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Chair

Mr. Kevin Sorenson

Standing Committee on Public Safety and National Security

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● (1150)

[*English*]

The Chair (Mr. Kevin Sorenson (Crowfoot, CPC)): Good morning. We'll be broadcasting live again today.

We apologize to those who are so patiently waiting via teleconference. There was a vote in the House of Commons this morning and we were unable to begin earlier.

We're going to continue our study on drugs and alcohol in prisons. We are specifically examining how drugs and alcohol enter prisons, the impacts they have on the rehabilitation of prisoners, the safety issues related to the correctional officers within our institutions being surrounded by drugs in prisons, and the consequences of crimes taking place in prisons.

Our first panel of witnesses is with us by video conference from Toronto, Ontario. Our committee members appreciate very much witnesses testifying before us with this relatively new technology.

From the Canadian HIV/AIDS Legal Network we have Sandra Ka Hon Chu, senior policy analyst. From the Prisoners with HIV/AIDS Support Action Network we have Seth Clarke, community development coordinator.

I understand that each of you may have some opening statements, and then we will proceed into a round of questioning. This will be approximately 35 minutes. We've had to cut it short because of other witnesses coming later and the votes this morning.

Welcome, and thank you. We look forward to your comments.

Mrs. Sandra Ka Hon Chu (Senior Policy Analyst, Canadian HIV/AIDS Legal Network): Thank you, Chair.

I'll begin, if that's okay.

Thank you to the standing committee for allowing us to make this submission. I'm with the Canadian HIV/AIDS Legal Network. We're a national non-governmental organization working to promote the human rights of people living with and vulnerable to HIV/AIDS in Canada and internationally, through research, legal and policy analysis, education, and community mobilization. We have 150 members across Canada. Many of them are AIDS service organizations.

For many years we have worked on the issue of HIV in prisons, most recently focusing on federal institutions. Two years ago we released a report documenting the experiences of prisoners and former prisoners with injection drug use. Because of the proven linkages between injection drug use and HIV and hepatitis C epidemics behind bars, we have also studied the issue of prison-based needle and syringe programs. In 2006 we released the most comprehensive international report on this issue, looking at the international experience. Last year I testified before this committee on the pressing need for these programs in relation to the study of mental health and addiction in prisons.

I'm going to go into the research now quickly. What it demonstrates is that despite the sustained efforts of prison systems to keep drugs out, people in prison use drugs. And they do enter the prison system. This has been confirmed by all of the witnesses to this committee in previous meetings, including those who work in corrections. While positive urinalysis test results may be down, rates of HIV and hepatitis C behind bars are increasing. The 2010 figures released by CSC indicated a self-reported HIV prevalence rate of 4.6 % among prisoners. This is 15 times the HIV prevalence in the community. Aboriginal women reported the highest rate of HIV, at 11.7%. Among those ever tested for hepatitis C virus, 31% reported a hepatitis C positive test result, which is 39 times greater than the rate in the community. Again, aboriginal women reported the highest hepatitis C rate, at 49.1%. That's almost one in two aboriginal women testing positive for hepatitis C.

These prevalence rates rival those in sub-Saharan Africa. Significantly, people are not only coming to prison infected with HIV or hepatitis C, but they are also sero-converting inside, and I know a number of prison physicians will attest to this.

In our interviews with prisoners and former prisoners across Canada, many confirmed the accessibility of drugs, the extent of addiction, and the pervasiveness of injection drug use in prison. Because of the scarcity of injection equipment in prison, people who inject drugs, including those with addictions, are more likely to share injection equipment than those in the community, thereby increasing their risk of contracting HIV and hepatitis C.

The 2010 CSC report that I just referred to indicated that 17% of men and 14% of women injected drugs in prison. About half of those people who injected drugs shared injection equipment, including with people who they knew had HIV, hepatitis C, or unknown infection status.

Though these figures are high, they are likely understating the pervasiveness of this practice, given the repercussions for those who admit to this illegal behaviour. Moreover, these numbers represent an increase in reported injection drug use since a 1995 CSC survey. In 1995, this survey indicated 11% of prisoners reported drug use by injection. So it's quite a significant increase.

Programs that ensure access to sterile injection equipment are therefore an important component of a comprehensive approach to reducing prisoners' vulnerability to HIV and hepatitis C infection. To date, these programs have been introduced in more than 60 prisons in at least 11 countries. They're mentioned in my report, but I'll just give you a quick rundown: Switzerland, Spain, Moldova, Belarus, Kyrgyzstan, Tajikistan, Germany, Luxembourg, Iran, Romania, and Armenia. We know they're operating in well-funded prison systems and severely under-funded prison systems, in civilian and military prison systems, in institutions with drastically different physical arrangements for the housing of prisoners, in men's and women's institutions, and in prisons of all security classifications and sizes.

They also use different methods for distributing the equipment. They use hand-to-hand exchange by nurses or the prison physician; distribution by one-for-one automated syringe dispensing machines; peer outreach workers and other prisoners who are distributing the equipment; and external NGOs or other health professionals who come in and do the distribution.

The best available evidence all points to the fact that these programs work. They reduce risk behaviour and disease; they don't increase drug consumption or injecting; they do not endanger staff or prisoner safety—and I think that's really an important point, because I know a correctional officer has previously testified about his concern about this posing a risk to his staff—and they have other positive outcomes for the health of people in prison, including increasing referrals of users to drug addiction treatment programs.

● (1155)

Since the first program was introduced in a Swiss prison in 1992, there has not been a single reported case of injection equipment being used as a weapon against either a staff member or another prisoner. Prisoners are usually required to keep their equipment in a predetermined location in their cells. This assists staff when they enter the cell to conduct searches and has decreased accidental needle stick injuries. Staff are much less likely to encounter used needles that are hidden in prisoners' cells and to be accidentally pricked with a needle that has been used countless times by countless people. These findings were all confirmed in a review by the Public Health Agency of Canada called *Prison Needle Exchange: Review of the Evidence*. It was done in 2006 at the request of Correctional Service Canada.

A focus on drug interdiction and abstinence, especially in a federal prison context where there are waiting lists for substance abuse treatment programs, ignores a substantial body of research that demonstrates that addiction is a chronic and relapsing condition shaped by many behavioural and social contextual characteristics. By refusing to implement prison-based needle and syringe programs, CSC unnecessarily places individuals with the most severe drug dependence at risk of hepatitis C and HIV infection.

Many have relied on these programs in the community. I know that all of you are aware there are over 200 needle and syringe programs operating in communities across Canada, with more in development. They've had the support of all levels of government, and the evidence shows that they work.

Denying these programs to prisoners also discriminates against people who inject drugs in prison and aggravates the public health by contributing further to the harms associated with unsafe drug use. As we discussed in our written brief, prisoners disproportionately embody multiple characteristics recognized as traditional grounds on which discrimination is prohibited. In particular, the denial of these programs to prisoners disproportionately affects aboriginal communities, which are disproportionately represented already in Canadian prisons, and among people who inject drugs and people living with HIV in the population as a whole.

The denial of these programs to people in prison also disproportionately impacts women. Though they constitute a minority of those incarcerated in Canada, a significant percentage of women were incarcerated for offences related to drug use often linked to underlying factors such as experiences of sexual and physical violence and abuse. A previous history of injection drug use is also consistently found more frequently among women than men in Canadian prisons.

Already HIV and hepatitis C prevalence is significantly higher among incarcerated women than men in Canada. As the Canadian Human Rights Commission has concluded, "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", an impact that "may be particularly acute for federally sentenced aboriginal women".

With increasing rates of HIV and hepatitis C in prison, society also bears the cost of treatment for those who are infected. According to Correctional Service Canada, treating a prisoner with hepatitis C costs $22,000, and treating a prisoner with HIV costs $29,000 per year. This is a lifetime cost. It is far more cost-effective to provide prisoners with sterile injection equipment than to treat their HIV or hepatitis C infection.

The World Health Organization actually provided an informal quotation for the unit cost of this equipment, and it came to $4 to $10 U.S. per person per year. These costs are for programs in the community, but I think they're applicable in the prison context as well.

In 2006, more than 2,000 people were released from prison into the community with hepatitis C and more than 200 people were released into the community with HIV. Prison health is public health. There is no reason to treat prisoners differently from people in the community who are struggling with addiction. By reducing the risk of HIV and of hepatitis C infection among prisoners who inject drugs, the majority of whom return to the community upon release, the health of the Canadian public is also better protected.

Thank you.

● (1200)

The Chair: Thank you very much.

We'll now move to the next presentation.

Mr. Clarke.

Mr. Seth Clarke (Community Development Coordinator, Prisoners with HIV/AIDS Support Action Network): Thank you.

I would like to start by thanking the committee for inviting me here to speak with you today.

PASAN is a community-based organization that provides support and prevention education services to prisoners around infectious diseases, with a focus on HIV/AIDS and hepatitis C.

My comments today will be focused around drug use and drug dependency in prison and its connection to prisoners' pain management needs and issues.

The federal prison population is comprised of a diverse spectrum of people, and within it there are disproportionate numbers of people of low income, racialized communities, people with disabilities. And obviously, as you well know, it is hugely over-represented by indigenous people, many of whom are suffering from trauma and have been survivors of the residential school program. Prison also has many people with diagnosed and undiagnosed mental health issues, substance abuse habits, and dependencies. Obviously, there are many people in prison with drug-related convictions, going from possession to possession for the purposes of trafficking, but also many people are in prison with convictions for fraud or theft, which are related to their drug use habits.

I want to start by clearly saying that there is a level of trauma and all kinds of issues that prisoners are dealing with as they come in. Also, there's the fact that they're in prison and isolated from their family and from their communities. Obviously, they're in an environment where there's some hostility, and trust and support is quite hard to access for prisoners. These things all play a role in terms of a prisoner's ability to maintain a level of good health.

Just a few notes about how this has been studied over a period of time....

A report was commissioned by CSC. It was a health care needs assessment of federal inmates in Canada that found that inmates were thirty times more likely to inject drugs than people outside, two to ten times more likely to have an alcohol or substance use or abuse disorder, more than twenty times more likely to have been infected with HCV, ten times more likely to be infected with HIV, more than twice as likely to have any mental health disorder, and four times more likely to die of suicide than people on the outside.

These figures point to the fact that prison is not a place where it's easy to maintain a level of health. Also, the correctional investigator's report from 2009-2010 stated that hepatitis C rates have increased by 50% between 2000 and 2008, and also stated that it is a fact that HIV and HCV are acquired, transmitted, and spread in prisons.

I want to talk a little bit about pain management issues in prison generally. Prisoners, like people in the community, are going to have different pain management issues in their lives. This can be based on physical pain, emotional and psychological pain, and distress. As I said earlier, many prisoners are survivors of trauma and abuse in their past. One of the difficulties in terms of drug use in prison and pain management in prison is that a lot of prisoners, as I said earlier, will come into prison already with drug use habits that they need to deal with. The process that the prison service goes through with people is one in which the first response to a drug use situation is often a punitive response rather than a therapeutic response. The policies in prison are ones that obviously try to reduce drug use and try, first and foremost, from a security perspective, to control that situation.

● (1205)

Also, on both sides, prisoners and staff, there is a degree a suspicion, which is a part of the culture of the prison environment. Trust levels are low on both sides.

Often, prisoners who are presenting with pain management needs of all types are at risk of being labelled as having drug-seeking behaviour and are at risk of having a higher level of scrutiny from the guards and the correctional system because they are considered to be a potential risk.

Again, the fact that prisoners know this means that oftentimes there is a greater likelihood that the prisoners are going to become involved in more risky practices—if they are using drugs, they will use them more quickly—and the lack of effective harm reduction materials and services means that prisoners are in a situation in which they are at much greater risk of contracting and spreading infectious diseases.

There is also the allegation that prisoners with the label of potentially being drug-seeking might divert drugs to other prisoners. Again this brings greater scrutiny on prisoners. There are many consequences for suspicion of drug use or diversion, and also the potential that somebody might have a positive urine analysis test. These consequences include potential loss of institutional work, movement within an institution or transfer out of an institution, possibly a period of time in segregation, loss of visits and so more isolation from family, and also potential institutional charges.

The existence of this as a part of the drug strategy again makes it less likely that prisoners are going to come forward looking for support treatment around drug-use types of issues and around self-medication types of issues.

One of the things that is key around this is that in spite of addiction being as a disability, as I said, the first response often tends to be punitive rather than therapeutic. Programming that is available in prison for prisoners around drug use and treatment-type issues tends to be limited. There tend to be fairly long waiting lists to get into the programs that exist.

But when I say “limited”, it is also often the case that people need a certain level of support in order to make changes in their lives. Often the treatment options available are of a certain type and do not recognize that people are struggling to meet their pain management needs at the same time as looking to make changes in their lives, hopefully, so that they have a better chance of staying out when they do eventually get out.

Security considerations often trump the health needs of prisoners around these kinds of issues. I would argue that there's no effective one-size-fits-all strategy around drug treatment for people generally. In the community there are usually greater options for people when they are looking at treatment and rehabilitation with regard to drugs. I think this is important, because we always want to look at the principle of equivalency, in terms of whether what is available to prisoners is as close to possible to being equivalent to that which is available in the community.

In terms of the broad things that are available in the community, from harm reduction services to support services to treatment services, there isn't the same access, and very importantly in terms of people being able to make different choices, it is important that a large proportion of the different options available to prisoners around drug use be provided, hopefully, by community organizations that are going into prisons to provide those services. That gives people different options, options that do not necessarily expose them to a system in which there are obvious concerns about the potential punitive repercussions people are going to face.

● (1210)

I just want to give a very quick example—

The Chair: I'll just jump in here.

Could you conclude quickly? We have to move into some questions. We have a number of members who want to ask you some questions. Maybe in response to some of those questions you can fill in some of the things you didn't get to say and include them in your answers.

Are there a couple of sentences you want to conclude with?

Mr. Seth Clarke: I'll just say that a comprehensive drug strategy in prison would include a review of pain management procedures and of the drug formulary that exists for prisoners; an increase in harm reduction services, including prison needle and syringe programs; an increased level of support for treatment options for prisoners, including having community-based organizations provide them, and so developing partnerships between the institutions and community organizations.

The Chair: Thank you very much.

I thank you both, Ms. Chu and Mr. Clarke.

We'll proceed into the first round with Madam Hoeppner.

Ms. Candice Hoeppner (Portage—Lisgar, CPC): Thank you, Mr. Chair. I'm going to be sharing my time with Mr. Norlock.

I have a very short amount of time, so my questions will be rather quick. I'm hoping you can respond with short answers to begin with, if that would be all right.

Ms. Chu, as part of our anti-drug policy our government has committed to a zero tolerance drug policy in prisons. We recognize that this is obviously a very difficult goal to aspire to, but we believe it's best to aim high.

Would you agree that a zero drug policy is probably the very best policy? Do you agree with that for prisons?

Mrs. Sandra Ka Hon Chu: I think it's unrealistic. Although we have a zero tolerance policy for drugs outside in the community, we have needle and syringe programs in the community for people who are drug-dependent, to protect their health.

Ms. Candice Hoeppner: It's prisons, though, that I'm wondering about. Prisons are places where there are other.... For example, tobacco is legal outside of prisons. There are different things that have different standards inside prisons from those outside prisons.

I'm wondering, specifically in prisons, whether you would agree with a zero tolerance drug policy.

Mrs. Sandra Ka Hon Chu: I think it's laudable but unrealistic. These people are arguably suffering more greatly from drug dependence because, as Seth mentioned, many people are incarcerated for drug-related offences. The correctional investigator pointed out that 15% of people on any given day are actually on treatment.

You can aim for zero tolerance, but in the meantime people are going to be infected with HIV.

Ms. Candice Hoeppner: I understand. Thank you. I've heard your presentation, so I do understand your position. I just wondered whether you would agree with that ideal, even though it obviously is very difficult to achieve. Ideally it would be great if there were no drugs in prison. Would you agree with that?

Mrs. Sandra Ka Hon Chu: I think aiming for that will undermine people's health. I mean, without implementing other programs—

Ms. Candice Hoeppner: You would not agree with that, then. You're saying you would not agree with that. Is that correct?

Mrs. Sandra Ka Hon Chu: I'm saying it's unrealistic. There's no prison in the world that has no drugs.

Ms. Candice Hoeppner: Right. Okay, thank you.

The next point I want to talk about.... I have great concern with what seems to me a great imbalance towards helping inmates who are addicted to drugs being able to access more drugs and access paraphernalia to administer those drugs, against the safety of officers who are doing their job every day, putting their lives at risk.

They are law-abiding citizens. They have not committed any crimes. They may have had issues in their lives as well by virtue of which they could have made bad decisions, but these are individuals who are working on behalf of Canadians. It appears to me that their safety is, with your presentation, completely ignored.

I wonder whether you could please tell me—and I would ask you not to cite the Swedish study, because I don't have that in front of me—how you could practically.... Talk about unrealistic goals. How can you practically say and try to make us believe that needles would not be used as weapons against officers?

● (1215)

Mrs. Sandra Ka Hon Chu: I absolutely agree that the safety of staff is paramount and important.

We work on an evidence base. We've looked at the needle-syringe programs that have existed since 1992. It's been almost 20 years that they've existed around the world, and as I mentioned, in multiple sites and in different contexts. There has not been a single case in which they have been used as a weapon.

There's one example I'd like to point out. In Germany the staff were also very much against it. They were concerned, and it's an understandable concern: needles can be used as weapons. But in that case they had the program implemented and the staff became wholly supportive of it, because they felt they were protected in the end. There's less chance for accidental needle injuries when the equipment is in a specific place in each person's cell. They know that when they search someone they're not going to be pricked. And if it does happen, God forbid, then it's not with a needle that has been passed around by numerous people and possibly infected with HIV or hepatitis C.

Ms. Candice Hoeppner: Unfortunately, I don't know that this would be satisfactory to Canadians. If you're giving inmates who have already shown that they have trouble obeying laws, basic laws, and sometimes have trouble respecting the safety and rights of others.... I think it's very....

Again, talk about a difficult stretch, trying to think that needles would not be used as weapons; I really have trouble with that.

The Chair: Thank you, Ms. Hoeppner.

We'll now move to Madame Morin.

[*Translation*]

Ms. Morin, you have five minutes.

Ms. Marie-Claude Morin (Saint-Hyacinthe—Bagot, NDP): Good afternoon. I want to start by thanking the witness for her presentation; it was very informative.

Your remarks once again confirmed for me that harm reduction is much more effective than zero tolerance, given that it is less repressive for inmates. When that approach is taken, inmates are much less likely to turn against guards using syringes as weapons since they do not feel quite as suppressed.

Could the syringe programs we were talking about earlier become a necessity in order to keep the public safe? I will explain. Given the long wait times for psychological support and substance abuse treatment programs, could someone who is released from prison have contracted HIV/AIDS while in prison and not know? If so, there is a greater likelihood of that person infecting the public. With that in mind, could we say that a syringe program is a necessary measure in order to protect the safety of the public, as well as the safety of guards?

[*English*]

Mrs. Sandra Ka Hon Chu: Absolutely. We always underscore the fact that prison health is public health.

I've spoken to a number of prison physicians who work in Canada and who treat people with HIV and hepatitis C who say they are 100% certain that people are being infected inside while they're on waiting lists for treatment. Over 90% of the prison population in Canada are released into the community. It's not as though we throw people into prison and then walk away and forget about them. The health of people in prison is very intimately linked to the health of the community.

[*Translation*]

Ms. Marie-Claude Morin: Thank you.

My next question is for Mr. Clarke.

I was quite struck by what you said earlier about a comprehensive strategy being a good way to, at least, reduce the incidence of drugs in prisons and thereby make those facilities safer. Could you elaborate on that a bit further since you did not really have enough time before?

[*English*]

Mr. Seth Clarke: I'm sorry; could I just have the first part again? What strategy do you mean? Is it the drug strategy?

The Chair: Yes, the first part was dealing basically with the drug strategy.

Mr. Seth Clarke: What I'm proposing is that an effective drug strategy would involve dealing with prisoners' pain management issues, and not purely physical pain management issues but pain management issues that basically speak to people's experience in some cases before they come into the institutions. Many people, when they start to use drugs, are trying to mask something; they are self-medicating, and there are underlying issues that might need psychiatric support. In many cases people are in that situation both before they come in but also through their experience in the institution.

As to levels of isolation, I've always argued that if people do not have mental health issues when they come into prison, if they're doing a federal sentence they are likely to have mental health issues when they leave.

So a drug strategy should definitely look at people's pain management issues and people's mental health needs in the institution and would include broader options for treatment and programming, many of which, I would argue—and this is partly to get past the issues of trust and fear—should be provided by community organizations that are relocating their services into the institution. Again, that would support the principle of equivalency, in terms of people having comparable services for health available to them in prison to those that exist in the community.

A part of that effective drug strategy would also involve comprehensive harm reduction services available to prisoners, hopefully lowering the risk to prisoners—and eventually to the community as prisoners get out—from there being much higher rates of HIV and HCV among the prison population.

● (1220)

The Chair: Thank you very much.

We'll now move to Mr. Norlock and then to Mr. Scarpaleggia to conclude the first round.

Mr. Rick Norlock (Northumberland—Quinte West, CPC): Thank you, Mr. Chair, and through you to the witnesses.

Mr. Clarke, I have written down a couple of things you had to say.

I'll preface my remarks by saying that there is a responsibility on behalf of the state to make sure that those people who are incarcerated by the state for crimes committed against society...that the state should do as much as it can so that you leave our institutions with the tools you need in order not to return. That's what I'll preface my remarks with.

You say prison is not a good place to maintain a good level of health. One of the things I noted on visiting many prisons across this country of ours is the degree among some prisoners of possessing, I would say, a healthy body, meaning to say that they take part in exercise programs, have gym facilities available, and have an adequate diet with which to maintain health.

I wonder if you could, in a very succinct way—because I have several other issues to address—explain what you mean by its being difficult to maintain a good level of health.

Mr. Seth Clarke: I would generally argue that for many prisoners their ability to physically exercise is limited. Many prisoners are for many hours of the day locked inside, locked in their cell. They do not necessarily always have access to those facilities—although there is access, there's no question about that. I would also say that the available diet for prisoners is not all it could be.

In terms of my comments about its being a place where it is difficult to maintain health, I think the isolation people experience, from family and community—

Mr. Rick Norlock: Okay, sir, I get what you're saying. You and I could have a discussion about doing sit-ups and push-ups and other things within a confined space, as many Canadians do at home. There are reasons....

The other comment was in regard to pain management. You said in one of your statements that pain management as well is associated to mental anguish—I think those would be the appropriate terms—and that prison is not a good place to be because you're confined, and you have anguish because you're confined in prison.

I'm going to leave out the mental anguish and pain suffered by the victims of the people that are the reason some men and women are in jail. But are you telling us that if you have physical pain, from an injury incurred either within the confines of prison or outside prison, there isn't an availability of proper medication such as aspirin, ibuprofen, and those types of things through the health clinics that we have in our prisons? Are you saying that there are people suffering pain because they're not getting adequately seen by a nurse or other medical practitioner?

● (1225)

Mr. Seth Clarke: I'm absolutely saying that the services available around pain management for physical pain are not what they are in a community. It is not at all unusual for prisoners to be aggressively tapered off certain drugs. Kadian would be an example of a drug that prisoners are often tapered off from when they come into the institution; then there's a new process which the prisoner, obviously with the health care people in the prison, has to go through to define exactly what their pain management needs are and then in some cases to try to get back on medication they've been on for several years.

Mr. Rick Norlock: I think what you're referring to is that some medications are habit-forming and that they try to get you onto other habit-forming....

You also mentioned that when prison officials are looking for drugs, etc., it causes mistrust. I think you said that trust levels are low on both sides.

You have to realize that this is a public hearing and that people outside are going to be asking, isn't it a natural and a needed thing that our prison officials are looking for illegal drugs being brought into our prisons? And if that causes low morale, maybe the prisoner has within himself or herself an ability to change that trust level by adhering to the programs that are in prison and appreciating the fact that we're trying to keep illegal drugs outside of our prisons.

If you use your argument to the converse, we'd have really good trust levels if they didn't look for drugs at all.

The Chair: Thank you, Mr. Norlock. Unfortunately we're out of time, and we really are watching our time.

We'll have to move to Mr. Scarpaleggia, who will have some questions for you.

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

Welcome to the committee.

This is kind of a basic question, maybe a bit naive, but how do needles get into prisons? One understands how a substance or a pill or marijuana can get in, but it seems to me I couldn't board a plane with a needle after going through the electronic screening device. How do needles get in? How can a family member, for example, bring a needle into a prison undetected? I just don't understand.

Mr. Seth Clarke: I think when you look at how needles and/or drugs get into prison, you have to look at who has access to the prisons. In terms of access, there would be people who work in the prisons, people who visit relatives and friends in the prisons, and people who come into the prisons to provide services and programs of other types. Obviously with needles, every institution would have a health care department, and obviously there will be needles there for other uses. So there's the potential that some of those get diverted....

There are lots of ways in which different things get in our prisons. All the others suggest that has always happened.

Mr. Francis Scarpaleggia: No, but what I'm saying is—

Mr. Seth Clarke: So I think that when you figure out how drugs get in, it's very similar.

Mr. Francis Scarpaleggia: Except that—

Mrs. Sandra Ka Hon Chu: I have also spoken.... Oftentimes some of this injection equipment is fashioned from BIC pens, from different materials that are found in the prison system. We've seen numerous examples of things that prisoners have constructed out of the available material they already have access to.

Mr. Francis Scarpaleggia: Now, you mentioned something—I missed this—about drug formularies in prison. One of you mentioned...this was part of someone's comments. Could you repeat that and explain that? I missed it.

Mr. Seth Clarke: Sure. CSC has a drug formulary. It's basically a list of all the medications available for prescription in the institutions. So there will be certain drugs available in the community that would not be available on the drug formulary for reasons of their being potential security risks, of their being considered to be more addictive, etc.…. So the drug formulary from CSC health care lists all the medications that are available. And it is reviewed quite regularly.

● (1230)

Mr. Francis Scarpaleggia: Okay. We talked a bit about this in the last meeting, and Mr. Leef made a good point. I was wondering about prisoners suffering from withdrawal. The point was made that by the time they get to a penitentiary, they've been in a holding cell or another form of detainment, maybe awaiting trial, and therefore withdrawal is not an issue. Is that the case in federal penitentiaries? By the time a prisoner gets through the doors any immediate withdrawal symptoms have disappeared and withdrawal does not require treatment?

Mr. Seth Clarke: No, I would say it's not necessarily the case. Obviously most prisoners will have spent an amount of time in a provincial institution or another institution prior to coming to a federal penitentiary. It probably depends on what that other institution was prescribing for the person. In terms of street drugs, the vast majority of people would be in a situation where they haven't had the same access for as long. There are different arguments as to what availability there is of illicit drugs in the provincial system.

But as you said, oftentimes we see prisoners coming into the federal system and then having medication changed—often pain management such as Kadian, as I mentioned, being tapered. So we get many phone calls from prisoners who are struggling at times like that, and in some cases they talk to us about how they say they haven't really used drugs in a long time. All of our clients are HIV positive, some are co-infected with—

Mr. Francis Scarpaleggia: Are they getting the help they need?

Mr. Seth Clarke: They talk about being withdrawn from drugs and feeling that they might go to the underground drug system in the institutions, obviously again raising the risk of—

Mr. Francis Scarpaleggia: But are they getting the help they need at that crucial pivotal point when they're going through withdrawal and starting to look at the underground drug market in the prison? Are they getting the interventions they need at that very pivotal point?

The Chair: Thank you, Mr. Scarpaleggia.

Go ahead and answer.

Mr. Seth Clarke: I think it's uneven, as far as the support they're getting at that time. Many prisoners report to us they're not getting support at the time. Sometimes prisoners try to transfer to methadone and other drugs while in the institution, but it's often not seamless. In some cases people have withdrawn from the drug and are not given an alternative. So I would say it's uneven.

The Chair: Thank you very much.

I want to thank both Mr. Clarke and Ms. Chu for being with us today. I apologize again for cutting back on some of the time because of the votes we had in the Commons this morning. But thank you for your points.

Something new that you have brought out that we haven't heard from others is pain management. Maybe that's something we'll be able to explore a little more. There were a few questions on that.

I invite our new guests to the table.

In our second hour today we have, from Corrections Services Canada, Mr. Don Head, the Commissioner of CSC; and Mr. Christer McLauchlan, security intelligence officer at the Stony Mountain Institution.

You obviously heard in the first hour what our study is on, so I won't go through all that again. We thank you for coming back on this study that we're doing. We appreciate your assisting us by ensuring that we have your testimony and testimony from your staff, including Mr. McLauchlan.

Commissioner Head, please proceed. Thank you again.

● (1235)

Mr. Don Head (Commissioner, Correctional Service of Canada): Thank you, Mr. Chair and members of the committee. Thanks for having me back to discuss how the Correctional Service of Canada manages the issue of drugs within our penitentiaries.

As you have already indicated, I am joined this afternoon by one of my security intelligence officers, Chris McLauchlan, who works out of Stony Mountain Institution, a medium-security institution near Winnipeg. I will point out as well that Mr. McLauchlan has also been a drug detector dog team handler and a correctional officer, so he has tremendous experience on the front line. He will be able to speak to his personal experiences in relation to detecting and interdicting drugs in the federal correctional system.

Mr. Chair, in managing the issue of drugs in our federal penitentiaries, as I've pointed out previously, CSC takes a three-pronged approach: prevention, treatment, and interdiction. This approach is employed to addresses the significant challenges we face every day in dealing with a complex and diverse offender population, many of whom present with significant substance abuse problems.

We are also challenged by motivated individuals on the outside who utilize a myriad of innovative ways to get drugs inside institutional walls. In the recent past we have intercepted drug delivery mechanisms such as dead birds, bows and arrows, and tennis balls.

In fact, just three days ago staff at Matsqui Institution in the Pacific region recovered a package of drugs and paraphernalia that had been lobbed inside the prison. We are investigating the exact nature by which the drugs were projected this significant distance, but we suspect that a potato gun was used. The package contained marijuana, heroin, and a digital scale, all of which have an institutional value of approximately $21,000.

As well, staff intercepted drugs at Leclerc Institution, in Quebec, the other day, with an institutional value of $28,900. They were able to intercept this before it made its way into the hands of the offender population.

I continue to be extremely proud of the great work that my staff do on a daily basis to keep our institutions safe.

CSC is also facing an increase in the number of offenders who have a gang affiliation. Currently there are approximately 2,200 offenders who have gang affiliations, and there are over 50 different gangs inside our institutions across the country. The majority of members had gang affiliations prior to their incarceration, and most of these came from street gangs. These now outnumber those associated with outlaw motorcycle groups or traditional organized crime groups that we've come to know.

Mr. Chair, I know this committee is specifically interested in the link between gangs and drugs, and I can tell you that approximately one-quarter of incarcerated offenders who have a gang affiliation are serving time for drug-related offences. This includes possession, importing, and trafficking of drugs, among others.

I will share with the committee a typical schematic that shows how gangs try to introduce drugs into a penitentiary. I believe members of the committee have that in front of them.

CSC has a wide range of tools at our disposal to detect and interdict any attempts to introduce drugs into our institutions. Our complement of security intelligence officers, like Mr. McLauchlan, has increased over the last couple of years and it will continue to do so. We expect that by the fiscal year 2012-13, we will have 250 dedicated officers across the country to enhance our capacity to detect a possible drug delivery into our institutions. This will also increase our knowledge of the drug problem and allow Chris and his colleagues to better share information across the regions.

Furthermore, we are now delivering new training to our security intelligence officers as well as our correctional officers that will focus more attention on dynamic security and gang management.

As I mentioned at my last appearance, we are also increasing our complement of drug detector dog teams, enhancing perimeter security, and making better use of technology to keep drugs out.

These are just a few examples, and they barely scratch the surface of what is a complex, integrated approach to drug interdiction within the federal institutions.

Mr. Chair, every day CSC employees across the country are working to ensure safe, drug-free institutions that will promote offender rehabilitation and create safer communities for Canadians. I am proud of my dedicated staff, like Chris, who exemplify the best of our mission, our mandate, our values, and our ethics.

● (1240)

At this point, Mr. Chair and members, I would welcome any questions you might have for me or Mr. McLauchlan.

The Chair: Thank you again, Commissioner.

Thank you, Mr. McLauchlan, for coming.

Although he didn't have a presentation, Mr. McLauchlan is willing and able to answer any questions you may have in relation to his position and to his responsibilities in prison.

We'll move to the first round, and we'll start with Mr. Leef, please.

Mr. Ryan Leef (Yukon, CPC): Thank you very much, gentlemen, for joining us today.

Welcome to Mr. McLauchlan, who's new to joining us here during this study.

Thank you very much for the schematic, because it shows in great detail the high level of organization and complexity that goes on in the federal prisons to bring drugs into the institutions.

So far, quite a bit of the study has really been focused on treatment and rehabilitative needs. I do like CSC's three-pronged approach with prevention, treatment, and interdiction. Certainly I think everybody on the committee has agreed that rehabilitative efforts and treatment are an essential element to corrections in Canada. But it almost appears as though we've forgotten about the level of complexity and organization that would go, in my opinion, beyond just somebody who is a victim to circumstances in life and who finds himself addicted and into pain management and those sorts of things. We are now seeing a growing concern with criminal organizations, gangs, and criminal choice, which is feeding a huge part of our problem within the institutions.

Are we having a tough time balancing this focus on treatment of addictions with the absolute need to deal with people who are making criminal choices in a criminal organization? What kind of relationship is that creating between staff and inmates?

Staff, as you know, are trying to really deliver that front-line program delivery, be that direct supervision or working and living with these inmates every day, but then having to really focus, at the same time, on slowing down this criminal organization and criminal choice versus a truly “addicted” concern, where rehabilitation would be necessary.

Mr. Don Head: I think there is a significant challenge for the staff. It is a balancing act in terms of dealing with those individuals who are prepared to address their problems, the problems that have brought them into conflict with the law, and in this case problems with substance abuse, versus those who continue to be involved in an underground economy, a criminal activity, within the institution.

That's one of the reasons why we've structured ourselves around that three-pronged approach. It allows us to have the capacity to help those who have come to a realization that they need to get their lives in order. They want to participate in programs and they want to change things around. At the same time, we have the capacity—with, for example, Mr. McLauchlan, security intelligence officers, our drug-detector dog teams, even our front-line correction officers—to deal with those who are still actively involved in criminal activity or are bringing drugs into the institution.

So it is an ongoing balancing act, at times more challenging than at other times. Mr. McLauchlan can talk about some of the significant challenges coming from an institution where there are significant aboriginal gangs who are constantly involved in trying to bring drugs into the institution.

Mr. Ryan Leef: To Mr. McLauchlan, have you experienced occasions when inmates have specifically asked you or staff working under you to really get a handle on the drug situation, to find great strategies to stop it from coming in, to intervene on that flow from outside and inside, to relieve pressure on their family members, to relieve pressure on themselves? Have you experienced inmates directly coming to you and asking you to please intervene?

Mr. Christer McLauchlan (Security Intelligence Officer, Stony Mountain Institution, Correctional Service of Canada): Absolutely. We have individuals who come to us because they're already in trouble and they're looking for our assistance in dealing with that, whether they've already brought drugs into the institution or they're being pressured to do so. We deal with that from our security intelligence standpoint. We utilize the information they provide and we try to assist them and combat the drugs coming in.

I personally have been approached generally by inmates who say "I wish you could help stop the drugs coming into this institution. I'm an addict, and if I have these drugs available to me, I am going to use them." I've actually had inmates say they wished we could do more to stop the drugs coming in.

So yes, I definitely have experienced that myself.

● (1245)

The Chair: Thank you, Mr. Leef. Unfortunately, your time has expired.

Mr. Sandhu.

Mr. Jasbir Sandhu (Surrey North, NDP): Thank you for being here today again.

I mentioned on Tuesday in this committee that it's very difficult to look at the impact of drugs and alcohol in prisons in isolation. We're finding out that it's a complex system, where drugs are part of the prison community.

Rehabilitation, access to programs, the spread of disease, mental illness, and the safety of prisoners or guards are all part of the problem with drugs in prisons. I think the goal of our committee is to improve public safety, which I think any study of our committee should be. I think it's clear that we need to consider a balanced approach that includes rehabilitation and interdiction programs.

I keep hearing from the government members about having drug-free institutions. I think that's a great idea and would like to see that. My question is to the commissioner. Is that possible? How realistic is it?

Mr. Don Head: I know it comes with challenges, but I believe it is possible. Just to give you an example, in some of our institutions we have offenders who are looking to get away from the subculture that Mr. McLauchlan was talking about. I have worked actively with the staff to create drug-free ranges in the institutions.

For example, in Mr. McLauchlan's institution there is the Pathways unit for aboriginal offenders to be able to follow an aboriginal healing path. We can do urinalysis of offenders on a random basis if we suspect they may be involved in drugs, but in this unit the offenders agree to submit voluntarily to urinalysis to show that they continually want to lead a drug-free life. If we are able to stop the drugs coming in, as Mr. McLauchlan has talked about, and create a safe environment, we'll get more offenders who will want to address their criminogenic needs that brought them into conflict.

So the more I can create those opportunities, the closer I'm going to get to a drug-free prison. I believe it's possible, but it has challenges.

Mr. Jasbir Sandhu: If the supply of drugs is not there, will you require more treatment programs for the prisoners to get them off the habit?

Mr. Don Head: That's part of the challenge, because 80% of offenders who come in have had some kind of substance abuse problem some time in their lives. Just over half of the individuals who come into our system were under the influence of a substance at the time they committed their offence. So we have to work with them to get them involved and motivated to take the program.

As we shut down the drugs coming in, we need to make sure we have the interventions, programs, and services so they can get their lives in order and ultimately return to communities in a way that it's not going to jeopardize Canadians.

Mr. Jasbir Sandhu: Even though I have a hard time believing it, and stats would back that up, I would like to see drug-free prisons. I doubt we'll get there. What sorts of resources would you require?

Mr. Don Head: Continuing to support us along the three prongs of prevention, treatment, and interdiction is what's needed. When the government injected $122 million into the organization a few years ago to help us combat the issue of drugs, we saw a decrease—not to zero—in positive urinalyses. We saw an increase in the number of seizures. At the same time, we received an infusion of money for increasing the number of programs we delivered in our institution.

So we're seeing some positive outcomes associated with that, but we need to continue to maintain that financial base in order to produce positive results.

● (1250)

Mr. Jasbir Sandhu: I want to ask the question again. If we were to get to zero tolerance or zero drugs in prisons, you would need money for interdiction and rehabilitation programs. How much would you need from the government?

Mr. Don Head: I can't put an exact figure on that, but the zone we're in now is helping us to move in the right direction. Unfortunately, I just can't give you a dollar figure today.

Mr. Jasbir Sandhu: Would you say there would be a time when you would get diminishing returns on the amount of money you're spending on interdiction?

Mr. Don Head: I wouldn't necessarily say that. Offenders have multiple needs when they come into the system. They are always going to look at approaches or things offenders will look at to try to satisfy some kind of need. It's going to be an ongoing challenge.

Mr. Jasbir Sandhu: Let me get this correct. You're telling this committee that if we give you *x* amount of money, you will have drug-free prisons.

Mr. Don Head: I'm saying that's the direction I will continue to move in.

The Chair: Thank you, Mr. Sandhu.

We'll now move to Mr. Aspin.

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

Welcome, gentlemen. We appreciate your expertise and your help in our work with this committee.

A few weeks ago a particular individual from the Canadian Association of Elizabeth Fry Societies who testified indicated that strip-searching inmates in order to look for contraband was tantamount to state-sponsored sexual assault. Mr. McLauchlan, as someone who works on the front lines of keeping contraband out of institutions, could you comment on the necessity of strip searches as a tool for interdicting contraband?

Mr. Christer McLauchlan: Certainly.

Obviously when people are attempting to introduce drugs into the institution or to conceal drugs within the institution, they're going to use any means available to them to prevent us from finding those drugs. They're very rarely going to have the drugs just sitting in their pocket where a frisk search is going to find them.

The fact of the matter is that strip searches are necessary in some cases. The Corrections and Conditional Release Act is very restrictive about when we can do the strip searches. We have to have reasonable grounds to believe the individual is in possession of contraband. We also have to have reasonable grounds to believe that the strip search is necessary in order to find those drugs. Finally, we have to convince our institutional head that a strip search is necessary in this particular case. It is not like we're just doing these searches on visitors on a whim.

In regard to routine strip searches of the inmates, again, the CCRA gives us the right to do those in particular cases. I would certainly disagree with any characterization of these as any type of sexual assault. These are a necessary tool to deal with the presence of contraband coming into our institutions.

Mr. Don Head: If I could just add something as well, I don't know if you have the pictures in your package, but on the third page, at the bottom, you'll see a series of five packages of drugs. These were drugs that were internally concealed. If we can't do those strip searches, that amount of drugs inside my institution is going to lead to violence and is going to lead to somebody dying.

If we did not have the ability under law to do the strip searches, not just willy-nilly but following some very strict procedures, and those drugs had gotten into my institution, somebody would have died.

Mr. Jay Aspin: Thank you. That is reassuring.

If I may continue briefly, as my colleague Mr. Leef indicated, we are really appreciative of this chart on the subculture model. Mr. Head, could you just briefly describe the key elements of this chart, just so I have the right interpretation?

● (1255)

Mr. Don Head: I'll actually give Mr. McLauchlan the opportunity. He does these kinds of charts on a daily basis. I can explain it, but he lives these every single day.

The Chair: Do so very quickly, because time is limited.

Mr. Christer McLauchlan: You're looking at several different aspects. You'll have a drug leader who won't necessarily involve himself directly in bringing the drugs into the institution, although he will involve his community contacts. He might be talking to his wife to make arrangements for things to be dropped off.

Obviously somebody in the community is going to have to get those drugs, whether they're doing it because they're being muscled or whether they're doing it because they're getting money themselves. It could be girlfriends. They're going to have to have contact with drug suppliers on the outside.

Those drugs are then going to have to get in somehow, and they could get in with an inmate work gang, for instance. That's a group of individuals who are working out in the community. There could be pressure to have a family member of an inmate bring them into the institution. There might be staff corruption, simply paying enough money to have a staff member bring those drugs in.

It could be done through a transfer by an individual who goes to a program at an adjacent minimum security institution, for instance, and then returns to the medium security institution.

This is actually a relatively simple model. I've had much more complex models of actual drug transactions, but they usually involve multiple individuals in the community and within the institution. It's very rare that we'll see one person bringing drugs in just for their own personal use.

The Chair: Thank you.

Now to Mr. Scarpaleggia, please.

Mr. Francis Scarpaleggia: I'm still intrigued by how the drugs get into the prison. Going back to a point Mr. Sandhu brought up about having drug-free prisons, I would think you could have a drug-free prison if, as others have suggested, you cut off all access to the outside, you monitor inmate phone calls to their spouses. But obviously I don't think you want to go to that extent. I'm not mistaken in believing that, am I?

Mr. Don Head: No.

Mr. Francis Scarpaleggia: I'm really intrigued about how syringes get into the institution. I know some are homemade in the institution. I understand that visitors and so on can conceal drugs and bring them in that way, but is it not much more difficult for a visitor to bring a syringe into the institution than a package of cocaine or heroin or what have you? Every visitor would have to go through a metal detector, I imagine. I don't think I could get on a plane concealing a syringe, so I don't quite understand how visitors can bring syringes in. I can understand about the drug substances, but I just don't get it when it comes to syringes.

Are the syringes that are not homemade coming from inside the institution, from the medical clinics, for example?

Mr. Don Head: I will make just a couple of quick comments on that. Similar to that picture I was showing you, a syringe could be inside that package surrounded by the drugs and put into a body cavity without necessarily causing injury to the individual. The metal density in a syringe is too small. As a matter of fact, I go through the airport right now, and my belt buckle is not overly big but it's more dense than a needle and the detector doesn't go off. I hope I'm not giving away secrets for the airport.

So it is possible. One of the things we have seen is a decrease in the number of properly manufactured syringes coming into the institution; there's been a decrease over the years. But we have seen, as Mr. McLauchlan can testify, that the number of homemade syringes inside has increased.

As for syringes, I want to make a comment because it was made by the previous witnesses. Needles inside the institution are a dangerous thing for us. We have to give my staff protective gloves when they're searching cells because if somebody has even a homemade needle secreted somewhere, if they don't have the protective equipment and they get a puncture wound, they have to go through a very significant protocol at the hospital to take various concoctions to hopefully address any infections they may pick up.

● (1300)

Mr. Francis Scarpaleggia: At the last meeting when you appeared with the head of the correctional officers union I addressed a question to the union chief, Mr. Mallette. I asked if they have guards in the towers at night watching for possible drugs being lobbed into the yards. He said that in some cases they remove the officer from the tower because they need him somewhere else.

It sounds like you have a resource constraint that is preventing you from properly monitoring the prison walls for drugs being lobbed into the yards. Would you say that's correct?

Mr. Don Head: Yes, it's interesting. When we removed the towers many years ago it was because the threat we were worried about at that time was offenders escaping. We removed the towers because we put in technology around the perimeter—fence detection systems, motion detection systems, and armed mobile patrols—that actually provide us with a better response capability if somebody is trying to escape.

In those years we never worried about the intrusion from the outside-in. This is a new phenomenon over the last five or so years, so this is a challenge for us. In some of our institutions we have put the towers back, and in other cases we've been experimenting with new technology. For example, in Drumheller Institution and one of the institutions in Quebec, we've been experimenting with thermal imaging radar to detect people on our perimeter before they get close to our fences. The early indications of that technology are very positive and we'll be looking at how we can apply that in some places.

Mr. Francis Scarpaleggia: On treatment programs, I've heard that there are many unfilled vacancies for prison psychologists. I'd like to know if that's indeed the case. Is it a question of not being able to find psychologists who want to do that work, or is it because of financial constraints on the prison system?

The Chair: Thank you, Mr. Scarpaleggia.

Mr. Head, you may answer.

Mr. Don Head: The issue for us is not necessarily a financial one. It's the availability in the geographic locations of some of our facilities. Places like Port-Cartier, Quebec, are very isolated, and finding a psychologist is even difficult for that town. We have some challenges around where we're located geographically.

The Chair: All right. Thank you.

Ms. Hoeppner.

Ms. Candice Hoeppner: Before we adjourn I would like to make a suggestion.

I don't know about the other committee members, but I know Mr. Scarpaleggia expressed some concern that he's still trying to understand how certain items are smuggled in. I still have a lot of questions. This is a great diagram, a great resource. We probably could have had both of you gentlemen here for a full two hours.

We've just extended our study by another six meetings. I'm going to suggest, through you, Mr. Chair, inviting both of these gentlemen back, if they would consider coming back, so we can have a fulsome discussion. I think we need to get a picture on how drugs are coming in, and outside gang activity. We can't get that in 30 minutes.

The Chair: Mr. Garrison.

Mr. Randall Garrison (Esquimalt—Juan de Fuca, NDP): Thanks very much.

We'd very much like to have Mr. Head back. In his diagram today he includes the demand side of drugs. When he comes back we would very much like to hear about the part of the programming on the ability to reduce the demand for drugs. We'd be quite happy to see him again.

Ms. Candice Hoeppner: He could bring the investigator as well—Mr. McLauchlan. It was very beneficial.

The Chair: Mr. McLauchlan, is the boss going to give you time off to come back?

Mr. Christer McLauchlan: I'm sure we can arrange something.

The Chair: All right. Thank you very much.

Again, thank you all. You asked very good questions.

Thank you, Commissioner and Mr. McLauchlan, for appearing again.

We are now adjourned.

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