House of Commons
CANADA

Standing Committee on Public Safety and National Security

SECU • NUMBER 002 • 3rd SESSION • 40th PARLIAMENT

EVIDENCE

Tuesday, March 16, 2010

Chair

Mr. Garry Breitkreuz

Standing Committee on Public Safety and National Security

Tuesday, March 16, 2010

● (1530)

[*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. This is our second meeting in this session. We are continuing our study of federal corrections, focusing on mental health and addiction.

We would like to welcome our witnesses this afternoon: Brenda Tole, retired warden; Ruth Martin, clinical professor; and Amber-Anne Christie, a research assistant. We welcome all of you to the committee.

At the beginning of your remarks, you may introduce yourselves a little more than I have and tell us about yourselves. Then you'll have approximately ten minutes each for an opening statement.

In case you have never been before the committee, I'll mention that we usually start with the official opposition making some comments and asking questions, and then we just go around, giving all the political parties a turn. That's how we run the committee.

Have you decided who would like to go first?

Ms. Christie, go ahead.

Ms. Amber-Anne Christie (Research Assistant, Women in 2 Healing): I'm just going to read my bio.

I am a Cree first nations woman. I was first incarcerated at the age of 20 and returned to prison 30 times over the next five years. In my most recent incarceration I spent six months inside of Alouette Correctional Centre for Women. Previous to that, I had spent time in Surrey Pretrial and Burnaby Correctional Centre for Women, as I suffered from a severe heroin addiction for many years and lived on the streets of Vancouver's east side. I have been free of drugs and alcohol and prisons for four and a half years. I am a mother and a contributing member of society.

I am a research assistant for the University of British Columbia, working in community-based participatory research. I am employed by the project called Doing Time and I am part of the Women in 2 Healing team in which I interview women who have been incarcerated in a provincial institution within the last year. I interview women at zero, three, six, nine, and twelve months after their release from prison and ask them about how they are achieving their nine health goals.

We also have a community-based participatory research project called Aboriginal Healing Outside Of The Gates, which I will get into in more depth in my opening statement. Our goal is to support women in the reintegration process so that they can safely reintegrate into their chosen communities.

Thank you for having me here today, and I hope that you will listen to what we have to say.

As I sat and reviewed the documentary footage made of Ashley Smith's time in prison, I couldn't help but find myself being able to identify with her. I myself have been in prison 30 times. Of those 30 times, 29 of them were spent either all in segregation or the majority of time in segregation. I can identify completely with the desperate need to have human contact and the loneliness and isolation that you feel being locked in a cell with nothing to do all day. I remember I would look forward to meals because I could read the labels of my drink containers over and over and over again. I was not segregated because of behaviour issues or security issues, but because I was withdrawing from heroin.

I was still unable to have anything in my cell to help me stay occupied, such as a book or a pen or paper. I looked forward to count, when the guard would come and count us and hopefully we'd have a nice guard to sometimes tell us how their day was. It was human contact.

I continued to go through those revolving doors until my last stay in corrections in 2005. For the first time I was sent to Alouette Correctional Centre for Women and for the first time I was not segregated. This happened to be when Brenda Tole was the warden and Ruth Martin was the doctor in the prison. When I arrived at Alouette I was checked into health care, and to my amazement I was sent to a unit.

From there on I got a job in the institution, as it was a work camp, and I reconnected with family outside of prison with the help of a wonderful doctor who encouraged me to do so. I also received health care when I was in prison, something I had rarely ever encountered in other prisons. I was a very sick girl with many different complications from my drug use. I was on remand, so I was unable to access any of the programs geared towards substance abuse or anger management.

However, there was a program that was happening all around me that was hard to go unnoticed. There were babies in this prison. I was shocked when I first saw the babies. The way the prison was being run was more like a rehabilitation centre than a prison. It was amazing. Not only was there a library and a gym there, there was a native elder there to talk to. As well, there was drumming and dancing every Tuesday night. As a mother myself, I have to say that it helped me to remember the things I was giving up, and I know that the other inmates dealt with their problems and reacted differently because there was a baby there.

I was released from prison in October 2005, and I have not been back since. I will be the first to say that this exact prison changed my life. I had been in many prisons before, but this prison treated me like I was a person and not a number.

A year after my release I connected on Facebook with a group called ACCW alumni. We all met up outside of prison and started up the research that Ruth had started us on in the institution. Today I am employed by the University of British Columbia as a research assistant, and have been for over a year, and I am a team member of Women in 2 Healing. We research our passions with the hope to create change.

● (1535)

We are a supportive network of women who are facing the challenges of being incarcerated. Working with Women in 2 Healing has changed my life in so many ways. I can help other inmates today to face those challenges.

I also work for the Doing Time project. I interview women when they are released from prison, as well as at three, six, nine, and twelve months after release. We ask them questions about health care access, housing, community resources, drug use, spirituality, self-esteem, and employment, and numerous other questions. Our team has interviewed over 500 women.

We have just gotten to the halfway point of our third grant-funded project, another community-based participatory research project, and it's called Aboriginal Healing Outside of the Gates. In this project, we are doing interviews with aboriginal women who have been in a provincial or federal correctional centre.

The goal of this project is to see exactly what challenges women face after they have been in the community for a while, what kind of impact incarceration has had on their journey into reintegrating, and what the barriers are. We're also looking at what percentage of women have been accessing health care and community resources after their release.

What we have heard from women so far is that a big percentage of women have reverted to doing drugs and alcohol due to an inability to properly access resources and gain employment. But women still have hope that they will be able to make things change.

They have also told us that they need to treated with dignity and respect. That's not always the case after being incarcerated. They all have a need to not be pushed into anything after they've been incarcerated. They don't want that. I have to say that stable employment, a supportive network of safe people, and having someone who listens to me are the biggest positives in my life today.

Among some of the biggest challenges we see with women when they are released—and I want to stress this—is that women are not getting housing referrals when they are released and they are ending up homeless. Of 500 women, 40% women leave prison homeless—that's 40%—and many more, a bigger majority, end up homeless within months. This has to change.

They're also not getting the proper drug and mental health treatment that they need and want. Also, they're not given enough places that take women from prison, the treatment centres that will accept women from prison. The ones that do accept them have long waiting periods, as the majority of centres will not accept women from prison just because they've been in prison.

Giving a woman in prison a welfare cheque and saying “be on your way” is not rehabilitation. The gaps in the system need to be closed.

Thank you for listening.

● (1540)

The Chair: Thank you very much. We appreciate that.

Who's next?

Ms. Martin, go ahead.

Dr. Ruth Martin (Clinical Professor, Department of Family Practice and Collaborating Centre for Prison Health and Education, University of British Columbia, As an Individual): Thank you, Mr. Chairman and members of the committee, for inviting me to be a witness.

I come wearing three hats. I juggle a few hats, but these are the ones I'm wearing today.

As a prison family physician, I've worked in corrections systems for 16 years, mostly with women and mostly in the provincial system, but I do have some experience with men's facilities and federal systems.

The second hat I wear is as a clinical professor in the UBC department of family practice. Amber has talked about some of the research in which I'm involved.

My third hat, more recently acquired, is as director of the Collaborating Centre for Prison Health and Education. It is a group of academics and community organizations—actually anybody who wants to join—that is looking at ways to facilitate collaborative opportunities for health education research service and advocacy for people in custody, their families, and communities.

I'd like to share with you five personal reflections that I formulated about mental health, primarily in female corrections. These personal reflections are consistent with prison health publications, which I've footnoted in my written submission to you. I'd be happy to supply any of the documents to you if you'd like to read them further at a later stage. Don't hesitate to ask me.

It's well established that prison populations throughout the world suffer more ill health than the general population, and that female prison populations suffer more ill health than male prison populations. As a prison physician I've witnessed this over the years. As I've witnessed women cycle in and out of the system over the years, I've come to learn that most women are incarcerated because of crimes due to their disordered health and social lives. Therefore I've come to realize and reflect that the key to women's successful reintegration into society lies with figuring out how to empower incarcerated women to improve their health.

The second reflection pertains to the aboriginal people, who are tragically overrepresented in our systems. Over the years I've listened to aboriginal patients and aboriginal colleagues explain to me about their understanding of health. They've taught me that mental health is not a stand-alone thing. It is closely interwoven with a person's physical, emotional, and spiritual health. I realize that I started off in my career with a very Eurocentric or western-centric view of health, and I've come to appreciate that in order to engage incarcerated people to improve their health, we all need to improve our cultural knowledge and sensitivity.

My third reflection that I wish to share with you is that women with incarceration experience are experts about their own health. This was reinforced for me during this participatory health research project that we started in prison. I thought we would focus our research on HIV, hepatitis C, and addictions, but in fact when we asked women in prison what they would like to research in order to improve their health they told us they wanted to become better mothers. They wanted to become involved in meaningful work. They wanted to improve their community support and have safe housing.

The goals that women in prison identified that were important to improving their health were very similar to my own goals and probably to your goals. They are consistent with the public literature that pertains to mental health, social inclusion, and health promotion. All of these published studies agree that in order to improve the mental health of a population we have to affirm people's self-confidence, engage people in decision-making processes, and focus on people's strengths rather than their deficits. Doing so will enhance their sense of hope and their belief that they can succeed and change.

A fourth reflection that I've learned through my work with the collaborating centre is that numerous multi-sector organizations are keen and eager to collaborate with prisons to foster health. In fact, they recognize that they should be playing a role, particularly in two components of service.

First, individuals in prison should be offered the best multi-disciplinary, patient-centred prison services that we can, including health. The second component is that during their transition to the outside community, individuals should be offered well-coordinated continuity of care. I can share three examples of that: inter-ministerial collaborations in other countries on health, academic collaborations on health, and collaborations at the local prison community level, if you wish.

● (1545)

The final reflection I wish to address is that most of the incarcerated people I've met are not mentally healthy. The prevalence rates, as you know, vary, depending on how you diagnose mental illness or how you measure it. In the literature it varies from 12% up to between 76% and 80%, and you've heard those figures in the statements of your previous witnesses.

Most of the women I see in prison clinics do not fall into a mentally ill psychiatric diagnosis, nor do they warrant transfer to a psychiatric hospital or treatment centre. However, the majority of people I have met in prison suffer from mental health difficulties such as anxiety, insomnia, flashbacks to previous trauma, depressive episodes, interpersonal conflicts, and poor impulse control. Many also have substance dependence, which is associated with their mental health difficulties. Some may be related to an under-diagnosed or under-screened condition such as a learning difficulty or fetal alcohol syndrome.

Regardless, women in prison across the board tell me that if they could figure out how to improve their mental health while they're inside prison, they will have a better chance of succeeding when they leave prison. I have reflected on about six suggestions—probably more—over my experience of working with people in prison, and also reading the prison literature.

The first one would be that incarceration in this country should be viewed as an opportunity for individuals to improve their mental health and to turn their lives around. Therefore, we should be doing everything we can to nurture processes inside prison that demonstrate success in improving health.

The second one is that we should be incorporating into every correctional system participatory processes that listen to and act upon the voice of individuals with incarceration experience about ways to improve mental health.

The third one is that prisons are really stressful places to work. There's a real tension that staff experience between nurture versus security and it's very wearing on prison staff. The mental health of inmates is really influenced and impacted by the morale of prison staff. Therefore, prisons should adopt what the literature calls a “whole prison settings approach” for health promotion that engages staff and inmates, because then prisons will become more effective in helping the mental health of inmates.

The fourth suggestion is that healthy prison environments should be fostered, because healthy environments will reinforce the educational benefits of inmates who participate in prison educational programs. By contrast, unhealthy prison environments will negate and undermine the benefits of these programs.

The fifth one is that prisons that use creative alternatives to solitary confinement foster healthier mental health both for the staff and for the incarcerated individuals. The use of solitary confinement does not enhance an individual's mental health. It worsens it, especially among those with pre-existing mental health difficulties. In Canada, therefore, we should support and commend prison management teams that do not use solitary confinement. In fact, we should discourage the use of solitary confinement in Canada.

The sixth suggestion is that because the overall prison ethos influences the mental health of inmates and staff, we should do everything we can, from top ministerial levels all the way down the chain, to support prison management teams that create and sustain a healthy prison ethos.

Thank you very much for listening to my reflections, and I welcome your questions.

The Chair: Thank you very much. We appreciate that.

Ms. Tole, finally.

Mrs. Brenda Tole (Retired Warden of Alouette Correctional Centre for Women, As an Individual): Mr. Chair and committee members, I am very pleased to be here and to have this opportunity to speak to you regarding these very important issues within corrections.

My experience is in the British Columbia corrections system. I spent 36 years in this field, both in community and custody settings, and have worked with youth, men, and women. The last position I held was warden of the Alouette Correctional Centre for Women.

British Columbia has benefited over the years from its relationship with Correctional Service of Canada. CSC is generous and resourceful when sharing research and program and policy information. The provincial system houses remanded and sentenced offenders and immigration detainees. The maximum sentence length is two years less one day in the provincial system. However, people often spend long periods, sometimes several years, remanded and awaiting trial. All offenders who are admitted to CSC have been in the provincial correctional system prior to their admission. In B.C. there are approximately 2,500 in custody and 25,000 supervised in the community on bail or probation on any given day. The difference in sentence length has huge implications for program and service delivery and community reintegration, but both systems face many similar challenges. Corrections has a mandate to ensure public safety while exercising humane control. Balancing public attitudes to offenders with research and best correctional practice is a very difficult process.

This committee is focused on offenders with mental health disorders and offender programming. I'd like to talk a bit about interventions and initiatives that I have found to have a positive outcome for staff, contractors, and offenders in a custody setting. I'm going to focus on women offenders, which is the area of my most recent experience, but many of these issues are relevant to both populations.

Women make up approximately 10% of the custody population and due to the small numbers have been greatly influenced by the larger male population in areas of physical plant design, security, classification, risk needs assessment, and programs. When we opened Alouette Correctional Centre for Women, we had an opportunity to slowly move away from a model focused on security and control towards a more pro-social offender responsibility model. It is very difficult to move away from long-standing attitudes and ideas around safety and security. However, we found the more normalized environment made the centre safer for staff and inmates, and institutional violence and use of force incidents were greatly reduced.

I am mindful of time, so I will briefly list some of the factors I felt contributed to positive change at this centre.

The actual physical plant design and centre environment have a significant impact on staff and offenders, particularly those offenders suffering from mental health disorders. All benefit from access to natural light, fresh air, regular physical activity, and non-controlled movement whenever possible. It is important to note that this type of building is generally much cheaper to build and to maintain. Classification of women to the least restrictive setting needs to be a high priority. Women, particularly aboriginal women, tend to be classified to higher security levels than required. Placing people at the least restrictive setting using a good classification process immediately rather than making them apply for or earn the placement is a much more consistent and efficient process. All offenders, particularly those with mental health disorders, manage much better in a less restrictive and therapeutic setting.

For example, we had a number of offenders at Alouette who were on remand prior to moving to Correctional Services of Canada. They managed for periods of over a year at a medium open centre, which is what we had. When they were sentenced they moved to the federal system, and then were required to stay in a maximum security setting for two years due to policy. That's an example of how, from the viewpoint of classification, you can have a huge impact. Policy has no flexibility. It makes it very difficult to actually do what's in the best interests of everybody.

Offenders have a huge interest in programs and services in a correctional centre and if engaged can contribute to defining their needs. Open communication with staff and administration can reduce the development of a negative subculture, which often operates in a correctional centre. Offenders, supervised by staff, should be encouraged to take responsibility for appropriate aspects of programs and operations. Aboriginal women seem to be even more impacted by the isolation from their family and community. Programs that facilitate the return of these women to their community, under supervision of band or community justice components whenever possible, seem to present the most positive outcome. The ever-increasing over-representation of aboriginal women in custody continues to be of grave concern. It is a tragedy, and I do not think that more aboriginal programming and services within our present correctional environment will impact the situation.

● (1550)

Supporting aboriginal governments, organizations, and service providers to assume more responsibility for the management of aboriginal offenders presents the most promise.

Mutual respect between staff and offenders is critical for a safe and secure environment. Staff who engage offenders with respect and who focus on being professional and helpful contribute to an environment that is pro-social. A better working environment affects staff recruitment and retention and lowers rates of staff absenteeism. The positive aspects of good staff-offender relations are seen in program interest and participation. It needs to be recognized that the negative effects of being in custody increase with sentence length.

Good health services are one of the most important components of the correctional centre. Physical and mental health professionals who work in coordination with corrections in delivering consistent and timely health services, including preventive education, are essential. Providing health services to a community standard is an ongoing struggle. There is also a need for continuity of care upon reintegration into the community. Partnerships with provincial health authorities could provide continuity of care and community standards and would promote a “patient first, offender second” approach. Staff training from forensic mental health services has helped our staff, in the past, understand mental health symptoms and non-compliant behaviours from a different perspective. It has also exposed them to hospital model interventions for dealing with offenders who have mental health disorders.

The use of segregation, other than for serious disciplinary matters, has a very negative effect on offenders, particularly women and those with mental health disorders. I have not seen any benefit from isolating an individual from support, comforts, and human contact for extended periods of time. If anything, this procedure tends to escalate problem behaviours. What has benefited these offenders is not isolation but rather extra staff or contractors to engage with them and close attention from health professionals.

Self-harm is a very complex and difficult issue. In four years at Alouette, we had one minor incident of self-harm occur, and it was not repeated. I think it's important, when looking at self-harm, to see it not in isolation but to see it basically in the environment in which it happens. It's really a symptom of extreme emotional distress.

On women and their children, a high percentage of women in custody have dependent children. Women are often in centres that are large distances from their children and families. This should be a major consideration in any administrative transfer. Initiatives that promote and foster contact between women and their children is beneficial to both. These include enhanced visits, email, tapes, telephone calls, and letters. Research shows that the children of incarcerated women are more negatively impacted if the contact with their mothers is limited or absent. One of the most compelling factors for women to change their behaviour or lifestyle is pregnancy and having children. Having a supportive mother-baby program at Alouette had an amazing, positive impact on the mothers involved and on the other inmates and staff. This initiative was basically a health initiative, and it was done in conjunction with the Vancouver Women's Hospital, which had requested that we give consideration to it. They worked very closely with us on that program.

Of the 12 mothers who brought babies back from the hospital and were released to the community with their babies, 11 have remained out of custody. The initiative was also a partnership with several other ministries, community agencies, and women offenders and their families. It was based on the best interests of the child.

The one thing that is not in my notes that I would like to make a comment on is reintegration. Integration is really a combination of having the community involved inside the centre and with offenders outside the centre. The community is a very interested group that is quite willing to participate inside the centre. It will provide expertise and the standards of the community. That applies to a number of areas, including what Dr. Martin has talked about in terms of health, but also in terms of education and job preparation and vocational courses. There is an amazing source of information and program availability actually sitting right in the community.

● (1555)

I think it's really important for the community to have involvement in the centres. It's a way for the public to gain an education on what actually works for offenders and not necessarily the public perception we sometimes have, which is quite negative. It also reduces the fear factor.

In terms of increasing the number of temporary absences and the ability for offenders to return to the community, I think that supportive transitional housing in the community, particularly accommodation for women and children, is essential.

It's important to recognize that women tend to be associated with the same risk that men present to public safety, which is simply inaccurate. When it comes to release into the community, for that population, I think it presents an opportunity to really increase the access that women offenders have to the community.

I want to thank you for this opportunity. I'd be happy to answer questions the committee has.

Thank you.

● (1600)

The Chair: Thank you very much.

We'll turn now to the official opposition.

Mr. Holland, do you want to go first?

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

Thank you to the witnesses.

If I could start with Ms. Christie, I want to take the opportunity to thank you for your courage in coming before the committee and sharing your story. I think it's very instructive, and I know that it couldn't have been easy to share it

You had an experience where, like most inmates, you were facing an addiction issue. We know that over 80% of inmates in federal facilities face some kind of addiction issue. If you can reflect upon your first experience in prison, as you went there numerous times, can you think about what might have made a difference for you at that moment in time? Were you at a point in your life where that first interaction in a prison and with the judicial system could have been such that it might have led you to turn away from that path at the time?

Ms. Amber-Anne Christie: I think that if they would've let me out of segregation, I would've had the opportunity to go out and try to access the programs. I tried to access programs. After I was let out of segregation the first time, I've never been back. I had the ability to be able to access those things.

Mr. Mark Holland: You're talking about all the times you were there.

Ms. Amber-Anne Christie: It was one time.

Mr. Mark Holland: There was only one time that you were actually given the opportunity to pursue the services that you needed.

Ms. Amber-Anne Christie: Yes. For the majority of the time that I was in prison, I was in maximum security and I was segregated for drug withdrawal. It was only the last time, when they moved me to Alouette, that I was allowed out from segregation.

Mr. Mark Holland: Ms. Martin and Ms. Tole, the problem I have is that there are literally billions of dollars slated for the construction of new prisons. I don't really see any money being put on the table for new programs, new services, and aid to the provinces to deal with early intervention. We have an exploding prison population. We know the female prison population is growing faster than any other prison population. We know women are more likely to face mental health issues and are more likely to potentially have self-harming incidents. The stakes are high, and yet you seem to be telling us that we need to invest in the front end.

Ms. Martin, how are we doing? You talked about the goals we need to hit and that we need to help women to integrate and move away from the problems they're facing. How are we meeting those goals? How do you feel about the trajectory of things right now?

Dr. Ruth Martin: I'm very dismayed by the trajectory. I've been working in this situation for 16 years. I see that when people are sentenced, they are sent to corrections, but I think the sentence is the punishment and being taken away from society is the punishment. From that moment on, first of all, everything should be done to stabilize any acute medical-mental conditions. Everything from there on in should be geared towards helping them with their overall health, so that when they leave, they will become contributing members of society.

We have to look at what is working and to do what is working. Building big massive structures, with lots of segregation units, is not going to help.

Mr. Mark Holland: You touched on this topic as well, Ms. Tole or Ms. Martin, but how do we get the continuity of care?

One of the things I'm hearing—and Ms. Christie, you mentioned it in your statement at the beginning—is that there's a lack of continuity. So people leave, and maybe they've been getting some support and are beginning to head in the right way. They go out and they find themselves homeless. They find themselves without any support to deal with their addiction. They don't have a support network in the community.

What are the elements that you think are needed on the other side of that prison wall to make sure that people get the support they need to not wind up back in prison all over again?

● (1605)

Dr. Ruth Martin: I think care is multi-faceted. It's health, but it's also mental health, and as Brenda alluded to, it's education. Canada probably hasn't done a very good job, but we actually can learn from other countries.

One of the documents I footnoted was a report from four countries —Australia, France, Norway, and Britain. Norway has obviously done it the longest. They have integrated not just collaboration with their national and public health care system, but they have actually transferred the health care over.

In Canada, in Nova Scotia, that has already happened. In Alberta, it is happening, and in B.C. we're certainly discussing it. I think the only hope in terms of health care, in terms of continuity of care when people leave but also ensuring that the standards of care inside prison are equivalent to the community standards, would be actually if the health care services are merged.

Mr. Mark Holland: We had an opportunity to visit both London and Norway, so I think it's instructive to revisit that example.

I would also maybe ask the following question. In terms of cost, it is much more expensive to incarcerate a female inmate than a male inmate. It's well over $100,000. I can't remember the exact figure. Have any of you taken a look at the cost of providing those types of services on the front end—in other words, after the first experience—versus having somebody go back in 10, 20, or 30 times, and the cost of incarcerating somebody over a period of a decade or less, that sort of contrast?

Maybe there's even a financial argument to be made here that it's actually cheaper to do it the right way.

Dr. Ruth Martin: Yes, I'm sure there is. Maybe your committee could look at resourcing that kind of study, because I'm sure there's a cost benefit, never mind a human rights argument as well in terms of equivalence of care.

I don't know, Brenda, if you have anything to add.

Mrs. Brenda Tole: The only thing I would add is that I think some of the provinces are moving somewhat away from this, but corrections systems tend to feel that they must develop their own programs for everything, that whether it be health, education, or whatever the program is, they must create that. In reality, a good percentage of that is available in the community with partnershipping, which I think is a lot more economically viable. Also it gives you a link, because those organizations and ministries, and whatever you partner with, that are in the community are basically current all the time. The continuity comes, to some degree, with that partnership because those people are in the community already. So you get a tremendous spinoff from it.

Our experience is that a lot of those organizations, ministries, or other government agencies are quite willing to partner. They see the population as part of their community and they are quite willing to engage and do that. It's just that correction tends to be an entity upon itself and sticks to itself and is quite closed. In reality, I think it does us a disservice. I also think we lose a lot of the ability to educate the public and to have the community learn about the population and learn about what works and what doesn't work.

The Chair: Thank you.

We'll have to move on to the Bloc next.

Ms. Mourani.

[*Translation*]

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

First of all, I would like to welcome the individuals who are appearing today, and to thank them for their testimony.

I need some clarification. Ms. Tole, in your presentation, you referred to the Correctional Service of Canada and the Alouette Correctional Centre. Does this centre come under provincial or federal jurisdiction?

● (1610)

[*English*]

Mrs. Brenda Tole: It's provincial.

[*Translation*]

Mrs. Maria Mourani: Right, since you referred to sentences that were two years less a day, this is a provincial institution. Is it a minimum-security establishment?

[*English*]

Mrs. Brenda Tole: Yes, it's a medium open establishment.

[*Translation*]

Mrs. Maria Mourani: Fine.

So, we are not talking about the Correctional Service of Canada, but the correctional service for British Columbia.

[*English*]

Mrs. Brenda Tole: Yes.

[*Translation*]

Mrs. Maria Mourani: Furthermore, I would like one more clarification, Ms. Christie. You spoke about 30 incarcerations over 5 years. Did these 30 incarcerations take place in the federal system?

Then, when you found yourself in the provincial system, it would appear that things went better for you.

[*English*]

Ms. Amber-Anne Christie: They were all provincial, yes.

[*Translation*]

Mrs. Maria Mourani: One more point and then I will ask my more open-ended questions.

Ms. Martin, you said in your presentation—I must confess that I do not understand this very well—that incarceration could be seen as an opportunity for inmates to improve their mental health and turn their lives around.

We visited a certain number of federal penitentiaries. We even went elsewhere, but we are talking just about Canada here. Indeed, what I saw would not help these people improve their mental health or turn their lives around. We are talking about people suffering from mental disorders. I noted that these people were given more treatment in segregation. Yes, certain federal institutions did have other ways of operating. So I'm wondering about this sentence: is incarceration a solution for people suffering from mental illness?

[*English*]

Dr. Ruth Martin: Maybe the wording is incorrect on that, but what I am saying is once you have incarcerated people that becomes an opportunity for them to improve their mental health. So therefore we should be doing everything we can in Canada to facilitate the improvement of mental health, not the worsening of mental health.

[*Translation*]

Mrs. Maria Mourani: Fine.

[*English*]

Dr. Ruth Martin: Does that answer your question?

[*Translation*]

Mrs. Maria Mourani: Do you believe that the current correctional system—I am not referring to the provincial system, and I do not know whether you have had any experience at the federal level—as we know it, helps those individuals suffering from mental disorders and even people who have addiction problems? Do you feel that the system is tailored to suit the needs of this inmate population?

[*English*]

Dr. Ruth Martin: When I work inside the system I'm trying to regard people I see as my patients, but I think the primary objective of many staff and correctional systems is security, so that tension is always there. Obviously, individuals within the system may find certain things helpful at certain times, but I don't see that the overall ethos of the prison environment, for many prison environments, is conducive to improving mental health. Over the 16 years I've worked, I've worked with many different wardens and management systems, and I think the prison warden is the person who can influence the prison ethos.

I don't know how many of the 56 Canadian federal penitentiaries are conducive to improving mental health. Obviously, you've heard some examples from previous witnesses of things that have been successful. I think we need to identify the ones that are successful, and we need to describe them and describe what's working and laud them, commend them, and give them medals, because that's what we need to see more of.

[*Translation*]

Mrs. Maria Mourani: Thank you.

For example, when people are arrested and put on trial, do you not think that, as soon as we realize that someone has a mental health problem, regardless of what crime has been committed, that this individual should be transferred to a hospital rather than a prison?

[*English*]

Dr. Ruth Martin: Frankly, most of the people I see in prison have a range of mental health issues; it's a spectrum. We all have that in the sense of how well we're coping with life. We all have mental issues at one point in our lives. The majority of people I see in the provincial system are not psychiatrically ill patients who require transferring to a hospital, but they do have difficulties with their mental health.

For example, we all use the example of Ashley Smith, because that's probably why you're studying this issue. Ashley Smith started off as a troubled teenager. Was she psychiatrically ill? No, but she did have some difficulties, and obviously her difficulties worsened with time.

I think what you're saying is once you've sentenced them, you could then suggest that they all need a therapeutic environment, yes, and they all need assistance. Can prisons provide that? With the correct warden and the correct atmosphere and with community partnerships it could be done. It means you would look at changing your ethos for correctional facilities.

● (1615)

[*Translation*]

Mrs. Maria Mourani: Do I have any time remaining, Mr. Chair?

[*English*]

The Chair: You have half a minute.

[*Translation*]

Mrs. Maria Mourani: I have a question for Ms. Tole.

You work at the provincial level. You understand that health comes under provincial jurisdiction. I am trying to understand how, in Canada's federal system, the Correctional Service of Canada—which is responsible for administering legislation on the correctional system and parole but has no responsibility for provincial jurisdiction—can take action to ensure that these individuals receive treatment?

I will give you an example: in England, individuals with clearly identified psychiatric mental health problems come under the purview of England's Health Act. This is a country, therefore it has a law.

Here, however, our laws vary depending on whether they come under a specific province or the federal government. Since we have these two levels of government, how can the Correctional Service of Canada intervene to administer provincial health legislation in addition to the Canada Health Act?

[*English*]

Mrs. Brenda Tole: I think the most plausible is to basically have an agreement with the health authorities in the provinces; then you would have a consistent level or standard of health, which would match a community health level. That's really what the province has done. They just basically have an agreement. It's not their own health system, it's an agreement with the provincial health system. That would work for the federal system also. It's just something to look at.

The Chair: Thank you.

Mr. Davies, please.

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

First of all, I want to thank all three of you for coming out here and taking time out of your busy lives to help us better understand the problems and challenges facing us.

I also really want to take a moment to focus on the fact that we're dealing with women's mental health and substance abuse issues. As I think you know, our committee has toured a lot of facilities and focused a lot on male issues. I know there are a lot of similarities, but there are some important differences, so I thank you for bringing to us the voice of experience with women in custody.

I'm going to start off with Ms. Tole. You said that when you opened Alouette Correctional Centre for Women and you were the warden, you had the opportunity to move away from a security and control-focused model towards a more pro-social offender responsibility model, and you found that this more normalized environment made the centre safer for staff and inmates, and institutional violence and use-of-force incidents were reduced. I wonder if you could expand on why you think that happened.

Mrs. Brenda Tole: I think we basically had a physical environment that was conducive. It was a campus-style environment and it had a very large fence around it, so it certainly was secure from that perspective. We had an opportunity to start out with a small population to work with. We started with about 45, and when I left there were 144. It basically was a process of encouraging staff and gently relaxing what had come from a very restrictive environment at, which was a joint provincial and federal institution.

It was a slow process. I'd have to say to you that it is difficult for staff used to operating in a certain environment to move away from it. The continued positive reaction we got from the population was there—we literally did not have violence against staff. I won't say that we didn't have any violence. We had occasional fights between the women who were there, but it was much reduced. We had, as I mentioned, almost no self-harm.

It was just basically a process of continued engagement on the basis of the staff, so that it was dynamic security. They were out on the grounds and in the units with the women rather than sitting in an office. It was engaging the women in terms of what was going on in the centre, listening to them, involving them in the research that Dr. Martin spoke of, and continually expanding their responsibility. It wasn't without occasional problems. I'm not going to say it was perfect, because it wasn't. But we also noticed that our staff absence went from one of the highest in the province in terms of institutional staff to the lowest, at the time I left.

It is a fallacy that the more structured the environment, the safer it is. It isn't. The more confined, structured, and authoritarian the environment is, the more difficulty they have in living within that environment, and they tend to produce much more in the way of management problems. As a result, it's not a safe environment. It's unfortunate when institutions move more and more towards that—more technology, more security, more restrictive movement—because what you actually generate is a very dysfunctional population that presents a threat to the staff.

● (1620)

Mr. Don Davies: Thanks.

Ms. Christie, first of all, I want to congratulate you on your success and on dealing with your addiction as well. I know that it takes a lot of courage to do that and I think it's a remarkable achievement.

You've said that you're doing in-depth interviews with aboriginal women at the federal and provincial levels of incarceration, and they're sharing their stories about accessing community health resources and about the ways their incarceration affected their mental health.

On that last part, could you tell us a bit more about what you're hearing from these women on how incarceration affected their mental health? Also, the other part of it is what we can do that may help address that situation. What would you do if you were a warden of a prison with women and you could address those issues?

Ms. Amber-Anne Christie: Well, first of all, I'll talk about what we're hearing women say. I'm not going to say a lot of the words that some women say. The majority of the women we have interviewed have been at the federal level. They all say that none of their mental health needs were met in prison. They say they were disrespected. They say their culture was disrespected and therefore they were disrespected.

What was the other question?

Mr. Don Davies: The first part was about how their mental health was affected by incarceration. The second part was on what you would do to make it better. Having been incarcerated, what would you do to help the mental health issues of women if you were a warden?

Ms. Amber-Anne Christie: I would definitely be approaching corrections more like what Brenda Tole was talking about. I personally have seen a difference. There are nine members I work with who were all incarcerated at the same time in the institution that Brenda Tole was running. We're all doing well. We're all employed. We're all doing very, very well. We went from being restricted to being unrestricted. Taking the segregation out was such a huge, huge thing.

I'm just going to talk about one thing that I remember. Earlier, we were talking about fighting. This is how the jail dealt with some of the issues that came up. When I was there, there were two girls who fought. They were sent to segregation for one hour—not one night, not two days, not 16 days, but one hour—and then they were sent to conflict resolution. If they didn't deal with their differences, they were sent back to the maximum security prison. Nobody wanted to go back to maximum security prison so they dealt with their issues. It's amazing how women can actually deal with their issues if they're given the chance to deal with them.

We've been talking about bringing in the community. We need the community in the prisons. When women are in prison, how are they supposed to learn about the things they need to do on the outside? They're being taught by somebody who is dealing with them for security, you know what I mean, like the correctional officers. I'll tell you something right now. I don't want to learn about substance abuse from a correctional officer. I don't want to learn about anger management from a correctional officer. I want to learn about it from a registered counsellor or from somebody from the community, somebody who is neutral, not somebody who is going to lock my cell at night.

● (1625)

Mr. Don Davies: Thank you. I have—

The Chair: Your time is up. Could you be very brief?

Mr. Don Davies: Thank you, Mr. Chairman.

All three of you mentioned segregation. I just want you to drill down a little bit. Some people say you can't avoid it, that we just must have segregation. Is that the case?

Dr. Ruth Martin: Well, we've obviously seen this first-hand, through Brenda. Some might argue that it was a provincial situation and it can't apply federally, but I know of other instances internationally where they are using that same model.

For example, I visited Styal prison in the U.K., where there are 450 women of all different securities, from murderers down to those on remand, and that prison doesn't use segregation. They haven't for the last three years. They instituted that because of the high suicide rate. As a result, I think they've had only one suicide in three or four years with 450 women.

So it is possible to do. It has to be a paradigm shift in the way we look at doing corrections in Canada. It will take a major shift in terms of attitudes among the staff, as Brenda has experienced, but it is possible, and the results will speak for themselves.

Thank you.

The Chair: Thank you very much.

We'll go over to the government side now.

For seven minutes, Mr. Rathgeber, please.

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

Thank you to all the witnesses for your testimony and for travelling a great distance to do so.

Let's start with the paradigm shift, Dr. Martin. In your paper you indicate, and I think it's probably easy to defend the proposition, that we should actively discourage the use of solitary confinement. But what do we replace it with in cases of inmates who are acting out, who are violent, and cause a physical threat, potential or real, to other inmates or to staff?

Dr. Ruth Martin: I'm not an expert on this. I just know from a humane point of view and from a mental health point of that it makes sense. I can just speak to the experiences I've encountered in other countries.

My understanding is that many of the behaviour issues that we encounter are from mental health issues. As I talked about in my opening statement, the majority of people in prison do have some mental health difficulties.

First of all, sending them to segregation isn't the answer to actually help them with their problems. In one centre that I visited, instead of sending people to segregation they would actually have a special unit where there were more counsellors, more people to work with them, more psychiatric nurses, more community players, and they actually worked with them fairly intensely or closely so that actually they weren't left alone. It takes more resources in some ways, or more community involvement or more health involvement, but the premise is that actually people will do better by being with other people rather than being isolated and alone. So if you put people in isolation, as Amber has talked about and also as the studies say, and you deprive them of contact with other people, and you deprive them of many of the things that we would normally have as humans, they actually get worse. They get more angry, more aggressive, more violent, and then their mental health actually starts to take a quite serious turn for the worse.

Mr. Brent Rathgeber: Okay. I appreciate that your expertise is limited to mental health and the treatment of prisoners.

Warden Tole, you have to deal with the safety of your staff and of the other prisoners. Perhaps you could pick up with Dr. Martin's suggestion that we need to look for creative alternatives to solitary confinement. I accept that cutting prisoners off from social contact does not do anything to benefit their mental health, but you, as a former warden, have to balance that with the safety of your staff and other inmates.

Mrs. Brenda Tole: Yes, and I'd like to clarify.

There are also different types of segregation. You have administrative segregation or segregation that has been used and is often used in systems for mental health issues or self-harm issues, and then you have segregation that is used for separation because of violence that is not related to mental health.

I would say that there are a lot of creative solutions that you can use from the mental health aspect, and Dr. Martin has spoken to a number of those. It's not that you don't, on occasion, have to separate people from the other population, it's the manner in which you do it and it's the timeframe in which you do it, because you cannot expect improvement when you put people in very severe conditions over very long periods of time. What you will end up doing is generating much more dangerous, much more violent individuals.

In the systems I worked in, both male institutions and female institutions, yes, there's segregation there, and on occasion there is a reason to segregate people. I think that the type of environment you build does not need to look as austere as usually it does because it basically deprives peoples of just basic human needs.

The other thing is the length of time. If you separate someone because of a disciplinary issue, because of violence, you don't need to keep them separate for great long periods of time. My experience in the male institutions was that it was something that was reviewed on a daily basis by management, and the sooner you could get that person out and into another environment, into a normalized environment, the safer the staff were. I know it's a very difficult thing to look to when you see this end product that's very violent and is acting out, but in reality, if you track back you'll see, in most cases, that this has been an ongoing process, that it didn't start out that way. When you segregate people for long periods of time you end up with a very violent and very dangerous population. It doesn't improve them; they don't get better.

If you relate it to kids, if you use extreme punishment on kids when they make mistakes or are difficult, you don't generate a positive reaction. And when you do that over periods of years, you're going to generate something that's very unfortunate.

● (1630)

Mr. Brent Rathgeber: Thank you.

Dr. Martin, does the B.C. Solicitor General allow physicians to prescribe methadone to the prison population dealing with opiate addictions?

Dr. Ruth Martin: Yes.

Mr. Brent Rathgeber: Do you track the success of the methadone prescription program from your population once they reintegrate into society?

Dr. Ruth Martin: I don't personally.

Mr. Brent Rathgeber: Do you know if the B.C. Solicitor General does?

Dr. Ruth Martin: I don't know. I think that if and when the health care.... Right now the health care in the provincial system is run by a private health care contractor. So I don't know if there is any sense in which it is tracked at this point. But I would hope that if we have an integrated service whereby the provincial health system is actually assisting with prison health care, those are the kinds of data we'll be able to look at.

Mr. Brent Rathgeber: Anecdotally or otherwise, can you comment on how successful methadone prescription has been in dealing with heroin, morphine, and opiate addictions, in your experience?

Dr. Ruth Martin: When I'm working inside the prison as a prison physician, all I see over time are the failures, as do the prison staff, because we see people coming back when they're not doing well. When people don't come back to prison, you don't know if it's because they're doing well or that they've died. So it's a difficult position to be in to see whether it's successful. My own understanding from the medical point of view is that methadone is the only medical option we have for heroin treatment. So just anecdotally, seeing people come in if they're on methadone maintenance treatment, I know they are not as ill as if they're using heroin on the street.

I don't know if I'm answering.... I'm not quite sure what's underlying your question and what you really want me to get at.

Mr. Brent Rathgeber: I think you've answered it.

How am I doing for time, Mr. Chair?

The Chair: Your time is up.

Mr. Brent Rathgeber: Thank you to all the witnesses.

The Chair: I was so engrossed in listening to the commentary I forgot to note the time.

● (1635)

Mr. Brent Rathgeber: I could have kept going and you would never have known.

The Chair: Okay. We'll come back now to the Liberal Party.

Mr. Wrzesnewskyj.

Mr. Borys Wrzesnewskyj (Etobicoke Centre, Lib.): Ms. Martin, we saw that approximately 10% of those incarcerated are women. I would also assume that the characteristics of the types of crimes they are incarcerated for are quite different from in the male population. Is that correct?

Dr. Ruth Martin: I don't think I'm the best expert on that, but that's certainly consistent with the prison health literature. There's a different profile among women versus men.

Mr. Borys Wrzesnewskyj: Perhaps Warden Tole could answer that.

Mrs. Brenda Tole: As far as the provincial population is concerned, 40% of those who are sentenced are on a non-compliant type of a sentence, so they're in breach of bail, breach of probation, non-compliant with a court order of some type. A very high percentage just break the rules of the court enough times that they end up being sentenced.

Mr. Borys Wrzesnewskyj: Is that the general population or the female population?

Mrs. Brenda Tole: I'm talking about the female population. Then I would say that a very large chunk, probably the next 50%, would be drugs and property offences, and then there's a very small percentage that are violent.

Mr. Borys Wrzesnewskyj: So there seems to be a significantly different profile in types of crimes committed, which would seem to point to the root causes being significantly different. Just listening to your testimonies, it seems that, besides the mental health or health issues, etc., the root causes are issues of desperation. I would assume that root causes would be similar when it comes to the male population in many cases, but also there would be significantly different motivators.

Is desperation the prime motivator when you get to the root cause of why women are incarcerated?

Dr. Ruth Martin: My experience is that most women have had very traumatic experiences. You can imagine the sort of trauma. Often when I'm listening to a woman, I have the box of kleenex between us and I'm dipping into the box of kleenex as is the woman. So there are very many traumatic experiences that contribute both to their mental health difficulties and also to their drug and/or alcohol use. So many of them are using drugs and alcohol to either control the emotions that arise from the trauma or to numb the emotions. Then they're committing crimes because of the drug and alcohol issues and/or the desperation.

Mr. Borys Wrzesnewskyj: All this seems to further underline that perhaps a large proportion if not a large majority of incarcerated women, with the right treatment, with the right programs, can be reintegrated. Would you concur, and would you hazard a guess at a percentage?

Dr. Ruth Martin: I would say that 90% or even 95% of the women I talk to want to turn their lives around. They want to become members of society. They want to give up their drugs. Many of them don't know how. They don't know what normal is.

Mr. Borys Wrzesnewskyj: There is tremendous motivation.

Dr. Ruth Martin: Oh, yes. They might be saying they are not quite ready yet, but they know they want to.

Mr. Borys Wrzesnewskyj: There seems to be tremendous motivation. We seem to have different root causes. Obviously there are concrete examples of success stories. When you look at the straight monetary cost difference between $100,000-plus to incarcerate and $20,000 to provide the programming per year to reintegrate, never mind the societal cost difference between someone reoffending and someone becoming a productive member.... Those are indirect benefits as well.

I'd like to first concur with my colleague and tell you, Ms. Christie, it is tremendously courageous of you to be doing what you are doing, not just appearing here but doing the work you are doing with other women who are facing issues you have faced in the past.

● (1640)

The Chair: Your time is up, actually.

Mr. Borys Wrzesnewskyj: Perhaps I'll have another chance.

The Chair: Yes, there will be another round.

Mr. MacKenzie, please.

Mr. Dave MacKenzie (Oxford, CPC): Thank you, Chair.

Thank you to the witnesses for being here today. We do really appreciate that.

Some of your comments are interesting, Dr. Martin, because we did go to Norway, and we did go to Britain. You talk about the studies. Interestingly, we had some of the information previously about segregation. It turned out, when we dug a little bit under the surface, they did use segregation more than what they would seem to indicate in their document. It fits with what Warden Tole is saying: nobody wants to see segregation, but there are sometimes places for it.

That being said, like everyone else here, I am impressed with Ms. Christie coming here today to tell us her story. There is a great deal we can learn. It seems to me that by the time many of these people get to the federal prison system, we have already lost. Something went wrong somewhere while growing up, being a young adult, being in correctional systems in the province, and in health care systems in some cases. Then they're into the federal system, which indicates that all of those other things haven't worked. What have we done wrong?

I am kind of appalled when I look at it. You were incarcerated 30 times in five years, which is once every two months, and then, you told us, you were in segregation and when you got out you wanted to change. You talked about the two girls who were fighting who were put in segregation, and they didn't want to go back to maximum security so they straightened their lives out. It almost seems that they needed something sharp in the way of incarceration to say "This is not the path you need to follow. You need to seek help or find help." Am I looking at that wrongly? There were 29 times when obviously either you didn't receive what you needed or the system didn't deter you from going back.

Ms. Amber-Anne Christie: You know—

Mr. Dave MacKenzie: I'm not saying that is your fault. That's our fault. The system doesn't work.

Ms. Amber-Anne Christie: I am completely in agreement that the system failed, 100%, and I'm almost 100% positive that maybe if I had been given the chance to be out of segregation, I would have been able to make it.

Brenda was talking about the time women spend in segregation. That is a really big thing. I am talking one hour, and that was for girls to cool down, not because they were being punished but for them to cool down because they were fighting. I was in segregation for 16 days at a time. That's a long time. I don't know if you have ever been segregated for half an hour or 45 minutes—

Mr. Dave MacKenzie: Not recently.

An hon. member: We'll put that in the recommendations.

Ms. Amber-Anne Christie: Maybe it's something to take a look at, because when you're counting the bricks on the walls just to keep your mind from going crazy—

Mr. Dave MacKenzie: Were you ever in segregation before that last time?

Ms. Amber-Anne Christie: What do you mean? I've never gone back to prison.

Mr. Dave MacKenzie: No, but in the 29 times that you were in jail before that, were you segregated then?

Ms. Amber-Anne Christie: Every time.

● (1645)

Mr. Dave MacKenzie: So if we're looking to fix the system, what made you change the last time?

Ms. Amber-Anne Christie: I was sent to a prison that let me have segregation that dealt with.... I was waiting to get into prison—prisons were so full at that time—and had spent nine days detoxing in city cells, which was just wonderful. So not only was I throwing up in city cells, but I had no food and I was sleeping on metal.

By the time I got to the prison I was already detoxed, so they didn't have to keep me in there for detox. I was sent to Alouette, where I was able to come out of my shell and start looking around at the world clean. When you're sitting isolated in a cell for days and days on end and then you just get released back onto the streets, what are you supposed to do? There was no rehabilitation whatsoever.

Mr. Dave MacKenzie: Fair enough. How do we get you detoxed the first time, second time, or fifth time so you don't have to go back in?

Ms. Amber-Anne Christie: Well, Ruth was talking about bringing in community health care. Coming off drugs is not an easy thing. I didn't have the luxury of getting onto the methadone maintenance plan like some people. I had to do it cold, hard turkey. In the majority of cases people don't get methadone when they go to jail. They get methadone if they're already on it when they go to jail. So you have to do that cold, hard bit. When you're doing it for 13 days at a time and most of that time you're segregated like I was, there's no time for you to have any sort of treatment plan afterwards. Then you're just released right back onto the street anyway.

Mrs. Brenda Tole: Just to clarify something, you don't have to segregate people when they're coming off drugs. That's not a necessity at all.

Mr. Dave MacKenzie: I understand that.

Mrs. Brenda Tole: Amber didn't go into segregation when she came to Alouette. I think you were sort of implying that she was in segregation and then got out when she was there, but she wasn't in segregation there.

Mr. Dave MacKenzie: Somehow I got the impression that during the time she spent in city cells, which was almost segregation—I don't know what else you would call it—she dried out, rightly or wrongly, with or without any medical help to get her there.

But is that what you needed—to get detoxed? Was that the biggest single thing that changed?

Ms. Amber-Anne Christie: Yes. I needed a detox where I was safe. It was not segregation. I had six other women in the cell with me.

Mr. Dave MacKenzie: Thank you very much. I appreciate it.

The Chair: Thank you.

We'll go back to the Bloc and Mr. Desnoyers.

[*Translation*]

Mr. Luc Desnoyers (Rivière-des-Mille-Îles, BQ): Thank you, Mr. Chair.

I am the newcomer to the committee and I am fascinated by what I hear regarding prevention and the way you work in this establishment. I'm going to ask you three or four questions and then you can respond to them. I have one question in particular for Ms. Christie.

Would we be able to transfer this approach so that it can be used for both men and women? Obviously, at the provincial level, there may be medium-security prisons—as you mentioned earlier, where it is easier to operate in this way, compared to the federal system. Earlier, we talked about costs. In my opinion, interesting projects that can lead someone, with respect to mental health, to a level where the individual will become productive when he returns to society are priceless. These are major, significant projects that we should be proud about, as a society, if we are successful.

I would like to hear Ms. Christie speak about the Doing Time project. You meet with the women on a regular basis. However, there seems to be a problem, from the way you describe the situation, regarding community services that are not always available, including social housing. You talked at great length about the women who get out of prison and had no housing. Eventually, they even find themselves homeless.

Unless I am mistaken, our society creates poverty despite the fact that there is a great deal of wealth. We put people in prison and segregate them. You, however, have a new formula which enables these people to be reintegrated into society, through significant partnerships. I am fascinated by this and I would like to hear you speak about the Doing Time project, among other things, and find out whether this project is transferable.

[*English*]

Ms. Amber-Anne Christie: Absolutely. We are hoping to be able to start training men to do what we're doing. The Doing Time project is a community-based participatory action research project. I can't remember how many team members we have, but we've got nine women, I think—maybe more, maybe less—who are employed now by the University of British Columbia, who are going out and interviewing other women who have been incarcerated within the last year. We are asking them questions and we seem to get better answers when it's coming from somebody who's done some time herself. We seem to get some really, really honest answers, not to mention that we invite them to come and do research with us.

We're hoping that it will have the same effect on men that it has had on us. I am only one. I am part of a team that could fill this room with women whose lives have changed through doing this. So it can definitely work and it can definitely change.

● (1650)

[*Translation*]

Mr. Luc Desnoyers: I would like to ask you a question about social housing. You said that the women found it difficult to find housing.

Could you comment on this issue and on the transferability of this project to other prisons, be they at the federal or provincial level?

[*English*]

Dr. Ruth Martin: I'm not sure if I understand the question correctly, but we have a research grant to do this among women, and we're following women for this year. It's a three-year research project, but I think the next step will be to actually see if we can get equivalent research funding to actually see if we can apply this same type of research with men. There is a similar project working in the south of England I am in consultation with.

The power of participatory research, as Amber has attested to, is that people are engaged in helping design the research questions and actually gathering the data and helping also with the analysis. So the transformation of people engaged in this type of community-based participatory research is profound. It's a mutual learning experience.

[*Translation*]

Mr. Luc Desnoyers: Do I still have some time left?

[*English*]

The Chair: You have ten seconds.

[*Translation*]

Mr. Luc Desnoyers: We are told that there are 2,500 people in jail and 25,000 under supervision in British Columbia. For these 25,000 others, are there any organizations that work with these individuals before they get to prison?

[*English*]

Mrs. Brenda Tole: One of the things that hasn't been mentioned in terms of mental health, and one of the things that probably you're alluding to, is having interventions prior to sentencing. In B.C., they have a community court that's operating, they have a drug court that's operating, and one of the things for mental health patients that would probably be very beneficial is a mental health court. The focus of those courts is to divert people to resources that are in the community—residential and treatment types of resources—that will benefit them and keep them out of the jail system, because a good percentage of those people don't belong in the jail system. I think you've had much previous testimony about that.

Those are the interventions that I see. And with mental health, that's an intervention that I think would make a huge difference, for both the federal and provincial systems.

The Chair: Thank you.

Mr. Norlock, please.

Mr. Rick Norlock (Northumberland—Quinte West, CPC): Thank you very much.

Thank you to the witnesses for coming today. It's been very instructive.

When we visited the prisons in Great Britain—you alluded to Great Britain—I can tell you some of the people we spoke to have varying opinions as to the cost and the affordability of some of the programs. My challenge is going to be for you to tell me, given the real world we live in, and the fact that the cash register is not open and you don't just make a wish list and the money flows.... I guess the challenge to me, when I was working in my previous job, was the boss would come to us and say, given the resources we have, I want you to reconstruct or to change some things. Given, though, that the federal government.... You know we're operating in silos, and I think, Ms. Tole, you alluded to the fact that some of the things we're dealing with can't be dealt with in a silo. So you have the federal government's responsibility, you have provincial responsibility—we were talking about social housing—and we sometimes have municipal responsibilities.,

You were talking about some of your experiences going to a local lockup and the hint is that the federal government hasn't done its share. We've increased and we will be increasing every year by 3% social transfer payments to the provinces. For Ontario, that's $9 billion in various transfers. But I think we have to do things better.

I'm going to ask you some hit-and-miss questions on some of the things I'm going to talk about. We went to Okimaw Ochi in Saskatchewan, first nations treatments—very successful, from what I understand, building on what Ms. Christie has to say. We went to Saskatchewan, and the integration.... One of the prisons there is now basically treated as a hospital, as opposed to a prison.

Then we went to Dorchester and we talked to some of the inmates. One of the inmates who was suffering from mental illness told us that he actually tells them when he needs to go to segregation, that he needs to be by himself. I forget what he was suffering from—schizophrenia, I believe—and he thought it very helpful to his mental illness to be alone. So if we're going to wave a wand and say do away with segregation, I think we have to be careful—that it does have some usages and sometimes people need to be alone and need to be afforded an opportunity to do that.

There's social housing, $2 billion towards that. In my community, $400,000 is going to a home for battered women.

I just wondered if you would each comment on the fact that maybe we need to have some new relationships between the federal government and provinces and share best practices and do some of those things.

My former executive assistant was on leave from Corrections Canada and he's now back working in one of Canada's largest institutions, which is Warkworth. Sometimes we're dealing with staff and unions that actually demand some of those things. So it's not as easy as saying we'll wave a wand and do away with it, when we have unions saying we want more of it.

Some comments, please.

● (1655)

Mrs. Brenda Tole: I would like to comment about that, because that is a situation. The staff, often through the union, will push very hard for more technology, more security, and there is a balance. When we opened the institution that we did and moved things in a different direction, it took a tremendous amount of communication and time. There was slow movement to change that.

All I would say is my experience has repeated over and over again—making the institution more secure and more restrictive does not make a safer place at all. I agree with you that at times.... At Alouette we had people come to us and say we need to be separate and apart. There's absolutely nothing wrong with that. It's the way in which it's done. It's the conditions under which it's done, and it's the fact that the person who's saying I need to be alone is basically still having some level of control in their life.

A lot of the acting out, the self-harm, is an issue of control. A lot of it is those people have no control whatsoever in anything in their lives, and it's a desperate sort of act. So there's a balance. And I know that Corrections Services Canada has a different union from what we have, so it's tough. But I think it's a matter of communication and education, because best practices at the end of the day will make a safer community.

Ms. Amber-Anne Christie: I'm in agreement with Brenda. You will find those instances where there are going to be people who will want segregation. I don't know why, but it's the manner in which you do it, right? Taking away someone's mattress and blanket and pillow and a magazine is inhumane. That's not segregation. It's not right. If segregation were treated differently and it weren't taking absolutely everything away, maybe it could be different, but they're not dealing with it in the right way.

Dr. Ruth Martin: As she was talking, I was just reflecting on something we said at lunch. I think it was Amber who said it doesn't actually cost any money for people to be kind.

You say there is difficulty with staff, maybe, or opposition. I think, frankly, your committee here has an enormous opportunity at this point to actually influence the future of corrections. We've all been appalled by the Ashley Smith death. It would be wrong to say that things like that happen all the time; however, unfortunately I suspect that many people are mistreated because of the system we have.

You have an enormous opportunity to make recommendations that maybe aren't going to cost very much but actually could bring about profound changes. Increasing staff's cultural competence, cultural knowledge, cultural sensitivity, and gender sensitivity probably costs less than trying to increase their security skills.

Rewarding and commending wardens for providing safe, healthy settings would probably not cost very much but actually would reap enormous benefits in terms of staff satisfaction and job enjoyment. I can't see that any staff who are dealing with hostile, angry individuals, locking them in segregation, are actually enjoying their day. I suspect that if they're actually engaged in meaningful ways with the people they're caring for and they're feeling that the whole prison is working on the same vision, it would be a much more fun place to work.

So yes, it will take a paradigm shift and it will take recommendations, but it's not an impossible task.

● (1700)

The Chair: Thank you. We've gone a bit over time, but I wanted to give you all a chance to respond.

We'll go now to Ms. Crombie, but we have to be out of here in about ten minutes. So we have time for two more—

Mr. Mark Holland: Chair—

The Chair: Is this a point of order?

Mr. Mark Holland: It is a point of order.

Just quickly on that, I don't think the vote actually takes place until 5:30, and it's only a five-minute walk, so we can probably pretty safely go until 20 minutes after.

The Chair: We have marching orders from our side of the table here. We have only two more people on the list anyway, and then we will have gone through the whole rotation, so I think it's going to work out quite well.

Mrs. Bonnie Crombie (Mississauga—Streetsville, Lib.): All right, let's get to it.

Thank you, Mr. Chairman.

I must say that I do find this sort of preoccupation with the segregation from the other side of the table a little bit curious. It's something I would abhor, personally.

Ms. Christie, I am really, really proud of you, and I think you're a real inspiration to young women who have turned their lives around.

Ms. Amber-Anne Christie: Thank you.

Mrs. Bonnie Crombie: Thank you so much for sharing so much about your intimate personal life with us, because I know that must have been difficult for you.

I wonder if I might prod even a little bit further, if you'll grant me the indulgence. I find you extremely articulate. I just want to know if you had some formal education. Then also, could you comment to me on what led you to the path of heroin addiction? Is that too personal? If it is, it's okay; we can move on.

Ms. Amber-Anne Christie: No, that's all right.

Ruth is my mentor. I've been working with Ruth and she has been educating me for the last couple of years. Other than that, formally I have a grade 12 education, like everybody else, and I'm sure I would exceed that now.

What led me to heroin addiction was methadone. I was 16 and I had a baby. They were going to take the baby away from me, so they told me I had to go on methadone. I went on methadone, and then I missed my methadone appointment. I didn't even know heroin could get me better, but somebody told me, so I started doing heroin to get myself better from methadone. That's how it started, and then eventually it all went downhill and I ended up on—

Mrs. Bonnie Crombie: It's the converse of what I thought you were going to say. I was going to ask you if any methadone treatments would have helped, but obviously it was the cause rather than the effect.

Ms. Amber-Anne Christie: Yes.

Mrs. Bonnie Crombie: You've changed your life around largely because of the program and the treatment you received. To what else do you attribute your success? Was it just the hope, or the housing or the job that you now have? You're obviously very good at what you do. Was it the support?

Ms. Amber-Anne Christie: The employment has definitely been a big thing. I actually didn't take the step of taking the employment; I was doing it as a volunteer for a couple of years. They kept prodding me to take the job, and I did. It has been really, really good in my life.

● (1705)

Mrs. Bonnie Crombie: Thank you for being so personal with us.

Obviously, with 10% of those who are in prison being women, even one is too many, and such a large percentage are aboriginal. Do you think, panellists, that treatment for mental health and substance abuse issues or homelessness, all the social issues, would help to reduce our prison population? In your opinion, if we could cure some of these social ills ahead of time, would we have fewer men and women in the corrective system?

Dr. Ruth Martin: Absolutely. As I alluded to, mental health is so interrelated with the emotional, the physical, and the spiritual. When we actually asked women what would help them to get healthy, they came up with these nine health goals over the course of the two years of the project.

The Doing Time project actually asks women who are now out in the community what is assisting them in achieving those nine health goals and what is preventing them from doing so. As Amber alluded to, so far in the interviews, 40% of the women are homeless when they're released from prison. So how is anybody going to get healthy when they don't have a place to live, and how are they going to support themselves? The easiest route for them is to go back to what they know, which is their drug addiction and their substance use. Hence, they commit a crime and they go back to prison.

Mrs. Bonnie Crombie: I'll try to get in as many questions as I can, so you can all feel free to answer.

Warden Tole, with respect to the aboriginal population, where we seem to see such a large percentage of your prison population being aboriginal women, what more could we be doing for our aboriginal population in terms of services, programs, or preventative measures? What's lacking such that we see so many aboriginal women in incarceration? Is it a lack of systems, a lack of hope, opportunity, education, or employment? What is it that you could put your finger on?

Perhaps Ms. Christie would like to respond as well.

Mrs. Brenda Tole: It's probably all of those things. Poverty is one, in addition to a number of the systemic things the population has suffered.

Generally speaking, from my experience, the first nations population, or aboriginal population, does not do well in our prison system, provincial or federal. Supporting the process of transfer of programs and responsibility to the bands and nations that are able to manage them, and to support that process, would probably have a great deal more success. You can't get much worse than what we're doing. In terms of managing that population, we really can't.

I just want to make one comment about what you said in terms of how to stop people from coming into prison. The female population in Canada, the United States, Australia, and Great Britain has drastically increased, really incredibly, over the last five years. If you look at all those countries you'll see that there has been a reduction in social programs. It affects every population, but women are affected first.

Basically, the leaning more towards a kind of war on drugs, against crime, and the reduction in social programs has basically pulled a lot of that population into our system.

Mrs. Bonnie Crombie: I wouldn't mind hearing from Ms. Christie on it as well, particularly with respect to treatment from an aboriginal perspective and using the alternative approaches.

The Chair: After that, we'll have to wrap it up.

Go ahead.

Ms. Amber-Anne Christie: You're going to find that everybody is different. What we've found in our research with aboriginal women is that everybody comes from a different band, everybody believes different things, and cultural sensitivity is not always followed in institutions. Actually, only once have I ever seen my culture in a prison setting.

In terms of having outside organizations, I could go on and on about what our aboriginal research project has done and how we have brought in our women from institutions. We've brought so many different members of our community together and then brought the women in and let them all meet and mingle. Do you know what I mean? It's a learning process in terms of what women need and want and what they're willing to take.

● (1710)

The Chair: Mr. McColeman, please.

Mr. Phil McColeman (Brant, CPC): First of all, let me also say thank you for being here. This has been incredibly good information you're bringing to us. I appreciate your taking the time to travel and having the courage to be here as well.

The first thing I want to do is bring up the fact that the comment about our being concerned about segregation really, if we want to be partisan about it, came up on the other side. We think it's an issue as well. We want to get our heads around that issue.

I just would like your comments about my comments. In the federal system we're typically dealing with longer sentences, and we have more time for different types of rehabilitation. The one thing, when we travelled and saw the various institutions, is we saw some programming but in my opinion not nearly enough about getting people trained for meaningful work when they exit. Does that play a role?

Warden Tole, perhaps you could answer that from your perspective. I know you don't have a lot of time in the provincial system because it's two years less a day, but I'm interested in exploring that just a bit in terms of how useful it would be, in your mind, that we concentrate some kind of focus on education for people and retraining for people when they're in the institutions so that they can integrate better when they get out and have meaningful work.

Mrs. Brenda Tole: I think that is really key. It's very important. I think that a longer sentence is a sort of double-edged sword. Having a longer sentence gives you an opportunity to provide more programming, but in reality the longer that you keep people isolated from a normalized environment, from a real living environment, you're working against that all the time because it has a negative effect on people when they're removed.

They can concentrate on things, they can participate, and certainly, while they're incarcerated, there are things that you can do in terms of therapeutic programming, but also meaningful work, vocational training in areas that probably will allow them to have a real job when they get out. Also, there are meaningful activities like allowing them, if it's a reasonable thing to do, to participate in the community on a basis of just volunteer work, on doing a number of good things with the community. Again, it gives a lot of good feedback.

I've never actually seen a population that wouldn't prefer to be actively engaged, whether it be work, education. They'll do all of it. It also provides a healthy sort of lifestyle for them, and that's really what you need. These people are going to be there, sometimes, for a long time. It's very difficult to then go back out to the community when you've been in a very isolated situation.

Mr. Phil McColeman: It seems to me the successes we are having are when we give people self-esteem. Part of that self-esteem and health is having something meaningful to do in your life and something that is fulfilling. Obviously, if we can, we should focus efforts in that regard.

Dr. Martin, you said there were a lot of low-cost things that can be done. I'd be very curious to see your list of things. It would be helpful, if you were so inclined, if you could provide that for us. We have your submission today, but actual practical, put-in-place procedures, policies, whatever, would be helpful.

You all nodded your heads when we mentioned—I hope I pronounce this right—Okimaw Ochi, which we visited, as a totally different model for aboriginal women in terms of institutions. Number one, have you been there? Have any of you viewed it? Are you familiar with the model? I just want to know your thoughts about that model in terms of its structure, how it works, and how effective it is.

Mrs. Brenda Tole: I'm familiar with it. I haven't actually seen it. It basically operates on a therapeutic type of model, and it uses first nations spirituality, teaching. I don't know, I haven't been familiar with the recent situation, but I know that it did encourage women to have their children there.

I think the only criticism I would have is it hasn't expanded for women. The only thing I would see is, considering the population that's in both the federal and provincial system, it hasn't been something that has been expanded. It seems to be probably the most successful of the women's centres in terms of less violence, fewer mental health problems, a healthier environment, people doing well, better staff relations. That's what my understanding is, and I haven't actually seen it but certainly I've read a lot about it and talked to people about it.

● (1715)

Mr. Phil McColeman: It was very different and very impressive. I don't have the actual numbers, but the one thing that was a little surprising was that rate of recidivism of people coming out of there was still very high.

It's a unique model. I just wondered whether you could comment on it as a model.

As you're finding through your research, people really have to want to change, correct? Everybody's timing is different, I suppose, in terms of when you're prepared to look in the mirror and make those changes, especially in these populations. I would like your thoughts, and particularly the doctor's thoughts, on what the true motivators are. What are the true motivators to bring people to the point where things click and the light bulb goes on?

Dr. Ruth Martin: I think you can learn the answer by listening to those stories. For each woman it's a bit different, but the things that have come through that I've heard are a hope that it is possible that they can succeed, actually having people who believe in them, and community support. It's those constellations, and people will often say that they had a moment when they thought, "Aha—it is possible that I can do it".

That's another research project, to actually gather those stories that tell us about the moment. It will be a realization. It might take a while for them to effect it. It's almost like a teeter-totter; the motivation turns, and things align for them so that they can actually turn it around, but they have to have that hope.

Mr. Phil McColeman: Thank you.

The Chair: There was a request for a short question here. I have one.

One of the things we were told as we were travelling is that the people who observed the mental health issues in the prisons indicated that they were never, ever separated from drug issues, and that the drug issue always preceded the mental health issue. In your experience, is that true?

Dr. Ruth Martin: Sorry; you said the mental health issue preceded the drug issue?

The Chair: No, the opposite; it was preceded by a drug issue.

Dr. Ruth Martin: I would say they're associated. I don't know if you could say the timing on it. I don't think so, but they're certainly associated. They certainly go together.

The Chair: Okay.

I'll give you one minute.

Mr. Borys Wrzesnewskyj: Thank you, Chair.

I'm very glad that Mr. McColeman raised the important public debate that's taking place right now about longer sentencing in general. He referred to it in terms of providing enough time to help reintegrate those who are incarcerated. I'm glad that he's put it within that context, because, unfortunately, most of the debate is around sloganeering—"You do the crime, you do the time"—so it's about punishment. It's also often about that issue of security: we're scared of these people, so let's segregate them for as long as possible.

Ms. Christie, you would have been a poster child for those arguments five years ago. You were in and out 30 times.

Something changed. We heard what changed: the programming. A different approach made that change in your life, and you said you could fill this room with other examples of women whose lives have been changed.

In that previous time, when you were in and out and in and out, if you'd been incarcerated in those previous circumstances for a longer period of time, would that have broken that cycle for you? Please give us a quick yes or no.

● (1720)

Ms. Amber-Anne Christie: Probably not. No.

Mr. Borys Wrzesnewskyj: Thank you.

The Chair: Thank you all very much.

This meeting stands adjourned.

Published under the authority of the Speaker of the House of Commons

SPEAKER'S PERMISSION

Additional copies may be obtained from: Publishing and Depository Services
Public Works and Government Services Canada
Ottawa, Ontario K1A 0S5
Telephone: 613-941-5995 or 1-800-635-7943
Fax: 613-954-5779 or 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Also available on the Parliament of Canada Web Site at the following address: http://www.parl.gc.ca

Publié en conformité de l'autorité du Président de la Chambre des communes

PERMISSION DU PRÉSIDENT

On peut obtenir des copies supplémentaires en écrivant à : Les Éditions et Services de dépôt
Travaux publics et Services gouvernementaux Canada
Ottawa (Ontario) K1A 0S5
Téléphone : 613-941-5995 ou 1-800-635-7943
Télécopieur : 613-954-5779 ou 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante : http://www.parl.gc.ca