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Chair

Mr. Kevin Sorenson

Standing Committee on Public Safety and National Security

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● (1100)

[*English*]

The Chair (Mr. Kevin Sorenson (Crowfoot, CPC)): Good morning, everyone. This is meeting number seven of the Standing Committee on Public Safety and National Security, on Tuesday, October 18, 2011.

I want to remind our committee that in the final 30 minutes of our meeting we will go in camera to consider committee business and details of our pending field trip to Kingston.

Today we will continue our study of drugs and alcohol in prisons. We're studying how drugs and alcohol enter the prisons and the impact they have on the rehabilitation of offenders, on the safety of correctional officers, and on crime within our institutions.

Today two of our witnesses will join us by teleconference from Toronto, Ontario. We will hear from the Centre for Addiction and Mental Health. Sandy Simpson is the clinical director of the law and mental health program, and Wayne Skinner is deputy clinical director of the addictions program.

On behalf on our committee, I want to thank you for joining us this morning via teleconference. We look forward to your conference. I'd just ask if we're coming in loud and clear.

Dr. Sandy Simpson (Clinical Director, Law and Mental Health Program, Centre for Addiction and Mental Health): Yes, you are.

The Chair: All right, and likewise back.

I'm not certain if you've appeared before committee before, but we would welcome opening comments you may have on the subject and then we will go into a couple of rounds of questioning, if that suits. I'm not certain which of you would like to begin, or if you both of you have opening statements. I would assume that you do.

We look forward to your comments. Thank you for joining us today.

Dr. Sandy Simpson: Thank you very much, Mr. Sorenson and the committee, for hearing from us.

My name is Sandy Simpson. As you've said, I'm the clinical director of the law and mental health program at CAMH. I'm also head of the division of forensic psychiatry at the University of Toronto. Thank you for the opportunity to speak to you today.

CAMH is the largest mental health and addiction hospital in the country. We are involved with and interested in issues of substance misuse and criminal behaviour, among other things, and welcome very much the opportunity to speak with you today.

I'm a psychiatrist by trade. I'm relatively new to Canada. I came here 16 months ago. I'm from New Zealand, where I have 20 years experience in developing and running forensic mental health services there, and have done research in and service development in prisons in the area of mental health and addictions over the last decade or so.

To perhaps contextualize a little bit of the clinical work that law and mental health does, we have 165 beds at CAMH. We provide assessments, treatment, and rehabilitation services for review board patients under the Criminal Code, persons found NCR or persons unfit to stand trial. We have 300 patients in the community, about a third of Ontario's forensic mental health population.

We also provide court-related assessment services, a little bit of treatment services into the prison, and have a specialized sexual behaviours clinic, which has had contracts with Correctional Service Canada around the care of high-risk sexual offenders.

What is the nexus between substance misuse, abuse, and dependence, mental health problems, and the law? As the committee is well aware from the work that you've done previously, it is a highly prevalent problem, both among persons who are incarcerated.... Various epidemiological surveys show that, depending on where you put the severity cut, anywhere up to 90% of a standing prison population will have a lifetime problem of substance misuse or dependence. If one adds gambling to that, frequently comorbid with a number of those problems, substance misuse is a driver of crime. It is a driver of mental ill health and it is also a barrier to recovery, wellness, and reducing recidivism. Patently, it also represents major security and safety risks within the prison.

Our own experience is relatively limited to providing treatment services in prisons, and that is primarily focused around the persons who have a serious mental illness. For them, over 90% of them are comorbid for substance misuse as well. So the whole thing works together as one aspect of the problem. Frequently their offending is in part related to the need to obtain drugs through minor criminal offending, or a failing that occurs during periods of intoxication, though they may also have a mental health problem.

I guess we are more experts in treatment and rehabilitation than we are in running secure institutions, although the 165 beds I'm responsible for are secure beds. We have security and staff-related safety issues in relation to managing the problems of drugs getting onto our wards and the problems in behavioural dysfunction and staff safety that come from that. So we have a little bit of shared experience with corrections in that regard.

Thinking of it, though, more as a health opportunity, one would want to say that we see imprisonment as a health opportunity. It's not that prisons are of themselves a place for health treatment, but during the period of incarceration, if we're going to think in public health terms, trying to do something about the health needs of prison inmates is a good idea, because most of them will return to the community. If we can return them in better drug and alcohol health, mental health, and infectious disease health, then we're doing positive things for the community as a whole as well as for them. That hopefully will also impact risk of recidivism.

Our evidence will be around issues of systems of care coming from that health focus, rather than quite so much from a security focus, although there may be comments that we can add that might be of assistance in that direction.

● (1105)

Perhaps I'll pause there and pass over to Wayne for the more specialist addictions perspective.

Mr. Wayne Skinner (Deputy Clinical Director, Addictions Program, Centre for Addiction and Mental Health): Good morning, and thank you, Sandy. It's a pleasure to be invited here today.

My name is Wayne Skinner, and I work in the addictions program at the Centre for Addiction and Mental Health. I'm deputy clinical director there.

My work over the last while actually has been in the area of concurrent disorders—co-occurring addiction and mental health problems. We've done some substantial work in that area. We've also done some work in terms of trying to work with our partners in the system to be more aware that to be working with either addiction or mental health clients is to very likely be working with people who have both sets of problems. Historically, neither of those systems has been well set up to deal with those services.

In the addictions program, we started with a few select concurrent disorder programs, and now we've actually moved to a broader approach whereby we're challenging ourselves to make all of our programs able to include and work with people because of their complexity. Historically, many people with complex problems were excluded from treatment because of the requirement that the other set of problems be either dormant or absent as a condition of entry.

The reality for many people with addiction and mental health issues is that they do have these complex issues. In fact, an axiom I have come to believe in, based on experience and the literature, is that when we're working with people with addiction and mental health problems, severity predicts complexity. Wherever we see people with severe problems, I think we should be challenging ourselves to be seeing what other issues are there. The logic, in my view, shouldn't be to be surprised; we should be challenging ourselves to prove that they're not there. The assumption should be that the complexity is there.

Certainly that means significant change in how we work in systems. When you think of the three axes of corrections, addictions, and mental health, there's a tidy assumption that people who go into those systems have a primary problem. That's how they get sorted in. And if the other issues are there, they're not significant. Actually, what we know from the real lives of people in these systems is that there is huge overlap. We work in addictions with people who have serious mental health issues, criminal justice involvement, and other social problems.

I'm very impressed with the report you issued in December 2010, in which you describe the problem in the correctional system very well. I think it creates a foundation for moving ahead to working on solutions. We don't need to bring the argument to this committee, I think, about the reality of these problems. It's a great opportunity, actually, to be able to sit with you and talk about where some of the solutions might be.

I have personally had the chance over my career to work with people at the Correctional Service of Canada. I've been involved in the National Summer Institution on Addictions that CCSA has co-sponsored in Prince Edward Island over the last decade on a bi-annual basis. One of the things I know is that some very good models of care and products, if you will, have been developed. Some of my colleagues at CAMH and in the addictions and mental health systems across the country have contributed to making really good treatment programs for women and men who are federal inmates. I think that represents an important resource in the criminal justice system for finding solutions for people.

I support the recommendation you make in your report that when we're looking at a policy and at systems approaches, we need to think of these things comprehensively. We need to think about the opportunity to do intervention with people who are in the criminal justice system. But there are also prevention opportunities with these individuals, because they're at risk of having other problems in their lives because of what they're dealing with already. We know about the higher suicide rate and the risks that go along with this population, for example. We know about the domestic violence and the like. To use Dr. Simpson's notion, there is an opportunity for intervention here that we are not making an optimal response to right now. Thinking about how to make better responses is really very important.

● (1110)

The other thing is that these approaches need to be oriented so there are phases to them. How do we identify the individual with these issues? What interventions do we have available to them? How do we support people as we ready them to return to communities, and when they are back into community life? We need to have that kind of phased approach to the work we do to be really successful doing it.

Those are the comments I want to make at this point. I'll stop here. I look forward to your questions.

The Chair: Thank you, Mr. Simpson and Mr. Skinner.

We will proceed to the first round of questioning. We'll go to the parliamentary secretary to the minister, Ms. Hoeppner.

Ms. Candice Hoeppner (Portage—Lisgar, CPC): Thanks very much, Mr. Chair.

Thank you, Mr. Simpson and Mr. Skinner, for being here and for the expertise you're bringing.

We're studying quite specifically the whole issue of drugs in prison and the effect they have, not only on the inmates but on the staff, the officers—the whole picture of drugs in prison. One of the issues with any kind of addiction is enablers—those individuals who are around the addicted person and enable and almost help them. Sometimes they have the best of intentions, but they help the person in a system to continue their addiction.

We've all seen the show *Intervention*, where families have to come together to create a bottom line so that people who are addicted say "Okay, I'm going to get treatment because there's really no other option". You transfer that whole idea into the prison system, where you already have people who have kind of reached the bottom already. Their addictions are probably in many cases what caused them to commit crimes or assist in crimes, so now they're in prison.

I wonder if you can answer two questions.

First of all, what can we do as legislators to help families who are maybe smuggling in drugs for various reasons? Many times it's that same enabler mentality. They love their family member and are concerned about them. Maybe they're feeling pressure. There are so many issues surrounding why people who are not addicts would enable an addicted inmate who might be a family member or a friend. Are there things we as legislators can do to assist enablers and empower them to stop what they're doing? We need to make sure drugs aren't getting into the prisons.

Secondly, are we doing anything in these prisons? Are we enabling prisoners and sometimes giving them a soft landing when they need more of a harder floor or a harder bottom?

● (1115)

The Chair: Thank you, Ms. Hoeppner.

Ms. Candice Hoeppner: Mr. Skinner might be able to answer that.

Mr. Wayne Skinner: Those were very stimulating comments. I think *Intervention*, the TV show, makes great television. It's not best practice, in terms of how to deal with families.

A fair bit of my work has been with families affected by concurrent disorders. We have to be careful here to not characterize family members as enablers in the way you described.

I don't know the percentage on this, but many families are concerned that ultimately they're going to be part of the solution people will need when they return to the community. Having social support and family engagement while people are incarcerated are positive things. The issue of detecting individuals who are collusive with an inmate who wants substances brought in or who think they're actually helping the inmate by doing that has a number of challenges against it, for sure.

Educating folks is an important thing in this regard, but I would frame it quite differently. We need to have more family engagement and support, including support for family members on a peer basis. You could create a culture where you would be promoting the message that the best solution for people with addiction issues in prison is to deal with the addiction, rather than feeding it while doing time.

Ms. Candice Hoeppner: Exactly. I appreciate that. All of us would certainly agree that positive and constructive family interaction is of benefit. But we hear about mothers bringing in drugs for their kids who are in prison. I'm thinking very specifically of people who are smuggling in drugs. There's the whole issue of gangs, drugs coming in because of gangs, and the monetary issue. But I guess I was hoping that with your expertise you might be able to deal directly with family members.

I agree we want to make sure that positive family interaction happens. But very specifically, for those who for various reasons feel guilt, pity, or a variety of emotions that cause them to bring in these drugs, is there something we as legislators can do? I guess you're saying that in your opinion it's more a matter of education, as opposed to any kind of a deterrent.

Mr. Wayne Skinner: I think education is one strategy. I'm not sure what the deterrent strategies would be except to have better detection as people come in. I do think it's worth noting that people who are in the criminal justice system with substance use problems are more likely than others to come from families that themselves have substance use issues. So being aware of family history and family context might be helpful in terms of the efforts to intervene preventively around this and in terms of surveillance. So that's another element I think is worth noting, that there are inmates whose families have substance use histories and they have perhaps learned these behaviours in the home. I'm not sure if those individuals are more likely to be smuggling substances in or not, but it's another factor I would suggest for consideration.

Dr. Sandy Simpson: I would respond on three levels. One is that you must have very tight security and detection at the gates. The best deterrent is your risk of getting caught, not the risk of the magnitude of the punishment. The higher the likelihood that you'll catch people at the gate, the more you will deter.

The second level of response has to be that your family member with the drug problem in prison will get care and support for that. You don't have to do that misplaced caring that you think you're doing by bringing drugs in. The more the prison and the health authorities within prison are saying to families that there is care and support for people who are dealing with these problems, the less families will need to keep fueling those problems.

The third response is dealing as much as you can with the family systems themselves that people will return to, even though in the federal system it will clearly be two years or more before they will get back, and there might be greater distance from the family. The more you can do that and reach out to the healthy members of the family rather than the co-dependent or co-addicted members of the family, the better long-term-recidivism impact you might have.

● (1120)

The Chair: Thank you, Mr. Simpson.

We will now proceed to the opposition side.

Mr. Sandhu, go ahead, please, for seven minutes.

Mr. Jasbir Sandhu (Surrey North, NDP): Thank you.

Thank you for being here today, Dr. Simpson and Mr. Skinner.

It's pretty clear. During this study so far, we've seen the government members attempt to look at the issue of drugs and alcohol in prisons in isolation, focusing narrowly on interdiction measures. Earlier this morning at the justice committee I clearly heard that families play a vital role in integrating the prisoner back into society. The interaction between family members and the prisoner is vital to making sure that the prisoner comes back into society as a good citizen.

On this side of the table, the New Democrat members believe that in order to conduct an effective study, we need a balanced approach that is focused on understanding the problem that exists and on finding real solutions based on evidence and measurable outcomes.

In our prison system, mental health and drug use are interrelated. Overpopulation of prisons and drug use are interrelated. Gangs and organized crime in prisons and the spread of HIV/AIDS and drugs are interrelated. I think we have to look at the whole issue not in isolation but as co-dependent upon a number of different issues.

Having said that, my first question would be to Dr. Simpson. Given the interrelated nature of these issues and the knowledge that prison populations show a greater prevalence of mental health issues than does the general population, Dr. Simpson, could you explain to us how the greater prevalence of mental health problems affects the use and demand of contraband substances in prison? Also, do these drugs play a role in individuals' day-to-day lives in coping strategies?

Dr. Sandy Simpson: In answer to the first question as to how the intercorrelation between drug addiction and mental health problems gives rise to more people being in prisons, or with those problems, there are multiple pathways to that in people's lives. We see some people who develop a primary mental illness and who self-medicate to some degree with drugs or alcohol, particularly cannabis, which drives both criminal behaviour and mental ill health.

So you wind up with people in prison with both problems. They have whatever the symptoms of mental illness and distress they may be suffering, but they also have problems of addiction and poor patterns of using drugs to cope with symptoms of illness, which actually, perversely, exacerbate the very problems, coupled, then, with the withdrawal from those effects. You get a complex mix of addiction, withdrawal, and the loss of the health-damaging mechanisms that the person has developed, as well as the mental health problem. Those things wind up getting bound together.

It's not a matter of treating only one. You must be able to address both, as well as the criminogenic drivers from whatever the attitude sets are, and the criminal thinking that the people have as well. People will continue to seek drugs within prison, and that may lead to problems of security, of mental instability, of violence, and of standover tactics and vulnerability and so on that can emerge in that regard, which places security risks between inmate and staff, and there's an inmate-to-inmate violence risk as well. So clearly, being able to address across those multiple levels is very important to both screen for and address health and addiction problems in different ways at different phases of the process while they're in custody.

You made reference to families and community reintroduction at the end. Clearly, whatever those processes are that have gone on within prison, they need to relate to the reintegration approaches that are taken at the end, so that whatever gains may have been achieved during imprisonment are able to be transferred to the community. We're not terribly good at that at the moment, and that's not a Canada-specific statement; that's an international statement.

● (1125)

Mr. Jasbir Sandhu: Thank you.

Mr. Skinner, I have a question for you. Given your knowledge of concurrent disorders, can you explain what sorts of outcomes we might expect from a patient who does not receive a holistic approach to their treatment, such as, for instance, if a person were to stop drugs cold turkey but not receive adequate rehabilitation or counselling?

Mr. Wayne Skinner: First of all, it's worth noting that about three-quarters of people who seek addiction treatment have a prior mental health history. There is an important relationship to note between these. Again, it's just a common thing, so one of the realities we can speak about is that people with co-occurring disorders and who are in the general health care system are more likely to seek help, but we do a worse job of retaining them in treatment and they have poorer outcomes.

So again, one of the problems we have is systems of care that really don't do a good job of addressing complexity in terms of being able to engage people and retain them. Where we're coming from generally is a bit of a disadvantage. We know that when we can offer integrated programs of care with people—and there has been some important research done, particularly with people with severe mental illness and addiction—we do have better treatment engagement and better long-term outcomes.

The interesting thing about some of this research is that the programs that have worked with individuals with severe mental illness and addiction have needed periods of time of up to five years to be able to demonstrate the efficacy of the treatment. If these are long-term interventions with people with chronic problems, you usually don't show an immediate effect. You need time. Then you can demonstrate an effect.

In Ontario, for example, in the 1990s when, for a variety of reasons, there were some reductions in health spending, the government of the day actually—it was a Conservative government—invested actively in ACT teams, assertive community treatment teams, which offered integrated treatment for people with serious addiction and mental health problems. The important thing about it was that the economics were suggesting that by making that investment they were saving money in other ways.

So generally, the advice for people with co-occurring addiction and mental health problems is to have strategies that offer integrated care. There is a high level of confidence that when you do that, even though it requires a particular kind of investment, you produce savings in a whole bunch of different sectors, not just in the health care sector, but in terms of criminal justice and a variety of areas across a person's functioning.

The Chair: Thank you, Mr. Skinner.

We'll now move back to the government side with Mr. Aspin.

Mr. Jay Aspin (Nipissing—Timiskaming, CPC): Thank you, Mr. Chair.

Good morning, gentlemen.

I'm particularly interested in your stance on mandatory drug testing. I'd like to obtain the views of each of you on mandatory drug testing within our federal institutions. Do you feel that those who are caught using drugs and alcohol should be remanded further, not just by taking away their perks, but by treating them as they might be treated outside the prison walls with respect to further charges and possible extensions of their prison sentences?

Dr. Sandy Simpson: There are two questions in that. One is whether or not we should have mandatory testing; the other is what the response should be to somebody's testing positive.

As many people are in prison for drug-related offences, does testing positive for drugs mean that one is then further punished for the thing one has already been caught for? Is that a thing that warrants treatment? We get to one of the nubs of the problems here: addiction is a problem with health and criminal justice consequences.

How we view a model of response to it, as a health issue or a correctional issue, becomes important for one to be clear about. We can wind up with both systems either tripping over one another or working synergistically. If drug misuse is a major contributor to why somebody is offending, should there be ongoing assessment of whether or not they're still abusing drugs? I think that's perfectly legitimate to do.

From a correctional perspective, what should be the response to somebody's testing positive? Should that be a right that ups your priority for getting treatment for that problem, or does that result in an extension of your incarceration or a loss of privileges? That's the point at which you get mixed messages about whether this is a health or correctional system response.

Why is that important? If you're wanting people from a health perspective to take responsibility for what they're doing, you want them to own up. If owning up is going to result in a worse outcome for them, rather than access to the treatment that they need, then you might drive further underground the problem that you're trying to address. Getting clarity in what we're doing is important.

Does this have to be mandatory for people with drug and alcohol problems in prisons? Yes, I think it probably does, but where it leads is also an important issue to get clear. It should be a process that encourages people to own up to what they're doing and then to access appropriate care. I know of some systems of in-prison drug and alcohol treatment under which a positive test for drug use makes you less likely to get treatment, because you're not yet abstinent, which seems perverse. You'd think it would be an increased demonstration of your need to get into treatment.

We have to be careful about not creating perverse drivers. We want a policy that encourages people to own up and then get access to treatment. This results in greater safety within prison as well as reduced public risk. Mandatory testing for ongoing drug use may well be a reasonable thing to do.

● (1130)

Mr. Wayne Skinner: From a treatment point of view, we have experience with drug screening. We have clients who want us to do this. We have other people who are reluctant to do it. But we need to determine what model we're operating from. Is this primarily a health problem, or are we trying to impose consequences on people for rule violations? These are two different ways of going about the same thing.

Mr. Jay Aspin: Mr. Simpson, you said that you spent 20 years in New Zealand doing your work there. I wonder if you can share with us any experience from that work that would shed some light on our current situation with the drug and alcohol problems we have in prisons in Canada.

Dr. Sandy Simpson: There is much that is similar. There are significant things that are different, but much that is similar in terms of the nature of the problems, and I think those are problems with offenders, drugs in prisons internationally. We have similar prevalence rates for drug misuse in New Zealand prisons, not quite the same drugs as here. Alcohol and cannabis are big ones. There's much less crack in New Zealand, much more methamphetamine as a major driver of crime and a major problem in terms of gangs bringing drugs into prisons. We were not too bad at screening for problems, and with quite good focus areas for drug and alcohol treatment within prisons that were quite effective.

The other model that is strong in New Zealand, and is relatively less so here, is culture-based, Maori-based programming using indigenous models of well-being creating.... Maori are the indigenous people, the first people of New Zealand. For them, running treatment services, or more properly for them setting the cultural context in which treatment services occur, both for sexual offender treatment and drug and alcohol and non-violence treatment within the prisons was a very effective thing in rebuilding healthy cultural structures around people. It relates to some of the things we were talking about earlier about families as well, and some of those things, particularly where there are large numbers of first nations people, I think have a number of successful models that could be valuable for Canada to learn from.

The other experience is that we in New Zealand imprison about twice the number of people per capita that Canada does. We're at about 200 per 100,000; Canada is just over 100 per 100,000 now. So the New Zealand fondness, and increasing fondness, for incarceration was leading us to quite difficult positions as well, and major problems with keeping up with the health needs of our rapidly rising prison population. It's a problem that's clearly been anticipated here, and much has been written about it at the moment.

● (1135)

The Chair: Thank you very much, Mr. Simpson.

We'll now move to Mr. Scarpaleggia.

Mr. Francis Scarpaleggia (Lac-Saint-Louis, Lib.): Thank you, Chair.

Good morning, Mr. Skinner.

You were mentioning that 80% of inmates are grappling with a drug addiction problem. Is that correct? Do I understand correctly, or is it just simply 80% who are inmates have used drugs? When we're talking about that 80% of inmates who have some involvement with drugs, are we talking about serious addiction?

Dr. Sandy Simpson: Serious addiction. We're talking about more than simple use. The 80% involves...some people have abuse problems, rather than true addiction.

The core addicts might be much more like what, 30% or so, Wayne?

Mr. Wayne Skinner: Right, but your own report I think gives this figure, and it describes people as having serious addiction. That is more than moderate, shall we say. It's a very significant problem.

Mr. Francis Scarpaleggia: Of this 80% of the prison population who have a serious problem with drugs—excuse me if this question is simplistic—what's the cause-and-effect relationship? Are mental health problems driving these problems with drugs among that 80%, or are some of the problems with drugs of another nature? How would you break that down? I know it's very hard to do that, but if you had to make a point about that, how would you do it?

Dr. Sandy Simpson: Yes to all of the things that you listed, I think.

For some people, if you have a risk of developing a mental illness and you also use drugs and alcohol, your risk of manifesting that mental illness goes up. Once you then have the mental illness, the risk of it being worse in terms of its course and outcome is raised by ongoing drug and alcohol use. For some people, drug and alcohol abuse and dependence arises as they self-medicate for low-mood, post-traumatic abuse problems. Aspects of psychosis that some people can self-medicate from results in worsening of the course and outcome. They're not only having the core problem they had to begin with, but now an addiction problem on top. There are other people for whom the problem is a primary addiction one that results in secondary mental health problems as the rest of life tends to decay. So I think all of the above are pathways, and in each individual case you need to—

Mr. Francis Scarpaleggia: But of the 80%, we're dealing essentially with addiction and mental health problems; whether as cause or effect, there's a strong mental health component.

Dr. Sandy Simpson: The prevalence of serious mental illness in prison is much lower than that. Psychotic illness runs in a varying rate between about 5% and 8% of the standing prison population; bipolar disorder, around 2% to 3% of the prison population; and current major depression, maybe 15% to 20%, depending upon which study you look at. So the total is about 25% or so.

Between 15% and 25% have one of those diagnoses. Of the people who have one of those diagnoses and are in prison, more than 90% will also have a drug addiction or alcohol addiction problem. Once you have a mental illness, your co-morbidity is very high against the rest of the prison population.

● (1140)

Mr. Francis Scarpaleggia: When someone enters a penitentiary, would you say a large proportion of these new inmates suffer from serious drug or alcohol withdrawal in the clinical sense—not as in wishing they had some substance to satisfy themselves but they don't and are frustrated, but a serious withdrawal problem? Are they coming in with serious withdrawal problems, and are these being treated by proper professionals upon entry into prison?

Mr. Wayne Skinner: I think acute withdrawal depends on the circumstances of people's entry. Certainly upon arrest some individuals might well be drug-dependent and would show a variety of withdrawal symptoms from whatever substance they were on. That's one level of dependence, if you will. But if people have been using substances as a way of coping with stress and now find themselves in a hyper-stressful environment, their urge to use is going to be very high. That's part of the pathology of addiction, actually: that you really have one way of coping, which is to use substances.

But on your particular question about the moment of entry and whether people are in withdrawal, usually if people are in acute withdrawal they show demonstrable signs that can be assessed and treated.

I'm not sure what the answer is in terms of the numbers.

Mr. Francis Scarpaleggia: And concerning the help they need upon entry, are they getting access to the psychologists? I was told that there are many unfilled vacancies for psychologist positions in our institutions. That would imply that you have a prison population that is dealing with some very serious addiction or other mental health problems that require the intervention of a psychologist and other professionals; yet from the get-go they may not be getting the treatment they need.

Dr. Sandy Simpson: If you're talking about acute biological withdrawal, often that will manifest in the police lock-up over the first couple of days after arrest and in the provincial receiving remand prisons, rather than at the federal level. From what I've seen through the contact I've had with those cases locally in Toronto, the health care staff in the prisons are on to that as a risk, and the primary mental health and drug and alcohol screening and general practitioner services there are certainly looking for those things.

In terms of addiction counsellors being available to follow up from there, I think they are thin on the ground, from what I've seen.

Of course, remand prisoners particularly are in very unstable situations. Soon after you've been arrested, you don't know how long you'll be in for. It's an entirely new world—or it may be a familiar one for you, if you're a frequent flyer. For some of those people, engagement at that point is really very important, particularly—and this is a provincial rather than a federal issue, I guess—for the rapidly turning-over remand people, who often have less serious offending but may have major drug and alcohol problems. Getting those people to turn to drug and alcohol treatment at that point is something for which you would get a good bang for your buck.

The Chair: Thank you very much.

We'll now move back to Mr. Garrison.

Mr. Randall Garrison (Esquimalt—Juan de Fuca, NDP): Thank you, Mr. Chair, and thank you to Dr. Simpson and Mr. Skinner for sharing both your time and expertise with us this morning.

I think we have a common concern around the committee table with public safety, and my own view really focuses, since such a high number of offenders have both substance abuse and mental health disorders, on the treatment.

There are two things I'd like to ask about. The first concerns your emphasis on the concurrent substance abuse and mental health disorders. Would you say that corrections treatment programming now reflects that concern well? How well does corrections deal with the concurrent disorders?

● (1145)

The Chair: Mr. Simpson.

Mr. Wayne Skinner: I'm not in a position, actually...because I am not familiar on the ground with their programs and how they are delivered. I am familiar with attempts to develop models; for example, in the treatment of women with substance use and mental health issues some good models have been developed. But I am not sure how well disseminated or available those programs are to people in the correctional system.

I think the understanding of the need to offer concurrent treatment is well established with the staff who do this work in correctional services, but I am not sure about the prevalence of the programs or how they are actually delivered.

Dr. Sandy Simpson: I would say similarly, from the work I have done since I have been here in contact with federal and provincial corrections and from the things I have read—both your report from late last year, as well as Howard Sapers' report after the Ashley Smith death—and the contact I've had in terms of the work federal corrections is doing around trying to develop systems of care within corrections, that I have no doubt that federal corrections understands how vital this area of work is.

The people I have spoken with have a strong sense that they have a long way to go in developing the services. They have a vision and drive that they want to implement, but they are the first to admit that services are not where they want them to be now. So the high-level commitment is clearly there, as well as the recognition that although there may be areas where good programming is going on, we don't know much about what percentage of all the people who have need are actually getting it met in the current system. That is clearly one of the answers one would wish the system to be able to give.

Mr. Randall Garrison: To follow up on that, are there models of concurrent programming or treatment that would show differences with respect to gender and cultural background in the concurrent treatment, or are you talking about a more focused approach?

Dr. Sandy Simpson: Most of the correctional literature concerns males, obviously, as 90% of inmates are male. The concurrent work, as Wayne was saying earlier, shows that getting your mental health and addictions treatment from the same team works better than farming it out among different providers. Particularly for the people with serious mental illness, the more we can integrate the care with one treatment intervention group, the better. That seems to work for men and for women.

In terms of different models of care, my own experience is that culture-specific programming improves efficacy. Often, people of minority ethnicity or first nations people feel marginalized. Creating therapeutic venues in which their culture is celebrated and given primacy helps them rebuild a sense of self, which puts them in a position in which they are better able to pick up the same therapeutic challenges that everybody else has.

Altering the cultural context within which the same evidence-based practices are delivered improves efficacy. So looking at where you have common cultural groups of sufficient size to permit having some of your programming culturally based would improve the likelihood of its success.

Mr. Randall Garrison: Thank you.

My last question concerns discussion of how long it takes to treat addictions and of there being some implication that people should spend longer times in institutions. Would you say, given the length of time it takes for treatment, that it could be started in an institution and then, with proper follow-ups, be more successfully completed in the community?

Mr. Wayne Skinner: Yes, I would. In fact, I would say that this is an ideal way of thinking about it.

When we work with people with even serious addictions, the length of time they need to be in a residential program or whatever would be measured at most in months. The important work, actually, is the work of continuing care and change maintenance when they return to the community. That is really the testing point. That is where you need services and supports. I think the same model would apply in criminal justice.

The Chair: Thank you very much.

We will now move back to Ms. Young.

Ms. Wai Young (Vancouver South, CPC): I'd like to echo my colleagues. Thanks for your very insightful and interesting testimony this morning.

I now would like to take us back from looking at individual mental health issues, as we've been discussing in these last series of questions, to looking at systems. Obviously in the correctional system we have certain programs in place. Let's bring that back a bit, in particular noting Mr. Sandhu's comment earlier and to remind the NDP members of this committee that they did vote against the $122 million that this Conservative government put toward primarily preventive programs. We heard from the corrections office head that this has resulted in a decline of drug use in prison from 12% to 7.5%, which is substantive, I understand, and an envy internationally. We now have countries across the world coming to see what Canada's doing that has resulted in this great outcome.

I think this government has been outcome-focused, and it has put a substantive amount of funding into preventive programs. We're seeing the fruit of that investment in this. Having said that, though, I want to acknowledge that while people are still in jail and there's still the prevalence of drugs, that's why we're conducting the study and that it is important. We acknowledge that we perhaps need to take a multidisciplinary approach to this, and that's why you from the mental health centre are here today. We hope to also hear from people from the justice system as well.

Drug addiction in jail is obviously not an isolated issue. It's like peeling back the tree bark, in that we now seem to be seeing roots all over the place. Issues spring up in the community. It's obviously a key focus in terms of marketing and the whole system that's in place around drugs in jail. We know the money is coming in and out, so it appears to be a far bigger issue than inmates being addicted in jail.

What other measures can we leverage or develop to further support the goal of establishing a drug-free prison? I want you to think specifically about systems and operations as opposed to individuals at this point. Do you have recommendations for us?

● (1150)

The Chair: Thank you, Ms. Young.

Mr. Skinner or Dr. Simpson.

Mr. Wayne Skinner: It's obviously a very important question: drug-free prisons from a systems point of view. When I think of what goes on there, I think right now of prison cultures that are very oriented to obtaining and using drugs. So are there things you could do to shift that culture or to create cultural alternatives for people in prison? That would be one thing I would think of doing.

Obviously, availability is a huge factor, so the ability to intercept or to reduce efforts people make to get drugs into prisons is a key element here.

I think the other thing would be actually trying to create a more health-oriented culture in prisons, where people are actually starting to go back to what Dr. Simpson mentioned at the beginning. Nobody wants to be in jail. However, is jail an opportunity to actually do a turnaround in your life, and are the resources there to support that?

When we talk with people who are trying to deal with addictions, they often are reluctant to change, and maybe, even worse, they don't believe they are personally capable of change. They'd love it perhaps, but they consider themselves losers. By creating a recovery culture in treatment that actually starts to get people to imagine that things could be different for them, you see change happen. That is a process. It takes time.

So changing the prison environment from one that is itself perhaps criminogenic to one that is more therapeutic I think would be an important thing for these individuals.

Those are some of the areas I would look to.

I found this very interesting. I was invited to speak to correctional staff because some of the work I do is in motivational interviewing. The staff were incredibly interested in using a whole different frame of working with people that is actually more strengths-oriented and more empowerment-oriented.

So there are these approaches we could pursue in trying to change. I see it as a bit of a culture shift that you'd be initiating in the prison environment. You actually indeed could make it more of an opportunity. I firmly believe this. I think there is evidence to guide that, actually. So it's not just my enthusiasm, which I hope I'm conveying, but also I think that if you looked at the evidence, it would lead you to want to do that and would tell you how to do it.

● (1155)

The Chair: Thank you, Mr. Skinner.

[*Translation*]

Mr. Chicoine, you have five minutes.

Mr. Sylvain Chicoine (Châteauguay—Saint-Constant, NDP): Thank you Mr. Chair.

Good day Mr. Skinner. Dr. Simpson, thank you for sharing your viewpoint on these matters with us.

Mr. Skinner, you spoke earlier about an integrated care model which has allowed Ontario prisons to achieve some economies in other situations, or on another scale. I would like you to tell us about the savings that were achieved by adopting this integrated care strategy.

[*English*]

Mr. Wayne Skinner: Indeed. I wasn't speaking about this as a program in prisons. I should clarify that. I'm talking about a substantial body of research that has been done with people with severe, persistent mental illness who also have substance use problems.

The problem with those populations is that one of the great factors that predict relapse is their return to substance use. Yet traditionally programs were mainly oriented to doing mental health treatment and not very interested in dealing with substance use issues.

What happened when they created integrated treatment teams, which included addiction treatment expertise and worked with individuals, was that they found that the longer they were actually able to retain people in treatment the better the health outcomes. The clients' draw on other parts of the health care system—emergency resources and the like, the need for hospitalization—and their involvement with the criminal justice system were reduced. On the positive side, their ability to be doing pro-social things, like part-time work or the like, and maintain housing in a stable way and to have better community and family connections were enhanced.

So the model of care was integrated. It does require a directed kind of investment. The result is that you make a savings over time.

The research that led Ontario to do it is worldwide right now, but a lot of the work was actually done in the United States, where there's a lot of really helpful knowledge. Canada is now building some of this knowledge base about integrated treatment as well. Again, it's for people with severe mental illness and addictions, and it's about using integrated strategies that do a better job of keeping them out of hospital and functioning better and actively as members of communities.

[*Translation*]

Mr. Sylvain Chicoine: Thank you.

In Canada, was this type of approach promoted afterwards or was it set aside?

[*English*]

Mr. Wayne Skinner: No. In Ontario the government has made a substantial investment, and now I think there are over 60 ACT teams—assertive community treatment—in Ontario alone, and it's seen as a best practice in working with severe, persistent mental illness and addictions. So it's definitely where the health care field is going, and I think you'll see evidence of this in every province across the country, actually, and broadly around the world. It is working with that 3% of people or less who have severe, persistent mental illness, and in that population, maybe the 60% who have high rates of co-occurring substance use. The model has been tried with other kinds of problems as well, actually, with as much promise.

● (1200)

Dr. Sandy Simpson: The evidence is pretty clear that ACT delivers best mental health outcomes and substance misuse problems when, as we were talking earlier, the two are combined. Unfortunately, ACT teams have been disappointing, in terms of reducing re-arrest or re-incarceration of people with serious mental illness and drug abuse problems. The only models showing improvement on ACT ones also have aspects of a community treatment order or some coercive element, in addition to the ACT team, with both mental health and addictions treatment going on for people.

So for that even smaller group—the ones who are the frequent flyers between courts, prisons, mental health facilities and police arrest—none of our services are managing terribly well. We need quite complex responses that have the ACT mental health element, the ACT substance-misuse elements, and some degree of integration with criminal justice to make sure that care is effective and stops those cycles.

The Chair: Thank you very much, Mr. Chicoine.

We'll now go to Mr. Leef, please. Mr. Leef, you have five minutes.

Mr. Ryan Leef (Yukon, CPC): All right.

Thank you, Dr. Simpson and Mr. Skinner.

I want to go back quickly to a comment that came out of a question a little earlier, and just a point of clarification.

In your opinion, would it be a fair characterization to say that the federal system doesn't necessarily deal with the harder-core withdrawal issues that the provincial remand centres or police cellblock issues deal with? From that perspective, that’s not really in the federal system where our attention or support or resources need to go, in terms of that support of the hard-core stuff—the DT’s and things that typically happen within the real, immediate sense for an inmate population.

Dr. Sandy Simpson: Generally, those acute medical problems will be more common within the provincial remand centres. There may be a little of that, of people at first point of sentence who've been on bail in the community entering federal corrections directly, but that will be a relatively small number and it's for a relatively short period of time. That sort of acute medical withdrawal is an hours-to-days’ problem in a year’s sentence. It's a relatively short area and not specifically one in need of major focus, though clearly acute alcohol or drug withdrawal can be a significant medical emergency. So there have to be good medical care facilities available to detect that straight away.

Mr. Ryan Leef: Fair enough. Thanks. I just wanted to clarify that a bit.

Now, this might be a little bit of a hypothetical scenario, but we've talked a bit about the federal corrections policy to have zero drugs within the correctional system in Canada. I’m just wondering, from your perspective, how difficult is treatment when we have that constant temptation, opportunity, threats, coercion, the sorts of things that come along with day-to-day availability and access to drugs in a correctional centre? In other words, how successful or positive do you think programming and addictions counselling would be if we were to have zero access to drugs, if there were no way they could get them?

And I understand this is hypothetical and an absolute perfect-case scenario, but in comparison to what we have now, where drugs are available all the time and they're accessible—and there's that temptation and threat and coercion that people fall into—if you were to compare zero access for somebody, how much more successful do you think the programs would be? Could you put some kind of variable to that?

Dr. Sandy Simpson: It is a hypothetical that one couldn't give a hard number to. I would say the 7.5% figure given earlier is impressive. If we think of 80% of people having the problem, and fewer than 10% of them actually manifesting it within prison, well, that's progress.

To get to zero, you would probably need to choke off a vast amount of access to community. So probably the cost of getting to zero would include other aspects of things you would want to do, like maintaining relationships with key people in the community, having exposure through rehabilitative opportunities, and preparing people for reintegration in the community. That means at some point in the process you'd have to ease off on the restrictions and allow people to make choices for themselves, which they would do well in some cases and badly in others. If you don't let people have a chance to make a mistake, they will never have the chance to test out their ability to resist making mistakes. Any system of treatment and rehabilitation has to have a graded re-exposure so people have to manage the learning they've achieved. That can mean some access to the community. That means some re-exposure to risk. Achieving zero percent drug and alcohol use within prison is theoretically possible if it is hermetically sealed, but in terms of dealing with the problems of reintegration of people back into the community, you'll be losing at that end if you try to aim that high.

Would it be fantastic to take all the things you've talked about—the standover tactics, the manipulation, the violence that comes from people fighting over access to drugs, and the things that people will do to get drugs—out of the equation within prisons so that people would have the opportunity to direct and find better ways of dealing with large problems? You bet. I don't think that's measurable, however. But there is that balance between needing eventual community reintegration to be a reality and trying to get the amount of drugs in prison down to as low as possible.

● (1205)

The Chair: Thank you very much.

Madame Morin.

[*Translation*]

Ms. Marie-Claude Morin (Saint-Hyacinthe—Bagot, NDP): Good day. First, I would like to thank Mr. Simpson and Mr. Skinner for being here today, even though they are not here physically.

My first question is for Mr. Simpson.

Earlier, you talked about your experience in New Zealand. I found this very interesting and I would like you to tell us a bit more. You explained that the inmate population in New Zealand is about twice the inmate population in Canada. We know that the Canadian inmate population is going to increase and I would like to know whether you feel this is going to make curtailing drug addiction and drugs more difficult in prisons.

[*English*]

Dr. Sandy Simpson: Not of itself more difficult.... It will be larger because there will be more people.

We don't have any good evidence in New Zealand or internationally as to whether in those countries with rising rates of incarceration the people coming into prison have more mental health or addiction problems than the prison populations had before that rise occurred. We don't have good epidemiology internationally to tell us whether that is so. But if the prison population thrives we will have more people with drug and alcohol problems in prisons, so we will need better health responses for them.

National and international controversy is being debated most clearly at the moment south of the border, because of the fiscal level that they've reached, as to what the right model for the war on drugs is: when is it right to use a more therapeutic response—the drug courts and those kinds of models; when is it necessary to use incarceration as the appropriate response; and who are the people we should be incarcerating for public protection, to hold people to account for the severity of their actions and the ongoing risk they may present to the public? Each society sets those thresholds a bit differently.

New Zealand has a higher crime rate than Canada, so that explains some of the increase. But some of the moves to mandatory sentencing of certain sorts—and we've even now got a three-strikes piece of legislation, which I'm not terribly enthusiastic about—do create other problems.

For me, the best model comes from an international group of criminologists and criminal psychologists. The “good lives” model was developed by Tony Ward and the Victoria University of Wellington, New Zealand, with a number of international colleagues, including Canadian, North American, Australian, and British colleagues. That model sees offenders not as a different class of being, but as fellow travellers, people who have problems in life that overlap but are not entirely separate from ourselves, and for whom we engender crucially important aspects of common humanity, hope, and accountability. So if we imprison people for the things they have done wrong, and rightly so, then that space we bring them into needs to be as healthy as we can make it as we hold them to account, and it gives them the opportunity to learn better ways, rather than have their maladaptive old ways simply reinforced.

We're probably good at reinforcing maladaptive old ways, and at times with the young offenders teaching them bad ways, rather than creating incarceration as a different sort of opportunity, and that's holding people to account. One's duty as a citizen means respecting the rights of other citizens. Imprisonment is a vital means of passing that message to people: that if you have violated the rights of others you need to be held to account for that and pay a debt; and while you are doing that, we will also give you the opportunity—it's not necessarily the right, but the opportunity—to rebuild your life in a better way.

Getting that mix of messages right, as well as having long-term incarceration for that small number of people who do present a very long and serious risk to the population as a whole, is that kind of balance we need to get. I'm not sure New Zealand has got any of that right, but I think we need all of those pieces on the agenda as we discuss these issues.

● (1210)

The Chair: Thank you very much, Dr. Simpson.

Now we'll move to Ms. Hoeppner, please.

Ms. Candice Hoeppner: Thank you, Mr. Chair.

Mr. Simpson, I just want to thank you for your comments. I think you articulated very well what all of us around this table are looking at, which is the right balance between true accountability and protecting victims and innocent people, but also helping those individuals who are incarcerated. I think all of us would agree with your statement, and I want to thank you for making it. It's something I think all of us can look back on in this study.

I want to shift gears for a moment. With your expertise, when you look at individuals who are working in correctional facilities—staff and guards—can you talk a little bit about some of the increased pressures and stress and very immense challenges they face every day when they go to work? They're not only in a setting where they're dealing with people who have broken the law, but they're also dealing with a large percentage of individuals who are addicted to drugs, and it's not only the addictions, but also the gangs and the very dangerous activities that surround those addictions. Can you talk a little bit about the cost to society and about rehabilitation in prison? Because we have guards and staff who are under tremendous pressure and probably dealing with a lot of their own issues. Can you just tell us what they might be dealing with, from your experience?

Dr. Sandy Simpson: Thank you for that.

I think the things that we ask prison officers to do are complex and difficult. We often underestimate the magnitude of their task, especially when we're trying to tell them to be rehabilitative as well when they're in situations where there are people who have got their way through life using manipulation, menace, and standover tactics as the ways of getting the things they want in life, as offenders are wont to do. That is a difficult world in which to live and to face when you come to work every day.

I think the other group that prison officers talk about having real trouble coping with are people who do things like chronic self-harm and behave in irrational ways that they can't understand. Coping with people with severe personality disorders and maladept at coping styles are also very difficult for prison officers. That can result in very significant emotional burnout and hardening of attitudes, and the interpersonal distance that comes from that in any institution. That's true of a secure hospital just as it is of a prison. The more staff under pressure, under threat and menace, then the more risk of negative staff practices emerging, as well as staff burnout and inappropriate use of authority or bullying.

How to create interpersonal environments where people can grow is what we're expecting of the inmates, and a healthy work environment for staff to come into who don't get burned out is very important. Good staff training, good levels of staffing, and good staff supervision are all crucially important to that, and having specialized units able to cope with people with particular levels of difficult need is also very important.

Some officers will be better at dealing with people at different phases of recovery. Some that I've worked with over the years are extremely good at working with mentally ill people in custody. Other officers will say they don't want to have anything to do with that inmate group, but they'll be very good in the minimum secure places and the work gangs and other areas like that. So I guess it's having emotionally and HR-sophisticated personal leadership that can provide staff with the training and support, staffing levels and awareness of the workplace hazards, the risks of burnout, the risks of malign behaviour, the risks of gangs to prison staff members, of intimidation, of threats to staff.

It's a tough place to work. It's very important work. The sophistication with which we can bring support structures around prison officers so they can understand that, so they can do things like develop people more, use things and pick up on issues like motivational interviewing that they're often hungry for, is really important.

● (1215)

Ms. Candice Hoeppner: Thank you very much for that. I also want to talk a bit about drug treatment. We had a previous witness talk about the fact that we need to find ways to actually measure whether the treatment programs work.

When you're treating someone, is the measurement very simply that they are no longer addicted to whatever substance they were addicted to? In the prison system, how would we measure whether the program actually worked, or whether someone simply went through a program for a variety of reasons, maybe so they could tick off a box and get their parole? Maybe it was for the right reasons, but we're not sure if we've had success. How do you measure success when you're implementing a drug treatment program?

Dr. Sandy Simpson: Whether you attend, whether you contribute, whether you learn and pick up stuff in the program itself are the sorts of things the people running the programs will be measuring. Much of that is the kind of acquisition of knowledge and information, becoming more educated and having an understanding and taking pride in graduating from the program.

Within prison, as you've implied, there are a number of drivers that may be good or may be about gaming the system. It may be about if I do the right courses and show I've done these things it will improve my chance of release. The proof of that pudding is what happens in the community when re-exposure emerges again and how the work that has started within the prison, because it doesn't finish there.... You do the program, but then it is how you implement that, how that gets translated into real world experience that is crucially important. We know that from residential and community drug and alcohol work. We know that in terms of mental health in-patient treatments, community-based treatment. It's all very well to get the learning and understanding within one venue. It is your capacity to translate that learning into the new one that is where the rubber hits the road, and that's where you need high-quality community reintegration, supervision, and follow-up to ensure success. That's really the only place in which you can tell that it's worked or not, and that means measuring abstinence.

Ms. Candice Hoeppner: Sorry for interrupting. I have a very short moment and I want to ask if you can very quickly comment.

You touched briefly on the importance of culturally appropriate treatment in reference to aboriginal people. Aboriginal culture and spirituality are very closely related. Would you agree, moving that further to other faiths, that faith-based treatment also can be effective, whether it's for Christians, Muslims, Jews, or aboriginal people? What's your opinion on that? Do we again get into the problem of mixing religion with government programs?

Dr. Sandy Simpson: No, I don't think it brings religion or spirituality into government programs. I think it's being culturally specific in one's delivery of care. I've seen faith-based units in New Zealand—Christian faith-based ones—that have received encouraging data. There's not a lot of outcome data on that. There's better outcome data on culturally based things.

It's about connecting with healthy social, cultural, and spiritual practices. It's about developing healthy aspects of people at the same time as you address the unhealthy aspects. I think that's important in terms of working with the whole of a person.

Most of the long-standing prisoner rehab organizations have been charities that are based on Christian values. The John Howard Society, the Salvation Army, and so many others over the years have had a Christian base to what they've done. They have often been the only social groups willing to step up to help offenders. I think we need to tap into those healthy cultures and spiritual practices.

● (1220)

Mr. Wayne Skinner: I was going to add to your comment that all prisons have abstinence cultures that are oriented around the twelve-step movement. They're already there. Again, what is important is thinking of where the alternatives are we can build on and tap into.

Just to support your question, I think they deserve a lot of respect. We need to think of ways of seeing it as a base that can draw people together, and certainly respect spirituality as a very important aspect of recovery.

The Chair: Thank you.

Mr. Aspin, you have a comment. We have about 30 seconds left.

Mr. Jay Aspin: Gentlemen, as you're aware, our government has expanded the use of correctional plans to help offenders get off drugs. Could you offer a quick comment on that—positive, negative, any quick comment?

Mr. Wayne Skinner: I'm not sure what you mean by correctional plans, but this work actually does require, as much as possible, identifying problems early to intervene actively when people are in jail and then plan and offer continuing care. I'm assuming, when you speak of correctional planning, that those are the things being developed.

Yes, I think it is very important, on a person-by-person basis, to have a very intentional strategy, based on an understanding of a person's strengths and needs, to help people move forward with their lives.

The Chair: Thank you very much.

We'll move to Mr. Sandhu. This may be the last question. Maybe we'll take one more quick one.

Mr. Jasbir Sandhu: I'll follow up on the last discussion we were having.

We know that the aboriginal population is over-represented in the prisons and also in the ranks of those suffering from mental illness and substance abuse. Could you, Dr. Simpson, tell us, in your opinion, how we can invest to help improve outcomes for aboriginal people? How can we improve the outcomes by investing in programs?

Dr. Sandy Simpson: It's a very broad question, and I would hesitate to answer it. I suspect that there are many other people in Canada much better able to answer that than I.

I would simply repeat some of what I said earlier. We know that the more you can reconnect people with healthy structures, and the more we can do things to retain the health and integrity of communities, the lower the measures of community ill health. Offending, drug and alcohol misuse, and mental health problems, which are all good measures of community ill health, will be reduced.

I would take a community development answer to that in terms of the aboriginal communities as a whole. Where you have well-developed communities and healthy community structures, use those as the contextual basis upon which we deliver care and support to people. And reconnect people with healthy structures upon release. We need to enhance and celebrate those aspects of cultural identity and origin actively in terms of what we do, rather than have a one-size-fits-all approach.

Mr. Wayne Skinner: CSC's Addiction Research Centre has developed some impressive protocols for doing culture-based treatment with aboriginals. Those are materials that are available. I'm not sure how well disseminated they are, or how well delivered they are across the country, but there are these models.

Rather than thinking of this as an overwhelming problem, it's important to start to segment it. An effective strategy that has an aboriginal focus takes care of a fifth of the problem, because 20% of people in prisons are aboriginal. The more you can have targeted strategies that address that population and others, the more effective your overall approach will be.

You could also develop strategies oriented to particular forms of addiction and mental health, targeting programs to those populations. It's through developing targeted approaches that we can have more success in our interventions.

● (1225)

Mr. Jasbir Sandhu: Mr. Skinner, you mentioned the study done by this committee back in 2010, and you talked about some of the things that we can do to move forward. Can you touch upon some of the things that we can do to reduce drug use in the prisons? What would be the most effective things we could do, just a couple of things?

Mr. Wayne Skinner: I was impressed by the plan for the six objectives that were articulated by Correctional Services Canada: screening and assessment upon admission; having primary mental health care in all institutions; developing the intermediate mental health units for offenders who require a higher level of care; enhancing regional treatment centres; focusing on community; and improving training for staff. The sixth objective has to do with the people who work in these environments. The work they do is arduous and demanding, and it needs to be skilful. So it's important to do more to train staff to have more of a mental health frame in the work they do. These are the things that have been articulated. I think it provides a pathway that would be valid for continuing to work in this area.

The Chair: Thank you, Mr. Skinner and Mr. Sandhu.

I think that pretty well brings our time to a close. I want to thank both of you for appearing for an hour and a half. Most witnesses get one hour, so thank you for staying longer today. I think your expertise in the area has been noted and appreciated today by the committee.

Although all committee members, I'm sure, have read and studied the 2010 report, I should mention that it is pretty well a new committee that sits here today trying to build on the report from 2010. It seems as if we've had three elections since 2010, so there are many new members sitting on this committee.

We appreciate your testimony today to help us understand this problem a little more.

With that, we will adjourn this part of the meeting. Again, thank you.

We will suspend and return to an in camera portion of this. I want to remind committee members that you are allowed one staffer. Your whip's office can have someone here as well, but one staffer per office. We'll begin in about five minutes.

[*Proceedings continue in camera*]

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