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## Thursday, December 8, 2011

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## Chair

**Mr. Kevin Sorenson**

# Standing Committee on Public Safety and National Security

**Thursday, December 8, 2011**

● (1100)

[*English*]

**The Chair (Mr. Kevin Sorenson (Crowfoot, CPC)):** Good morning, everyone, and welcome.

This is meeting number eighteen of the Standing Committee on Public Safety and National Security, Thursday, December 8, 2011. Although committees can always change their minds and extend meetings, this may very well be the last day of our study on drugs and alcohol in prisons.

In our first hour we will hear from our final witness. In terms of our second hour, we had asked a number of witnesses but all were unable to attend. So in the second hour we'll go in camera and discuss a little bit on the draft report, and there will possibly be more we can do with that on Tuesday.

We have appearing before us, from Correctional Service of Canada, Jan Looman, clinical manager of the regional treatment centre at Kingston, Ontario. This committee very much appreciates the large amount of input we have received from the Correctional Service of Canada. Certainly in your position as clinical manager at the regional treatment centre, I know we will have questions for you after your opening comments.

Mr. Looman, we look forward to your opening comments, and then we will move into a couple of rounds of questioning.

**Dr. Jan Looman (Clinical Manager, Regional Treatment Centre, Kingston, Ontario, Correctional Service of Canada):** Good morning, Mr. Chair and members of the committee.

My name is Dr. Jan Looman. I have worked at the Correctional Service of Canada as a psychologist for 18 years, all of that time spent at the regional treatment centre in the Ontario region.

For most of my career I was the clinical director of the high-intensity sex offender treatment program. This provides treatment for the highest-risk sex offenders in the Ontario region, many of whom suffer from major mental disorders.

In the summer of 2010 I assumed the responsibilities of chief psychologist at the regional treatment centre, overseeing a department of 14 mental health professionals: two occupational therapists, two social workers, five psychologists, and five behavioural counsellors. As of this week, I'm now the clinical manager at the RTC, responsible for overseeing the clinical process at our facility.

Mr. Chair, I'm pleased to be here today to share my insight and experiences with you as you study the issue of drugs and alcohol in the federal correctional environment.

By way of background, the RTC in Ontario is a 148-bed psychiatric hospital located in Kingston. It provides mental health services to federally sentenced offenders in the Ontario region. It's a multi-level facility that admits offenders from institutions across the region for assessment, stabilization, and in some cases longer-term treatment.

The most frequent diagnosis for offenders admitted to the facility is schizophrenia and mood disorders, such as major depression. Anxiety disorders are also common diagnoses. Most of these offenders at the RTC also have concurrent substance abuse disorders. That I'm sure is not a surprise to you, as I know you have already heard that between 70% and 80% of offenders suffer from substance abuse problems.

From the perspective of providing treatment to mentally disordered offenders, a concurrent substance abuse problem certainly complicates the clinical presentation. Most mental disorders are made worse by substance abuse, and much substance abuse is motivated by the desire to self-medicate.

Furthermore, when offenders with concurrent disorders are abusing substances, it becomes even more likely they will suffer an acute episode of their illness. This is further complicated by interactions between psychotropic medications and illicit substances, which may lead to accidental overdose or the prescribed medication being rendered ineffective.

Mr. Chair, at the RTC as well as at other institutions in Canada, mentally disordered offenders have a difficult time functioning at the best of times. Penitentiaries are stressful environments that make it difficult for these offenders to find and maintain any degree of stability. In addition, mentally disordered offenders can be victimized by higher-functioning offenders, which increases their stress.

Unfortunately, it is often difficult for offenders with mental illnesses to be admitted to NSAP, the national substance abuse program. Because of their mental disorder, many of the men who need the program do not get the opportunity to participate. These are offenders who end up in segregation at the institutions, or whose functioning in the program is too disruptive to be maintained.

To this end, the RTC in Ontario has an NSAP program that is delivered in a modified format to those men who meet the referral criteria. In 2012 the psychology department will also be offering a program for men who present more challenging substance abuse programming requirements due to a concurrent mental illness.

Leaving aside the issue of concurrent disorders, substance abuse in the general population has other impacts on the delivery of treatment services. First and most obviously, men who are abusing substances are not able to participate meaningfully in treatment programs. Their impairment diminishes their ability to benefit from the programs, and they're also maintaining their anti-social behaviours by being involved in the drug subculture.

Furthermore, inside penitentiaries the drug subculture is often associated with gang activity and violence. This destabilizes institutions and makes it difficult for offenders to focus on self-improvement when they fear for their own safety. Drug activity often leads to muscling behaviour and the use of weaker offenders to hold or transport drugs. All of this negatively impacts the institutional environment and therefore diminishes the ability of offenders to benefit from programming.

Mr. Chair, in closing I would like to say that I appreciate the attention of this committee to the issue of drugs and alcohol in the federal correctional system. As I hope I have conveyed to you today, it is certainly challenging to treat offenders who present with concurrent mental health issues.

Thank you once again for the opportunity to appear before you today, and I will be pleased to answer any questions you may have for me.

● (1105)

**The Chair:** All right, thank you very much. I may add that this is a little different. Your being here, Doctor, provides a little different perspective from what we've seen in the past. We do appreciate your attendance here with us this morning.

We'll move into the first round of questioning and we will go to Mr. Norlock, please, for seven minutes.

**Mr. Rick Norlock (Northumberland—Quinte West, CPC):** Thank you very much, Mr. Chair, and I thank our witness for attending today.

I can say that in a previous Parliament I had the privilege of visiting Kingston Penitentiary, and I did go to an area where persons were treated for mental illness, because that was the purpose of the study: looking into mental illness and other aspects of our prison system. We know that one of the reasons we have people in our facilities—federal facilities as well as provincial, I suspect—is because during the.... This is a western hemispheric phenomenon that we closed, and rightly so, some of the institutions where we warehoused people with mental illness. Of course some fell through the cracks and ended up in our prisons primarily because of that, and that leads me into the question of the self-medicated with drugs.

You're a doctor. Can I ask if you are a clinical psychologist or a psychiatrist?

**Dr. Jan Looman:** I'm a clinical psychologist.

**Mr. Rick Norlock:** Thank you.

I am going to say, at the risk of the ire perhaps on my side, that I found the treatment facility in Kingston, where people were being treated, akin to somewhat of a dungeon. It was constructed prior to Confederation. I think folks will find our government is working very hard at replacing some of those older institutions with more modern institutions where we can really treat people in institutions that are properly designed to take care of people with mental illness.

You may feel free to respond to my comment, rather than my question. Specifically, I wonder if a clinical psychologist could create an atmosphere in a federal penitentiary that was conducive to removing people or helping people help themselves get off the terrible drugs many of them are on, including alcohol. Could you describe for me how the presence of drugs in an institution can affect your ability to properly bring those people with a drug problem to a healthier lifestyle—in other words, get off drugs and alcohol? Don't be afraid to give me sort of the nirvana part of where you'd like us to go.

Also because you mentioned it, I'd like you to explain a little further this program you're going to bring in, in 2012. I know it's a broad subject, but feel free to hit on some of those.... I'm sure there will be other people asking you to expand on it.

**The Chair:** Thank you, Mr. Norlock.

Mr. Looman.

**Dr. Jan Looman:** You touched on a number of things there.

First of all, the treatment centre is old and outdated. If I were to design the perfect treatment environment, it wouldn't look at all like the treatment centre does. It would be a modern building, purpose-built for providing treatment. There would be treatment rooms on the units. There would be a much less prison-like environment, a more hospital-like environment.

One of the advantages, though, of having a treatment centre separate from the mainstream institutions is that you have much better control of what goes on inside the building. When I was heading up the sex offender program, every year or so we'd have a couple of guys who would actually quit the program prematurely because they couldn't get access to drugs. So if you have a treatment centre where you've got a sort of isolated population, you've got much better control over those sorts of things. They're less able to transport drugs. Drugs are more easily detected and removed from the population. So having a separate environment in which to provide treatment is the ideal situation.

The concurrent disorders program I was talking about is a program that's designed to treat the mental illness at the same time as you treat the substance abuse problem. Substance abuse actually is a diagnosable mental disorder. It's not a behaviour problem. It's a psychiatric problem, so to speak. So treating the two concurrently is much more effective than treating them separately, because the problems interact with each other. People use substances because of their mental illness, and the mental illness is made worse by the substance abuse. So treating them together, you have a much more effective intervention.

● (1110)

**Mr. Rick Norlock:** Thank you.

Is that the sort of regime that you would use for 2012, the anticipated new program?

**Dr. Jan Looman:** Yes.

**Mr. Rick Norlock:** If you could—in layman's terms—in the two minutes that I—

**The Chair:** You have a minute and a half.

**Mr. Rick Norlock:** In the minute and a half that we have left, could you just give us a quick bird's-eye view of how the program starts, who you target, and what the goals and the treatment methods are?

**Dr. Jan Looman:** Like I said, it would be men who have a mental disorder as well as a substance abuse problem. So we'd be targeting people with schizophrenia, major depression, anxiety disorders, as well as a substance abuse problem, and it could be drugs or alcohol.

The target is to help them manage both disorders once they have finished the program. So it would be addressing issues related to the mental illness: how they manage their symptoms, maintenance on medication, how to identify when they're moving from a stable to an acute phase of illness, and how to compensate for that and at the same time how to cope with urges to use substances, education about the negative effect that substance abuse has on their mental illness, and that rather than using substances they should use their prescribed medication, and use it as it's prescribed.

I lost track of my thinking, but it's sort of addressing the two issues together. The main focus would be on the interaction of the two problems; how they interact, how to identify when they're decompensating, and how to intervene in that for themselves.

**The Chair:** Thank you very much, Doctor.

I should also make mention to the committee that with Dr. Looman's being here, he's really the first person we've heard from who is involved in a maximum security penitentiary as well.

Is that correct?

**Dr. Jan Looman:** Yes.

**The Chair:** We've heard about medium and minimum security, and I think we should be aware of the fact that although his expertise is more on mental health, there may be questions in regard to maximum security.

We'll move over to the opposition side, and we'll go to Mr. Sandhu, please, for seven minutes.

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

Welcome, Dr. Looman.

Dr. Looman, I was actually perusing the papers just a couple of days ago, and I came across an article in *The Globe and Mail*. The headline was “Canada's prisons becoming warehouses for the mentally ill”. I want to mention a couple of things that were quoted by the Canadian Psychiatric Association. Basically, what they were saying is that prisons are becoming the institute of last resort for the mentally ill.

Also, the article talked about the CSC not being geared towards handling the vast population of the mentally ill who are in our prison systems. I would have to agree with Mr. Norlock when he pointed out—and this was also quoted in the paper by this psychiatric association spokesperson—that we live in a first-world country, yet the conditions in which the mentally ill are treated in the prison system are appalling.

Can you maybe talk about the relationship between mental illness and substance abuse, and how inadequate treatments are for the mentally ill housed in our prisons, and how it affects the severity of problems of drugs and alcohol in prisons?

● (1115)

**Dr. Jan Looman:** First, I think the statement that we're not geared toward mental illness and that the conditions are appalling is a bit of an over-generalization.

In the past ten years CSC has made quite a bit of movement in addressing the problem of the increased number of mentally disordered offenders who are coming in. We're trying to identify them early in their sentences. Some of the institutions have what we call intermediate mental health units, where mentally disordered offenders can be housed in a more protected environment away from the general population so that some of the stressors and difficulties they face in the general population are minimized.

At least two of the treatment centres—the one in the prairies and the one in the Pacific region—are modern, state-of-the-art psychiatric hospitals. So at least in some areas the conditions are far from appalling. At the same time, movement can still be made. I work in a building that was built in the 1860s, and it's probably not the ideal situation for a lot of mentally disordered offenders.

To address the substance abuse and mental health issues, we try to identify the offenders in the institutions who are having difficulty functioning. Quite often they end up in segregation. They end up in acute crisis because of the stressors they face in the general population. So we try to identify those people and either get them moved from wherever they are to one of the intermediate mental health units or into the treatment centre, where they can be restabilized and taken out of the stressful environment they're in.

A lot of the people who come to the treatment centres stay, because we've identified that they can't function in the mainstream institutions. They're too fragile, low-functioning, or whatever, to be maintained in that environment. When we bring them to the treatment centre we stabilize them and get them functioning at a level where they can be maintained. We keep them at the treatment centre for the duration of their sentence, or try to get them transferred to a less secure environment where they can function better.

**Mr. Jasbir Sandhu:** Are there waiting times to get into treatment centres once somebody with a mental illness has been identified?

**Dr. Jan Looman:** I can only speak for ours; I'm not sure what happens in other regions.

If someone's in a crisis and needs to be brought in immediately, we are usually able to accommodate them, if not on the same day, then within a couple of days of their being identified. For people who are not in a crisis state, we can usually admit them within a couple of weeks. It depends on bed availability at the treatment centre.

**Mr. Jasbir Sandhu:** On the treatment centres, would you say they're functioning under stress to only deal with crisis cases, or are there cases where once somebody has been identified with a mental illness they would get immediate treatment?

**Dr. Jan Looman:** You asked two questions that didn't really....

**Mr. Jasbir Sandhu:** The first question is would it be too simplistic to say that the treatment centres only handle cases of severe distress?

● (1120)

**Dr. Jan Looman:** No. We have an acute unit, and if someone's in a crisis state we bring them to that unit and stabilize them. If we identify someone in an institution who is not in an acute state but is having difficulty functioning and would benefit from being taken out of that environment and put in a more structured and safe environment, we're able to bring that person to one of the other units and accommodate them in that way.

**Mr. Jasbir Sandhu:** How can the government help to improve treatment for drug abuse in prisons? What more can be done?

**Dr. Jan Looman:** I think one of the biggest things is infrastructure. As I said, the treatment centre I'm working in is appalling. The infrastructure we have makes it difficult to adequately address a lot of the needs the offenders have.

**The Chair:** Thank you very much.

We'll move to Ms.Young, please, for seven minutes.

**Ms. Wai Young (Vancouver South, CPC):** Thank you, Dr. Looman, for coming, and thank you so much for your amazing presentation. You're one of the first witnesses I've heard who has so directly linked drugs in prison with an inmate's well-being. I want to ask a question about that later, but I've only got five minutes, so I'm going to be fairly quick—

**The Chair:** Actually, Ms. Young, I'll give you seven, because you're still on the first round.

**Ms. Wai Young:** I'm still on the first round. That's wonderful. Our chair is fantastic.

Anyway, Mr. Sandhu was trying to imply that our jails are mainly warehouses for the mentally ill, and I guess you refuted that when you said “not really”.

There are these other more hospital-like institutions in the Pacific area, and I've heard from my colleagues that in Saskatchewan there's something like a healing lodge, outside of Saskatoon. They work quite closely with the local hospital and local university. In addition to being a treatment facility, and a very high-level one, more like a hospital, it's also a training facility.

Can you speak a little bit about that? I have not been there, and I don't know how that differs from the dungeon you currently work in.

**Dr. Jan Looman:** There are five regions across Canada, and each of them has a treatment centre building. The one in Saskatoon was built in 1981-82, and the one in the Pacific region was built in the late 1990s. The one I work in was built in the 1860s and it was renovated, to some extent, in 1990.

I haven't seen the ones in Quebec and Atlantic region, but the Atlantic region treatment centre is a wing of Dorchester Institution, which is also a very old maximum security prison. I'm not sure about the one in Quebec.

There's a lot of variation across the country in terms of what the facilities are like. I worked in the one in Saskatoon in the late 1980s, and it's a beautiful building. It looks like a modern hospital.

**Ms. Wai Young:** Would you say that is a warehouse for the mentally ill? Is that how you would describe that particular institution?

**Dr. Jan Looman:** I'm not sure that was the implication that Mr. Sandhu was getting at when he used the word “warehouse”. It's an—

**Ms. Wai Young:** Or an institution of last resort, if you know what I mean.

**Dr. Jan Looman:** It's a nice building.

**The Chair:** There's a point of order here.

Mr. Sandhu.

**Mr. Jasbir Sandhu:** Mr. Chair, I want to clarify that it's not Mr. Sandhu saying this. I'm quoting from an article in *The Globe and Mail* that said our prisons are becoming warehouses for the mentally ill.

**The Chair:** All right, point taken.

Continue, please

**Dr. Jan Looman:** As I said, the one in Saskatoon and the one in B.C. are nice modern buildings. They're well designed for the treatment of mentally disordered offenders. They're well designed for the function that is intended. Some of the other ones weren't designed for the function for which they're being used, and that is an issue.

● (1125)

**Ms. Wai Young:** Yes, and certainly that is something we've already identified in saying we need to modernize and spend more money on building new prisons and upgrading our prisons. We recognize that Kingston and some other institutions are old and they do need to be upgraded and/or replaced.

Would you say then that this kind of infrastructure and building these kinds of prisons would be a good use of federal taxpayer dollars, and absolutely needed?

**The Chair:** I appreciate the question, and again, if the advice for one side is given, it has to be given for the other side. If both sides would try to keep their focus on the drugs and alcohol that are in prisons, instead of—

**Ms. Wai Young:** I'm getting there, Mr. Chair.

Ultimately you're here because of your role in being the clinical manager for your institution, and obviously you care about the well-being of your inmates. I want to link this facility situation with the care of the inmates. Why do you think that upgrading or building a new prison is important for the well-being of the inmates?

**Dr. Jan Looman:** There are a number of reasons. The most important reason is that to provide treatment, you need adequate space and adequate facilities to provide the treatment. We need rooms we can deliver groups in. We need private interview rooms. We need to be able to access the offenders for more than an hour and a half a day to provide the treatment we're trying to provide. Some of the older, not purpose-built facilities don't have adequate group rooms. They don't have interview rooms. Because it's a maximum security environment, we fall into the routines of maximum security. An officer comes to a post for a certain period of time but then has to go off and do something else. You can't access the offenders when there aren't officers.

The design of the building has to be conducive to the purpose you're there for. You can't use a building designed for confining offenders to provide treatment, and that's what a lot of the institutions are doing.

**Ms. Wai Young:** Okay.

On page 7 of your presentation you say:

> The drug subculture is often associated with gang activity and violence.
>
> This destabilizes institutions and makes it difficult for offenders to focus on self-improvement, when they fear for their own safety.
>
> Drug activity also leads to muscling behaviour, and the use of weaker offenders to hold or transport drugs.

We've heard a lot about this from the Corrections officers' perspective. Can you tell us a little bit about this from an inmate's clinical psychological perspective?

**Dr. Jan Looman:** As I was saying, when the offenders are under pressure from gangs or from bigger, stronger offenders to carry drugs in the institution or to hold them in their cells or whatever, it's very intimidating. Some of them get beaten up. They end up in segregation. They don't want to come out of their cells, because if they come out of their cells they're going to be pressured into taking part in these activities they don't want to be part of.

If a guy is there and he wants to participate in programs, but he's under pressure from the gangs or the bigger, stronger offenders, he either doesn't participate in the programs, or when he does participate, he's preoccupied with who's going to approach him when he leaves the building and goes out into the yard. It makes it very difficult to take part in the treatment programs, because he's so preoccupied with these other things.

**Ms. Wai Young:** Therefore, how—

**The Chair:** No, your time is up.

Thank you, Mr. Looman.

We'll now move to Mr. Scarpaleggia, please, for seven minutes.

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

I just want to follow up on what you were saying about how the inmates who want treatment or don't want to have anything to do with the drug subculture feel constrained to remain in their cells and therefore become isolated from the general population. Is there no way to factor that into specifically where inmates are housed within the institution? What we're hearing from you and others is that you can identify these inmates who really want to take part in the programs and who are more likely to be victims than perpetrators of muscling. Is there no way they can be put in an area of the facility where they are with other like-minded inmates? Is there nothing that can be done in that respect? If they're generally weaker, or more vulnerable, I should say, than other inmates, why are we putting them in areas where they're going to be intimidated?

● (1130)

**Dr. Jan Looman:** That's a complicated situation.

In maximum security prisons, like in Kingston Penitentiary, they do that to some extent. They have a range that's gang members, and they have a range that's the lower-functioning, less capable guys. They have sub-populations. They try to keep those sub-populations separate—separate movement times and separate yard times. They do that, but that's possible because it's a maximum security prison. They're able to have that sort of control over movement.

As soon as you move down into the medium security institutions, which are more open environments, it becomes more difficult to keep those sub-populations separate. Even within sub-populations, you get men who are.... Any time you get a group of men together, there's the top of the chain, right? Even within the sub-populations, you have a range of 30 cells filled with offenders, and one of them is going to be stronger than everyone else. So they end up with some of the same problems, but to a lesser extent.

Back in the nineties, Warkworth Institution was the institution that the sex offenders and the lifers went to, and Joyceville Institution was where a different type of population went to. Collins Bay was the institution that was all the gang members and really violent guys. Now that the prison populations are increasing, it becomes a lot harder to do that sort of pen placement, and you do more, “Where's the bed available? Send the guy there.”

Some of the dynamics within the medium security institutions are changing as a result of that. There are attempts made to set up institutions, or areas of institutions, so that you're protecting people that need protection, but it's difficult.

**Mr. Francis Scarpaleggia:** That's interesting.

You were speaking about drug use as a mental disorder. I guess that means versus a behavioural problem.

Does drug use fall into both categories? Is there a line there? What is that fine line? Is it always a mental disorder, or is it sometimes a behavioural problem?

How do you respond to that situation if it is a dichotomy? How do you deal with that?

**Dr. Jan Looman:** It's one of those things that might start out as a behavioural problem, but when it moves into addiction and starts having an overall effect on a person's life, it becomes a mental disorder. It's an acquired mental disorder, I guess is the way to put it.

**Mr. Francis Scarpaleggia:** We've heard that many inmates who enter prison are already using drugs. So by the time they get to a penitentiary, have they crossed that line between it being a behavioural problem to being a mental disorder?

**Dr. Jan Looman:** Not in every case.

**Mr. Francis Scarpaleggia:** Not in every case. Okay.

We've heard about the excellent programs and the excellent work that you do, but are we making progress in terms of releasing people into the community who have markedly benefited from the treatment they've received in prison to the extent that their problem is, if not wholly resolved, sufficiently dealt with that they can become productive members of society, who will not reoffend and wind up back in prison?

I understand that the programs probably are very good at maintaining control over a situation, an illness, or a behaviour, but are there long-lasting effects? I guess that's the question.

● (1135)

**Dr. Jan Looman:** The only evidence we have to turn to in order to answer that is the recidivism rates. The research indicates that recidivism rates are reduced by, I think, about 45%.

**Mr. Francis Scarpaleggia:** That's pretty good, I guess.

**Dr. Jan Looman:** It's based on participation in the programs. So the answer would be yes, to some extent, but there's still room to improve.

**Mr. Francis Scarpaleggia:** Has the incidence of inmates with mental illness or the proportion with mental disorders gone up in recent years?

**Dr. Jan Looman:** Yes. I don't know the more recent data, but comparing it to probably about four years ago, it had gone up from about 12% to almost 20% of the offenders who were coming in and had mental disorders.

**Mr. Francis Scarpaleggia:** How do you see that? I mean, how do you view that in terms of cause? In your view, what is the cause of that?

**Dr. Jan Looman:** Part of the cause is the deinstitutionalization, as someone mentioned earlier, the shutting down of the psychiatric hospitals. I think—

**Mr. Francis Scarpaleggia:** But that's been going on for a long time.

**Dr. Jan Looman:** Yes. I think another part of the problem is that there were changes in the mental health laws in the 1990s that made it much more difficult to send people to psychiatric hospitals. I've been noticing that a lot of people who probably qualified for "not criminally responsible" are ending up in the prison system because of that.

Lawyers don't pursue that avenue, or the offenders don't pursue that avenue for themselves because it's more difficult, and they can probably get out of prison quicker than they can out of the psychiatric hospitals.

**The Chair:** Thank you very much, Dr. Looman.

[*Translation*]

Mr. Chicoine, you have the floor. You have five minutes.

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

I also want to thank Mr. Looman for having shared his experiences in the prison environment with us.

I'd like to continue in the same vein as Mr. Scarpaleggia. There has been an increase in the number of people with mental illnesses who have been imprisoned. Currently, between 12% and 20% of people who go to prison have mental diseases.

What happens when these people arrive in the penitentiary? Are they identified quickly as having mental illnesses or does it take a certain amount of time before that happens?

[*English*]

**Dr. Jan Looman:** As part of the initiative to address mental illness, CSC has introduced a computerized mental health assessment that everyone goes through on intake. In Ontario, they come into Millhaven Institution and everyone goes through a screening process for mental health problems. If they're identified in that process, then there's a further assessment, a more in-depth assessment, to identify their mental illnesses and to sort of flag them for follow-up in the institutions.

It's happening within the first 90 days, let's say, after admission—in Ontario. I'm not sure.... The same process is in place in other regions. I'm not sure how quickly they are able to do it in other regions. I know that in Ontario it's within the first 90 days.

[*Translation*]

**Mr. Sylvain Chicoine:** So it takes at least 90 days before they are identified as having mental illnesses. While they are waiting for treatment, do these people experience particular difficulties since they are in contact with people who do not have mental health issues?

[*English*]

**Dr. Jan Looman:** First of all, it's not "at least 90 days"; it's within 90 days. So it could be 40 days or it could be the first week.

Again, I can only speak for Ontario, but at Millhaven Institution, they have a mental health unit. If there's someone who, on intake, is having difficulties and that's noticed right away, then that person can be taken out of the general population and put on the mental health unit while he's going through the intake assessment process. The officers on the intake unit are watching for those sorts of things. There are mental health staff who work on the intake unit and are available to intervene with offenders when it's needed.

The guidelines say it's within 90 days, but some people are identified immediately on intake. They say "This is a guy with mental health problems and we need to address it". There's a psychiatrist who goes to the assessment unit and is able to prescribe medication. If they need immediate intervention, they're identified and sent to us at the treatment centre.

● (1140)

[*Translation*]

**Mr. Sylvain Chicoine:** I presume that there has been an increase in the prison population in the past few years. Can the overpopulation in the prisons affect the treatment of prisoners with mental illnesses?

[*English*]

**Dr. Jan Looman:** Yes. One of the impacts on the prison population is an increase in the disruption in the institutions. As the institutions become fuller, there's more double-bunking. As I was talking about earlier, in the mediums, there's more mix in the populations than there used to be.

At the treatment centre, we're operating at capacity. So even though we're able to admit people reasonably quickly, it's not as quickly as it used to be. We had more flexibility in the way we managed the population at the treatment centre, so we were able to address issues more quickly. Someone could immediately come in, whereas now they might have to wait a week or two because we have to shift our population around or wait for someone to be released or something like that. It's definitely had an impact on the population.

[*Translation*]

**Mr. Sylvain Chicoine:** If you had recommendations to improve this situation, would they be to send offenders to psychiatric hospitals that are better suited to address their issues? I'd like you to talk about a return to deinstitutionalization. Would it be possible to go back to a situation where we would have fewer inmates with psychiatric problems?

[*English*]

**Dr. Jan Looman:** If I could control the world and make happen whatever I wanted to happen, then I would say the way we deal with mentally disordered offenders would be completely different from the way it is now. But unfortunately I'm not that powerful.

As I said earlier, I think we need infrastructure changes. The treatment centre in Ontario, and probably in the Atlantic region and in Quebec, should be replaced with modern buildings and bigger buildings. I think the one in the prairie region has a capacity of over 200, and they're dealing with a smaller prison population in the prairie region than we are in Ontario and we have a capacity of 148. I think new buildings would be the reasonable solution.

**The Chair:** Thank you, Mr. Chicoine.

We'll now move back to Ms. Hoeppner, please, for five minutes.

**Ms. Candice Hoeppner (Portage—Lisgar, CPC):** Thank you, Mr. Chair.

Thank you, Dr. Looman, for being here today.

You made a comment a couple of moments ago. You said that in the past ten years CSC has made more moves towards addressing mental health issues, and I know our government has made some pretty substantial investments, I think $89 million, including community mental health and institutional.

**Dr. Jan Looman:** Yes.

**Ms. Candice Hoeppner:** Over the last two years, $21.5 million has been invested. I think you said you've been part of this process for 18 years; that's what your presentation said. Can you describe the difference you've seen—you said over ten years, but I'm wondering, even in the last five years? What are some of the gains we've made in helping people faster?

I wonder if you are able to compare it to treatments that people receive on the outside. If someone has a diagnosis of mental illness, how soon are they able to get treatment on the outside, versus how soon are inmates able to get treatment? If you could link that together with the recent investments....

● (1145)

**Dr. Jan Looman:** I'm not sure about wait times in the community for mental health treatment, so I can't comment on that. What I've seen in the past five years would be, as I said earlier, the establishment of the intermediate mental health units in the institutions. Some of the institutions have separate mental health units and others have.... Well, okay, I'll back up.

They all have an increase in the mental health staff. There are dedicated mental health teams in each of the institutions, and that's a new thing. There are psychiatric nurses, some of the institutions have social workers, and there are behavioural counsellors. Those were new positions set up specifically to address the mentally disordered population.

As I said, some of the institutions have dedicated mental health units and in the community there are also mental health teams that work with the mentally disordered offenders who have been released on supervision, and that's also new.

I can't remember what else you asked me.

**Ms. Candice Hoeppner:** Yes, that's good.

I probably have only two and a half minutes left. I'm going to bring it back to the issue of drugs and alcohol in prison, specifically inmates who are dealing with a mental illness.

What we need to understand is that there is a very different atmosphere in prisons as compared to where people are dealing with mental illness on the outside. Can you describe for us what the atmosphere is like in a prison? I believe it is inherently a dangerous atmosphere. Correct me if I'm wrong, but I would think most inmates, on average, wouldn't feel safe. They would probably feel they have to be on guard all the time.

For inmates who are dealing with mental illness, knowing that there are drugs—and you talked a bit about muscling—can you link it and describe for us the difference between trying to deal with a mental illness and maybe an addiction on the outside versus in the prison atmosphere and why that has to be dealt with in a different way and why legislators have to view it differently from the way we might for someone dealing with the same thing on the outside?

**Dr. Jan Looman:** As I said, the prison population is a very stressful place. There is a lot of risk for violence. Although most offenders aren't imminently violent, there is a risk for violence.

The institutions, because there are a bunch of men in the same place, tend to be controlled by the stronger, tougher guys, and gangs are in control of a lot of the institutions. The drug trade is a big part of that.

A lot of people actually develop substance abuse problems when they come into the prison as a way of coping with the stress. It's a way of sort of blocking out the environment they're dealing with and trying to deal with the stress. Before they came into prison they might have used pot or whatever, but when they come into prison, because of the stress, they move from pot to harder drugs as a way of coping.

In the community, people with mental illness can isolate themselves and remove themselves from the stress of dealing with people. If I don't want to leave my house, I don't need to. So if I have a mental illness and I find it difficult to function in the real world, I can isolate myself in my house. But in prison you don't have that luxury. You can try to isolate yourself in your cell, but you're still in that environment and it's very noisy and you have to go out to eat, so you're to some extent forced to go out into the prison environment. If you want medical care, you need to leave your cell to get it.

**Ms. Candice Hoeppner:** I'll just quickly ask you this. Would we be correct, then, as a committee, in recognizing the value of a zero tolerance policy towards drugs in prison because it would help those who are mentally ill? Again it's ideal, but if they knew there were very limited drugs and all of the negative activity that comes along with drugs in prisons.... I'm assuming you would support a zero tolerance policy in these penitentiaries.

● (1150)

**Dr. Jan Looman:** Yes, there is no question that it would improve the environment. I don't think it would solve all the problems, because you still have a bunch of anti-social guys living together, so it's going to be a stressful environment even without drugs. But it would certainly help.

**Ms. Candice Hoeppner:** Thank you.

**The Chair:** Thank you very much, Mr. Looman.

We'll now go to Madame Morin.

There is one other thing I should maybe mention. I have asked Mr. Looman if he has a little extra time beyond just the one hour. I know we find this fascinating. He has complied and said he could stay a little longer, so I'm hoping that everyone who has questions will have ample opportunity to ask them. As I said, we had guests who weren't able to appear for our second hour.

[*Translation*]

Ms. Morin, you have five minutes.

**Ms. Marie-Claude Morin (Saint-Hyacinthe—Bagot, NDP):** Thank you, Mr. Chair. First of all, I want to advise you that I will give the last minute of my time to Mr. Sandhu. I will share my time with him.

I would like to thank you. I found your testimony very interesting. Mental health is often neglected in our society. It is not always easy to understand it.

I have a few questions for you. First, I know that it would be important to treat people with mental health issues in prisons differently, given the repercussions on these people.

With regard to substance addiction, are there any programs or treatments specifically for these types of issues? Are these people treated the same way as so-called normal people in penitentiaries?

[*English*]

**Dr. Jan Looman:** The mainstream substance abuse program is designed for so-called normally functioning offenders. At the treatment centre we've adapted that program so that it can accommodate the mentally disordered population. It's still the national substance abuse program, which isn't designed to address mental illness. It's designed to address substance abuse. That's why I was saying that we are going to implement a program that's designed specifically to address the concurrent disorders. We're just researching that right now. We're hoping to get it going early in the new year.

[*Translation*]

**Ms. Marie-Claude Morin:** We know that people with mental health issues, be it schizophrenia, bipolar disease or anxiety issues, have an acute need for medication. Some of them take lithium and others take citalopram. I know that these medications could probably also be used as drugs.

However, since these people need the medication, how do you manage this problem within a prison? How do you ensure that an inmate has the medication he needs? How do you manage that situation?

[*English*]

**Dr. Jan Looman:** That's actually a fairly substantial problem. In a mainstream institution some of the prescribed drugs that are also drugs of abuse are handed out. There's a process. A lot of medication the guys get—we call them cards—are bubble packs. They're sort of like how you get a lot of gum in bubble packs. They get these cards of medication that they take to their cell. They are supposed to take it as prescribed.

Some of the medication that is more prone to abuse is handed out. The guy has to go to the health care centre in the institution and he is handed the pill. The nurse watches him taking the pill. We call that direct-observed therapy, or DOT. A lot of drugs that are prone to abuse are delivered on a DOT basis, as opposed to in the cards.

On the muscling I was talking about earlier, if people know that a certain offender is getting one of these medications, they might try to intimidate the guy into tonguing it. He would pretend to swallow it, but he doesn't actually swallow it. Then he goes away and spits it out, and he's forced to give it up to the guy who's muscling him. That does happen in mainstream institutions. One of the consequences of that is the guy isn't getting the medication he needs. So he tends to decompensate and he ends up having to come to the treatment centre, or whatever.

There are problems with that sort of thing in the mainstream institutions. They try to minimize it as much as possible. If I know that Joe is getting muscled for his medication, I might tell the nurse that Joe is getting muscled, so the nurse is more careful about the way she dispenses the medication to that guy. They might crush it and put it in applesauce or something like that so he can't spit it out. There are ways to get around those sorts of things. It does tend to be a problem.

In the treatment centre, because we have more direct observation of the offenders and we have more control over the medications and how medications are administered, practically everybody in the building is on DOT. We don't use cards. That problem is minimized.

● (1155)

**The Chair:** All right. We'll come back to you. You'll get a whole subsequent different question here.

We'll go to Mr. Leef for five minutes.

**Mr. Ryan Leef (Yukon, CPC):** Thank you, Mr. Chair.

And thank you to Mr. Looman for coming.

I'll be going back to the discussion we were having about the environment and the creation of that environment, bigger group rooms, bigger interview rooms, and the related impact that limited space has on the time people get with offenders, as you said, and directly related to staff not being present because of the security needs and not being able to leave them alone, move on, which shortens that length of time.

You did mention that new buildings would be the reasonable solution. I think that is what you said. When you're talking about that, we recognize there is some need for an institutional setting and wanting to protect society. We talk about keeping drugs and alcohol out of the prisons, to tie this directly to what we're studying. But would you say that investment in newer, bigger, cleaner correctional centres or prisons—just by virtue of these new open-space concepts and the technology we have—also would help limit or help enhance the limiting of drugs and alcohol access in the prisons, which would then further your efforts?

**Dr. Jan Looman:** Are you asking if I think providing new buildings would help with controlling drugs?

**Mr. Ryan Leef:** Yes—based on the design and the technological advancements that come with those nowadays.

**Dr. Jan Looman:** I don't know. That's not something I've ever thought of.

I think people are clever, and if they want to get drugs in, they'll get drugs in. I'm not sure giving us a new building would do that. I don't have the expertise to answer that question.

**Mr. Ryan Leef:** From your experience, what would be the advantages of having new spaces to work with?

**Dr. Jan Looman:** You would have an environment that's conducive to delivering treatment. That's what I was talking about.

Right now at the treatment centre in Kingston, if we're trying to deliver a program, we don't have any place on the living units where we can deliver that program. We have to take people off the living units into another area to deliver the program. As soon as you have to do that, there are costs for security and costs for other space. You have limited security officers, and you're drawing a security officer from one place to another place to supervise the program. He's only there for a limited time, so you're limiting the amount of time when you have access to the offenders for treatment. When you're taking an officer from one place to another, whatever was going on in the place he was coming from is limited, so it has impacts on the whole institution when you don't have spaces on the unit where you can deliver the programs.

● (1200)

**Mr. Ryan Leef:** Have you ever had any of your programs or opportunities to meet with offenders interrupted because of operational requirements, searches, and things that are taking precedence?

**Dr. Jan Looman:** Yes.

**Mr. Ryan Leef:** It would stand to reason then if there were some additional investment, let's say—and I know this is perhaps outside your area of expertise in terms of commenting on the specific technology that's required—if we had improved technology, and we had improved systems of drug detection, which becomes a daily operational requirement of the front-line staff, if that technology were improved, thus reducing the absolute dependency on what I would see as very slow and methodical physical searches of things, then that would actually start to enhance the opportunity and time inmates would have in program and one-on-one with you.

**Dr. Jan Looman:** Sure.

**Mr. Ryan Leef:** We've heard some testimony about the front-line officers saying they feel they're as much a part of a program as anybody else. They're with them 24/7 and have the ability to interact with positive behavioural change.

Do the officers involved have much opportunity or training to be involved in any of the mental disorder issues that do combine with substance abuse? I know some of the officers we heard took some substance abuse familiarity training, but are they receiving the same thing with the combination of mental illness and substance abuse?

**Dr. Jan Looman:** The officers are receiving mental health training. Two or three years ago mental health training for front-line officers was introduced, and that's ongoing right now. All the officers are being trained.

In a lot of the institutions, I know the officers are very much involved in intervening with the offenders on an ongoing basis. I worked at Warkworth for a while, and I know the officers there were very much involved in dealing with the offenders in terms of counselling and helping them with issues on an ongoing basis. The officers at the treatment centre are very much part of the treatment team and are involved in helping, especially the nursing staff, but other staff as well, to deliver treatment.

**The Chair:** Thank you for the excellent questions.

We'll move to Mr. Garrison, please.

**Mr. Randall Garrison (Esquimalt—Juan de Fuca, NDP):** Thank you very much, Mr. Chair.

Thank you for being here today. I do value the perspective that you are bringing to our discussions.

You talked about an increase in those in institutions with mental illness from 12% to 20%, which is something nearing a 100% increase. Has there been a 100% increase in programming resources to deal with that?

**Dr. Jan Looman:** No.

**Mr. Randall Garrison:** The second thing I want to explore was raised by Ms. Hoeppner, the idea of drug-free prisons. It seemed to me you were saying it would be a laudable goal, but you also said if they want to get drugs they will get drugs in. So do you believe drug-free prisons are a realistic goal?

**Dr. Jan Looman:** I think it's a goal to work towards.

**Mr. Randall Garrison:** Do you believe it can be accomplished?

**Dr. Jan Looman:** I would be surprised if it ever was.

**Mr. Randall Garrison:** You also said treatment at times is interrupted by operational requirements.

**Dr. Jan Looman:** Yes.

**Mr. Randall Garrison:** So if the goal of zero drugs in prisons required more restricted movements, more lockdowns, more searches, would that potentially even more restrict the time available for treatment?

**Dr. Jan Looman:** Yes, it would.

**Mr. Randall Garrison:** I guess that's moved us a little way away from the implication that was left in the initial discussion.

**Dr. Jan Looman:** I think what he was suggesting was if we could keep drugs from coming in, then we wouldn't have as much need for searches and stuff like that. And that's probably true.

**Mr. Randall Garrison:** But if the way of keeping them from coming in is more searches, more movement restrictions, it might also at the same time—-

**Dr. Jan Looman:** If that was the method you used, yes.

**Mr. Randall Garrison:** Okay.

We talked about consequences when people don't receive treatment for mental illness. I want to go back. We often hear people talk about self-medication. If you haven't got a 100% increase in resources and we have roughly double the number of people with mental illness, would you say this is a major contributor to the demand for drugs in prison, this failure to treat?

● (1205)

**Dr. Jan Looman:** I don't know, actually. It's hard to say, because people use drugs for a whole variety of reasons. One of them is self-medication. There are other reasons. So I—

**Mr. Randall Garrison:** Would it be a contributor then, would you say?

**Dr. Jan Looman:** It probably is a contributor, but it's hard to say definitively.

**Mr. Randall Garrison:** In terms of mental health treatment, we know that sometimes it takes a long period of time to complete that treatment. Prisoners move in and out of various institutions. Can you talk a little bit about what happens to their mental health treatment if they move from one institution to another?

**Dr. Jan Looman:** As I was saying earlier, the offenders go through a screening process on intake, and those with mental illnesses are identified, most of them anyway, and there's a flag put on their file. So if I start my sentence at Millhaven and go through the admission process and I move to Kingston Penitentiary, the mental health team at Kingston Penitentiary is aware that I have been identified as having a mental health problem, so they quickly follow up on me and make sure that my needs are being met. If I move from Kingston to Warkworth, the mental health team at Warkworth is notified that I'm coming and they follow up with me when I arrive.

**Mr. Randall Garrison:** There's good tracking.

**Dr. Jan Looman:** There's tracking and there's communication between the mental health teams. People are followed up in that fashion.

**Mr. Randall Garrison:** Can I then just ask about the follow-up? When those with mental illnesses leave the institutions and go into the community, does that tracking result in programming in the community? Do you have any knowledge of that?

**Dr. Jan Looman:** If they're released under supervision, the mental health team and the releasing institution communicate with the release destination. Appointments are set up. Sometimes the offender is even accompanied from the institution to the community so that there's good communication between the staff who are receiving him and the staff who are delivering him, so to speak. As long as he is getting released on supervision, that follow-up is there.

**Mr. Randall Garrison:** If they come to the warrant expiry date or statutory release, would that follow-up not be there?

**Dr. Jan Looman:** It's much more limited. If he says that he is going to downtown Toronto, the mental health team will try to set him up with services in the community he is going to. But in terms of making sure that he maintains contact with those people and all that sort of stuff, we have no control over that once his warrant has expired.

**Mr. Randall Garrison:** Those would be community services. It's no longer correctional programs.

**Dr. Jan Looman:** That is correct.

**Mr. Randall Garrison:** There is no knowledge of or necessary connection with community capacity in those cases.

**Dr. Jan Looman:** A lot of the organizations in the community that deal with mentally disordered people have some knowledge of the issues related to antisocial mentally disordered people. So there is some knowledge. It might not be as good as what CSC would be able to provide or as targeted as what CSC would be able to provide, but in terms of addressing the mental disorder, I think the community agencies are adequate, for the most part.

**Mr. Randall Garrison:** Thank you.

**The Chair:** Thank you, Mr. Garrison.

We will move over to Mr. Aspin, please.

**Ms. Candice Hoeppner:** May I have the first minute?

**The Chair:** You wanted to grab the first minute. Yes. Sorry.

**Ms. Candice Hoeppner:** Thanks very much.

It seems that throughout this entire study there's been a little bit of this back and forth between zero tolerance for drugs versus whether that is a realistic expectation.

Dr. Looman, is schizophrenia curable?

**Dr. Jan Looman:** No.

**Ms. Candice Hoeppner:** Do you ever say “We're not going to treat you, because it's not curable, it's not an attainable goal, so we're just going to leave you as you are”?

**Dr. Jan Looman:** No.

**Ms. Candice Hoeppner:** I think we all agree, at least on this side, that the philosophy of a government should be zero tolerance of any drugs in prison because of the negative and detrimental impact it has on those inmates. I just want to make that point.

I want to ask one really quick question. You said that when individuals come in they're assessed for any kind of mental illness. Is that part of their correctional plan? We've heard about correctional plans.

**Dr. Jan Looman:** That's part of developing the correctional plan.

**Ms. Candice Hoeppner:** It is part of the correctional plan and part of developing the entire plan.

**Dr. Jan Looman:** It is part of that process, yes.

**Ms. Candice Hoeppner:** That obviously is a valuable tool.

● (1210)

**Dr. Jan Looman:** Yes.

**Ms. Candice Hoeppner:** Would you say that it needs to be strengthened? Is it being tweaked constantly?

**Dr. Jan Looman:** Yes. As we speak, it's being tweaked.

**Ms. Candice Hoeppner:** Good. Thanks very much.

**Dr. Jan Looman:** You asked about new initiatives. That's one of them.

**Ms. Candice Hoeppner:** That is one of the new ones, that's right, under our government. Thank you.

**Dr. Jan Looman:** Yes.

**The Chair:** Go ahead, Mr. Aspin.

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

Dr. Looman, my question is basically about drug or gang activity. You've touched a bit on the drug subculture and how it's often associated with gang activity and violence. In your opinion, would you say that gang activity is in large part responsible for the control of drugs entering prisons in Canada?

**Dr. Jan Looman:** Probably. Yes.

**Mr. Jay Aspin:** We've heard that the prices for contraband cigarettes, etc., are incredibly high due to scarcity. Can you just elaborate on that? What are the driving factors for gangs in prisons in relation to the drug trade?

**Dr. Jan Looman:** I'm not sure what you're asking.

**Mr. Jay Aspin:** Could you just elaborate on the driving factors?

**Dr. Jan Looman:** It's money and control, just as it is in the community. The drug trade in prisons is very lucrative.

**Mr. Jay Aspin:** So it's related to scarcity.

**Dr. Jan Looman:** It is scarcity and demand. If I'm the leader of a gang that controls the flow of drugs in an institution, it makes me a lot of money.

**Mr. Jay Aspin:** That's all I have, Mr. Chair. Thank you.

**The Chair:** Thank you, Mr. Aspin.

Mr. Sandhu, did you have a question?

**Mr. Jasbir Sandhu:** No, thank you.

**The Chair:** Mr. Scarpaleggia, did you have anything else that you wanted to bring out?

**Mr. Francis Scarpaleggia:** No, not really.

**The Chair:** He's been gracious enough to give us a few more minutes, and I wanted to make sure that if anyone else had a question we'd get to hear it.

All right, if there are no other questions, thank you for being here today. In the prisons, the whole mental health issue ties in with the drug dependency issue. We thank you for your input and your recommendations. Thank you for coming, and have a safe trip back to Kingston.

**Dr. Jan Looman:** Thank you for inviting me.

**The Chair:** All right.

We are going to suspend momentarily. We will come back in two or three minutes in camera. We want to discuss a little bit about the upcoming report.

[*Proceedings continue in camera*]

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