and other days you think they're fine. It's a trauma for all of us to go through teenage years, and it's very difficult to know sometimes whether somebody's in serious difficulty or they're not. Somebody with a bit of training can begin to help sort that out for teachers and others in their school, so we need that kind of training as much as anything, I think.

We certainly need more people with advanced training. I know Correctional Services of Canada has difficulty getting enough psychologists, getting enough people who are trained in these various disciplines. Some of that has to do with whether they feel they're in an environment that can give them hope as a therapist, I guess, or as a helper. You have to change the environment of the institution to some extent to make it interesting to people, to make it attractive.

When I started in the Department of Reform Institutions in 1960 in Ontario, people at my social work school at the U of T said, “Well, there's one place not to work, and that's the Department of Reform Institutions. That's for sure.” So I was foolish enough to go there, and I stayed for 20 years. People have to be attracted into those kinds of difficult environments. Those of you who've worked in police work know the same thing. It isn't easy to be a police person. It certainly isn't easy to be a police person dealing with mentally ill people. That's for sure.

One of you asked where we are wasting our money. Those of you who are police officers will know that we're wasting a tremendous amount of money having two police officers sitting in an emergency ward of a hospital for hours and hours supervising someone who has a serious mental illness until somebody gets around to seeing them, and then they might be discharged. I see nodding heads, of course. That's a terrible waste of resources. So we need to do something about that, and we can do a better job in that kind of situation than we're doing now.

Mr. Phil McColeman: We had witnesses here on the addiction side—the drug courts and the mental health courts—which are developing.... I think the upfront streaming is an issue we would like to address in a proactive way. Do you see those institutions serving a major role in the future, in terms of further development and putting people into the right kinds of treatment?

The Chair: Let's take time for a brief response.

Go ahead.

Mr. Glenn Thompson: Are you thinking of the institutions in the community that deal with that kind of clientele?

● (1210)

Mr. Phil McColeman: Not so much. The person who is a first offender. They give them options in terms of going to those courts and being properly streamed instead of going into the wrong situation.

Mr. Glenn Thompson: Absolutely. The Scarborough court in Toronto is a good example of good streaming, so if you're looking for a good example, talk to the gentleman who's a PhD now, who works in that court, who works for the Canadian Mental Health Association. He's an expert in early streaming for people who have mental health or substance abuse issues or both, and he's trying to help the court and the police and others decide which ones should be referred to community agencies.

Yes, there's quite a bit known about that now, and it's being applied.

The Chair: Thank you.

Ms. Mourani, please.

[*Translation*]

Mrs. Maria Mourani: Thank you Mr. Chairman.

Mr. Thompson, I'd like you to tell me a little bit about the intermediate mental health facilities. What does this word intermediate actually mean? Would these facilities be under the authority of Corrections Canada, a community service, the provinces?

[*English*]

Mr. Glenn Thompson: I see them as a Correctional Service of Canada facility and I think they would be less intensive in the kind of care they would be trying to provide than the regional treatment centre you visited, or less intensive than the Brockville facility that I mentioned the province operates. It would be a step-down facility, but it's quite a crunch to go from any psychiatric hospital—forget about correctional services—right back into the community with absolutely no support. Imagine yourself in the Centre for Addiction and Mental Health in Toronto with a very advanced treatment program, and suddenly you're out in the community and you have no support or help. People who go from the regional treatment centre back into a regular penitentiary probably feel as though they've just hit a brick wall. They may well deteriorate, decompensate fairly quickly in that environment. They could be much better treated in a halfway house, if you want to call it that. That would be a correctional services institution with a less intensive kind of care, and that could very well be the avenue out into the community.

I think it's difficult for people with a serious mental illness to go from an RTC out into the community directly, and it's a waste of money to keep people in the RTC who could be handled in that less intensive environment. If that kind of facility were created, I'm sure you'd find people who could go there instead of to the RTC, to a somewhat less intensive program.

[*Translation*]

Mrs. Maria Mourani: When you refer to "intermediate" do you mean, in concrete terms, a new type of facility or the halfway houses that already exist? For instance, halfway houses already exist within Corrections, they are the CCCs, which are created specifically for people with mental health problems, like the CCC Martineau in Montreal.

Is that what you mean by intermediate? If not, should Corrections develop another facility, which would be more similar to a hospital? I do not understand the word intermediate, I'm sorry.

[*English*]

Mr. Glenn Thompson: It would be the latter. It would be an institution, because there are those community facilities. These would be people who are not yet ready to go out into the community but who are somewhere in their mental health status between the general population and somebody who is severely psychotic, for example. If you were in a severe schizophrenic state, you ought to be in the RTC. Once you begin to respond to care, whether you're depressed or whatever your particular psychiatric problem, then you can move out into a less intensive kind of program.

It would be similar to, I suppose, a community resource centre, the one you mentioned in Quebec, but it would be within the institutional setting. There are many, many people who aren't yet ready, I'm sure, to go out into the community who could use that intermediate facility. But as I said in the remarks I made at first, I would definitely make it a research demonstration project. I wouldn't just build a facility and hope it's going to work. I would research what I'm doing there very carefully and try different methods.

● (1215)

[*Translation*]

Mrs. Maria Mourani: Would these people be sent to these intermediate centres at the end of their term, in the middle or when the risk of danger to the public has decreased? Under what criteria would people be sent to an intermediate centre?

[*English*]

Mr. Glenn Thompson: The first use I'd recommend would be as a step-down in intensive care from an RTC. It would be persons who've been to a regional treatment centre, who have been very severely mentally ill, and who are now going to a less intensive facility but not back into the general population. Some of those people, if they're nearing the end of their sentence or able to be paroled, may very well go right out of the intermediate facility into the community. They're still mentally ill or have a serious substance abuse problem, and they probably then need to go out into the kind of facility you mentioned that's in Montreal.

[*Translation*]

Mrs. Maria Mourani: I am done? Very well. Thank you.

[*English*]

The Chair: Yes, sorry. Thank you.

We'll go over to the government side now, with Ms. Glover, and then back to Mr. Oliphant.

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

I want to welcome you, as well, and wish you a merry Christmas.

I was very interested to hear what you had to say about the waste of time and money on the policing side. I'm glad to hear someone acknowledge that, because I spent a number of years policing, much like my colleagues on this side of the House. I'll tell you that situation you described, where two police offers sit—as I was sitting—for between five and ten hours, sometimes longer, in a hospital, only to have the patient, who is clearly exhibiting some kind of mental illness, be released because the criterion that has to be met by the psychiatrist is simply whether they are a danger immediately to themselves or others—that is very disappointing. And I feel we fail these people at that point. I strongly believe that's where the prevention Mr. Kania talks about comes in. That's one aspect of prevention that needs to be inserted at that point. We will have to work strongly with the provinces to encourage them to see about perhaps alleviating some of that wasteful time and money.

I also enjoyed what you said in your dissertation at the beginning, when you talked about developing a program similar to what you have for health care professionals. I note that you've passed out some pamphlets that refer to those all-important projects and programs that the Mental Health Commission is endeavouring to offer. I would like you to explain how you suggest we mirror these in the Correctional Service.

I understand when you talk about the anti-stigma program. Your Opening Minds program is very clear in your pamphlet, so I understand education. I don't quite get how we do the research demonstration project, the one you have for the health care professionals and the one that is being financed by the Government of Canada, where we're taking homeless people and putting them into housing and studying whether or not that has a positive impact on their receiving further relations or further treatment, as opposed to the placebo group who will not be receiving housing, and they're going to watch and see how they transition into treatment. How do you suggest we do that within a correctional facility? How do we research and do a demonstration project, as you're suggesting, within a secure facility?

I'm not sure how we do that, and I'd love to hear your suggestions on how it gets done.

Mr. Glenn Thompson: To go back to the intermediate facility idea, for instance, the correctional services have many people at the moment who go from RTCs back to the general population. Take a group of 300 people who are going to that population, divert 150 of them randomly to the intermediate facility, and find out which one works better for those two groups. That would be a research-type way to do it.

● (1220)

Mrs. Shelly Glover: My only concern is that you don't have a population of 300 in one facility who are necessarily at that point in their recovery or treatment. That might involve having to pull people from all across the country to put them in this research demonstration project. That would be problematic, I believe, because they would want access to family and other supports they already have there. That's where I'm at a bit of a loss as to how we get this done while also taking into consideration their needs for support.

Mr. Glenn Thompson: I would bet that if the commissioner of corrections were here, he could find you 300 people in half an hour in the general population who would very well use an intermediate facility, plus people coming out of the RTC. I think people from both directions could use these kinds of facilities.

The Correctional Service of Canada has a lot of people who have mid-level mental illness, for sure. I don't think finding the number of people would be the problem; I think the difficulty is in the complexity of that kind of research. With the homelessness research we have going on, people who know about research—and I don't pretend to—tell us it's the biggest operational research on homelessness that's ever been done in the world. It's a very commendable project.

It's very expensive as well. These things are not something one can do without a significant piece of funding. That program, over five years, costs $110 million. I was deputy minister of housing in Ontario, and I know how much housing costs. Dividing $110 million by five doesn't give you a lot of housing dollars if you're putting people in rent geared to income accommodation. It costs a lot to live in our housing situations these days. Housing plus treatment is an expensive process.

Housing plus treatment plus research would be an expensive process, but it would very worth doing. It might very well alleviate a lot of the difficulties in the general correctional institutions federally that are caused by, if you can put it that way, people with a serious mental illness—people who are making the lives of correctional workers and their fellow inmates unbearable because they don't know what to do with them and they're very complex cases to deal with.

I think it would be doable to have that kind of research project. We have a lot of people who know a lot about research, and we can help the Correctional Service with that. We are running about 25 research projects now, plus these ones on homelessness.

The Chair: Thank you. We're going to have to leave it there for now.

Mr. Oliphant, please.

Mr. Robert Oliphant (Don Valley West, Lib.): Thank you, Mr. Thompson. I want to do three things while you're here.

One is to thank you for your amazing public service, which has continued, frankly, long after I expected it would have. I think you are representative of the finest public servants in our country. In the line of Bob Carman and people I worked with, I'm glad you continue to do what you do. It's wonderful.

Second, I want to take an opportunity to push back a bit. I do this when people come to my office to lobby me about issues; I push back and lobby them. I'd like to take a minute to lobby the commission to keep a focus on incarcerated people, which has not really been in your work.

I think what we see in our work is that this segment of the population are the leftovers. I think the commission has a responsibility to broaden its work to include those who are some of the least likeable of the mentally ill because they have sometimes committed terrible crimes. I think our society needs your help at the commission to do that.

That's just a little plea. I always take that opportunity.

Third, one of our witnesses said, and I want your comment on this, that prisons have become a risk factor for addictions and mental health. You have a long history in corrections and in mental health, and I'd like some comments on that.

● (1225)

Mr. Glenn Thompson: I suppose any kind of incarceration is a risk for a mentally ill person. If a mentally ill person is placed in a secure setting that doesn't attend to their mental health needs, it's bound to be a risk. Perhaps that's what the person who was speaking to you was saying. A custodial environment is not likely to be good for a person with a mental health problem. On the other hand, society has to be protected, and we need to deter the general population from committing offences.

We always have these competing features with us when we consider the offender population. We're trying to deter. The poor judge is sitting there trying to encourage a general deterrence while dealing with the person's needs. It's difficult to handle these competing requirements. However, that doesn't mean it can't be done. I think we have to adjust our correctional environments to make that happen. I take your admonition that the Mental Health Commission needs to concern itself with people who are in custody.

Yesterday, in a document from the Canadian Criminal Justice Association, I read that we recently had about 38,000 people in custody in Canada. That's a lot of people, especially when you take into account the number who go through provincial institutions at a rapid rate. I can't remember how many thousands of people used to go through Toronto Jail when we had just the one facility in Toronto. Thousands of people went through there every year.

So we can affect them for better or worse.

Mr. Robert Oliphant: Don't get me wrong; public safety is my first concern. We have to keep the public safe, so we incarcerate. I would put that over deterrence and punishment as the main reason for putting people in jail. It's for our safety. Are there a couple of things you have seen in your career that could mitigate this problem?

We were in the Kingston Penitentiary in the treatment centre, and the building did not physically lend itself to creating a healing environment. However, we were in other buildings that did. The physical architecture of buildings can actually promote healing. In your experience, is there anything else that you would want us to hear about?

Mr. Glenn Thompson: There's no doubt about the benefits of a good environment. I had someone the other day asking the commission, just because he thought we might know, about the design of a large new office. He wanted to know how to design it to promote mental health among his workers. So we did a bit of research on it.

Recently, I heard a physician on CBC Radio who discovered, through her own physical illness, the healing environment of place in which she received care. She's made it a career and has written books about it. I can give you that information, if you'd like. But there's absolutely no doubt about what you were saying.

Here's a vignette for you. Back in 1966, I was the superintendent of the Andrew Mercer Reformatory for Women. Can you imagine a guy doing that? They couldn't find a lady to do it, ladies. I was there for three or four years. We disposed of that institution and built the Vanier Centre for Women in Brampton. At the Mercer Reformatory for Women, people were carving their bodies in all sorts of grotesque ways. They were mostly teenage women cutting themselves as though to cut their wrists. They weren't really trying to kill themselves, but they were damaging their bodies and disturbing things terribly. When we moved to the new institution in Brampton, which had an entirely different physical facility, that behaviour stopped. It didn't occur after that. It was like pulling the blind up or down. It was the most amazing part of the change that we made. There were all sorts of other good things we were doing there—treatment programs, shop programs, and group therapy. But the change in environment stands out. It helped a lot.

● (1230)

The Chair: Thank you, sir.

We're going to have to wrap it up.

I'd like to thank you, Mr. Thompson. You're obviously very knowledgeable about this issue, and you've contributed a lot to our study. We appreciate it. Thanks again.

Mr. Glenn Thompson: Thanks, Mr. Chairman.

The Chair: Before we move in camera here, I just want to thank Mr. Roger Préfontaine, our clerk, who has done just a superb job. We are going to be going into a Christmas break here. He's probably going to be working hard the whole time, lining everything up for us for when we get back. I'd also like to thank our two analysts, Lyne Casavant and Tanya Dupuis, who do just a super job. I want to thank you very much. I want to thank all the members of the committee. I think there's no doubt that this is the best functioning committee on Parliament Hill, and it's all due to you people. Thank you very much. We have worked together very well, and I appreciate it very much.

In closing, I want to wish you all a very merry Christmas and a very happy new year, and we'll see you back here in January.

Thank you very much.

Mr. Davies.

Mr. Don Davies: We're not adjourning the meeting, are we?

The Chair: We're suspending for a minute, and then we're moving in camera.

This meeting is suspended.

[*Proceedings continue in camera*]

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