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Chair

Mr. Garry Breitkreuz

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● (1530)

[*English*]

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

This is the Standing Committee on Public Safety and National Security, meeting number five. We are dealing with a study on federal corrections. Mental health and addiction is our focus.

We welcome three representatives today from the Correctional Service of Canada.

Ms. Vallée, would you like to go ahead and introduce yourself and your colleagues?

[*Translation*]

Mrs. Maria Mourani (Ahuntsic, BQ): Mr. Chairman, I asked for someone from the Martineau Community Correctional Centre to testify today and I would like to know whether anyone from that centre is among the persons here present. Mr. Préfontaine could perhaps inform us on that matter.

[*English*]

The Chair: We did send out invitations to all the people you suggested. The clerk will give you the answer to the response we got from them.

[*Translation*]

The Clerk of the Committee (Mr. Roger Préfontaine): Mrs. Mourani, I informed your office as developments occurred. The other witnesses that you had suggested for today, Thérèse-Casgrain House as well as Anne Crocker and Céline Mercier, declined the invitation for various reasons.

Mrs. Maria Mourani: I am aware of that. That's fine.

The Clerk: Your request concerning the Martineau Community Correctional Centre and your list of questions were forwarded to the Correctional Service of Canada, and it decided that it would be represented today by Ms. Vallée, Ms. Gaudet and Ms. Perreault to discuss the issues you raised.

Mrs. Maria Mourani: Does that mean that people from the Martineau Community Correctional Centre were not allowed to be here today?

The Clerk: Perhaps Ms. Vallée could answer that.

Ms. Johanne Vallée (Deputy Commissioner, Quebec Region, Correctional Service Canada): In fact, as the topic of mental health goes beyond the context of Martineau Community Correctional Centre, we called on Ms. Andrée Gaudet, who is associate director of the Montreal-Metropolitan District and who, among other things, is responsible for Martineau CCC. We made sure, based on the information we had, that we would be able to answer all your questions concerning Martineau CCC. Furthermore, Ms. Perreault, who is regional coordinator and a psychologist, can also discuss the mental health caseload at Martineau CCC.

Mrs. Maria Mourani: All right. Thank you.

[*English*]

The Chair: I hope that answers your concerns. Thank you very much.

Madame Vallée, we will allow you an opening statement of approximately ten minutes. Then we'll go ahead with the rest of our meeting. Thank you.

[*Translation*]

Ms. Johanne Vallée: You requested a brief presentation.

[*English*]

I'm a criminologist. I joined CSC almost three years ago. Before that I was associate deputy minister for the public safety department in charge of correctional services of Quebec. I have also worked for almost twenty years in the community and in Quebec.

[*Translation*]

Ladies and gentlemen, thank you for your invitation to have me appear before the Standing Committee on Public Safety and National Security.

Your work on mental health and addiction has recently brought you to visit quite a few institutions across Canada, particularly in the Quebec Region. You visited the Regional Mental Health Centre, within Archambault Institution, and the Special Handling Unit, within the Regional Reception Centre. All of these visits have certainly given you a good idea about our work and achievements in the areas of addiction and mental health interventions with incarcerated offenders. However, inmate custody is only one component of the Correctional Service's mission, and we are pleased to be able to speak with you today about the tools available to the Correctional Service in the community to ensure effective and safe reintegration of the parolees under its supervision.

The Correctional Service places a great deal of importance on the continuum of care of offenders, from incarceration until the end of parole and even beyond. The availability and accessibility of community resources are important factors in assessing and managing an offender's risk, and the Correctional Service therefore considers them to be directly linked to public safety.

Initially, three other community workers were also to take part in today's session to present the addiction and mental health services they provide to offenders in the community. Although they were unable to accept your invitation, we are pleased to see you are interested in community services, given the importance of the partnership with these agencies that enables us to fully carry out our mandate in the community.

We have many community partners; together this creates a real safety net around parolees and former inmates based on each one's estimated degree of risk. While the police do certainly contribute to this safety net, community organizations, groups of volunteers and all the community support provided are also indispensable to true public safety. This network of resources, their operations and effectiveness are unfortunately not well known; this is why I will focus mainly on these aspects during my brief presentation. We will then be available to answer any questions from your members, and that is why Ms. Perreault, psychologist and manager of the Institutional Mental Health Initiative, and Andrée Gaudet, associate director and parole supervisor for the entire Montreal and South Shore area, will be able to supplement the presentation and answer your questions.

Before going into the details of the mechanisms the Correctional Service uses to provide the continuum of care in the community, I believe it would be appropriate to quickly review the organization of our mental health services. You saw at the Regional Mental Health Centre that we provide intensive specialized mental health care to inmates from institutions across the region. They are referred there when the services available in each institution are no longer adequate to meet their offenders' mental health needs. These may be particularly acute suicidal or self-injury cases, a psychiatric emergency, or a need for psychiatric assessment or long-term specialized treatment. Each institution has services to meet their inmates' mental health needs.

The Institutional Mental Health Initiative, which was rolled out almost two years ago, focused on mental health intake screening. We now have a computerized mental health screening system at intake and for the subsequent exhaustive assessment of mental health needs, and the delivery of primary mental health care. In this respect, the tangible impact of the Initiative in the Quebec Region has been to put in place mental health teams in all institutions, that is to say 12 teams at a number of locations in Quebec. These teams are made up of mental health professionals, psychologists and mental health nurses. It has also helped develop initial findings on the prevalence of mental health needs in our inmate population, which is 15% at intake for men and 58% at intake for women.

● (1535)

It has also made it possible to provide primary mental health care services to 19% of the male inmate population, or roughly 575 offenders in Quebec; to provide mental health training to our correctional staff at Joliette Institution and the Regional Mental Health Centre; to develop interdisciplinary clinical management plans in complex mental health cases, in particular repeated acts of self-injury and, of course, to follow up implementation of these plans.

Lastly, in a pilot project, through the Institutional Mental Health Initiative, we have rolled out a tracking system for mental health services provided in two institutions, Donnacona and Joliette, in order to better identify our needs for developing new mental health services.

Starting on April 1, all institutions in the Quebec region will have this system, which means that we will able to say exactly who and how many people have received mental health services, and when, something we have been unable to do until very recently.

Let us now go back to our continuum of services. Institutions facing problematic mental health cases that exceed their local capacity may refer these cases to the Regional Mental Health Centre. Now, while the Correctional Service has access to highly appropriate expertise and facilities, certain cases require even greater care and are then referred to the Institut Philippe Pinel de Montréal, which has been a partner of the Correctional Service for over 30 years. IPPM is the second level of referral for women offenders. It is a national unit that serves all regions of the Correctional Service.

Under the binding contractual agreement we have with them, IPPM has up to 12 beds available for sex offenders, specialized treatment for sex offenders who also present mental health needs, 12 other beds for women offenders, and three beds for offenders with acute mental health needs. In all cases, inmates staying at either the Regional Mental Health Centre or IPPM eventually return to their home institution. In fact, the link between the local case management team and the care team where the inmate or woman offender is referred to is never broken, in accordance with the principles of the timely sharing of information and of the continuum of care.

The special needs of offenders with mental health problems are considered during their incarceration, including as part of their preparation for returning to the community. When it comes time to make concrete reintegration plans, new professionals join the case management team. Another mental health initiative, this one in the community, plays a major role in planning the release of offenders with mental health needs. Clinical teams working with this initiative, nurses and social workers, are involved in organizing transitional mental health care several months prior the first potential release date.

Case management teams and workers from both mental health initiatives work together to identify mental health needs and support needs to ensure safe release. Essentially, their work involves identifying the best place for an offender to begin his return to society, by balancing off the intensity of his needs with the individual's resources and environment. Once the place—the resource—is identified, they then begin the real groundwork: they discuss with the resource, contact the surrounding services, the police, community health centres and community agencies, and inform the offender, thereby preparing him for his transition into society.

Currently, the Community Mental Health Initiative is monitoring 76 parolees. Of course, a greater number of offenders are presenting mental health needs upon release. However, only a fraction of these cases require supervision under this initiative. These 76 offenders currently monitored under the Initiative present supervision needs that go beyond what the regular release procedures are able to provide. Measures taken by the Community Mental Health Initiative are similar to but more intense than what is done when releasing cases with minor or no mental health needs.

● (1540)

In order to fulfill its mandate to ensure the successful transition of offenders, the Community Mental Health Initiative has forged ties with community partners whose mission is to work with, support and defend the human rights of people with mental health needs. These ties are intended to make these resources available to offenders with mental health needs. The areas targeted by these ties between the Correctional Service and specialized community mental health resources range from psychiatric supervision, adherence to pharmacological and/or psychosocial treatment and housing needs, to job skills through supervised workshops and support for day-to-day activities.

[*English*]

The Chair: May I just interrupt for a minute? Are you going to go through the entire report you have given us here?

● (1545)

Ms. Johanne Vallée: Almost. Okay?

The Chair: Can I just get the permission of the committee to allow you to finish? Normally we allow ten minutes.

All those in favour of letting her finish? It will probably take another seven or eight minutes.

Okay, it looks as if the committee is in favour.

Mr. Mark Holland (Ajax—Pickering, Lib.): Mr. Chair, I only saw two hands. It's not that I don't appreciate the presentation—I do—it's just that I want to make sure we have the opportunity for questions.

The Chair: You were the only one objecting.

Mrs. Maria Mourani: I agree with him. We need more time to ask questions.

The Chair: I guess then if you could wrap it up in a few minutes.

Mr. MacKenzie.

Mr. Dave MacKenzie (Oxford, CPC): Mr. Chair, from this side we don't mind; whatever satisfies the other side. But we will be out of here at 5:15, I believe.

The Chair: Okay.

Let me take another count. How many would like to have her finish the report?

Okay, if you could wrap it up within the next several minutes.

Ms. Johanne Vallée: Okay.

[*Translation*]

I'll be brief.

We've told you about the Institutional Mental Health Initiative, about the link with the community and the work being done in partnership with a number of community agencies to ensure offenders' return to society. We've also talked to you about the teams in the community, social workers, nurses and so on. We've also discussed the doctors and psychiatrists.

In Quebec, there is a special feature. And that is the Martineau Community Correctional Centre. It is an institution that belongs to the Correctional Service of Canada. It is located in Montreal north and operates in cooperation with the community. It is important that the community correctional centres ensure that their services are not provided separately from the community. We work with citizen advisory committees, which essentially consist of volunteers from the surrounding community where we operate. They enable us to get a better grasp of community needs and to adjust our services.

At the Martineau Community Correctional Centre, unless I'm mistaken, there are about 28 spaces for 60% of offenders. Of that number, 24 spaces are occupied by men and 4 by women. Some of those men have reduced mobility problems. They are in wheelchairs and need special medical care. Those 24 spaces for men are for people with mental health problems. The same is true for the women. At Martineau CCC, 60% of the male clientele comes from the Regional Mental Health Centre. We have provided follow-up, integrated our services and provided them with services through a clinical intervention plan carried out into in the community. It should also be understood that, at Martineau CCC, unlike at other CCCs, specialized staff are on-site 24 hours a day, 7 days a week, to provide services. There are nurses, whom we call clinical behavioural advisors, parole officers, psychologists and correctional officers. The clientele is met regularly so that we can monitor them, adjust medication and ensure that reintegration plans are being carefully followed.

I won't go any further. I will not address the issue of substance abuse. Based on the questions the clerk sent us, mental health appears to be what interests you most. That's a fundamental factor in Martineau CCC's success because that is the only place where we can really ensure continuity. There's no break in services for mental health cases. We are also developing ties with community agencies that continue the work beyond our mandate.

Thank you.

● (1550)

[*English*]

The Chair: Thank you.

You obviously have a lot that you want to communicate with us. We can read your report, but without any more hesitation we will go to the Liberal Party.

Mr. Holland, do you want to start?

[*Translation*]

Mr. Mark Holland: Thank you, Mr. Chairman.

Thanks to the witnesses for their presentation.

There will definitely be an increase in the inmate population as a result of the new bills in the House of Commons. Does the department intend to increase resources for individuals with mental health problems or drug problems?

Ms. Johanne Vallée: For the moment, we are conducting analyses on the bills' impact on the inmate population. Correctional Service Canada regularly assesses needs for infrastructure changes or infrastructure adjustments based on offender needs. The same is true for mental health. A little earlier, I talked to you about new assessment tools that are now being used at intake. We'll have to adjust our intervention as we acquire much more specific information on the nature of offender needs.

Mr. Mark Holland: Mr. Don Head appeared in committee last week and said that the population will definitely increase. Are you concerned that there is currently no plan to increase services, even though we know the population will be increasing?

Ms. Johanne Vallée: We are not concerned for the moment. Every year, we conduct assessments of our population because we obviously need to know for funding purposes. We review population increases, we establish averages and we are always careful because we can sometimes overestimate or underestimate them. So we're not really concerned.

Mr. Mark Holland: However, there's never been a situation like this.

There are currently a number of bills in the House of Commons that have major implications for the prisons. There will definitely be a big increase in the population. If there is no mental health services plan, I'm definitely concerned. For example, what do you think about double bunking? That's an issue. The minister said allowing double bunking isn't an issue, but there is an international convention.

[*English*]

Canada was a member of an international UN agreement that said this wasn't going to be permitted, yet now we're talking about double bunking. What impact do you think that will have on mental health?

[*Translation*]

Ms. Johanne Vallée: We haven't got to that stage yet. Bills haven't yet been passed. From our vantage point, they're still under review. As matters materialize, as we've always done in the past, the Correctional Service will adjust its services and review its infrastructure planning.

The double bunking issue is something we monitor as much as possible. When we resort to it, we definitely conduct analyses of inmate needs. So we aren't concerned for the moment.

Mr. Mark Holland: In your opinion, what would the impact of double bunking be if the minister decided it was the only option for the government? Last week, the minister said that it wasn't a problem for him. What is the impact on mental health issues, for example?

● (1555)

Ms. Johanne Vallée: I repeat the same answer.

We have to conduct analyses of those bills before really determining what the impact will be, whether it's for double bunking or for all inmate services as a whole. So we'll wait until we have the analyses in hand.

Mr. Mark Holland: Are there any on-going discussions with officials or the minister's office concerning planning for new prisons or new spaces for prisoners?

Ms. Johanne Vallée: I couldn't tell you. I handle the Quebec Region.

Mr. Mark Holland: I understand.

There will be an increase in the population. It's definitely logical for there to be a discussion on that point. What's the way to manage the situation if there's no discussion at this time?

Ms. Johanne Vallée: Every time there are changes in the inmate population, analyses are conducted and discussions are then held with the government in power. Obviously, if we have to seek additional funding, that will have to be done later. It's always done on the basis of rigorous analyses.

[*English*]

The Chair: Thank you.

We'll now go to Ms. Mourani.

[*Translation*]

Mrs. Maria Mourani: Thank you.

First of all, I would like to thank you for being here and for your testimony.

Supplementing somewhat what Mr. Holland just said, how many expansions do you think would be planned in Quebec in terms of future construction?

Ms. Johanne Vallée: For the moment, I don't have those figures, Ms. Mourani, and I don't have that planning.

Mrs. Maria Mourani: However, to your knowledge, will there be any expansions, renovations?

Ms. Johanne Vallée: There have always been renovations because we need to adapt our infrastructure. I believe that when you came—

Mrs. Maria Mourani: Yes, there were some, absolutely.

Ms. Johanne Vallée: There were some. We're planning others, particularly for the Regional Mental Health Centre. Some institutions can be more or less obsolete in certain respects. With the amounts we recently invested in security, we realize we have to adapt the entrances to institutions, for example. As you saw, we're installing metal detectors, new technological devices that require a little more space. So we're modernizing that aspect.

Mrs. Maria Mourani: Do you have any information on the expansions?

Ms. Johanne Vallée: We don't have that information for the moment.

Mrs. Maria Mourani: I'd like to address another point. On page 7 of your presentation, you cite some figures concerning reoffending. If I correctly understand what I'm reading, and I may be mistaken, these are reoffences that were committed while the individual was on supervised parole. So these are reoffences, not suspensions, if I understand correctly.

Ms. Johanne Vallée: These are reoffences, but you have to understand that, particularly for long-term supervision order cases, if a person does not comply with an order without committing a crime or an offence, failure to comply with that long-term supervision order is considered a reoffence.

Mrs. Maria Mourani: It's considered a reoffence. So that includes both breaches of condition and crimes.

I would like you to give me some figures, to send them to us in writing. Can you send us a breakdown in percentages, or absolute figures, not only of suspensions and breaches of condition—suspensions and breaches of condition are of course not always related, but nevertheless—but also of actual reoffences, by crime. Of course, we use the word "reoffence", but is that a reoffence in a similar crime, or are we seeing a deterioration or escalation in crime? I don't know whether you have those figures.

Ms. Johanne Vallée: I don't know whether we can be that specific, but we can definitely give you figures concerning violent and non-violent reoffences.

● (1600)

Mrs. Maria Mourani: That's already very good.

Furthermore, Ms. Gaudet, I understood that Martineau CCC is the only one—though I may be mistaken—in Quebec that handles only mental health cases. Is that correct?

Ms. Andrée Gaudet (Associate Director, Montreal-Metropolitan District, Correctional Service Canada): Yes.

Mrs. Maria Mourani: So the Martineau Community Correctional Centre is an example of a CCC that treats, on the outside, individuals suffering from varying degrees of mental disorders who are under the responsibility of Correctional Service Canada.

Ms. Andrée Gaudet: The centre will treat cases that have mental health problems and need special accommodation service.

Mrs. Maria Mourani: Individuals who cannot be at home because there might be much too great a risk involved. That's correct?

Ms. Andrée Gaudet: Yes, or who have high needs as a result of which they require that type of structure.

Mrs. Maria Mourani: At Martineau CCC, which is the only place in Quebec that handles mental health cases, do they still receive all criminal profiles, sex offenders, pedophiles, as well as mental health problems?

Ms. Andrée Gaudet: Yes, the criteria are associated with the mental health issues and do not exclude criminal behaviour.

Mrs. Maria Mourani: This is quite an unusual case since the community correctional centre is located two or three minutes by foot from a school and a large child care centre. I admit this is a major concern in the constituency, although I know perfectly well that Martineau CCC is very effective and that it is a very good organization. I have absolutely nothing to say about that. It is in my riding and that is why I know it well. I've met the director twice. He knows me very well too. So we have a very good relationship. I have absolutely nothing to say about that.

However, after two ministers of Public Safety—we now have a third one—two questions and three years, do you think we can accept the idea of having pedophiles at Martineau CCC like Mr. Bégin, who was in our area? These individuals, who have mental health problems, who come from the Regional Mental Health Centre—these are major cases in some instances—are not choir boys. I'm speaking as a citizen. Do you think it's acceptable for them to be at Martineau CCC next door to our children, to the school and to the child care centre? It's a new child care centre that has just opened: It has nearly 50 children. What do you think about that?

Ms. Johanne Vallée: I would say that all community resources—whether we're talking about CCCs or community residential centres—take in offenders for whom we've put a risk management mechanism in place. Martineau CCC does not have a larger concentration of pedophile cases; it has a concentration of cases with mental health problems. For Martineau CCC, of course, we've put in place an extremely tight monitoring mechanism for those offenders.

You visited the CCC yourselves and saw that they can't be released alone. They have to be accompanied by a CCC caseworker. And that will last as long as necessary in order to correctly assess the person's ability to—

Mrs. Maria Mourani: To be able to be released alone—

Ms. Johanne Vallée: To be released alone, but not only that. We also want to ensure the safety of people in the community.

So we go by stages. It's long, and it's a matter of supervision, but it's the best way to do it. What we believe is that—

Mrs. Maria Mourani: I understand all that.

[*English*]

The Chair: We're out of time.

Mrs. Maria Mourani: May I have one minute?

The Chair: You're almost half a minute over already.

Be very quick, okay?

[*Translation*]

Mrs. Maria Mourani: All right.

You understand that people who live nearby send their children to those child care centres or to the École secondaire Marie-Anne nearby, attended by 14 and 15-year-old girls. As you can understand, the public does not have all this criminological analysis that can be conducted. So it's a big concern for them to have individuals in their area who not only have mental health problems—which would be manageable—but also have serious sexual deviancies. Consider the fine example of Mr. Bégin. These are not pedophiles that we can control; these are guys who have committed very serious acts who wind up there and at the Regional Mental Health Centre.

● (1605)

[*English*]

The Chair: I have time for a brief response. Do you have a response?

[*Translation*]

Ms. Johanne Vallée: We understand the community's concerns and that is why Correctional Service Canada has put in place all kinds of mechanisms for consulting the community and for integrating them as well, particularly through the citizen advisory committees. The criminal problem is difficult for citizens to understand, and we understand that. So it's part of our mandate to go and explain how this is done and how we supervise them.

In practice, Mrs. Mourani, I would say it is much more comforting to know that they are supervised 24 hours a day, that we can monitor them if necessary and that we can bring them back to the institution rather than release them without supervision. It's a also a clinical service in that they are not left to their own devices and that they are really monitored regularly, not just with regard to the risk they present, but also with regard to their mental health status. If we stabilize their mental health status, we really help them reduce all the risk.

[*English*]

The Chair: Thank you very much.

We'll go to Mr. Davies, please.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you. *Merci beaucoup.*

It's nice to see you again, Madame Vallée. I will speak in English, if that's okay, but feel free to answer in English or French, as you're comfortable.

As you know, we're studying addictions and mental health in the corrections system, so I'm going to try to zero in on that.

On page 10 of your remarks you have some statistics about people who complete substance abuse programs in the institutions. You have a time period, from 2009 to 2010—it's close to our parliamentary fiscal year—during which 420 offenders began a substance abuse program and 326 completed the program. You say that this is a 78% success rate. That is upon completion, I take it.

A voice: It is completion.

Mr. Don Davies: I'm just wondering if you keep statistics on long-term sobriety or cleanliness so that we can track a year later, three years later, or five years later how well the addictions therapy is working.

Ms. Christine Perreault (Regional Coordinator, Institutional Mental Health, Quebec Region, Correctional Service Canada): We don't have those numbers with us, but in fact, yes, we do keep statistics on long-term success—five years, ten years.

Are you talking about relapse, and whether they go back to substance abuse?

Mr. Don Davies: Yes.

Ms. Christine Perreault: Yes, we have some statistics. Part of our population does come back inside, behind bars, so we know about them. But most of them do not come back, and we don't have statistics on them. But in fact, yes, we can find numbers for you.

Mr. Don Davies: Many offenders will be released into the community under conditions. I take it you would certainly have statistics on a large number of people who have left the institution and remain under conditions.

Ms. Christine Perreault: Do you mean statistics on from the time after they finish the program until the end of the sentence, whether or not they go back to substance abuse? Do you want to know about that?

Mr. Don Davies: Yes, I think it's one thing we're interested in. If 80% of offenders coming into the institutions have substance abuse problems, which I think was in your presentation, then one thing we need to find out is whether the programming we're giving these people has any long-term success.

Ms. Christine Perreault: Do you want to know about maintenance?

Mr. Don Davies: I would like to know that, if possible. Thank you.

On page seven of the presentation,you have some statistics on reoffending rates. Two things jumped out at me. One is that it shows how low the reoffending rate is for many people. I think you said that in 2008-09 CSC kept statistics on the rate for reoffending during supervision and only 0.74% of all supervised offenders reoffended during this period. It tells a layperson like myself that there is a very low rate for reoffending.

Ms. Johanne Vallée: It's for mental health offenders.

Mr. Don Davies: At the bottom of that, a closer look at the subgroup of offenders with mental health needs who were supervised showed that six offenders, or 1.48%, reoffended. Maybe there's a mistake. I take it the 0.74% is for all offenders. That's what it says. It's not only for people with mental health needs. It's for everybody.

● (1610)

Ms. Johanne Vallée: Yes.

Mr. Don Davies: At the bottom, the 1.48% is for people with health needs. It's funny that it's exactly double, if my math is right. Twice as many people who have mental health needs reoffend. It's 1.48% versus 0.74%. It would seem to me it's to be expected that people with mental health needs would be a more challenged population.

Could you tell us what ideas corrections might have to help lower the rate of reoffending for people with mental health needs? It's clearly higher than the normal population.

Ms. Johanne Vallée: I'll have to check the stats again. You have the English draft and I have the French one.

Yes, you're right.

We need to ensure clinically and also with the support of medication that we are able to stabilize the offenders. One of the challenges we have is to make sure that once they're released and after the end of the mandate, they will keep taking their medication and the network that we have put in place for them will remain. It's why it is so important for us to not only have, for example, the Martineau CCC, where we have specialized services, but to make sure that once they reach the end of the mandate they will have support in the community. It will make the difference in the success rate of the offender.

Mr. Don Davies: Do you have any suggestions to the committee on what specific resources in the community you think could be put in place to help those people with mental health needs? I take your point on making sure they take the medication, but what other community resource needs would be helpful to make sure they don't reoffend?

Ms. Johanne Vallée: For example, at the CCC Martineau we have partnerships with community organizations that can support the offender in finding a job. It's not easy for an offender with mental health problems, but they can help the offenders. Also, we have specialized *ateliers de réinsertion par le travail*—supervised workshops for mental health cases. We have developed a partnership with workshops because their reintegration relies not only on the supervision of CSC but also on the capacity for them to develop positive relationships with work and with a support group network.

For example, in the Quebec region we have the chaplains. They provide, on a voluntary basis, support to the mental health cases. They are there Saturday nights; they have a special place to go to. They can go to watch hockey and they have volunteers with them. So they feel that they belong to a community and they know they can have support. They know they can phone a nurse or doctor. It's the same in other regions. One of the biggest challenges for us is to bridge our services to the provincial health care services. It's the only way we will really establish a continuum of services, because at the end of the mandate, we are no longer there. It's very important for us to build that bridge with the provincial health care.

The Chair: Thank you.

I have one clarification on these statistics you have quoted on page seven in the English text. Do those statistics apply to all of Canada, or only to your institutions in Quebec?

Ms. Johanne Vallée: In Quebec.

The Chair: Only in Quebec. Thank you.

Ms. Glover.

[*Translation*]

Mrs. Shelly Glover (Saint Boniface, CPC): Good afternoon and welcome to all the witnesses. I'm pleased to see you again, Ms. Vallée.

I just wanted to clarify something before asking my questions. Mrs. Mourani, I believe, spoke about Martineau CCC. Did I correctly understand that a child care centre was opened after Martineau CCC was built?

Ms. Johanne Vallée: Yes.

Mrs. Shelly Glover: That makes us wonder why a child care centre was established or built near the site of an institution such as Martineau CCC, knowing what it was and without making every possible effort to allay concerns.

● (1615)

[*English*]

I seriously think that we have to give the population in that town a bit of credit. I would think they did their homework before they put a child day care in that place. So I'm sure they must have had some sense that it was a place that wouldn't be victimized.

Are there any specific incidents that you can tell me about with Martineau and anyone in the community being offended with these heinous crimes that have been described here? Have you got incidents?

Ms. Johanne Vallée: With the kindergarten? No.

What we have done is not too long ago we approached the director of the kindergarten to invite someone from their board to participate in our citizen advisory committee for the CCC, because truly I understand their fear and their concern. But I truly believe we can explain to them how we manage and make sure that they don't have any problems.

As a matter of fact, each time that we release an offender into the community, throughout Canada, not only in Quebec, we notify the police, and the police and the community around the CCC will know who's coming. They will know in advance so they will be able to monitor the situation.

Mrs. Shelly Glover: Okay. I wanted a clarification. I thought I heard it wrong.

Recently in my home province I celebrated with a company called Momentum Healthware Inc. They are producing software for different health care situations, and with some support form the Government of Canada and the National Research Council of Canada industrial research assistance program they have actually started an electronic tracking system that will help people suffering from mental health problems to address the continuum of care.

Do you have electronic health records that allow you to continue that continuum of care, which we all agree is very important?

Ms. Christine Perreault: We're still working on the paper for the mental health file, but CSC is working on this and moving forward to having something electronic. That's going to solve sharing of information, tracking, and continuum of care, but we're not there yet. It's quite complicated because we need a huge software. It's very complicated. It needs to be bilingual.

Mrs. Shelly Glover: I had a demonstration. It was fantastic. I believe in using all of the resources that are stakeholders in this problem and this willingness to help these people who suffer from mental illness. I would recommend it may be something you want to look at.

I want to move to another question, because I found it very interesting when I was on our tour. There was a woman that Mr. Davies and I met. She did not want to appear before all of the committee members because she was nervous: she suffers from mental health problems, and she also suffers from addiction. We spent some time with her asking her how she felt things were in the institution she was in. She commended the programming. She commended the things that were available.

I asked her what she would say to parliamentarians. If we could makes things better, what would she say to us? I was quite surprised at her response. She said to us, “Well, that's easy: have more consequences for the people inside who make brew, because I'm an addict and my treatment and my programming and the things I'm trying to do for myself are jeopardized because the consequence is a $5 fine.”

What are the consequences in prison, in your facilities, in the greater organization of the Correctional Service, for people within the organization who do things like this? How can we help this woman? What are the consequences for someone, for example, caught making brew in your institutions?

● (1620)

[*Translation*]

Ms. Johanne Vallée: That depends. We could resort to disciplinary court, privileges could be suspended or visiting rights could be cancelled; there could be fines. That really depends on the situation and obviously on the individual's file. It varies. I don't have any specific details, but we could check what is being done with regard to drug and alcohol abuse.

Mrs. Shelly Glover: I'd like to know what the harshest consequence is. In fact, I would like to know all the possible consequences.

Did you work for the correctional system or judicial system a number of years ago, when the provinces closed the provincial institutions specialized in mental health problems? Did anyone here work at the time of the old system? I'd like someone to draw a comparison between the old system and today's system because I think that has had an influence.

Ms. Johanne Vallée: That was a long time ago. It started more than 30 years ago and was done gradually. I can talk about Quebec. Since it was done gradually, it's hard for us to draw a comparison. It was done in stages. We aren't old enough.

[*English*]

We're not old enough to do that. Sorry, we don't have that privilege.

[*Translation*]

Mrs. Shelly Glover: Back home, I believe it was 18 years ago that they closed the last...

Do you think there is any benefit to having institutions for individuals with mental health problems managed by the provinces, that is to say to stop those individuals before they become criminals? We've heard a lot of witnesses say that, if only the mental problems of those individuals had been identified before the crime was committed, they could have prevented them from being incarcerated in a federal prison.

Do you agree with that?

[*English*]

The Chair: That will have to be the final question.

Go ahead.

[*Translation*]

Ms. Johanne Vallée: There are a number of perspectives on the way to manage mental health cases. Should they be criminalized or not?

The government has conducted consultations and Correctional Service Canada is working with the correctional services of the provinces and studying this mental health issue in the adult correctional system. Perhaps it might be worthwhile to see with the committee whether we can call the heads of the correctional services to see where they are in the midst of their proceedings.

I obviously don't have them in hand at this time, but there are also the analyses of the tribunals specialized in mental health. Such tribunals exist in various places. When an individual must appear before a judge, the mental health issue will be examined and the decision will be made whether to refer that case to the criminal justice system. An enormous amount of research is being done on those tribunals. That research is relatively recent. I think it would be worthwhile to look at what is coming out of that research.

[*English*]

The Chair: Thank you.

Mr. Kania, please.

Mr. Andrew Kania (Brampton West, Lib.): Mr. Chair, Ms. Mourani has asked for extra time, so I'd like to give my time to her.

[*Translation*]

Mrs. Maria Mourani: Thank you.

Ms. Vallée, I would like to go back to Martineau CCC. In what year was it established?

Ms. Johanne Vallée: I think it was more than 10 years ago, Mrs. Mourani.

Mrs. Maria Mourani: That's 10 years or more than 10 years ago?

Ms. Christine Perreault: It has been in existence since January 2000.

Ms. Johanne Vallée: In fact, it was in existence before that, as a CCC, but the Correctional Service decided to make it a specialized mental health facility in January 2000.

Mrs. Maria Mourani: You said it was in existence before that. In what year was it established?

Ms. Johanne Vallée: I couldn't tell you. I don't have that information with me.

● (1625)

Mrs. Maria Mourani: It was 40, 50 years ago or much more recent?

Ms. Johanne Vallée: It was more recent.

Mrs. Maria Mourani: Was it around in the 1920s, do you think?

Ms. Johanne Vallée: There were no CCCs or community residential centres in the 1920s.

Mrs. Maria Mourani: Absolutely.

I would like to go back to what Mrs. Glover said earlier. I moreover agree with her. I made submissions to my local authorities. I thought it was unacceptable for a child care centre to be located near a CCC. However, the school has been in existence since 1922.

How is it that the authorities responsible for that decided to build a CCC next door to a school that has been in existence since 1922? I can confirm for you that the first wing of the school has indeed been in existence since that year. The school was therefore already there before the CCC was established.

I'm not really trying to determine which of the two institutions was established first. My purpose instead is to answer Mrs. Glover and to show her that the question is still highly relevant in view of the fact that child protection seems to be an important point.

We are aware of the current neighbourhood dynamic. A school was built there long before the CCC was established, and there is also a child care centre. I'm not questioning the fact that the CCC takes in individuals who are suffering from mental health problems. What I am questioning, and what the Montreal School Board is questioning as well, is solely the presence of pedophiles.

Can you confirm for me, and for the parents in that area whose children attend the school, that there will never be an incident? I'm talking here about the children at that school, about the young girls who go by there, and so on. Can you confirm for me that there will never be an incident?

Ms. Johanne Vallée: Mrs. Mourani, we unfortunately cannot confirm that for any of our offenders. Whether we're talking about pedophiles or offenders who've committed other types of serious offences, we can never confirm that kind of thing. However, we can confirm our commitment to carefully selecting the inmates who are referred to those places and our commitment to supervise them effectively.

Mrs. Maria Mourani: I appreciate your honesty.

Ultimately, you're saying that you can't confirm a zero risk for us. The risk is always there. Consequently, you'll understand the concern of people who want to resort to prevention. So much the better if measures are taken to avoid a disaster, but are we going to wait for a disaster to occur in order to act? I frankly admit to you that, in my opinion, that isn't being done at your level. You aren't the ones who issue a directive concerning the CCC. That will be done at a higher level, and I respect that.

So I'm going to move on to another point, with your permission, Mr. Chairman.

We visited the SHU. I found the place very interesting and also very secure. And that's a very good thing. I don't doubt that state of affairs. However, we asked to see the segregation area, but that wasn't possible because an incident was in progress. One question troubles me. In a place as secure as that, inmates are alone and virtually never see each other. I was told they spend approximately 23 hours a day in their cells. When they take programs or courses, they are behind a bullet-proof window. So they have no contact with anyone, perhaps apart from the guards who bring them in and take them out. There's even a wall in the middle, between the cells, which prevents them from seeing each other.

Why are they confined in segregation when they are already so isolated? I didn't really understand. The SHU is already a form of segregation in itself.

[*English*]

The Chair: There is time for a brief response. You're out of time.

[*Translation*]

Ms. Johanne Vallée: They occasionally go out. They have common areas. I don't know whether you noticed, but there are common areas that inmates on the same side share. This is a small group. I don't remember exactly the number of individuals involved. Incidents may occasionally occur when inmates refuse to obey an order to enter their cells, for example. Then we're forced to use pepper, in particular. There may be friction at certain times. It's rare, but it can happen. The inmates come from across Canada. We obviously try to manage the incompatibilities, but sometimes it's a bit volatile. Then there's a little friction, hence segregation.

● (1630)

[*English*]

The Chair: Thank you.

Mr. McColeman, please.

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

I would like to thank the witnesses for appearing here today. Thank you for giving us your time and your expertise.

As part of the preamble to my question, I just want to let you know that we're not fixated on the number of inmates. What we're fixated on is making sure we're providing the best mental health and addiction services we can to inmates.

On that point, I would like to make a comment on page ten of your report. The statistics, as I read them, are quite impressive. They're quite impressive in terms of the outcomes and the results you're having with the continuum of care you outline. I'll just refer to page seven of your report, which talks about the teams of people involved: nurses, behavioural counsellors, parole officers, psychologists, and correctional officers who review the cases every two weeks. These teams are to be commended because of the results showing up.

My question has more to do with what more we can do. That's what we're here to study. What more can we do to have successful outcomes? I guess it's a two-part question in one way. Having been involved in my community with mental health issues, on balance I think the services we're providing to reintegrate people into the community, compared to the population with mental health issues who aren't criminal offenders.... We're doing a fantastic job in a comparative situation.

Do you ever compare the outcomes of people who have committed crimes and are reintegrated to those with mental health issues and successful outcomes in the community?

Ms. Christine Perreault: I would need to go back to the statistics we do have. Do you now want to know if offenders with mental health issues will be more inclined to recidivism? Is this what you want to know?

Mr. Phil McColeman: Not really recidivism as much as positive outcomes to overcome their mental health challenges.

Ms. Christine Perreault: Yes, because they are never cured.

We need to do the follow-up. It's a lifetime project for them. This is why we need to build stronger links with the provincial mental health agencies and resources, because at the end of the mandate they're going to need this support from the mental health agency.

Something I do know is that we are under the impression—and I will have to check with the numbers—that right now the problem we are facing with offenders with mental health issues is that they are coming back behind bars. They are suspended more frequently than regular offenders.

I don't know if you are interested in this.

● (1635)

Mr. Phil McColeman: Yes.

Ms. Christine Perreault: The problem we do have is that when you go back into the community you are confronted with all the stressors, which has a huge impact on people with mental health problems. There is a link with the motivation, the treatment adherence, the acceptance of the illness. Sometimes they don't understand what we do expect from them. Sometimes it's just a problem of understanding the rules in a CCC or a CRC. It's just understanding what is expected of them. And sometimes they are in breach of conditions just because of that. They are suspended and they come back behind bars because for the moment these are the means we do have.

This is a huge problem we are having with people with mental health problems. It's just that they don't understand, and we are still working on adjusting the way we are taking care of them in the community. So they don't reoffend more, but they are suspended more just because of that. It's a breach of condition, but only based on a lack of understanding of what we are expecting from them.

And sometimes they will go back to self-medication, because for someone with a mental health problem, going back to substance abuse is a slide that one can take very easily. That's because self-medication makes it sometimes easier to deal with that and it masks the mental illness. So they will go back to substance abuse and they will abandon their medication. They don't understand what we are expecting, but it's not in the anti-social frame of mind. They don't understand, period.

Mr. Phil McColeman: You say in the last paragraph that shorter sentences are more frequently the case. You talk about how the system could improve, perhaps helping people on shorter sentences within our institutions. One line that popped off the page for me is “ensuring that these offenders are in the right program, at the right intensity, at the right time”. That is so salient to our discussion about looking for ways we can improve the system.

Do you have any thoughts you'd like to share with us about how to improve delivery of services in terms of timing?

Ms. Christine Perreault: We're going to have a new way of dealing with correctional programming. We're going to work with domains. We'll have an integrated approach to correctional programming that will be more efficient.

Right now there is overlap in our programs, so we will have a more integrated approach that is domain-focused. In different correctional programs you can find the same domains that are targeted with intervention from all the professionals working in the correctional programming. So now it's going to be more integrated. It's going to be by domains, and we'll be able to put more people in programs. The level of risk with the level of intervention, according to the research, is very important. For high risk, a high-intensity program works better. So we have to do that, keep that, and stay on that track. If it's a shorter sentence we need to go faster; start at the very beginning and do programming with them from the very beginning.

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

Mr. Desnoyers.

[*Translation*]

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

Welcome.

At the community correctional centres, we're talking about thousands of offenders under your responsibility, either internally, or on parole, or day parole, etc. My questions concern the usual number of offenders under the permanent care and custody of every person who works in those community centres. What is the standard?

Then, when the person winds up on the outside, when that person leaves the rural centre, does that standard change? Does the correctional officer or the person who takes care of that person receive additional assistance in handling the individual, and even more as the situation progresses?

Ms. Johanne Vallée: Mr. Desnoyers, you're challenging me. Oh, oh!

I never calculated the resources in that way. I can tell you that, currently in the Quebec Region, we have 3,331 inmates—and that may vary from day to day, depending on the number of individuals released and incarcerated—who are actually in institutions, in penitentiaries, and we have approximately 2,100 parolees in all of Quebec. To supervise those 5,000 or so individuals, we have approximately 4,105 employees in Quebec distributed as follows: 1,882 correctional officers—and that can also vary from day to day, but that's an average—203 nurses, 85 psychologists and 102 program officers, parole officers. I've never made that connection, but obviously in the penitentiaries, you have to understand one thing—and I always say this to people who don't know them well—it's like a hotel, 24 hours a day, 7 days a week, with food services and all that entails in custody terms, both in the penitentiary and within its perimeter.

The ratio will obviously be a little lower at a community correctional centre, apart from the Martineau CCC for specialized care where there is specialized staff: a health care centre open 24 hours a day, 7 days a week. However, there is always surveillance, 24 hours a day, which is provided in all community correctional centres. We have parole officers and program officers at the community correctional centres. When I say "community correctional centres", I'm really talking about everything that is done in the community, under supervision.

● (1640)

Mr. Luc Desnoyers: When a person winds up on the outside, I imagine it's the same rule for women as for men, as regards services and staff. It's the same rule for aboriginal offenders as well, I imagine. There aren't any different rules.

Ms. Johanne Vallée: There aren't any different rules in that sense. There are different rules from the standpoint of a number of employees, which will vary.

More employees will obviously be working at a maximum-security institution, such as Donnacona and Port-Cartier Institutions, for example, because they are, precisely, maximum-security institutions.

Mr. Luc Desnoyers: All right. When someone leaves the institution to go back to the community... You mentioned a partnership between community agencies.

Is there a big rotation in those agencies and do they maintain the same service as that provided in community centres? I imagine that, in mental health, as you said earlier, a major follow-up must be required with regard to medication and so on.

However, when it comes to community agencies, major cuts have often been made and agencies have therefore disappeared. Hasn't that created situations in which it is more difficult for your service to maintain services?

I am continuing along the lines of a question that my colleague from the Liberal Party asked you earlier. Some bills currently before the House of Commons will definitely result in an increase in the number of offenders. You said you were studying that and conducting analyses. Would it be possible to have copies of those analyses?

Ms. Johanne Vallée: First I'll answer your first question. As regards the community agencies that work in partnership with the Correctional Service, I would say that Correctional Service Canada has excellent partnerships with the agencies.

I'll tell you about Quebec. The partnership with the community agencies has definitely been in existence for more than 40 years, across all of Quebec. In Quebec, we have what's called a "tripartite agreement", which involves both the Government of Quebec, the federal government and the community agencies. That tripartite agreement provides for service standards to ensure quality of service, whether it be at a community correctional centre or at a community residential centre. The community residential centres belong to the community and are managed by volunteer boards of directors. However, within those agencies and houses, it's the professionals who provide the services: criminologists, social workers and psychologists.

I believe that the funding granted to the community agencies could be increased, and that's an issue in the discussions that we constantly have with them. However, the level of funding has enabled us to stabilize the community agencies in Quebec. So we have partnerships such as that with the Montreal YMCA, a partner in business and in the supervision of our offenders in the community for more than 35 years.

[*English*]

The Chair: We'll have to wrap it up here. I'm sorry, but you're two minutes over.

Go ahead, Mr. MacKenzie, please.

[*Translation*]

Mr. Luc Desnoyers: All right, but the last question I asked concerning... I don't want her to tell me about analyses; I want her to send me copies of the analyses.

[*English*]

The Chair: I'm sorry, but you have no time. We'll have to come back to you.

Go ahead, Mr. MacKenzie.

● (1645)

Mr. Dave MacKenzie: Thank you, Mr. Chair.

I want to make one thing perfectly clear: my friend and I understood that you're far too young to know when the provincial institutions close.

I enjoyed your information because I think it's very valid information. As my colleague said, we want to know what we can do to improve the mental health and drug addiction situation in the prisons. One of the things we've seen as we went across the country, and even in some other countries, is that retention of professionals in the health care field gets very difficult, it seems. It may be even more difficult when the institutions are located outside urban areas, because there's an attraction for professionals to work in urban areas.

Could you elaborate, in French or English, about what you see in Quebec with respect to being able to first get and then retain professionals to assist in those areas?

Ms. Christine Perreault: In Quebec we are in a much better position than the rest of Canada in terms of recruiting nurses, mental health nurses, psychologists, psycho-educators, and the mental health specialties we need. It is very hard to recruit people for Port-Cartier, which is a maximum institution. There are offenders with mental health problems there, so it's not easy to recruit. But we are in a much better position.

In fact with the institutional mental health initiatives we were able to staff.... We have 24 mental health specialists who we were able to add to our regular staff during the last two years. We were quite lucky in Quebec to get those people. I'ts the same with community mental health initiatives.

A better way to keep people—it's very easy to get them sometimes, but we want to keep them—is diversification of the tasks they have. It's the training. It's working on the culture also, because working in corrections when you are a mental health specialist is not always easy. So we are working on the culture. We are training our people. We give them the possibility of changing their workloads and the people they work with.

So I guess in Quebec we are in good shape.

Mr. Dave MacKenzie: Can you illustrate if there is the ability to do those things when you are closer to an urban area, as opposed to being out in the—

Ms. Christine Perreault: It's much easier. We can have a relationship with universities and we can have students come in to do their internships. So yes, it's easier.

Mr. Dave MacKenzie: I think we see that where there tends to be an opportunity to work with universities and community partners it's far easier to build those partnerships in an area where partnerships can exist.

Ms. Johanne Vallée: Yes, because you have a diversity of partnerships also.

When we have specialists, like psychologists, working in an institution in northern Quebec, it's important to support them and to make sure they will not be isolated from other professionals in their field of expertise. As an organization, we need to build that kind of partnership to attract and retain them.

It's also difficult because of what we see right now in the health care system. The competition is quite aggressive—for example, in Port-Cartier we have one institution and one hospital and they both want doctors, nurses, psychologists, so the market will compete to attract them.

It's very difficult. I think that in building partnerships we will be in a better position to retain people and to stabilize the quality and the services to offenders. That's one of the biggest priorities we have.

We need to stabilize the team. We had a discussion before we came, and our challenge now is not only to hire the people but to stabilize the team. With the demographic, there are a lot of people leaving the organization right now and we have hired a lot of new people. Younger generations know they can work there and have all sorts of opportunities.

This is the kind of discussion we sometimes have with human resources—what we can do, how they can support us, innovative ways to manage human resources.

● (1650)

Mr. Dave MacKenzie: Is it fair to say that's it's not only compensation but lifestyle that's important to people?

Ms. Johanne Vallée: Oh, yes. If you are coming from the University of Ottawa and we offer you a job in Port-Cartier, if you don't know the community and you have problems integrating into the community, certainly it will have an impact.

Mr. Dave MacKenzie: It's the same kind of scenario as in communities that are a bit outside the norm—not outside the norm, but smaller communities that have difficulty in attracting medical practitioners.

Ms. Johanne Vallée: Yes. An institution we have, La Macaza Institution, had a lot of problems in attracting psychologists and has built a partnership with the Université du Québec à Trois-Rivières. They have marketed the fact that if you want to live outdoors and near Mont Tremblant, you can do it there, and at the same time, they have maintained a good relationship with the university, so the psychologists who work at La Macaza are not isolated and can work with their colleagues at the university. I think we also need to do that elsewhere.

The Chair: Thank you.

We'll move to the Liberal Party now.

Mr. Wrzesnewskyj.

Mr. Borys Wrzesnewskyj (Etobicoke Centre, Lib.): I am passing on my time to Ms. Mourani.

The Chair: Ms. Mourani.

[*Translation*]

Mrs. Maria Mourani: I have a brief question on administrative segregation. During our tour, we talked to various caseworkers. Many of them told us that the use of segregation in mental health cases was not really a good idea. I was speaking with the chaplain at the SHU, I believe. He told me that, on the one hand, segregation was a disaster for individuals with mental health problems, because it aggravated those problems. Sometimes individuals arrived at the SHU without any mental health problems but after a while went crazy. That's what he told me. When I questioned the psychiatrist who was there, she hesitated on that point.

I would like to know whether Ms. Perreault, who deals with the psychologists and psychiatrists, and Ms. Vallée can tell me whether segregation is really effective in treatment terms.

Ms. Christine Perreault: Your question is very complex. You just mentioned the SHU. Currently, there are 20 offenders in administrative segregation at the Special Handling Unit and two of them have mental health problems. Segregation, the removal of stimulation, is a significant contextual variable which can contribute to the disorganization of certain individuals who have mental health needs. However, that helps other individuals.

We're working on this issue, and the number of offenders who have mental health needs and who wind up in administrative segregation is falling. There's a decline. As a result of new mental health services being put in place in the regular institutions, we are working against the use of administrative segregation as a way of solving problems. Instead we are working on a different therapeutic proposal. The idea is to provide mental health nursing care. The psychological approach and participation of the parole officer are combined in this case. Currently, the number of individuals who are in administrative segregation because they have mental health problems is declining. That's one of our goals.

● (1655)

Mrs. Maria Mourani: How long has it been declining?

Ms. Christine Perreault: The Institutional Mental Health Initiative is two years old. It's a gradual decline.

Ms. Johanne Vallée: I'd like to add something. We can see the contribution of the Institutional Mental Health Initiative. It was adopted in 2005 or 2006, but the resources appeared later. It in fact took time to hire and train the staff and develop a genuine multidisciplinary team spirit. Now we're seeing very concrete results, including this.

Mrs. Maria Mourani: If I understand correctly, you are working from the assumption that a person suffering from mental health problems must be segregated as little as possible. That is why you established this Initiative.

Ms. Christine Perreault: That is indeed one of the expected results. There are many others, such as adherence to treatment, better understanding of the illness, better symptom management and so on. The fact that individuals are no longer confined in administrative segregation because they have mental health problems is definitely one of the desired objectives. We are gradually achieving it. Administrative segregation is not where they should be. It is not a quiet place, like a spa. You're not comfortable there. And yet, certain individuals in administrative segregation did not want to come out because their mental health problems were comfortable. In the case of other individuals, it had a totally disorganizing effect. That is why I say that we can't say it's good; it depends on the case. However, now that offenders are breaking the administrative segregation cycle because they have mental health problems, they no longer want to return there because they have found another type of structure; they've found help.

Mrs. Maria Mourani: Is this typically Quebecois or is this the way it is in the entire Canadian system?

Ms. Christine Perreault: It's a pan-Canadian trend to seek refuge in administrative segregation in order to manage one's symptoms and go unnoticed so that people leave you alone.

Mrs. Maria Mourani: I'm talking about the Initiative—

Ms. Christine Perreault: Yes, it's pan-Canadian, with the same objectives.

Mrs. Maria Mourani: One of those objectives, in particular, is for there to be as few segregation cases as possible.

Ms. Christine Perreault: That's one of the effects we want to see. In fact, it's an objective. It's one of the direct effects that correctional officers can see: less use of force and less confinement in administrative segregation for those people. That's one of the preventive effects that we can see in short order.

[*English*]

The Chair: You'll have to just wrap it up.

[*Translation*]

Mrs. Maria Mourani: How do you go about administering the act you have to administer, and the Quebec health legislation? You have to administer two acts, if I'm not mistaken. How do you do that?

Ms. Christine Perreault: We can't answer that question in five minutes. From the moment someone is no longer capable of consenting to treatment, is no longer right in his mind and cannot consent to treatment, the provincial act applies. At that point the doctors, psychiatrists and psychologists have other professional duties. As long as someone is capable of consent, has his mind intact, and refuses treatment, we can continue all our practices. However, when someone no longer has that capability, the provincial legislation comes into play. It's a very complex issue.

Mrs. Maria Mourani: I know. Thank you.

[*English*]

The Chair: Thank you.

Mr. Norlock, please.

Mr. Rick Norlock (Northumberland—Quinte West, CPC): Thank you very much, Mr. Chair, and thank you to the witnesses for coming.

I have a few different questions in different areas. The first is that we had a witness here not too long ago, a very fine witness who has settled a lot of her addiction issues and is of value in helping other people in similar circumstances. I was intrigued when we spoke to her about methadone and the methadone treatment and she said one of the reasons she became addicted to heroin was her use of methadone. I just wondered if you had similar experiences. What's your experience with methadone and this treatment, and have you seen that sort of reverse of the norm in your institution?

Ms. Christine Perreault: I will have to get back to you on this. Sorry, I don't have that kind of information.

Mr. Rick Norlock: You don't use methadone treatment?

Ms. Johanne Vallée: We use methadone, but we cannot answer your question.

Mr. Rick Norlock: You don't know its efficacy?

Ms. Christine Perreault: We know about the efficacy, but I thought you were talking about provoking the counter-effect.

Mr. Rick Norlock: Yes, that was one thing. But in general, what is your experience with the treatment? Is it positive? Do you believe there are alternatives, or is it just part of the tools in your valise of treatment?

● (1700)

Ms. Christine Perreault: We don't have numbers about this now. It's a good question. We'll have to get back to you. We are using methadone as a treatment, and it's working, and it's helping a lot of people stay away from substance abuse.

Mr. Rick Norlock: I don't need the numbers. I just need your general—

Ms. Johanne Vallée: Okay. It's working. It's part of our tool kit, if I can say that, and it's working fine in our institution but also in the community when we have to supervise offenders. It's probably one of the best tools that we have to manage their drug addiction. Again, you need some support. You need to make sure they will be supported, they will be seen by nurses, and they will be monitored. Otherwise, it's a bit like the mental health—if they stop that's another game. But I have to say it's working quite well.

Mr. Rick Norlock: Thank you very much.

I'll move on just briefly to isolation. I know the use of isolation is usually a last resort, but before we become so negative towards it, I can recall when we went to Dorchester Institution, we met with some inmates. One of the inmates said sometimes he would go to his doctor, practitioner, psychologist and ask if he could be alone for a while, and it was considered isolation. My feeling was that it was rather healthy that the person knew that he just needed it.

I also know, because I deal with people who work in an institution in my riding, and I speak to many of the men and women there and often the shop stewards of the union, and quite frankly, the people who work there feel there are times when a person needs to be in isolation for the safety of the people who actually work in the institution. There seems to be a difference—and I can appreciate that difference—because one of the witnesses who came here said they didn't have isolation any more, and it was very difficult for them to get the people who work in the institution to accept the abolition or the gradual abolition of isolation.

I wondered what your experiences have been surrounding that.

Ms. Christine Perreault: You're right. From a clinical point of view, sometimes we need to be left alone, because there is what we call therapeutic heat, there is too much intervention; it's well documented in the research, and sometimes they need to be left alone. But it needs to be part of a plan, meaning that this is what the inmate with mental health issues will try to do before he asks to be voluntarily placed in his own cell with his stuff. If he doesn't succeed in putting all those strategies in place, he will be able to go into his cell on a voluntary basis and they will close the door and he will be monitored for a certain period of time. After that, there will be a meeting with the mental health team to find out if this time away was beneficial, is part of the plan, and next time do we need to do that again.

But that's not what we call segregation in terms of the legal status of segregation. It's a clinical treatment when we do that, and it's voluntary. As long as it's voluntary and it's part of a plan and it's part of something we're going to try, and after that there is an assessment, we are in treatment here. So we need that. We need to have this period, this time out for many people with mental health issues. Yes, you're right. But it's not segregation. They're not losing all their personal belongings. They're not put in a range with other inmates who might be very disturbing, who are there because they did something against the internal rules. They're not very happy with the system, so they're not calm. So that might be very disturbing for someone with mental health issues.

Mr. Rick Norlock: Do you, Madame Vallée, have experience with your unionized staff who say that in some circumstances they believe segregation is necessary for their safety or the safety of other prisoners or even the safety of the inmate himself or herself?

● (1705)

Ms. Johanne Vallée: It's part of the tools we have when the staff and other offenders are being threatened. Sometimes we don't have any choice; we have to use segregation. But again, you need to monitor segregation. You need to make sure the person won't be left alone and you need to understand why exactly he behaved like that and to address that within the correctional plan. But segregation, unfortunately.... It's like the institution: we may say we don't like penitentiaries, but human nature is such that sometimes we need to put people aside. It's the same within an institution.

The Chair: You're over your time, Mr. Norlock.

That takes us through our lineup.

Does the Liberal Party have any more questions? No more questions.

Does the Bloc Québécois have any more questions?

Mr. Desnoyers, how long do you need? I'm just trying to indicate to Mr. Davies if he has any more....

[*Translation*]

Mr. Luc Desnoyers: Mr. Chairman, I would like to make sure of one thing. Following my last remarks, Ms. Vallée talked to us about analyses that had been conducted on various bills that might substantially increase the number of offenders. I would like to have copies of those analyses.

[*English*]

The Chair: Okay. You heard that request. Thank you.

Mr. Davies, do you have any more questions, or are you ready to wrap up?

Mr. Don Davies: I'll be quick, Mr. Chairman.

Just briefly, I've been interested in segregation, and I think it may not be helpful when you talk about solitary confinement generally, because I think the details are where it matters. Would you agree with me that long-term solitary confinement—it seems to me from what I've heard from witnesses—is not helpful as a carceral tool? Would you agree with that?

Ms. Johanne Vallée: We need to monitor segregation to avoid long-term segregation, and that's why I was saying segregation is the last tool we have, but there shouldn't be long-term segregation. In our region we have a regional segregation committee that meets on a regular basis and analyzes each case. Sometimes we are faced with a situation when the offenders for all sorts of reasons don't want to leave segregation, whether they are afraid of others, whether they have some debt. We need to address that. We need to make sure the case management team will meet them on a regular basis, and we need to find alternatives to segregation.

Mr. Don Davies: If that's the case, if someone doesn't want to use segregation, surely there is no need to keep someone in a cell that has nothing in it. I've seen segregation cells; they're cement walls with nothing in them. If a person is in there to avoid a debt, what is the purpose of keeping them in a room that has no stimulation whatsoever?

Ms. Johanne Vallée: What I mean is that sometimes the person doesn't want to leave segregation. That's what I meant.

We are facing different challenges with segregation. Sometimes it will be a mental health case. It won't be segregation; it will be clinical isolation, because the person needs to rest, in a way, and to be left alone and apart from the rest of the population. That's one thing.

Sometimes we use segregation to manage behavioural problems or disciplinary problems. That is something else and has other rules. We also need to make sure, even if it is because a person is aggressive, that we manage that. We cannot leave people in segregation for a long term without monitoring them. We need to address that. We need to look at alternatives. Should we transfer them? Should we ensure a smooth reintegration to a sector in the institution? Should we change the sector where a person is being held? We need to look at alternatives.

Then we have a small number of offenders who, for different reasons, don't want to be in contact with the rest of the population, and they will stay in isolation and segregation. We need to go to them and try to understand why they are so afraid of being with the rest of the population. What can we do? Sometimes what we do is find another inmate who will be able to act as a peer, and we'll try to convince the person that he can go live with the rest of the population. We'll monitor that person.

● (1710)

The Chair: Thank you.

We'll have Mr. MacKenzie, please.

Mr. Dave MacKenzie: Thank you, Chair.

I'd just like to go back, if I could, to the methadone issue, because I think it is a very important tool, obviously, as you said. One of the questions we have come up with is how we end up getting people off methadone. We've substituted methadone for the opiates. I was there when our witness the other day indicated that she was on methadone after childbirth. My understanding is that methadone may have come into play during the Second World War as a treatment for pain.

All we're doing is switching from an opiate to methadone. If we don't have any means to get them off it, are we not perpetrating long-term issues? Or is it something we shouldn't be concerned about?

Ms. Christine Perreault: Again, I am not a specialist on methadone.

Some people on methadone will phase it out and won't need methadone any more. I guess that is the purpose and the target. But there are people who will have to stay on methadone for a long period of time. It depends on the importance of their addiction and on the personal resources they have. It's a very complex question, and I don't have a satisfying answer for you. I'm very sorry about that. We know that we have people on methadone who are less violent. They are away from substance abuse, and it is having an effect on their behaviour. So for safety inside and outside, it's helping them.

I cannot go further. If you need more information on methadone, I will....

Mr. Dave MacKenzie: I think we may have some other witnesses coming on that issue, but I just wondered if you had any sense of it from your personal experience.

The other issue we heard about in one of the institutions was trafficking of methadone inside the facility. They now insist that people who receive the methadone stay in the.... Is it the same issue?

Ms. Johanne Vallée: It's the same issue.

What we do is try to make sure that they stay in the room under supervision for a while, and we try to make sure that they take their methadone. Unfortunately, again, it's human nature. If they have drug addiction problems or they want to make quick money, sometimes they will try to do that. I don't think it's something we see often. On the other hand, it is true that we have to supervise.

Ms. Christine Perreault: It's not only a matter of security; it is also a matter of health care. When you take methadone, you have to stay under supervision for a certain period of time just to make sure that you are okay. So we can meet both purposes. It's a matter of security and health.

Mr. Dave MacKenzie: Do you have a fairly constant number or percentage of people who come into the institution either on opiates, with addictions, or already on methadone?

Ms. Christine Perreault: We'll provide numbers for you.

Mr. Dave MacKenzie: Thank you.

My other comment would be with respect to segregation.

I know there are lots of people out there who don't work in the institutions who have opinions about what we should do with isolation or segregation, or whatever it might be called. We certainly went to two other countries, Norway and Great Britain, and in both cases we heard that they are doing better than us. I rather doubt that's true. When we went there and started to dig below the surface, we found that they use similar facilities to what we use, and I believe for many of the same reasons.

Certainly I know that in institutions we saw in Canada we have some people who wish to remain segregated for their own safety. I think when we were in Kingston there were several. If some of those folks were out in the general population, I don't know how we would protect them, and they obviously feel the same way. I saw just recently where an inmate in an institution is now suing because of not being protected.

Do you have any sense of where we would go in terms of turning some people into the general population, who for their own safety don't want to be there?

● (1715)

Ms. Johanne Vallée: You have to manage your population, that's for sure.

Regionally, we manage the population. We have a regional management population committee, and on a regular basis, with the support of the security and intelligence officers, we'll gather information on the population and try to be sure that by putting different kinds of inmates together we won't create a bigger problem. So we manage that.

Also, locally, at the institutional level, you need to manage your population to make sure that you don't have too much incompatibility among offenders, and again, to use all sorts of strategies to reduce the level of segregation. Sometimes it's true that they are afraid, but sometimes they are afraid for bad reasons—because of perception of the population; because they don't know exactly how they will integrate—and you need to support them and to monitor that. That's why we have a peer program in Quebec in some institutions where other offenders will support the reintegration in the wing of the other offenders.

We cannot avoid segregation, but we truly need to monitor it.

Mr. Dave MacKenzie: I think it's fair to say that the people running the institutions and the people working in the institutions would like to find other means but sometimes don't have those means, whatever they may be, out there. You use all the tools you have, but sometimes it just comes down to needing to find that space to have someone isolated from others.

Is that fair?

Ms. Johanne Vallée: I don't think it happens a lot.

Mr. Dave MacKenzie: No, but there are times, and that's what we saw in England. They told us exactly the same story, and then you find that they have a room in that manner. And in Norway also.

The Chair: We're going to have to wrap it up. The bells are ringing.

Thank you very, very much. We appreciate you coming before the committee. You've had a lot of questions here and things have gone well. Thank you again.

The meeting stands adjourned.

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