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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 bring this meeting to order.

This is the Standing Committee on Public Safety and National Security, meeting number seven. We are continuing our study of federal corrections, focusing on mental health and addictions.

We would like to welcome our witnesses for the first 45 minutes of our meeting. Ms. Oades is deputy commissioner for women. Ms. Jackson is the director general of clinical services. Ms. Thompson is regional director of health services for the prairie region. We welcome you all.

Do any of you have an opening statement?

Mrs. Jennifer Oades (Deputy Commissioner for Women, Correctional Service Canada): We do, for five minutes each.

The Chair: Go ahead. Thank you.

Mrs. Jennifer Oades: Thank you.

Good afternoon, Mr. Chair and committee members. I'm pleased to have the opportunity to appear before you today to discuss issues related to the federal population of women offenders.

In my brief opening remarks, I don't want to repeat what the previous deputy commissioner for women related to you at her appearance last November. I'll instead use my time to bring you up to date on a number of developments in the women offender file over the past five months.

First of all, I understand that the committee had the opportunity to visit a number of our institutions late last year, including Okimaw Ohci, our aboriginal healing lodge, and the regional psychiatric centre in Saskatoon, where we have the Churchill unit dedicated to the treatment of women offenders who require intensive mental health care. As such, you were able to see two very different approaches to managing our complex and diverse women offender population. If the committee members intend to visit one of the five regional facilities for women to expand your knowledge of how we manage the majority of incarcerated women offenders in our care, I would certainly be pleased to organize that for you.

The area of mental health continues to challenge us. We are committed to look for new strategies that will work for everyone: the women offenders, CSC staff, and the general public. To this end, we are working with our research branch, particularly in a project to develop a national profile of the mental health needs of women offenders. This will help us to better target our interventions and provide more effective counselling and programming to the women in our custody and in the community.

We are also examining how we manage women who pose a high risk to other offenders and CSC staff. We are currently using a system called the management protocol. It has come under criticism from the Office of the Correctional Investigator and the Canadian Association of Elizabeth Fry Societies, among others. CSC agrees that the approach is not ideal and we are currently reviewing our strategy to move away from the management protocol. We have been engaged in national consultations with various stakeholders and experts over the past few months. I expect to receive a report of their findings in the near future, which will help guide the development of an alternative and more comprehensive approach that is more in line with a fully integrated correctional plan.

As part of CSC's transformation agenda, we are now in the final stages of implementing a community framework for women offenders that will provide more support and opportunities for these offenders when they're conditionally released into the community. Over half of the federally sentenced women are in the community. This framework will affect most of the women under our care. I am exceptionally proud of this new model that will enhance the continuum of care for federally sentenced women, better support their transition into the community, and help to achieve greater public safety results for all Canadians.

I continue to work closely with my colleagues in health services, the Office of the Correctional Investigator, and our other partners to ensure we exchange information and best practices on how to effectively manage our more complex cases. To this end, I hold teleconferences and face-to-face meetings on a regular basis with the wardens of women's institutions and other officials as needed.

I would like to state in closing that I'm delighted with the challenges this new job entails. I'm very excited to be part of the group of CSC staff who work every day to improve the lives of our women offenders and help them return to the community as law-abiding citizens.

Thank you.

● (1535)

Mrs. Kate Jackson (Director General, Clinical Services, Correctional Service Canada): Ms. Thompson and I are pleased to appear here before you to discuss issues related to the opiate substitution program for the offender population within the Correctional Service of Canada. The commissioner, Mr. Don Head, and the assistant commissioner of health services, Ms. Leslie MacLean, appeared before you in June 2009 and provided with you with information about the mental health strategies and initiatives within CSC. Today we will brief you on the CSC's opiate substitution program.

Injection drug use, primarily the practice of sharing injection equipment, is a major risk in the transmission of infectious diseases such as HIV and hepatitis C. Substance abuse is also a factor contributing to the commission of many crimes. Providing an opiate substitution treatment program to federal offenders helps to reduce the demand for drugs, thus improving our ability to contribute to public safety.

Research has shown that active participation in opiate substitution therapy is associated with positive release outcomes for offenders. Johnson et al. (2001) found that offenders who had participated in a methadone maintenance treatment program while incarcerated were 28% less likely to be returned to custody after release to the community than offenders who had not.

l'II provide you with the background on the program. Originally called the national methadone maintenance treatment program, it was implemented in two phases. In 1997, phase one allowed opiate-addicted offenders who were in a community methadone program prior to being sentenced to be considered for continuation of methadone treatment. Phase two, announced in May 2002, increased CSC's capacity to initiate treatment of opiate-addicted offenders requesting methadone if such treatment was deemed medically appropriate.

In December 2008 the methadone program was renamed the national opiate substitution treatment program because of the addition of an alternative opiate substitute medication called Suboxone.

When used in conjunction with cognitive programming, intensive monitoring, and support, opiate substitution has been found to be extremely helpful for opiate-dependent persons. These medications can help free the opiate-dependent person from the continuous cycle of withdrawal and opiate use. Stabilization on opiate substitutes allows offenders to concentrate in school and participate in programming and work, thus increasing their ability to actively engage in their correctional plan.

Prior to initiation of treatment, a detailed health and mental health assessment is conducted with each offender to determine whether the offender meets the necessary criteria, such as whether the offender has received from a physician a diagnosis of dependency to opiates. Congruent with community practice, the assessment process includes a review of the rules of the program outlined in a treatment agreement between the offender and care providers, outlining what each commits to, including the requirement for ongoing monitoring.

In 2009-10 the cost of CSC's opiate substitution program was over $12 million. As of January 2010, there were 701 offenders on opiate substitution therapy across the country, of whom 55 were women offenders. Due to offender flow-through, over 1,000 offenders are managed on the program by CSC every year. CSC's opiate substitution program is managed in a multi-disciplinary team approach, with involvement from case management, programs, and health services, and in accordance with national guidelines.

In 2009, of the 512 offenders who were admitted to the CSC opiate substitution program from the community, most were received from provincial correctional facilities. The majority of these facilities provide treatment to offenders who are already on methadone in the community. For those offenders entering CSC already on methadone, CSC maintains their treatment while they undergo assessment to ensure they meet the program criteria.

To ensure safety and security, offenders are observed for 20 minutes after taking their methadone, which reduces the risk that offenders will divert the medications. A nurse provides each dose directly to the offender and watches the offender swallow the medication. The offenders are observed for 20 minutes to ensure that most of the medication is absorbed.

All offenders in treatment are expected to participate in regular substance abuse programs, which are specifically geared to opiate dependence and delivered by trained program delivery officers. An offender's progress is monitored and reviewed on a regular basis through meetings with their individualized intervention team.

The opiate substitution program is subject to regular medical and institutional reviews to provide early identification of areas of concern, tailor educational training sessions for staff, and modify procedural policies.

Extensive preparation is done for any offender being released to the community on opiate substitution to ensure the transition is smooth and continuity of care is maintained. This process starts at the onset of initiation into the program. The availability of a community provider is reviewed and confirmed six months prior to release.

Thank you.

● (1540)

The Chair: Ms. Thompson, go ahead.

Ms. Heather Thompson (Regional Director, Health Services, Prairie Region, Correctional Service Canada): I have no opening comments.

The Chair: Okay.

Then we'll go over to the official opposition for a seven-minute round of questions and comments.

Mr. Holland, please.

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

Mr Chair, I'm going to start the meeting actually before my time, if I could, with just a point of order.

I think it's important that we have disagreements in this committee about whether or not one another's policies are better than another policy, but I think inferring motive on another member is very problematic. As members of this committee, Ms. Glover and I both did a forum, and it was stated that the reason why we have the policies we do is because we have a conflict of interest. We support criminals because they vote Liberal is what was said.

Mrs. Shelly Glover (Saint Boniface, CPC): Nonsense.

Mr. Mark Holland: It was said. It's part of the record.

Let me say this, Ms. Glover: you're a good person. I do not question your motives. I disagree with policies that you may advocate, but I never question your motives. The idea that somehow I care less about my children or my family than you do yours does a tremendous disservice to this process.

I would simply ask that Ms. Glover correct the record on that. It was an unfortunate comment, and I would ask her to correct the record. The exact words were that the Liberals have a vested interest because prisoners vote for Liberals. This is what you said.

I just think that this is the sort of discussion that infers motive on other members and I think is very disappointing. I would ask you, Ms. Glover, to retract the statement.

The Chair: I'm not sure that's a point of order, Mr. Holland. I don't see how that's a point of order.

Go ahead and ask your question.

Mr. Mark Holland: It was for me.

The Chair: Go ahead and ask your question.

Mr. Mark Holland: To the witnesses, thank you for appearing before committee today. I'm greatly appreciative of you taking the time.

One of the things that concerns me, obviously, is that more than 80% of our inmates are facing addictions issues. So they're coming into our facilities often because they're facing addictions problems. The chief way of dealing with addictions that has been introduced by this government has been to try to shut down access. There's been an enormous amount of money spent on that. Now, we know that the drug usage in prisons in 2005 was 12% in random urine test samplings, and in 2008, which is the last date we have data, it is now up to 13.2%.

You know how much has been spent on these efforts to clamp down, and given the fact that drug use in prisons has actually gone up in this period of time, how would you assess the efficacy of that spending?

Mrs. Kate Jackson: I think what we can say is that we have evidence to show that the substance abuse programs that offenders are involved in generally result in positive results. For the offender, they're better able to participate in programs and they have a better release—

Mr. Mark Holland: Sorry, I don't mean to interrupt, but I think you misunderstood the question.

I'm very much in favour of the programs that help rehabilitate inmates. I'm talking about the principal money. I'm wondering if you know the figure of how much has gone into trying to stop and clamp down drugs coming into the system. There's been a tremendous amount of money spent to stop drugs coming into the system, and yet drug usage rates over the last number of years have actually increased at the same time. So I'm asking for your feeling on the efficacy of that spending.

Mrs. Jennifer Oades: I don't have the numbers of how much, but we can get them for you. There has been a huge effort over the last few years in terms of drug interdiction, new processes, including drug dogs, etc. So we can provide you with those numbers. We can probably provide you with updated.... You're suggesting that the urinalysis reports are indicating that they still show a high level of offenders using drugs?

● (1545)

Mr. Mark Holland: Right.

Mrs. Jennifer Oades: I don't know that it is still the case, but we will look into it and get you that material.

Mr. Mark Holland: Thank you. Another thing that is of great concern and that witnesses will be discussing later is the prevalence of both HIV/AIDS and hepatitis C, and infectious diseases generally within the prison system. As an example, we know that some 30% of the prison population has hepatitis C and that HIV rates are actually ten times higher than in the average population.

Often what people don't think about is that given that 91% of inmates will eventually be released into society, this poses not only a health threat inside the prisons but a serious public health threat outside the prisons. So given the fact that we have witnesses coming here later on today to say that the rate of infectious disease is accelerating, not slowing down, what specifically are you doing to stop the spread of infectious diseases in our prisons?

Mrs. Kate Jackson: I think there are a number of health promotion initiatives within the prisons to help reduce the spread of infection. We do health education for inmates. One of the objectives of the methadone program is to help reduce the spread of infection, to reduce the demand for injected drug use. We also provide some preventive devices such condoms, dental dams, and immunization programs, which also help reduce the rate of infection.

Mr. Mark Holland: How well resourced do you feel those programs are, and how would you assess the efficacy of those programs, particularly in light of the fact that we are seeing infectious disease rates continue to climb in our prisons and be at such a staggeringly high level relative to the rest of the population?

Mrs. Kate Jackson: Right, and some of that is not just the spread within the prison but the population that's coming in, their behaviour. Generally speaking, the risk behaviours of the offender population is much greater than the risk behaviours of the population at large prior to admission to the institutions. We're continuing to monitor the efficacy of the different programs we provide in the prisons to try to see what the outcomes are and to try to improve those programs based on the results and also based on the efficacy of programs outside the prison environment.

Mr. Mark Holland: Mrs. Oades, on the issue of mental health specifically, we know that female inmates are more prone than others to face mental health issues. One of the things police officers are telling us is they don't have facilities for the mentally ill and the prisons end up becoming a repository, a de facto mental institution that is not properly resourced. Given the fact that now more than 20% of women are facing serious mental health issues, and there are suggestions it's even higher because of lack of proper diagnosis, can you assess the efficacy of efforts to this point to find other avenues to help women who have mental illness to not end up in prison? What do you feel has to be done to bring down those dangerous numbers?

Mrs. Jennifer Oades: I think up to 24% of women now being admitted to federal prisons have a serious mental health disorder. We're not talking just anti-social personality disorders, but serious disorders.

It is a huge concern. It remains an enormous challenge. I think when Commissioner Head was here not long ago.... It's trying to find that balance: how good do we want to be in terms of a mental health institution, because then it becomes de facto, but we also have to do something for these women offenders, who clearly need assistance. It's trying to find that balance.

In terms of the community part of it, so they don't get to a prison, that has to be an initiative that would involve all levels of government, probably likely private sector, a voluntary sector.

There is not an easy solution to this burgeoning crisis.

● (1550)

The Chair: Thank you very much.

We'll go over to the Bloc Québécois. Monsieur Desnoyers, please.

[*Translation*]

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

My first question is similar to my colleague's. I really wonder about that topic.

How can we prevent drugs from being brought into prison? It seems to me that prisons are highly secure places. How is it possible for drugs to be brought in? I must admit that I am not aware of the methods used to do that. I am not sure if you know them. Whatever they are, they worry me. If we stopped this process from the start, we would solve many of the problems.

Mrs. Jennifer Oades: Yes.

Mr. Luc Desnoyers: Like my colleague, I would like you to provide us with the reports and the exact numbers. Could you tell me what is being done and how much money is being spent to get the situation under control? When it comes down to it, we are investing millions of dollars, but if we put a portion towards that, we might not need to invest that much money elsewhere.

[*English*]

Mrs. Jennifer Oades: I will briefly say that I have done quite a bit of work with jurisdictions around the world in a previous job with a correctional NGO. I would like to say that we have not yet found a prison around the world that has been successful in keeping drugs out of prisons, despite everybody's best efforts. We continue to have drug dogs. We have made enhancements at our principal entrances in terms of the equipment, the threat risk assessments that are being done now, and the ion scanners.

Short of shutting down a prison and never letting a visitor, a volunteer, or anyone in, I think it will be impossible, regardless of our best efforts. There's a lot of creativity out there in terms of how to get things in. Things are being thrown over the fence. It's difficult. We do our best.

[*Translation*]

Mr. Luc Desnoyers: Do you have any statistics showing whether we have succeeded in reducing drug smuggling?

[*English*]

Mrs. Jennifer Oades: I think there are some statistics that I have seen recently. I will find out and get back to you about it. I know we do a report every day in terms of contraband—either coming in, being thrown over the fence, or however it gets there—that's been seized or found through cell searches. Having received reports over some time, I am seeing an increase in the amounts of seizures.

[*Translation*]

Mr. Luc Desnoyers: As far as you know, has introducing methadone treatment helped to reduce the spread of infectious diseases in correctional facilities?

[*English*]

Mrs. Kate Jackson: Certainly the evidence in research conducted in various jurisdictions has shown that people on methadone are less likely to.... The whole purpose of having people placed on methadone is to reduce their need for drugs, which results in risk behaviours related to infectious diseases. So yes, we do believe that.

[*Translation*]

Mr. Luc Desnoyers: Is it difficult to stop taking methadone once you start that program?

[*English*]

Mrs. Kate Jackson: Generally speaking, methadone is prescribed for people with a diagnosis of opiate dependence. This goes above and beyond just abusing opiates: you are dependent on opiates. It's a long-term treatment. Generally speaking, it's not something that you go on and then go off. It's a substitute for an opiate. The effect does not provide the euphoric high that you would get using an opiate. It stops the craving and it also stops the withdrawal. It allows a person to stabilize so that they no longer go through the cycle of craving a drug and withdrawing from the drug.

There are instances, though, where people either voluntarily or involuntarily stop the program. In those instances, working very closely with the physicians, the drug is tapered very, very slowly to reduce the symptoms of withdrawal, but people still experience withdrawal.

● (1555)

[*Translation*]

Mr. Luc Desnoyers: You said that it is a long-term treatment. How long does it last?

[*English*]

Mrs. Kate Jackson: Some people are on it for 10, 15, 20 years, or for life.

Mr. Luc Desnoyers: Years.

Mrs. Kate Jackson: Yes.

[*Translation*]

Mr. Luc Desnoyers: In the correctional investigator's last report, methadone treatment was one of the inmates' main reasons for complaints. Why are they complaining about this treatment?

[*English*]

Mrs. Kate Jackson: I'm sorry, I'm not familiar with the specific complaints they were commenting on. I'd have to know some more specific complaints.

The complaints we hear from offenders, generally speaking, have to do with wait times. Sometimes they may not be happy if they aren't admitted to the program, or things like that. Without knowing the specifics, it's hard to comment.

[*Translation*]

Mr. Luc Desnoyers: Do we see the same types of problems with men and women, whether in terms of drugs being brought into prisons or the access to various treatments for drug use? Are there any statistics about that?

[*English*]

Mrs. Kate Jackson: As a sample of how many women on methadone, on average we have about 700 offenders on methadone; in January there were 719 or so, and 55 are women.

[*Translation*]

Mr. Luc Desnoyers: Okay.

[*English*]

Mrs. Kate Jackson: Proportionally, I'd have to do the math.

[*Translation*]

Mr. Luc Desnoyers: Is smuggling drugs into correctional facilities as prevalent for women as it is for men?

[*English*]

Mrs. Jennifer Oades: Yes, it is.

[*Translation*]

Mr. Luc Desnoyers: So we can say that we have an equitable system; we let as many drugs in for women as for men.

Mrs. Jennifer Oades: Exactly.

[*English*]

The Chair: Thank you very much.

Mr. Davies, please, for seven minutes.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you for being here today.

I heard one of you say, and I was writing quickly but I think I got the essence, that sharing paraphernalia is a major source of disease transmission. I'm going to just read a brief quote from a submission we got from the senior policy analyst of the Canadian HIV/AIDS Legal Network, where it said:

> Substance abuse is a contributing factor for the criminal behaviour of 70% of people admitted to federal institutions. Because of the scarcity of needles and syringes in prison, people who inject drugs in prison, including those with addictions, are more likely to share injecting equipment than those in the community, thereby increasing their risk of contracting HIV and HCV.
>
> Programs that ensure access to sterile injecting equipment are therefore an important component of a comprehensive approach to reducing the vulnerability of incarcerated people to HIV and HCV infection.
>
> The best available evidence strongly suggests that in countries where prison-based needle and syringe programs exist, such programs reduce risk behaviour and disease, do not increase drug consumption or injecting, do not endanger staff or prisoner safety, and have other positive outcomes for the health of people in prison including increasing referrals of users to drug addiction treatment programs.

I'm just wondering if any of you would like to comment on that. Is that accurate or not accurate?

Mrs. Kate Jackson: That's a different question from what I thought I might get.

I think there has been research to show that providing safe and sterile equipment in some environments does reduce the infection rate. However, within CSC our harm reduction strategies include, as I mentioned before, such things as education, training, and we do provide dental dams and condoms, and we do also provide bleach. But currently we do not have a needle exchange program.

Mr. Don Davies: The last sentence of the quote—and I'm sorry, I didn't mean to hold this back, but I think it's important—said:

> These findings were confirmed in prison needle exchange review of the evidence, a 2006 review by the Public Health Agency of Canada undertaken at the request of Correctional Services Canada.

Are you familiar with that report? Okay.

The reason I ask is that we're opposed to drugs in prison, but we have methadone, and methadone is an opiate. We are opposed to sex between inmates in prison, yet we have dental dams and condoms. We are opposed to having paraphernalia in prison, but we supply bleach. This committee saw a rig, a very grotesque homemade piece, that was shared by inmates, passed among the inmates.

I'm just wondering, does it not make sense to go that final step, if drug use is going to happen in prison, to ensure that at the very least we're not spreading the disease? As pointed out by my colleague, it's something that will spill into the general population and become a public health issue as well. Is that not a logical conclusion?

● (1600)

Mrs. Kate Jackson: I think at this stage of the game, based on the evidence, CSC, in terms of harm reduction, does have a few initiatives in place, which I've stated, but we currently do not provide a needle exchange program or other such paraphernalia.

Mr. Don Davies: I want to shift to mental health.

We had Mr. Sapers appear before our committee last June. I'll quote what he said:

> This problem is compounded by the inability of the Correctional Service to recruit and retain trained mental health professionals, and by security staff that are ill-equipped to deal with health-related disruptive behaviours.
>
> For example, the majority of a psychologist's day within the Correctional Service of Canada is spent conducting mandatory risk assessments to facilitate security for conditional release requirements rather than treating or interacting with offenders in need of their clinical help.
>
> Those offenders who have acute needs or who require specialized intervention may be sent to one of the five regional treatment centres; however, this is only if they meet the admission criterion that they possess a serious and acute psychiatric illness. Typically, however, the offender is monitored at a regional treatment centre only to be returned to the referring institution after a period of stabilization. Driven by volume, the regional treatment centres have become a revolving door of referrals, admissions, and discharges.
>
> The overwhelming majority of offenders suffering from mental illness in prison do not generally meet the admission criteria that would allow them to benefit from the services provided in the regional treatment centre. They stay in general institutions, and their illnesses are often portrayed as behavioural problems.

It's not mental health issues per se.

That seems to jibe with my own observations when I participated in the prison tour. We have a lot of people with mental illnesses. We are not doing a very good job providing intermediate mental health care and we are not actually providing a lot of counselling and therapeutic time. Is that something you see from your point of view?

Mrs. Jennifer Oades: I'll start, and I'll let the experts finish.

The mental health file is certainly a huge challenge. Intermediate care is the bigger challenge. I think we are getting better at it. We have received funding to get better at it over the past couple of years.

Part of the problem has been the actual assessments. We now have a system in place that is done right at intake. We know as early as possible if the person has a mental health disorder or not. We can then start working at that right away, rather than waiting.

Mr. Don Davies: Do you mean for women or do you mean in general?

Mrs. Jennifer Oades: That is generally.

For the women, you haven't been to one of our facilities where there are structured living environments, which is very much seen as a Cadillac model for an intermediate care facility. It has been recognized internationally. It was recognized by the Glube report. It was recognized by Her Majesty's prison inspector.

Mr. Don Davies: Is that in B.C.?

Mrs. Jennifer Oades: No, there is one in every single regional facility, other than Okimaw Ohci. It's a house. It is staffed 24/7. It's been set up a little differently.

Mr. Don Davies: How many inmates in total are in those across the country?

Mrs. Jennifer Oades: There are 40 beds in total across the country. For five institutions, there are eight beds in each one.

Mr. Don Davies: How many women are incarcerated across the country?

Mrs. Jennifer Oades: There are 492 today.

Mr. Don Davies: I have one last question. One thing I've heard is that practically every woman in prison has suffered a trauma. It's probably an exaggeration, but I think it makes the point. We can certainly agree that the vast majority of women in prison have had some type of severe trauma. Do you have any special programs or advice to give this committee on how we could better respond to treat female offenders who have suffered from serious trauma?

● (1605)

Mrs. Jennifer Oades: You might be exaggerating as to all of them having suffered trauma, but there are certainly many more incidents of women who have suffered physical abuse, mental abuse, or sexual abuse at some point in time before becoming inmates. It is even higher when you look at the aboriginal offender population.

Mr. Don Davies: What percentage would you use?

Mrs. Jennifer Oades: I'm not sure I have that with me. I can check, but I would say it's somewhere around 70 percent. I can find out for you, but I don't have it.

The Chair: Okay.

Mrs. Jennifer Oades: We have a number of programs they can take. The new “Spirit of a Warrior” program, which was actually developed by the Native Counselling Services of Alberta, certainly has a component to address that aspect, because it is more of a holistic program. We also have counselling and trauma services available in every one of our institutions, should they wish to partake in those programs.

The Chair: Thank you very much. We're over time here.

Mr. McColeman, please.

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

Thank you to the witnesses for being here today and taking the time to share your expertise with us.

There was a reference in one presentation to the drug Suboxone, and that's the first time I've heard of it. Perhaps other committee members heard of it for the first time. I'd like to find out a little bit more about this drug. Obviously, we know about methadone, but is this something new? Is it cutting edge? And what does it do—obviously the same types of effects, outcomes, but how does it differ from methadone?

Mrs. Kate Jackson: Without getting into a lot of technical detail, it's a slightly different chemical compound, but it works very much the same way as methadone, and it's administered differently.

We introduced it because it's starting to be introduced in community programs and in other programs outside the correctional environment. It's been shown to be an effective alternative sometimes for people who can't tolerate methadone, or if for some reason methadone doesn't work for them.

We currently only have one person on Suboxone.

Mr. Phil McColeman: Is it taken orally, like methadone?

Mrs. Kate Jackson: Yes. It's placed under the tongue, as opposed to swallowed.

Mr. Phil McColeman: You mentioned, and I'd like you to expand a little bit more on it, what is referred to in the presentation in the very next paragraph, and you said “When used in conjunction with cognitive programming”.... Can you expand on what the cognitive programming is?

Mrs. Kate Jackson: Just at a high level....

Ms. Heather Thompson: We're not the experts in programming, so I want to say that up front. Cognitive programming looks at skill development and lifestyle management to deal with some of the issues that may have started them using drugs.

Mr. Phil McColeman: Okay.

The next question is relating to the long-term dependency. As you've said, many people never get off their dependency on the methadone or the alternative opiates. These are probably expensive drugs, I would think. Are they covered under health plans for them after they're released?

Mrs. Kate Jackson: Yes. There are many community methadone clinics that run just like our program. When we developed our program, we developed it based on models out in the community. So there are a lot of methadone programs covered through provincial health care systems.

Mr. Phil McColeman: Okay.

I want to pick up on my colleague's comments about what I'll call the needle exchange programs—I forget the right words—that some institutions have. When we were touring some of the prisons, it was brought up by one of the wardens, I believe, that having a program would greatly endanger people because of the safety issues involved with providing needles to inmates.

I'm wondering if you have any comments with that side of the story in terms of how that's managed and whether or not the guards and others would have a concern because these items would be accessible to the inmates.

● (1610)

Mrs. Jennifer Oades: I'm not going to speak on behalf of all staff, but I'm sure a significant number of them would raise some concern about needles or any other sharp and pointy thing.

Mr. Phil McColeman: Have any of the unions who represent these workers, to your awareness, made any comments about these programs?

Mrs. Kate Jackson: I'm not sure.

Mr. Phil McColeman: You're not sure. Okay. You're not here, obviously, to answer that question.

In the presentation of the deputy commissioner, you mentioned managing more complex cases. One of the observations in touring the facilities was that certain of these more complex cases take up inordinate amounts of the time of programming and management and resources in institutions. You talk about it in terms of some of the transition agendas you're going through. Learning best practices is referred to in your comments about these. Can you share with us any kind of insight on how to be better control those more complex cases, the cases that are so hard to manage in terms of the behaviour of inmates?

Mrs. Jennifer Oades: I think so. I'll try.

They are very much a challenge, and there are very few of them, which makes it even more difficult to come up with some concrete ideas.

One of the major problems we have is the actual structure itself. I would include infrastructure, and I would talk about the model too. I think we really have to look at something quite different for some of these complex cases.

As I said, on the management protocol, we're not particularly pleased with the results we've seen. We are moving away from it. There is an ongoing external review into long-term segregation. We will use their findings to help inform us. We have consulted with the correctional investigator and with other stakeholders to look at what would best work for these very challenging cases.

Mr. Phil McColeman: I appreciate that. I appreciate also that you're working on those models for best practices that would focus on, first of all, the safety of the individual and the people around them in most of these cases, and then also the kinds of therapies they require.

Mrs. Jennifer Oades: Yes, you're right, but we also have to think that whatever we build on in terms of an incarceration period will have to be supported once that person leaves. It's no good doing one thing in one end of the system and not having the ability to then support that on the outside when they are eventually released. And most of them will eventually be released. There's going to have to be some groundswell of support from the community in terms of assisted living units, supported housing, more efforts to support these women when they are released.

Mr. Phil McColeman: Do I have more time, Mr. Chair?

The Chair: To be fair, you could have another minute, because everybody else ran over by one minute.

Mr. Phil McColeman: That's very nice of you. Thank you so much.

I hear exactly that, that this is a much broader continuum of care that is required, particularly in the case of people who have severe mental illness and it's recognized early and up front when they're admitted to the institution and in setting out their programs.

Are these typically repeat offenders? Are these people you see repeatedly in the institutions?

● (1615)

Mrs. Jennifer Oades: For women, no, they're not. Most women actually are serving their first federal sentence, 53% of them for a violent offence. But on average, for most women, it's their first time in the federal system.

Mr. Phil McColeman: Would they have gone through the provincial system in a lot of cases?

Mrs. Jennifer Oades: Some of them, yes, but in comparison to our male offender population, they haven't been through the provincial system as much as the male offender population has.

Mr. Phil McColeman: Thank you.

The Chair: Thank you very much.

I'd like to thank you all for appearing before this committee. It was a short and sweet session. You've given us some valuable information and I thank you very much.

Mrs. Jennifer Oades: Thank you.

The Chair: I'll ask our next witness, Mr. Penner, to come forward, please, and we'll begin the next session.

We welcome Mr. Bruce Penner, the general manager of Canadian operations at Momentum Healthware.

Committee members, we tried to translate the materials this morning but were unable to do so. The powerpoint presentation has not been translated and is not available in both languages. Is it okay with the committee if we proceed with the translation taking place from anything the witness says?

[*Translation*]

Mr. Mark Holland: That is fine.

[*English*]

The Chair: Okay, there are no objections.

Go ahead, sir.

[*Translation*]

Mrs. Maria Mourani (Ahuntsic, BQ): I have an objection.

[*English*]

The Chair: Shall we suspend for half an hour, then? Will there be no presentation?

[*Translation*]

Mrs. Maria Mourani: Mr. Chair, can you hear me?

[*English*]

The Chair: Yes.

[*Translation*]

Mrs. Maria Mourani: Since it is not in both official languages, I suggest that the witness make the presentation by simply looking at his laptop rather than using the projector. We will be able to understand what he is saying.

[*English*]

The Chair: Do you understand what that request is?

Mr. Bruce Penner (General Manager, Canadian Operations, Momentum Healthware): I do understand the request, and I came prepared to deal with this presentation in that way, if that's the wish of the committee.

The Chair: Okay. Everything you say will be translated.

Go ahead. We have a very short time here, so go ahead.

Mr. Bruce Penner: Fair enough.

The Chair: The order for questions in this round will be first to you, Mr. Holland, and then the Conservatives and then the Bloc. The NDP won't get a turn this time.

Go ahead, Mr. Penner.

Mr. Bruce Penner: I'll try to be efficient with my comments, but I would be remiss if I didn't begin by saying thank you to this committee for the privilege of coming to Ottawa from Manitoba to address my government.

You have had just a brief moment to see an untranslated picture of my family, and you would have seen that four of our children are Ethiopian, first-generation Canadians, and they're very proud of this country and the privilege that I have today to serve in some small way.

The reason I'm here today—and that brings me to my second thank you—is that Shelly Glover was in our offices a few weeks ago to present to Momentum Healthware a certificate recognizing Momentum Healthware as an innovation leader in Canada. That certificate also came with the recognition that you, our government, have invested in Momentum Healthware over the last number of years. Most recently you have spent $111,000 of National Research Council money to invest in the development of a mental health module for Momentum Healthware's health IT solution. That was recognized at a press conference. I want to thank you for that investment in our research and development and I want to give you at least some feedback on the effectiveness of that investment. We are now already moving into the pilot stage in Manitoba with our community mental health module. We've had expressions of interest from a number of other provinces, as well as New Zealand, for possible deployment of that module as well. So I think it speaks for itself that the National Research Council has invested well.

Canada is a country that has many jurisdictions in it. I recognize, as a health IT executive, that my job is in fact a very, very simple job compared to the role that you have and that the executives who sat in these chairs before me have, in terms of forming policy and respecting the incredibly complementary but sometimes conflicting values that come from the different jurisdictions we are made up of. As an IT solution provider, I have often found in my experience in the health IT sector that as I come into different sectors of health care—Momentum Healthware's solutions span long-term care, home care, community care, community mental health, palliative care—in each of these sectors of care and each of these forums of care, the health care providers use a different language to describe their activities. They use different processes to provide care to their clients. One of the things that we've done with the software solutions is we've really focused on trying to abstract that or reduce that down to what things are common across the different health care sectors, and create a solution that is highly translatable. It's translatable among sectors of health care and it's also translatable among different languages in order to be able to provide a single repository for health information to the multiple health care providers.

As a citizen of Canada, it's something I'm very conscious of. At the same time, I'm also a citizen of Manitoba. In my early years as a child growing up, I was educated on the God's River First Nation, so I also have both an allegiance and interest in the first nations communities of Canada. Each of those communities will treat me as a stakeholder to some extent. The work that you're doing with Corrections Canada also deals with, again, those same citizens. For them, you also represent an important stakeholder in their health care.

What we try to do with the software solutions that we've developed—and I want to really treat this as general information available to you—is really highlight the fact that information technology is a determinant of health care. There are so many different things that you have the opportunity to review as determinants of health care, and I would submit to you that this information is perhaps one of the greatest determinants of health care.

● (1620)

If you were to ask health care providers in any sector of care whether they would appreciate or benefit from or whether the care of their clients would benefit from the knowledge of the other health care providers in the continuum of care, whether they are federal or provincial or whether they work for an aboriginal healing centre or within a correctional facility or a parole centre, every health care provider would understand that the care they provide would be better, more informed, and more effective if they were able to have access to the information that was provided by the other health care providers who are caring for that same client.

I'm reminded of an Indian fable—and in this case I mean Indian as in India—a story about six blind men who discover an elephant and seek to define it. One of them defines it as being very much like a tree because he has come across the leg of the elephant. One of them describes it as being very much like a wall because he has come across the side of the elephant. One of them describes it as a spear because he has a tusk in his hand. One of them describes it as a rope because he has encountered the tail. They then get into heated debates about what exactly an elephant is. Is it more like a spear or more like a tree? None of them is capable of seeing the whole elephant, and it blunts their ability to have an effective discussion about elephants.

I want to offer my services to you this afternoon to inform your discussion about how health information technology could serve to bridge the gap between federal correctional institutions and community mental health.

We have developed a software solution that has the capacity to model the health care delivery system in any form of care. I did go through the effort to develop some slides for you that demonstrate the ability to deliver care within a correctional facility. It's not necessary for the purposes of the discussion to simply understand that the same client can be seen in different forms of care and can be treated by different teams of providers. He or she can have selective information appropriately shared through the privacy and the security you define—or negotiate with the other health-care-providing constituents—to deliver the most effective care and to be able to most effectively understand what the elephant is that you're trying to understand in each individual case.

I'll limit my comments to that and make myself available to any questions.

● (1625)

The Chair: Thank you very much.

We're in five-minute rounds now.

Mr. Kennedy.

Mr. Gerard Kennedy (Parkdale—High Park, Lib.): Thank you.

Mr. Penner, welcome.

I was born and raised in The Pas, Manitoba, so it's good to see a fellow Manitoban here.

I understand you're a health information services provider. Have you formed any opinions about the availability of information, the degree to which integration is available within federal corrections? You said you had some slides, but we didn't see them.

Some of the preceding witnesses were talking about aspects of the problem, and the specific thing we're looking at is addictions and mental health, to what degree there is knowledge of the problems, to what degree there is action about it, obviously what is effective and what isn't, specifically methadone and other drug treatments. There are also public safety concerns as well as individual concerns. I think there seem to be some missing pieces.

Have you been able to come to any understanding about what goes on in corrections in terms of the work you have done on your own software?

Mr. Bruce Penner: Certainly.

I was paying rapt attention to the previous witnesses and took some statistics from their conversation, like the statistic that 24% of the women in their particular form of care had significant mental health issues. I recognize that the 24% of that population are likely or ultimately going to be released back into the community or into residential care facilities within the community.

I certainly have done no assessment of the quality of information systems within the correctional system. In terms of my assessment, I am aware, again from the previous witnesses, that they have developed standardized assessments and are finding them to be very effective when women are being taken into the process. Obviously information technology is just a tool, but it is a great tool for taking standardized assessments, collecting information in a way that can easily be shared where appropriate, and then informing future decisions as you start to try to understand the impact of assessment, recovery planning, and outcomes.

I'm not well informed in the area of how much information technology has taken hold in the correction system. Anecdotally, it seems to be limited, but I haven't researched it.

● (1630)

Mr. Gerard Kennedy: Okay.

There was a pledge in the 2008 budget of about $500 million to develop the Health Infoway, which I'm sure you're versed in and at least somewhat oriented to, whether provincially or nationally. That money has yet to flow, for a variety of reasons.

What can you tell us about the development within Manitoba? Because provincial health systems often make their own decisions independently of that federal funding. Is there an idea about what the plan looks like? Have you heard nationally how that fits with Manitoba's system? Again, I'm not trying to pigeonhole you just because you're from Manitoba, but it may be a health system you're more familiar with. Nonetheless, from whatever purview, what is that federal money going to be used for? How effective can it be? Can it help us with the problem we're looking at today? You touched on that in a general way.

In the private sector, in the community helping to develop these various potential solutions, what is the anticipation and knowledge of where that $500 million—a fair bit of money—needs to be, and when will it be available?

Mr. Bruce Penner: There are a few answers to that question. First, to the degree that I am conversant with where Manitoba is planning to target that funding, I do understand it has been targeted significantly to primary health care. I think there's a real sense that it has to be targeted in significant blocks of funding to deal with significant issues that need to be dealt with so that you're not spraying it all over the place.

There are two components to the Health Infoway funding block that are of potential specific interest to this topic. There's an innovation component and an interoperability component, both of which might well be tapped to enhance innovation and sponsor or fund the interoperability of health care systems between the different forms of care. I don't know to what extent Health Infoway funding is applicable to the Correctional Service of Canada, but that does seem like a very useful place to look at potentially fostering interoperability between systems.

The Chair: You have ten seconds.

Mr. Gerard Kennedy: Do you have faith in the system coming together? Because outside observers have been working on health information systems for a long time, and we have this big delay with the $500 million. Can it come together? Do you have faith that there can be a system that has interoperability and really does enhance the existing system?

Mr. Bruce Penner: Do I have—

Mr. Gerard Kennedy: Your own sense, as a practitioner.

Mr. Bruce Penner: My sense is that Health Infoway is funding the big blocks of repositories and electronic health records, which can draw the national eHealth population health records together. What it has not done and what at this point I do not see it focusing on yet are some of the grassroots systems that will form the record of care delivery at the grassroots level. I think this primary care investment is a beginning in that direction.

The Chair: Ms. Glover, please.

Mrs. Shelly Glover: I want to welcome you here today, Mr. Penner. Thank you very much for taking part in these discussions. I was quite impressed with the presentation. I actually got to see the presentation, which brought to my mind what's been repeated in this study continually, and that is continuum of care.

To me it was significant to have been able to see the slides showing that not only can you capture, retain, and track the health treatments and the proposals that have been made by different health officials, and what's worked and hasn't worked, but also to have been able to see that we can track information from places like the correctional service, the police, and other inter-agencies that will be functioning in tandem because they care about the individual suffering from mental illness.

I believe in trying to find solutions to problems. We've heard a number of times here from witnesses that they're still using paper files. Of course, in corrections, it's very difficult to get a paper file from one jurisdiction to another or to track someone effectively and quickly. That's why I believe that electronic records are something that ought to be considered so we can quickly get that information, which might lead to our better serving someone who is suffering from mental illness.

We just heard one of the deputy commissioners indicate that they must do an assessment in the prison system, which can be time-consuming. In your system, I believe that will reduce the time taken, because you're going to have access to previous treatment, what did and didn't work, and the diagnosis, of course, which will obviously help them treat that person more quickly.

Am I assessing your program correctly?

● (1635)

Mr. Bruce Penner: Yes, absolutely, and you of course have the singular benefit of having actually been able to see it on the screen.

If it would serve the committee's purpose, and I certainly don't want to impose in any way, I would be more than willing to go through the effort of doing those translations, and being able to come back at some future point and more effectively inform the complete committee. I will absolutely take your guidance on that.

The Chair: Let me interrupt here for a minute.

We can actually translate and distribute it to the committee. You've given us a copy in English. Thank you.

Mrs. Shelly Glover: The other thing I found very interesting was the fact that you can actually track things that have been tried and the results from these trials. For example, we talk a lot about segregation with regard to mentally ill people in the corrections system. it's very important, from what our witnesses have said, to know exactly how they react to segregation. Some willingly ask for segregation for particular reasons. Again, if they're transferred from jurisdiction to jurisdiction, that information is invaluable, I believe, to making sure they get the treatment that will help them become more proficient in their lifespan. Our goal, of course, is to help them free themselves of the criminal justice system and to be able to be productive individuals.

I did want to share that with the committee, because I did have an opportunity to see the slides. I believe that this could be potentially an answer to that question of continuum of care that continually is coming up. Everyone seems to acknowledge there is a gap in communication between every agency that deals with the mentally ill person.

Can you tell me, is anyone using a similar copy of what you have produced right now?

Mr. Bruce Penner: Yes. The continuing care solution, which is a platform that exists across the continuum of care, has been in place in various jurisdictions for 15 years. Most specifically, this recent module for community mental health is now going live in Winnipeg, and as I mentioned earlier, we have significant expressions of interest from around the world for deploying this.

Where the interest comes with the community mental health module is the ability to integrate it within the home care and long-term-care systems, although not so much within the palliative care system, but essentially across those other forums of care. There is the opportunity to also integrate it into the correctional system, where, again, mental health is clearly a significant element of the interaction.

Mrs. Shelly Glover: There is an essence of it having already been somewhat tried and true, and now we're just building on it to include perhaps corrections and mental illness and what not.

I just want to correct what Mr. Kennedy had to say, in saying that the money is flowing. I know that electronic records in fact exist in many provinces. I'm not entirely sure why Mr. Kennedy believed otherwise. Nevertheless, it is flowing and it is actually improving the situation in our health care system across the country. I believe there may be an opportunity here to help in the corrections area as well as with other stakeholders who become involved with people who suffer from mental illness and addiction, including police officers and parole officers, etc.

I have a technical question. Do I still have a couple—

The Chair: Very briefly.

Mrs. Shelly Glover: Then I won't ask it, because it's going to take more time. I know there was a slide presented, but I really do think if you have an opportunity to see this program, it could be an answer to many of the questions about continuum of care that we've addressed here.

● (1640)

The Chair: Thank you very much.

Ms. Mourani.

[*Translation*]

Mrs. Maria Mourani: Thank you, Mr. Chair.

Good afternoon, Mr. Penner. Thank you for coming to talk about your project. I must admit that I do not really understand. Obviously, it is a bit more difficult without the transparencies.

Does your software make it possible to gather all the information about a person with mental health problems?

[*English*]

Mr. Bruce Penner: Yes.

[*Translation*]

Mrs. Maria Mourani: It is like an electronic chart. Is that right?

[*English*]

Mr. Bruce Penner: That is correct. It gives you an electronic record of what you would otherwise store in a paper chart. In some instances, it is implemented so that it can be complementary to a paper chart. In other words, some processes can remain in a paper form, and some processes that are intended to be shareable or widely distributed can be in electronic form. In some instances, we have deployed the software in a completely paperless environment, where there is in fact no paper.

[*Translation*]

Mrs. Maria Mourani: If I understand correctly—tell me if I am wrong—your system is presently used in health care in Winnipeg, in community organizations.

[*English*]

Mr. Bruce Penner: Correct. It's just beginning.

[*Translation*]

Mrs. Maria Mourani: It is a start.

[*English*]

Mr. Bruce Penner: Yes.

[*Translation*]

Mrs. Maria Mourani: You know that the Correctional Service already has a computer system called OMS, the Offender Management System. Do you know that system?

[*English*]

Mr. Bruce Penner: I am not.

[*Translation*]

Mrs. Maria Mourani: It is a system that contains reasonably complete records of the offenders.

Generally, in health care, in hospitals—in Quebec at least, since I cannot speak for Manitoba—most records are computerized, but not all. I feel that there is still work to be done there.

I am trying to understand a bit how a system like yours would be beneficial for the Correctional Service. I am not able to understand that. I am trying to understand it.

[*English*]

Mr. Bruce Penner: I have one question. The system you referred to in the correctional system is a health care system, or is it limited to the correctional...?

[*Translation*]

Mrs. Maria Mourani: It is a complete offender management system. It has all the psychiatric and psychological records, the correctional plans, the notes of the case management officers and of the prison guards. Everything is there, and of course, the paper records are essential; they are also there.

For example, each health care unit has what we call a cardex, where records are updated and followed daily. Does that sound a bit like what you are doing?

[*English*]

Mr. Bruce Penner: So I now understand what is in place. The challenge that I see with the system—and you are obviously much more informed than I am about what is in place—is really the bridge between the correctional system and the community. I am not here to speak at all about whether or not the system you have in place inside the correctional facilities is an effective system. I can't speak to that.

This exists not just between the correctional systems and the community, it exists between psychiatric hospitals and the community as well. I know this first-hand. Again, it will be different from one province to the next. You are very familiar with Quebec. I am very familiar with Manitoba. But I know there are real challenges with the information flowing from the community into the psychiatric hospitals, and from the psychiatric hospitals back to the community. I am sure that is also true with the correctional system.

● (1645)

[*Translation*]

Mrs. Maria Mourani: You are raising an interesting point. From what I understand, your system allows you to keep groups, organizations, the hospital and other hospitals connected. There is a continuity in the information regardless of the organization.

What worries me is that the computerized system of the Correctional Service is currently internal, which means that only the branches of the Correctional Service have access to this system. So the hospital does not have access to the offender management system.

But do you not think that, due to data confidentiality, exchanging information could be a bit problematic?

[*English*]

The Chair: I'm sorry, but there won't even be time. We'll have to stop.

Do you have a brief comment, sir?

Mr. Bruce Penner: I have a very simple comment. The answer is, absolutely, you are right. The challenge is not on the technology side. The computers can share the information that you choose to share securely. The challenge is on agreeing to share; that's the challenge.

The Chair: Okay. Thank you very much.

This has been a very brief session, but we appreciate your coming in and sharing with us.

We'll suspend for a minute while we change witnesses.

●

(Pause)

●

The Chair: I'd like to reconvene the meeting.

I welcome our witness for our final session of witnesses. From the Canadian HIV/AIDS Legal Network, we have Ms. Sandra Ka Hon Chu. Thank you very much.

Maybe you can explain your position a little bit.

Mrs. Sandra Ka Hon Chu (Senior Policy Analyst, Canadian HIV/AIDS Legal Network): Sure. I have an opening statement, as well.

The Chair: Thank you very much.

Go ahead.

Mrs. Sandra Ka Hon Chu: Thank you, Mr. Chair and members of the standing committee, for giving us the opportunity to share some of our research on prison and HIV/AIDS.

I'm a senior policy analyst with the Canadian HIV/AIDS Legal Network. We're a human rights organization based in Toronto. We're a national organization that promotes the human rights of people living with and affected by HIV/AIDS. We do this through research and education, legal and policy analysis, education, and community mobilization.

We've studied the issue of HIV in prisons for many years now. More recently, we've focused on the issue of prison-based needle and syringe programs. In 2006, we released what was the most comprehensive international report on the evidence from prison-based needle and syringe programs around the world.

What the research demonstrates, as one of the last witnesses from CSC reinforced, is that there is no prison in the world where drugs do not exist. In spite of the many efforts of prison systems to prevent drugs from entering, drugs do come into prisons, and people use them. In our interviews with people who were formerly incarcerated, they often mentioned the availability of drugs and the fact that in some prisons, there are more drugs inside than what they have witnessed on the street. There's rampant addiction inside prisons. People inject drugs in prison, and they share needles because of the scarcity of sterile needles and syringes inside.

In 1995, CSC conducted a survey of drug use inside federal institutions. Thirty-eight percent of the people interviewed reported having used a drug since entering the institution, and 11% reported injecting a drug. This is quite an old study, as you can see. It's from 1995. We believe that the evidence today probably would indicate a much higher rate of injection drug use and needle sharing, given our interviews with people in prison. It's unfortunate. A 2007 study undertaken by CSC looked at risk behaviours and HIV and hepatitis C prevalence in federal prisons. It's about to be released in a week or so. If we were to have that information before us, I'm sure that it would reveal much higher rates of hepatitis C, HIV, and injection drug use.

As in many other countries, the rate of HIV and hepatitis C is much higher in Canadian prisons than it is in the population as a whole. I know that you've already heard from other witnesses that the HIV rate is at least ten times higher in the federal prison system. Hepatitis C is at least 30, close to 40, times higher in federal prisons than it is in the population as a whole. That rate has increased significantly in the last ten years. In 1999, the reported hepatitis C rate was 20%, and now it's close to 30%.

We studied prison needle and syringe programs around the world to see what the evidence would reveal, how they were working, and whether they were effective in reducing syringe sharing and infectious diseases.

These programs were first instituted in 1992 in a prison in Switzerland. They exist in over 60 prisons in at least 11 countries around the world. Most recently, in January 2010, Kyrgyzstan announced a pilot program.

These prisons are in western Europe, in Asia, and in well-resourced and less well-resourced systems. They're operating in civilian prison systems and in military systems, in women's and men's prisons, in prisons of all security classifications and sizes, and in institutions with drastically different physical arrangements.

They've used various methods to distribute syringes. Some prisons use automated dispensing machines, where you have a one-to-one exchange with the machine. Some use health care units to distribute the syringes and needles through either the prison nurse or the physician. In some cases, peer health workers distribute them in a one-to-one exchange. And in some cases, external NGOs or external practitioners—health professionals—distribute the needles and syringes inside the prison.

Based on the programs that exist around the world, there have been a number of systematic evaluations of these programs, including by the Public Health Agency of Canada in 2006, as a member previously mentioned. What this evidence shows is that these programs reduce risk behaviour and disease, do not increase drug consumption or injecting, and do not endanger staff or prisoner safety. In fact, there's been no single case of a needle or syringe from these programs being used to attack a staff member—not a single case since 1992, when these programs were instituted. They have other positive outcomes for people in prison, including referrals to drug addiction treatment programs.

What's interesting, as well, is that in spite of resistance from correctional officers in some of these countries—Germany and Switzerland, specifically—they have come to learn that their own security is protected when these programs are instituted, because they're less likely to come across a needle that's been hidden in a prisoner's cell and be accidentally pricked. If they are accidentally pricked, for whatever reason, it's less likely that the needle has been distributed among many people and is infected with HIV or hepatitis C.

● (1650)

We feel that by refusing to implement prison needle and syringe programs, CSC is unnecessarily placing those individuals with the most severe drug dependence at risk of severe HIV and hepatitis C infection. Needle and syringe programs have been operating in the community for many years now. In 2001 there were 200 needle and syringe programs operating in Canada, with support from all levels of government—municipal, provincial, territorial, and federal. Many of the people who are entering prison are realistic. They are using these needle and syringe programs in the community, and when they're entering prison suddenly they're denied access to them.

Denying prison needle and syringe programs also discriminates against people in prison who embody many of the characteristics upon which discrimination is prohibited. We've heard, I think, from previous witnesses for the standing committee about the disproportionate representation of aboriginal people in prisons. They're disproportionately represented in federal prisons, disproportionately represented in the community among injection drug users and as people living with HIV.

It also has a disproportionate impact on women. I guess the last witness mentioned the fact that many women entering the federal system have a history of injection drug use, more so than the men incarcerated. They come with a history of trauma. A history of injection drug use is consistently found more frequently among women than men in Canadian prisons. The Canadian Human Rights Commission actually recognizes this, and I provide a quote from them, which reads:

> Although sharing dirty needles poses risks for any inmate, the impact on women is greater because of the higher rate of drug use and HIV infection in this population. This impact may be particularly acute for federally sentenced Aboriginal women.

Conversely, prison needle and syringe programs benefit not only the people who use drugs in prison, but also other prisoners, prison staff, and the public as a whole. With increasing rates of HIV and hepatitis C, society bears the cost of treatment for those who are infected. According to CSC, treating one person in prison for hepatitis C costs $22,000 and treating one person with HIV in prison costs $29,000 a year. So this is a lifetime cost. It is far more effective to provide sterile needles and syringes than to treat someone for HIV and hepatitis C infection.

I'm going to conclude with another statistic from CSC. In 2006 over 2,000 people were released into the community with hepatitis C and over 200 people were released into the community with HIV. Prison health is public health. There is no reason to treat prisoners who are struggling with addiction differently from people in the community who have access to needle and syringe programs. By reducing the risk of HIV and hepatitis C infection among people who use drugs in prison, all Canadians face fewer risks of becoming infected with HIV and hepatitis C.

That's my presentation. I'll take questions now. Thank you.

● (1655)

The Chair: Thank you very much.

We'll go over to Mr. Rathgeber first of all, please, for five minutes.

Mr. Brent Rathgeber (Edmonton—St. Albert, CPC): Thank you for your presentation and for your attendance here his afternoon, although I take issue with much if not everything that you just said.

I take it you will agree with me that acquiescence of drug use by prisoners is—

Mr. Mark Holland: Sorry, I don't mean to interrupt, but I have a point of order.

The Chair: A point of order, Mr. Holland.

Mr. Mark Holland: It's forever been our practice that when we have a new witness that we start just as we did with the last witness.

The Chair: In other words, then the government would never get an opportunity to question them.

Mr. Mark Holland: I'm not suggesting never, I'm just saying—

The Chair: Well, they wouldn't, because you're saying that we should start from the beginning. I've been going down the list for the whole meeting.

Mr. Mark Holland: Mr. Chair, maybe I'd refer the matter to the clerk. I have just never heard of this ever being done before.

An hon. member: No, we've never seen it before, ever.

Mr. Mark Holland: In the six years I've been a member, I've never seen this done before, Chair.

An hon. member: With a witness, you start again from the opposition.

The Chair: In other words, if you have half an hour, then the government would never get to question. That's what you're suggesting.

Mr. Gerard Kennedy: No, you divide it equally.

Mr. Mark Holland: I don't have a problem dividing up my time so we all equally get time before we go here. I can drop my time or whatever.

The Chair: I've been doing this all the time.

Mrs. Maria Mourani: Five minutes?

The Chair: If the committee agrees to that, we can do it that way.

Mr. Mark Holland: Yes, let's do it that way. I've just never seen it done before.

The Chair: I'll let Mr. Rathgeber continue, and then we'll come over to you.

Mr. Don Davies: Mr. Chairman, will we get five minutes for the New Democrats? How about five minutes for each party?

Mr. Mark Holland: Again, this is an issue of protocol. I have never in my life seen this before.

The Chair: Well, we haven't done this before.

Mr. Mark Holland: Well, we've done it in other committees. I'm just confused.

The Chair: I just thought it was the fairest way to give everybody a turn and then you keep going down the list.

Mr. Mark Holland: All right, fine. But really in the future let's please correct this. You start with the list when you have a new set of witnesses.

The Chair: I can try to give every party five minutes, if that's your wish. But I've been doing this and nobody objected.

Mr. Rathgeber, I'll let you start again and then we'll come over to the Liberals.

Mr. Brent Rathgeber: Thank you, Mr. Chair. I'm sorry that I have to start over again.

The duty to accommodate is basically what you're advocating for, to accommodate individuals with addictions inside our prison population. Is that correct?

Mrs. Sandra Ka Hon Chu: Yes. I'm basically providing them with the same tools that people in the community already have.

Mr. Brent Rathgeber: Would you not agree with me, though, that the duty to accommodate is inconsistent with the stated goals of prevention and treating addiction?

Mrs. Sandra Ka Hon Chu: I don't believe so, and I think that's not recognized in the community, when we have needle and syringe programs available for people with addictions.

Mr. Brent Rathgeber: I understand that those programs exist in the community, but that's not my question. My question is, is the duty to accommodate not inconsistent with the stated goals of dealing with addiction and prevention?

Mrs. Sandra Ka Hon Chu: I don't believe so. I believe that for many people there is not a willingness or perhaps availability of treatment. In those cases, when there are needle and syringe programs available, they reduce the risk of hepatitis C and HIV infection.

Mr. Brent Rathgeber: I read your report about there never being a reported case of a syringe or a needle being used as a weapon. But you are aware that very, very few assaults within prison are actually reported to prison officials.

Mrs. Sandra Ka Hon Chu: These are based on the systematic evaluations that have been undertaken in prisons where they've existed. So I would assume that they would take actual consideration of that issue, since it has been raised by correctional officers as something that they fear.

Mr. Brent Rathgeber: Right. So you're acknowledging that correctional officers have stated their objection to this type of program on the very ground that they're concerned about their own safety and about the safety of other inmates.

Mrs. Sandra Ka Hon Chu: This was the case in Germany and Switzerland. In those cases, as I mentioned during my opening statement, they did state that fear, and the fear wasn't realized. In time, they came to support those programs.

Mr. Brent Rathgeber: Have you talked to Canadian prison officials or union leaders as to whether they have a concern about a needle exchange program within federal penitentiaries?

Mrs. Sandra Ka Hon Chu: I have not personally. My colleague at the legal network who was working on prison issues before me has spoken, and I believe that's their primary concern as well, the institutional safety.

Mr. Brent Rathgeber: You acknowledge that it is a concern.

Mrs. Sandra Ka Hon Chu: Yes.

● (1700)

Mr. Brent Rathgeber: Who would pay for the needles?

Mrs. Sandra Ka Hon Chu: It depends. There are different models in the different countries. In the less-well-resourced systems, in Kyrgyzstan and Moldova, the Global Fund to Fight AIDS, Tuberculosis and Malaria pays for it. The minister of justice in Spain pays for the distribution of needles. In some cases, the external NGOs that already provide needle exchange programs in the community continue that practice and get extended funding to deliver in prisons.

Mr. Brent Rathgeber: Since you're advocating for a needle exchange program in Canadian prisons, who would pay for them under such a program?

Mrs. Sandra Ka Hon Chu: I believe we would require a pilot to determine which method of delivery would be the most effective. But what we've heard from many prisoners is the need for confidentiality, and perhaps either someone from the health unit or external NGOs providing that would be preferable to correctional officers or staff who are otherwise not associated with the health unit.

Mr. Brent Rathgeber: Under this model you're advocating for, would other CSC officials be required, specifically a nurse, or would the inmates be allowed the needles and just inject on their own timetable?

Mrs. Sandra Ka Hon Chu: Again, it depends on the model that should be adopted in the different prison systems. We've never actually had a pilot, as you know. So I think we would have to test which model would work the best in our system. But there are many models we can learn from, based on the number of prisons where they've existed now for some years.

Mr. Brent Rathgeber: What about methadone and this other substance, suboxone? Are those not a more effective and better way of dealing with inmates who have addiction problems than handing out needles?

Mrs. Sandra Ka Hon Chu: Methadone is an effective method of dealing with addiction for people with opiate addictions, but I think we've heard from other witnesses that methadone treatment is not always available and not everyone wants to use it.

Not everyone has an opiate addiction. Some people might be using other drugs. Cocaine injection drug use is something that we've seen is prevalent within the prison system, within federal prisons as well.

So it's not effective for all people. It's a very effective treatment, but prison needle and syringe programs are another component of a more comprehensive harm reduction and public health program.

Mr. Brent Rathgeber: It takes two substances to accommodate an addiction: one is the drug; and one is the instrument. You will agree with that.

Mrs. Sandra Ka Hon Chu: I'm sorry, I don't think of the needle as a substance.

Mr. Brent Rathgeber: The needle is of no value without the drug.

Mrs. Sandra Ka Hon Chu: Right.

Mr. Brent Rathgeber: So does the duty to accommodate then not also extend to the drug?

Mrs. Sandra Ka Hon Chu: Drugs have been illegal in all the systems where the needle and syringe programs have existed. So they would remain illegal.

Mr. Brent Rathgeber: I understand that. But I read your brief and you talked about section 15 of the charter and dealing with prisoners equally to people of society. So if there is a duty to accommodate, the logic would be that the state should also provide the prisoner with the drug.

Mrs. Sandra Ka Hon Chu: That's not what we're advocating for at this time, and that's not what I'm speaking about.

Mr. Brent Rathgeber: Thank you.

The Chair: Okay. Mr. Holland, please.

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

Thank you to the witness for appearing today.

You might be aware—the minister recently announced a deal with ballooning prison populations—that Canada will violate an international agreement of which it is a signatory, a UN agreement, against double bunking.

I wonder what your feelings are around the implications for infectious disease with a ballooning prison population and double bunking. I think it's also important in terms of what that means to communities, given that 91% of inmates get back into the general population.

Mrs. Sandra Ka Hon Chu: I read the transcript of Craig Jones, who was here before. I agree with him 100% that double bunking and the increasing prison population will only contribute to the worsening of the environment within the prison system.

We've spoken to many prisoners who did not previously use drugs, but who use drugs once they enter prison because they're coping with a really harsh prison environment. Double bunking will only escalate that. It can't make it better. It's only going to make the infectious diseases rate go up. That's what we speculate will happen, and when I've talked to community groups who work with people in prison, that's what they feel as well.

I think it's important that you mentioned the 91%, the number of people who are being released into the community. There were 2,000 people infected with hepatitis C in 2006, and 200 people infected with HIV. That's unacceptable.

Mr. Mark Holland: That figure was 2,000 people being released with hepatitis C, and 2,000 with HIV?

Mrs. Sandra Ka Hon Chu: It's 200.

Mr. Mark Holland: That's 200 people into the general community.

Mrs. Sandra Ka Hon Chu: In 2006.

Mr. Mark Holland: I think this is important. We talk about the risk associated with a needle exchange program. You mentioned European jurisdictions that initially had these same concerns and they never materialized.

Perhaps you could weigh the risk, on the one hand, of the needle exchange program to inmates with the risk to public safety and public health, on the other side, of not having programs that curb this rapid rise in infectious disease within our prisons.

● (1705)

Mrs. Sandra Ka Hon Chu: That's precisely what the systemic evaluations have told us. The risks with the concerns about these needle and syringe programs have simply not materialized. There have been no increases to institutional violence. Needles have not been used against staff or other prisoners.

If we don't implement this, every passing day there are more people becoming infected with HIV and hepatitis C. I've spoken to people, as part of a report that we released earlier this year, who believed confidently that they were infected while they were inside.

Mr. Mark Holland: One of the arguments is that all we have to do is clamp down on drugs: stop the drugs from going in and we've got an answer. We've had many years of that policy being implemented and tens of millions of dollars spent. The result in random drug testing is that drug use has actually gone up during that period of time.

How do you assess the argument that the only answer is to shut the doors on drugs coming into the prisons and then we eliminate the problem?

Mrs. Sandra Ka Hon Chu: I think it's one component of an approach; it's one component to stop the drugs from coming in. But the last CSC deputy commissioner mentioned that it simply does not stop drugs. There's no prison in the world where drugs do not enter.

Given the significant amount of resources that have been spent in the last ten years, and the correctional investigator's finding that drug use has not gone down, you can't focus exclusively on drug interdiction. There needs to be a comprehensive approach.

Mr. Mark Holland: On the question of cost, can you compare the cost of some of the actions you're suggesting—needle exchange programs—with the cost of treating somebody with HIV/AIDS, hepatitis C? Comparing the costs of a preventative-type program versus a do-nothing approach, what would the cost differential be?

Mrs. Sandra Ka Hon Chu: We don't actually have information in terms of the cost of the different programs that exist in the world.

When we've spoken to the Spanish wardens, there is the cost of the needles and syringes themselves, and in many cases where the staff deliver the program, there's marginal time spent. There are discussions with prisoners about referrals—

Mr. Mark Holland: And what is the annualized cost of treating hepatitis C and HIV/AIDS for prisons?

Mrs. Sandra Ka Hon Chu: For someone in prison, it's $22,000 for hepatitis C, and $29,000 a year.

Mr. Mark Holland: And for HIV/AIDS?

Mrs. Sandra Ka Hon Chu: That's $29,000 a year.

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

Mrs. Sandra Ka Hon Chu: That's a lifetime cost.

The Chair: Thank you very much.

Ms. Mourani, please.

[*Translation*]

Mrs. Maria Mourani: Thank you, Mr. Chair.

Thank you for being here, Madam. I have a few quick questions. You said that 30% of offenders currently have hepatitis C. Is that right?

[*English*]

Mrs. Sandra Ka Hon Chu: I think 27.6% was the figure I saw. That was from 2006, and I believe those rates are probably higher.

[*Translation*]

Mrs. Maria Mourani: You were not talking about the present, but about 2006.

In the data that you brought, do you have the breakdown of offenders who became infected in prison versus those who had already been infected?

[*English*]

Mrs. Sandra Ka Hon Chu: We don't have a breakdown. I think in some cases it's very hard to determine when exactly they're infected and how. We don't have that data. The 2007 survey—

[*Translation*]

Mrs. Maria Mourani: So we cannot say that these people became infected in prison. We can only say that they are infected.

[*English*]

Mrs. Sandra Ka Hon Chu: Yes, but there is data that indicates upon admission when people test, the rates of HIV and hepatitis C, and the problems within the prison system. Those are significantly different, and I can share those with you.

[*Translation*]

Mrs. Maria Mourani: Before or after what? I do not understand.

[*English*]

Mrs. Sandra Ka Hon Chu: When people are tested upon admission—when they're about to enter prison—the rates of HIV and hepatitis C are significantly lower than the prevalence overall in the federal prison system. You can draw some conclusions from that, although you can't say definitively when they're infected.

[*Translation*]

Mrs. Maria Mourani: What conclusions can we draw?

[*English*]

Mrs. Sandra Ka Hon Chu: Some people are getting infected inside.

[*Translation*]

Mrs. Maria Mourani: That they got infected in prison?

[*English*]

Mrs. Sandra Ka Hon Chu: Yes.

[*Translation*]

Mrs. Maria Mourani: Let us look at it from the perspective of the Correctional Service Canada. The mandate of the Correctional Service is to offer programs to combat drug addiction, to help people overcome a drug addiction.

What do you think about the disconnect between our giving needles and everything to people in prison so that they can take drugs, and banning drugs from prison and offering programs that teach people how to work on themselves to beat the addiction and stop taking drugs?

● (1710)

[*English*]

Mrs. Sandra Ka Hon Chu: I don't think it's ambivalence. I think it's a recognition of the reality that people use drugs. In the community, we ban drugs, and we provide needle and syringe programs based on the public health and cost evidence. So I think it would be a recognition of the reality that people are suffering from addictions. They don't necessarily access treatment for whatever reason, and we want to prevent disease from being transmitted.

[*Translation*]

Mrs. Maria Mourani: How do you see the management of this needle program? Should the needles be provided to offenders in their cells, letting them figure it out? Is that how you see it?

[*English*]

Mrs. Sandra Ka Hon Chu: It depends on how you decide to deliver the program. There have been different models. There have been automated dispensing machines and peer health workers. In most of the cases where this program has existed, there has always been an increasing number of people who use the program being referred to addiction treatment programs. So there's always a conversation to be had about drug use, and the dangers of drug use.

[*Translation*]

Mrs. Maria Mourani: There is something I do not understand; when you talk about the program, you talk about the program outside the prison and not inside.

[*English*]

Mrs. Sandra Ka Hon Chu: No, prison-based needle and syringe programs in other countries.

[*Translation*]

Mrs. Maria Mourani: Oh, the programs are in other countries!

[*English*]

Mrs. Sandra Ka Hon Chu: Yes.

[*Translation*]

Mrs. Maria Mourani: I have not seen needle dispensing machines at the Correctional Service.

You do realize that correctional officers have to deal with violence inside the walls on a daily basis? This violence is a result of drugs being injected, but it is also a result of the offenders' ability and ingenuity to use any object to assault fellow inmates or guards.

[*English*]

The Chair: This is your final question. Please wrap it up.

[*Translation*]

Mrs. Maria Mourani: An unaccounted-for needle can become very dangerous, just like a pencil.

[*English*]

Mrs. Sandra Ka Hon Chu: We did an access to information request with CSC some years ago, and they showed I think it was over 100 accidental needle stick injuries in that period of about five years, and not a single case where a needle was used as a weapon.

I can speculate about the reason why. It's because these are very valuable. They're so scarce. People don't want to use them as weapons and give them up because you have to pay to use them. In the jurisdictions and other countries where these needle syringe programs exist, they have not been used as weapons.

The Chair: Thank you.

Mr. Davies.

Mr. Don Davies: Thank you.

First of all, I just want to thank you for the incredibly well-researched document you provided us. I don't think I've seen more footnotes in a presentation in any other thing we've had.

My colleague on the other side asked who would pay for the needles if they were provided. Who pays the $22,000 a year to treat someone with hepatitis C, and $29,000 a year to pay for an inmate with HIV?

Mrs. Sandra Ka Hon Chu: CSC.

Mr. Don Davies: CSC pays for that. Do you know what the annual cost of a needle supply would be?

Mrs. Sandra Ka Hon Chu: I'm not sure. When I speak to the people at the Ontario harm reduction distribution program, they tell me an actual needle costs between five cents and ten cents, each needle.

Mr. Don Davies: Okay, five cents and ten cents.

Mrs. Sandra Ka Hon Chu: And that's based on their distribution network.

Mr. Don Davies: Okay.

Mrs. Sandra Ka Hon Chu: They're pennies.

Mr. Don Davies: I think the conclusion on which is more cost-effective is pretty apparent.

In terms of accidental sticking in cells, I've talked to prison guards who have told me that a common workplace fear of theirs is when they're doing cell searches and there's the risk of being accidentally stuck by surreptitious needles, which are hidden in all manner of places.

Have you ever heard that concern expressed by prison guards?

Mrs. Sandra Ka Hon Chu: Yes, we have. The previous colleague, who has spoken to them before, did. When we did the access to information request, we found that this in fact happened quite a few times in the course of a five-year period, over 100 times.

Mr. Don Davies: Where I come from in Vancouver, in British Columbia, in Vancouver today—and it's gone on for years—we have had a safe needle exchange program on the streets, as well as a safe injection site. But just in terms of the safe needle exchange, where addicts can go and get a clean needle and they turn in their old one and get a clean one, successive governments of every stripe have continued to support that program. It strikes me that a drug addict on the street has access to better health care outcomes than someone who is under federal care when they come into the corrections system. Would that be an accurate statement?

Mrs. Sandra Ka Hon Chu: I believe so, yes. I think it makes absolutely no sense to deny someone who would, on the street, have access to the needle and syringe program. In fact, many of the people we have spoken to said they took advantage of those needle and syringe programs in the community, but when they were in prison there was no availability.

● (1715)

Mr. Don Davies: My last question is on a statement you make on page 19 of your report that PNSPs "facilitate referrals of users to drug addiction treatment programs". You made the point that it actually doesn't lead to increased drug use, but it actually may lead to accessing drug treatment. Can you maybe elaborate on that for us?

Mrs. Sandra Ka Hon Chu: Yes. In evaluations where these programs exist, the frank conversations that prisoners have with health care staff and with peer health workers who have been trained on harm reduction and drug addiction and treatment have led to referrals of people to drug treatment programs. So that was what the evidence has demonstrated. It creates an opportunity for a conversation with health care staff, peer health workers, or external NGOs.

Mr. Don Davies: I think everybody agrees that drugs in prison are undesirable, that they are dangerous, and it leads to a problem that we all agree is something to be dealt with. But I think we're talking about harm reduction here.

What I was going to ask you in my last question is that sex among inmates in prison is prohibited, yet we provide condoms and dental dams. Drugs in prison are prohibited, yet we just heard that we have methadone dispensed to people in prison. Does it not seem inconsistent to you that we would not go the final step and provide paraphernalia that we all agree, and all experts agree, including the United Nations, would reduce the spread of infectious blood-borne diseases?

Mrs. Sandra Ka Hon Chu: Yes. When we know that CSC provides bleach, and the singular reason for that bleach provision is to clean needles for HIV, and it's not effective at all for hepatitis C cleansing, then it's inconsistent, absolutely. Bleach is provided with instructions on how to clean syringes and needles for injection drug use.

Mr. Don Davies: So even if we don't approach this from a rights-based position, from a public health point of view—

The Chair: We'll have to wrap it up.

Mr. Don Davies: —or disease prevention point of view, it seems justified from that point of view?

Mrs. Sandra Ka Hon Chu: Absolutely. And from a cost view as well.

The Chair: Okay, thank you very much. We appreciate you coming before the committee.

Mrs. Sandra Ka Hon Chu: Thank you.

The Chair: We're going to suspend for a minute here and go in camera.

[*Proceedings continue in camera*]

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