



**HOUSE OF COMMONS
CANADA**

**MENTAL HEALTH AND DRUG AND ALCOHOL
ADDICTION IN THE FEDERAL CORRECTIONAL
SYSTEM**

**Report of the Standing Committee on
Public Safety and National Security**

**Kevin Sorenson, MP
Chair**

**DECEMBER 2010
40th PARLIAMENT, 3rd SESSION**

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has the honour to present its

FOURTH REPORT

Pursuant to its mandate under Standing Order 108(2), the Committee has studied Federal Corrections: Mental Health and Addiction and has agreed to report the following:

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MENTAL HEALTH AND DRUG AND ALCOHOL ADDICTION IN THE FEDERAL CORRECTIONAL SYSTEM

CHAPTER 1: INTRODUCTION

Correctional institutions in Canada, like those in many countries, including Norway and England, accommodate large numbers of inmates suffering from mental disorders and drug and alcohol addiction. In Canada, some 80% of offenders serving prison sentences of two years or more have problems with drugs and/or alcohol. Approximately one in ten male inmates (12%), and one in five female inmates (21%), suffer from serious mental disorders upon admission to a federal correctional institution.¹

This is not a recent development. Research has clearly shown that the correctional community, here as in elsewhere, is in poorer health overall than the population at large. The House of Commons Standing Committee on Public Safety and National Security (hereafter the Committee) is concerned however about the scope of this phenomenon within Canada's federal correctional system, and the lack of resources to enable Correctional Service Canada (CSC), which is responsible for the custody of offenders sentenced to two years or more, to meet the growing mental health and addiction needs of federal offenders.

This report contains the Committee's observations and recommendations based on its review of the policies, practices and programs adopted by CSC to provide treatment and support for federal offenders affected by mental disorders or addiction. The review highlighted the urgent need for an expansion of CSC's capacity to meet the growing needs of these offenders. The situation demands decisive federal government action; the Committee believes this should include the immediate allocation of additional financial resources to CSC for this purpose. The CSC should in turn give priority to improving how it deals with mental health disorders and addiction issues. This is a public safety issue because offenders who fail to receive appropriate treatment while in custody are more likely to reoffend after release, thus threatening the security of all Canadians.

That said, the Committee agrees with those who have testified before it that as far as possible, people suffering from mental disorders and addictions should not end up in detention because of these problems or the lack of community resources. Correctional institutions should not be serving as hospitals by default. In general, prison is not suited to caring for people affected by such problems. Indeed, mental health experts agree that the prison environment is harmful to mental health. Moreover, because of the constraints inherent in the prison setting, therapeutic interventions are complicated and expensive.

1 Correctional Service Canada, Briefing Book presented to the Committee in November 2009.

Like its witnesses, the Committee has concluded that CSC alone cannot cope with mental health and addiction problems in prisons. The criminalization and incarceration of those suffering from mental disorders or addictions is part of a broader context in which various players—government and non-government agencies—are active: the healthcare, social services and justice sectors. To avoid imprisoning people inappropriately because of their mental health disorders or addictions, all participants in the system have to work more closely together. Governments will have to establish a comprehensive, integrated and efficient mental health system based on promoting mental health and preventive care, early detection of mental disorders and addictions, access in the community to effective care and treatment and, as appropriate, the reintegration of those affected.

The Committee's study has also shed light on the need for rapid intervention, well before those concerned come into conflict with the law. When a crime is committed, there must be a capacity to assess the mental health of the accused in order to refer him or her to appropriate healthcare and support services and acquaint court officials with the accused's requirements. The Committee shares the view of most of its witnesses that such an approach is more consistent with the rights of those suffering from mental disorders and addictions and could generate substantial cost savings in the long run. Imprisonment is expensive and generally unsuited to caring for those rendered vulnerable by mental disorders and addiction issues.

1.1 THE COMMITTEE'S MANDATE AND PROCEDURE

The Committee decided in April 2009² to conduct a study of mental health and addictions in the federal correctional system, after examining relevant information on the tragic death of Ashley Smith, a young woman of 19 who committed suicide in 2007 while detained at the federal Grand Valley Correctional Facility in Kitchener, Ontario.³

The Committee's mandate was to examine the policies, practices and programs adopted by CSC to meet the needs of federal offenders suffering from mental disorders and addictions, and to study best practices in the field.

From June 2, 2009 to April 1, 2010, the Committee held ten public hearings in Ottawa and approximately 10 informal sessions at correctional institutions in Saskatchewan, Ontario, Quebec and New Brunswick during which it gathered evidence from representatives of CSC, the Office of the Correctional Investigator of Canada (OCI), the departments of Public Safety and Justice, the Mental Health Commission of Canada, the Canadian Mental Health Association, the Centre for Addiction and Mental Health, the John Howard Society of Canada, the Canadian Association of Elizabeth Fry Societies and

2 Pursuant to Standing Order 108(2). Minutes of the Committee, April 28, 2009.

3 In June 2008, two important reports were published on the subject: the report of the New Brunswick Ombudsman and Child and Youth Advocate, entitled *The Ashley Smith Report*, <http://www.gnb.ca/0073/PDF/AshleySmith-e.pdf>; and that of the Correctional Investigator of Canada, entitled, *A Preventable Death*, <http://www.oci-bec.gc.ca/rpt/oth-aut/oth-aut20080620-eng.aspx>.

numerous experts and stakeholders in the correctional, addictions and mental health fields, including a number of specialized tribunals.⁴

In Canada, the Committee visited as many correctional facilities as possible during the time available to it. Generally speaking, the institutions visited were of various sizes and security levels and represented a good balance of traditional correctional institutions, Aboriginal healing lodges and regional mental health centres. However, the Committee did not visit any correctional facilities in the Pacific Region, and visited only one institution for women.⁵

The Committee also wanted to place its findings and observations in an international context by travelling to Norway and England, where members spoke with experts and stakeholders in the mental health and addiction field and examined the practices adopted in those countries to address addiction and mental health problems in correctional settings. The Committee wanted to determine whether there were any lessons to be learned from approaches adopted in those countries, more specifically with regard to the provision of mental health and addiction services in prison. Throughout its international travel, Committee members spoke with criminologists, health professionals working in correctional settings, institutional heads, prison guards and persons responsible for correctional services oversight (ombudsmen). Members also visited three prisons for men and a forensic psychiatric hospital.⁶

The Committee's overseas travel was highly productive, thanks to the input of all the experts and caseworkers it had an opportunity to meet, and the best practices it observed in the delivery of health care in a correctional setting.

In fulfilling its mandate, the Committee also consulted relevant research, in particular the report by Lord Bradley, who was commissioned by the British government in 2007 to conduct an independent inquiry into the care of those with mental health problems or learning disabilities in the criminal justice system. It also reviewed the report by James Livingston, *Mental Health and Substance Use Services in Correctional Settings: A Review of Minimum Standards and Best Practices*, as well as the *Framework for a Mental Health Strategy for Canada*, developed by the Mental Health Commission of Canada (MHCC). The Committee also noted the excellent work done by the MHCC since it was established in the spring of 2007 to diminish the stigma and discrimination faced by Canadians living with mental illness and addictions.⁷

4 A list of witnesses will be found in Appendix A.

5 The Committee visited Dorchester Penitentiary and the Shepody Healing Centre in the Atlantic Region, the Regional Reception Centre and the Regional Mental Health Centre in the Quebec Region, the Regional Treatment Centre and Kingston Penitentiary in the Ontario Region and the Regional Psychiatric Centre and the Okimaw Ohci Healing Lodge in the Prairie Region.

6 The Committee visited Ila and Oslo prisons in Norway, the Bracton Centre (a forensic psychiatry facility) in London, and Whitemoor Prison in Cambridgeshire.

7 Mental Health Commission of Canada, *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada*, November 2009.

Lastly, throughout its study, the Committee noted the dedication and professionalism of staff who work on a daily basis—and often in substandard conditions—with offenders incarcerated at the correctional institutions of Canada, Norway and England, and the vital contribution of CSC volunteers to public safety.

1.2 STRUCTURE OF THE REPORT

This report contains five chapters, including this introduction. Chapter 2 outlines the constitutional division of powers with respect to the correctional and health fields in Canada. Chapter 3 provides some information about the capacity of CSC to address the mental health and addiction needs of offenders. Chapter 4 discusses the prevalence of mental disorders and addictions in the federal correctional system, the vulnerability of offenders affected by such problems and the challenges faced by CSC in the management of its inmate population. Lastly, Chapter 5 includes Committee observations and recommendations designed to correct the deficiencies pointed out by the witnesses it heard from throughout its study.

CHAPTER 2: SHARED RESPONSIBILITY FOR CORRECTIONS AND HEALTH CARE

Throughout the Committee's review, witnesses highlighted the specific challenges facing Canada with regard to the delivery of mental health and addiction services in correctional settings stemming from the constitutional distribution of legislative powers between the federal, provincial and territorial governments in the correctional and health fields. This chapter contains a brief discussion of the separation of powers in those fields.

2.1 CORRECTIONS

Under the Constitution Act, 1867, responsibility for correctional services is divided in Canada between the federal government and the provincial and territorial governments, on the basis of the sentences imposed by the courts. Adult offenders sentenced to prison terms of two years or more come under federal jurisdiction, while those serving terms of less than two years are under provincial or territorial government jurisdiction.⁸

CSC is the federal agency responsible for administering prison terms of two years or more. It reports to the Department of Public Safety, and is governed by the *Corrections and Conditional Release Act* (CCRA).⁹ It is responsible for managing federal correctional institutions, for the care and custody of offenders, for their preparation for gradual reintegration into the community and for the supervision of offenders on conditional release. It is thus responsible for offenders from sentencing to completion of their terms. It is also responsible for post-sentence supervision of offenders subject to long term supervision orders.

In contrast, all offenders sentenced to terms of imprisonment in Norway, England and Wales fall under the jurisdiction of a central administration. This is an important distinction since the Committee's study focused solely on offenders under federal responsibility. Some facilities visited in Norway and England housed offenders sentenced to very short prison terms, of less than one month in certain cases. The Committee learned that very short sentences pose specific challenges for the correctional administrations of those countries, particularly for the delivery of mental health care in prison and in the community. For example, the Committee learned that the correctional

8 Provincial and territorial correctional services are also responsible for accused persons being held in temporary detention and offenders serving sentences in the community.

9 The *Corrections and Conditional Release Act* (CCRA), proclaimed on November 1, 1992, replaced the *Penitentiary Act* and the *Parole Act*. The CCRA determines the respective responsibilities of the three agencies that constitute the federal correctional system: the Correctional Service of Canada (CSC), the National Parole Board (NPB) and the Office of the Correctional Investigator (OCI), as well as the principles that must guide their actions, and also sets out the definitions and regulations of all types of conditional release.

administration in England and Wales does not have supervisory powers over adults sentenced to terms of less than one year when they are released before the end of their term.

In Canada, only federal inmates released upon the expiry of their prison sentence are not subject to supervision in the community. The vast majority of offenders are released gradually into the community under CSC supervision before the expiration of their sentence. Research has shown that this is the surest way of monitoring the risk of recidivism and thus ensuring public safety.

2.2 HEALTH CARE

The Constitution Act of 1867 also dictates the distribution of legislative powers among the federal, provincial and territorial governments with respect to health. Within Canada's healthcare system, the provinces and territories have the most significant responsibilities in the delivery of healthcare services. They are responsible for mental health legislation, and for the establishment, maintenance and administration of psychiatric hospitals. Thus, each province and territory has its own mental health act.¹⁰

The federal government is responsible for assisting in the funding of provincial and territorial healthcare services through fiscal transfers, administering health system standards under the Canada Health Act (CHA), and providing healthcare services to specific groups within the Canadian population,¹¹ including penitentiary inmates, within the meaning of Part I of the CCRA.¹²

Federal inmates are thus excluded under section 2 of the CHA. As a result, their medical care is covered neither by Health Canada, nor by the healthcare system of the province in which they are located. Under the CCRA, the delivery of health care to offenders in federal institutions is a CSC responsibility. To ensure continuity of care when

10 See John E. Gray, Margaret A. Shone and Peter F. Liddle, *Canadian Mental Health Law and Policy*, 2nd ed., LexisNexis Canada Inc., 2008 at p. 19: British Columbia: *Mental Health Act*, R.S.B.C. 1996, c. 288; Alberta: *Mental Health Act*, R.S.A. 2000, c. M-13; Saskatchewan: *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1; Manitoba: *Mental Health Act*, C.C.S.M., c. M110; Ontario: *Mental Health Act*, R.S.O. 1990, c. M.7; Quebec: *An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others*, R.S.Q. c. P-38.001; New Brunswick: *Mental Health Act*, R.S.N.B. 1973, c. M-10; Nova Scotia: *Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42; Prince Edward Island: *Mental Health Act*, R.S.P.E.I. 1988, c. M-6.1; Newfoundland and Labrador: *Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1; Yukon Territory: *Mental Health Act*, R.S.Y. 2002, c. 150; Northwest Territories: *Mental Health Act*, R.S.N.W.T. 1988, c. M-10; Nunavut: *Mental Health Act (Nunavut)*, R.S.N.W.T. 1988, c. M-10.

11 The federal government has exclusive responsibility for six other groups of Canadians: First Nations and Inuit people, the Canadian Forces and veterans, the Royal Canadian Mounted Police, immigrants, refugees and federal public service employees.

12 Under the CCRA, "penitentiary" means "a facility of any description, including all lands connected therewith, that is operated, permanently or temporarily, by the Service for the care and custody of inmates," and "any place declared to be a penitentiary pursuant to section 7".

offenders are released into the community, CSC is also required to ensure that an offender has a health insurance card upon release, and an adequate supply of medication for any physical problem and/or mental health disorder.¹³

The nature of CSC's obligations with respect to health care within its institutions is set out in sections 85 to 89 of the CCRA, according to which every inmate is to receive essential health care, such as medical care, dental care as well as active and continuing mental health care. CSC is also required to provide every inmate with reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community. Health care for inmates is to be provided by registered healthcare professionals, in accordance with professionally recognized standards.

CSC is also responsible for providing programs and services designed to address the factors that may have led offenders to commit the crime for which they were sentenced. Under sections 3, 5 and 76 of the CCRA, CSC is to provide a range of correctional programs designed to address the needs of offenders, help them to change their behaviour, and contribute to their rehabilitation.

The administration and delivery of healthcare services presents significant challenges for CSC both in the institutional and in the community setting. It should be noted that under the CCRA, the administration of treatment is subject to the voluntary, informed consent of the inmate, who may refuse or terminate it. When an offender is unable to give informed consent, provincial mental health legislation applies.

13 Correctional Service Canada Commissioner's Directive no 712-4, Release Process.

CHAPTER 3: THE CORRECTIONAL SERVICE OF CANADA'S CAPACITY TO ADDRESS THE MENTAL HEALTH AND ADDICTION NEEDS OF OFFENDERS

3.1 CORRECTIONAL SERVICE CANADA'S RESPONSIBILITIES AND EXISTING INFRASTRUCTURE FOR ACCOMMODATING FEDERAL INMATES

Every year, CSC is responsible for slightly more than 22,000 offenders, approximately 13,000 of whom are inmates at a correctional facility and 8,800 others who have been released under community supervision.¹⁴ It operates a total of 57 correctional facilities: six for women and 51 for men. Of these, 16 are minimum security institutions, 20 are medium security, eight are maximum security and 13 are multi-level. All correctional facilities for women, including the five regional facilities and the aboriginal institution Okimaw Ohci Healing Lodge, are multi-level. The CSC also manages 16 community correctional centres, 175 community residential facilities and 84 parole offices.

To house offenders who are unable to function normally at a regular correctional institution as a result of mental disorders, CSC also operates five regional treatment centres (RTCs), also known as psychiatric or rehabilitation centres. They are located in Abbotsford, British Columbia, Dorchester, New Brunswick, Saskatoon, Saskatchewan, Kingston, Ontario and Sainte-Anne-des-Plaines, Quebec.¹⁵ CSC does not have an independent psychiatric facility to house and treat female offenders requiring intensive mental health care. However, it can accommodate female offenders in a specialized unit at the regional psychiatric centre in Saskatoon. This women's unit has 12 beds.¹⁶ Some female offenders can also receive treatment at the Institut Philippe-Pinel in Montreal pursuant to an agreement between CSC and the Government of Quebec which offers a total of 12 beds for psychiatric treatments of male and female offenders.

It is the responsibility of mental health professionals assigned to the regular institutions to recommend offenders (male and female) for admission to an RTC. According to documentation provided by CSC, only those offenders who meet the following conditions may be admitted:

14 In August 2009, CSC was responsible for 22,053 offenders, of whom 13,179 were in detention and 8,874 were on release under community supervision. Correctional Service Canada, Briefing Book presented to the Committee in November 2009.

15 As of December 31, 2009, three of the CSC's five RTCs had been accredited by Accreditation Canada, a private independent non-profit organization. Accreditation follows a peer review by outside experts, who assess the quality of service provided by an institution against standards of excellence. Institutions participate annually in the program on an optional basis. A list of accredited institutions is prepared and updated twice a year by Accreditation Canada. Accreditation is said to be the most efficient way of regularly reviewing service delivery in order to improve the standard of care. See *Accredited Health Organizations, as of December 31, 2009*, Accreditation Canada 2008, revised 2010.

16 Correctional Service Canada, Briefing Book presented to the Committee in November 2009.

- Offenders suffering from acute mental or psychiatric illnesses, such as psychoses;
- Offenders with chronic mental illnesses;
- Offenders with cognitive, cerebral disabilities or deficits, such as the full range of fetal alcohol syndrome disorders);
- Older offenders with physical or mental problems, such as dementia or Alzheimer's;
- Offenders in crisis, such as those who are suicidal, or cases of chronic self-injuring.

RTCs are therefore available to offenders (male and female) with serious mental health problems or who require special intervention. Their aim is to stabilize these individuals so that they can return to the general inmate population. During the Committee study, witnesses noted that some offenders are released too soon from RTCs and very quickly find themselves in crisis once again in the regular correctional institutions. The situation is attributable in part to insufficient space to accommodate all federal inmates with serious mental health problems. This reportedly contributes to a revolving-door syndrome, and a tendency towards crisis management rather than prevention.

Minimum or medium security women offenders with mental health needs who do not meet the admission criteria of the Saskatoon regional psychiatric treatment centre or the Institut Philippe-Pinel are treated in structured living units within the perimeter of women's regional correctional institutions. Maximum security women are treated in security units, also located at women's regional institutions. Here is what CSC's former Deputy Commissioner for Women, Elizabeth Van Allen, told the Committee:

CSC has implemented the structured living environment, which provides a separate living space and programming area within the institution for women classified as minimum or medium security. It is a therapeutic environment that is staffed 24 hours a day with an interdisciplinary team that can provide specialized correctional, rehabilitative, and mental health treatment.

Finally, for women requiring similar intensive intervention but who are classified as maximum security, CSC constructed security units at each of the five regional women's institutions. These units feature heightened security measures coupled with an interdisciplinary approach similar to the structured living environments that provides intensive staff intervention, programming, and treatment to these higher-risk women.¹⁷

According to testimony before the Committee, CSC's capacity to respond to the needs of offenders with mental disorders is largely limited to the care and treatment provided at RTCs. Canada's Correctional Investigator, Howard Sapers, stated the following in his most recent report:

17 *Evidence*, November 5, 2009.

Yet despite the need, the capacity of the federal correctional system to respond to and treat mental illness is largely reserved for the most acute or seriously chronic cases—those receiving psychiatric treatment in one of the five Regional Treatment Centres. Most other mental health problems are either untreated or receive limited clinical attention.¹⁸

The situation is all the more alarming in that most federal offenders with mental disorders do not meet the admission conditions for RTCs. This is the case in particular of many offenders with personality disorders, anxiety, insomnia, brain injuries, depression and fetal alcohol syndrome disorders. The Correctional Investigator points out in his report that fewer than “10% of offenders are ever admitted to or treated in the therapeutic environment of the RTCs.”¹⁹ Appearing before the Committee, Mr. Sapers stated:

The overwhelming majority of offenders suffering from mental illness in prison do not generally meet the admission criteria that would allow them to benefit from the services provided in the regional treatment centre. They stay in general institutions, and their illnesses are often portrayed as behavioural problems or... are labelled as disciplinary as opposed to health issues. This is especially true for offenders suffering from brain injuries and for those with fetal alcohol spectrum disorder.²⁰

3.2 CORRECTIONAL SERVICE CANADA’S BUDGET

To fulfill its mandate, CSC has a budget of almost \$2.5 billion for 2010-2011, up \$255.7 million from the previous year.²¹ When he appeared before the Committee, CSC Senior Deputy Commissioner, Marc-Arthur Hyppolite, indicated that most of CSC’s budget is consumed by fixed costs. The 2010-2011 Estimates in fact show that about 69% of its resources are allocated to the provision of care and custody of offenders, which includes fixed and semi-fixed costs for security systems, salaries for correctional staff, facilities maintenance, food services and capital. Some 18% is allocated to correctional interventions, which includes case management and offender programs that target criminogenic factors underlying criminal behaviour, and training and job readiness activities for offenders. Lastly, CSC devotes some 5% of its budget to community supervision of offenders.²² As will be noted in Chapter 5 of the report, a number of witnesses feel that CSC does not devote sufficient funds to correctional programming, which accounts for 2 to 2.7% of the budget.

3.3 CORRECTIONAL SERVICE CANADA’S STAFF

CSC has some 17,000 employees, including 7,000 correctional officers, 2,500 parole officers or program officers, 750 nurses and 340 psychologists.²³ Health

18 *Annual Report of the Office of the Correctional Investigator 2008-2009*, June 29, 2009, p. 12.

19 *Ibid.*, p. 15.

20 *Evidence*, June 2, 2009.

21 Correctional Service Canada, *2010-2011 Estimates, Part III—Report on Plans and Priorities*, 2010.

22 Correctional Service Canada, *2009-2010 Estimates, Part III—Report on Plans and Priorities*, 2009.

23 Correctional Service Canada, Briefing Book presented to the Committee in November 2009: data from the human resources management sector of CSC, August 16, 2009.

professionals represent approximately 3.7% of CSC's work force (excluding staff members who work in RTCs).²⁴ CSC also benefits from the contribution of some 9,000 volunteers working in its institutions and in the community. Volunteer activities include tutoring, literacy services, chaplaincy services, raising awareness of Aboriginal culture, traditions and spirituality, as well as multicultural and social events and substance abuse treatment programs. CSC also relies on the participation of citizen advisory committees, made up of volunteers who participate in various ways in developing CSC policy and practices.

24 Correctional Service Canada, *Strategic Plan for Human Resource Management, 2007-2010*, http://www.csc-scc.gc.ca/text/pblct/sphrm07_10/message-eng.shtml.

CHAPTER 4: OVERVIEW OF THE INCIDENCE OF MENTAL DISORDERS AND ADDICTIONS WITHIN THE FEDERAL INMATE POPULATION

This chapter provides an overview of the incidence of mental disorders and addiction problems within the federal inmate population. It also discusses the challenges facing CSC in the management of an offender population with complex and diversified characteristics.

4.1. THE IMPACT OF MENTAL DISORDERS AND ADDICTIONS WITHIN THE FEDERAL INMATE POPULATION

Appearing before the Committee, CSC Commissioner Don Head stated that slightly more than one in ten male offenders (12%) and one in five female offenders (21%) had serious mental health problems when admitted to detention,²⁵ representing respective increases of 61% and 71% since 1997.

Moreover, in 2007-2008:²⁶

- 21.8% of female offenders and 10.4% of male offenders had a “mental health indicator at time of admission”;
- 30.1% of female offenders and 14.5% of male offenders had had “past psychiatric hospitalization”;
- 33.2% of female offenders and 20.6% of male offenders admitted having had psychiatric medication prescribed, a percentage which had almost doubled since 1998-1999; and,
- 8.7% of female offenders and 5.9% of male offenders were psychiatric outpatients when admitted to detention.

According to information received by the Committee, mental disorders are up to three times as common among federal inmates as in the Canadian population at large.²⁷ According to the Correctional Investigator “federal penitentiaries in Canada probably house the largest populations of the mentally ill in this country.”²⁸

25 Don Head, Commissioner, Correctional Service Canada, *Evidence*, June 11, 2009. Correctional Service Canada, Briefing Book presented to the Committee in November 2009.

26 The following statistics were taken from Public Safety Canada, *Corrections and Conditional Release Statistical Overview*, Public Safety Canada Portfolio Corrections Statistics Committee, December 2009.

27 Ibid.

28 *Evidence*, June 2, 2009.

While these data are alarming, witnesses pointed out that they in fact considerably underestimate the actual incidence of mental disorders in the federal correctional system. This is because it was only recently that CSC set up a system for tracking mental illness upon admission, and also because mild or moderate mental health problems are often difficult to detect.²⁹ Finally, the Committee was informed that deficient diagnostic practices at admission also play a role in underestimating the actual incidence of mental health disorders.

According to the definition of mental illness used by the authors, James Livingston, researcher and author of the report *Mental Health and Substance Use Services in Correctional Settings: A Review of Minimum Standards and Best Practices*, notes that the incidence reported in the documentation varies from 10% to 80%.

Throughout the Committee's study, various explanations were advanced to account for the high prevalence of mental disorders in Canada's correctional system. They included the de-institutionalization of psychiatric patients, cuts in social services, the growing involvement of the justice system in social relations, the introduction of zero-tolerance policies with respect to drugs, and restrictions on committal practices.

A number of witnesses, including some in Norway and England, supported the theory of the de-institutionalization of psychiatric patients. The goal of this de-institutionalization movement, which followed developments in psychopharmacology, was to humanize mental health treatment by abandoning asylums as care facilities and limiting the number and duration of hospitalizations. It seems the expected results were not achieved, because the expansion in treatment services and community support fell short of what was needed to support such a movement.

Although all of our witnesses agreed that the de-institutionalization trend had an obvious impact on the Canadian correctional system, some emphasized that it cannot be the only explanation for the substantial increase in the number of federal offenders with mental disorders. Appearing before the Committee, the Correctional Investigator stated:

In fact, I think you can track some of the growth in the mentally ill being in federal corrections because of other policy changes elsewhere. But it's not just the de-institutionalization; there are policies around zero tolerance, and engaging the police in situations today that perhaps the police wouldn't have been engaged in a decade or more ago, and using the courts in some ways today that perhaps weren't being used a decade or more ago.³⁰

Throughout the study, many witnesses also told the Committee that the federal correctional system also house a large number of offenders addicted to drugs or alcohol. Data indicates that about four out of every five offenders admitted to CSC correctional institutions have serious drug or alcohol abuse problems. Half of these offenders

29 These include mood disorders (depressive conditions, bipolar disorder and so on), neurotic disorders (anxiety, obsessive-compulsive disorder and so on) and personality and behavioural disorders.

30 *Evidence*, June 2, 2009.

reportedly committed a crime under the influence of drugs, alcohol or other intoxicants.³¹ Regarding the Nova Institution for Women in Dorchester, Adèle McInnis, Warden, told the Committee that about 90% of the inmates have needs varying from moderate to high with respect to drugs, alcohol or both.

A number of witnesses heard from in Canada, Norway and England pointed out that many inmates who suffer from substance abuse also suffer from mental disorders; the expression they used was “concurrent disorders”.³²

In some cases, mental disorders are the result of the use of mood-altering drugs, while in other cases drug use conceals mental health disorders. This is true, for example, of those who abuse substances to cope with their anxiety or depression. As we propose in Chapter 5, in order to treat these offenders effectively, correctional administrations must use integrated treatment models: the concurrent treatment of substance abuse and the mental disorder.³³

Some witnesses also argued that “substance abuse disorders usually occur after the onset of... a mental illness of some kind.”³⁴ According to the Executive Director of the John Howard Society of Canada, Craig Jones: “... if we filter the [CSC] commissioner’s understanding [that about 80% of federal offenders have substance abuse problems, either alcohol and/or drugs when admitted] through what we know about the co-occurrence of substance abuse and mental health we can say reasonably that roughly 80% of the current prison population suffers from a concurrent disorder.”³⁵ This statement was, however, challenged by other witnesses who pointed out that not all offenders with drug or alcohol problems are necessarily addicts. Moreover, not all drug addicts necessarily suffer from mental health problems³⁶ just as not all persons affected by mental illness are necessarily addicts. The Committee was unable to come to a conclusion on this issue since the CSC officials met during the study did not provide any data regarding the incidence of mental health problems concomitant with addictions in the federal prison population.

31 Ivan Zinger, Executive Director and General Counsel, Office of the Correctional Investigator, *Evidence*, June 2, 2009.

32 The expression “concurrent disorders” is applied to those who are suffering from a number of disorders at the same time. These may include one or more mental health disorders, possibly combined with substance abuse problems, health problems and intellectual deficiencies.

33 James Livingston, Researcher, Mental Health and Addiction Services, Forensic Psychiatric Services Commission of British Columbia, *Evidence*, October 29, 2009.

34 Craig Jones, Executive Director, John Howard Society of Canada, *Evidence*, October 27, 2009.

35 *Evidence*, October 27, 2009.

36 Although addiction is associated with mental health problems, it is not considered a “mental illness”. That being said, the research shows however that addicts are at higher risk of developing mental illness, just as those with mental illness are at higher risk of developing an addiction problem. For more information about concurrent mental health disorders and addictions, consult the Centre for Addiction and Mental Health (CAMH) website at [15](http://www.camh.net/About>Addiction Mental Health/Concurrent Disorders/index.html.</p></div><div data-bbox=)

4.2 THE VULNERABILITY OF INMATES WITH MENTAL HEALTH AND ADDICTION PROBLEMS

Offenders with mental health problems are highly vulnerable within the inmate population. During our inquiry, all the offenders with mental disorders that the Committee spoke to said they did not feel safe in traditional correctional institutions. They also noted that they were frequently the victims of intimidation and violence by the other inmates.

In addition, statistics compiled by correctional administrations on suicides and self-injury incidents show that offenders with mental health disorders are more likely than other offenders to attempt suicide, or injure themselves.

The Committee recognizes that offenders with mental disorders generally have difficulty adapting to the correctional environment. “[They] do not always comprehend... the rules of institutional life, and do not always conform or adjust properly to them.”³⁷ Adjustment difficulties are exacerbated by the fact that irrational and compulsive behaviours associated with mental disorders are often interpreted as acts of violence, rather than mental health disorders, and lead to responsive actions based on notions of security rather than treatment.³⁸

4.3 THE CHALLENGE CORRECTIONAL SERVICE CANADA FACES IN MANAGING SUCH A POPULATION

Managing such an inmate population presents a substantial challenge for CSC, which has to ensure inmate security and provide care and programs designed to respond effectively to their needs. The challenge is complicated by the fact that in recent years, the federal correctional system has been coping with a change in the profile of the inmate population. Federal inmates have reportedly become more violent, and more aggressive. When our study was conducted, CSC estimated that about 60% of inmates had a history of violence.³⁹ They were more often classified as maximum security upon admission than in the past.⁴⁰ A greater number of inmates were also affiliated to gangs and other criminal organizations. As noted in the CSC Review Panel report, the CSC estimates that about one in six male offenders and one in ten female offenders currently have an affiliation to gang or organized crime.⁴¹ These factors are in addition to the substantial increase in the number of offenders affected by mental health disorders and serious drug or alcohol abuse problems when admitted to CSC facilities.

37 Howard Sapers, Correctional Investigator of Canada, *Evidence*, June 2, 2009.

38 Ivan Zinger, *Evidence*, June 2, 2009.

39 Correctional Service of Canada Review Panel, *A Roadmap to Strengthening Public Safety*, October 2007, p. 3.

40 *Ibid.*

41 *Ibid.*

In order to understand the challenges faced by CSC, we also have to consider the fact that in general, inmates are in poorer health than the population as a whole.⁴² The prison population is characterized in particular by a high prevalence of infectious diseases, such as HIV and hepatitis C. Estimates are that federal inmates are 7 to 10 times more likely than the rest of the population to be HIV positive, and close to 30 times more likely to have contracted hepatitis C⁴³. Moreover, as a group, they are generally disadvantaged in terms of employment, housing, income and social relations.

The growing seriousness of inmates' mental health problems presents substantial challenges for CSC, which admits to being fully aware of the problem. It openly acknowledges the harmful consequences of the inadequacy of mental health services provided in its correctional facilities. Indeed, it states in its 2008-2009 Report on Plans and Priorities:

Inmates with untreated mental health disorders cannot fully engage in their correctional plans. They may compromise the safety of other inmates and front-line staff, and may become unstable within the community upon release, particularly where service providers may not perceive offenders as one of their client groups.⁴⁴

For CSC, the difficulty of managing a population that needs more care and services is compounded by a number of factors. Among these are the aging infrastructure of a number of its correctional facilities, inadequate funding, difficulties in recruiting and retaining mental health professionals, and conflicting priorities in a correctional system designed to both assist and control offenders. The Correctional Investigator told us:

There are many reasons that progress is slow and hampered. A lot of it has to do with the timing of that money. A lot of it has to do with the recruitment and retention of health care professionals. A lot of it has to do with competing priorities within a prison system. Part of it has to do with that tension I talked about, when I said we're talking about a prison system and not a health system.

It would be very easy to say that the Correctional Service simply failed or mismanaged that file, but that would be easy, and it would be incorrect. The Correctional Service is very alive to this challenge. I know you're going to be meeting with the commissioner of corrections, and I would encourage you to ask him that question.

I'll tell you it's not due to a lack of good intentions, and there are some structural and operational reasons, but I'll also tell you it's a lack of a sense of urgency, immediacy, and priority.⁴⁵

The Committee urges the federal government to acknowledge the critical nature of this problem by contributing to research and the implementation of innovative and effective

42 Dr. Ruth Martin, Clinical Professor, Department of Family Practice and Collaborating Centre for Prison Health and Education, University of British Columbia, *Evidence*, March 16, 2010.

43 See for example the CSC publication, *Specific Guidelines for Methadone Maintenance Treatment* (2003), at <http://www.csc-scc.gc.ca/text/pblct/methadone/index-eng.shtml>.

44 Correctional Service Canada, *Report on Plans and Priorities 2008-2009*, 2007.

45 *Evidence*, June 2, 2009.

solutions for mental health and addictions and by substantially increasing CSC's budget for the management of an inmate population confronted by these problems. In order to reduce the burden on federal, provincial and territorial correctional facilities in the longer term, governments should, in the Committee's opinion, invest more in mental health disorder prevention and diversion initiatives. The next chapter of this report contains more specific observations and recommendations concerning mental health and addiction services provided in the community and within the federal correctional system.

CHAPTER 5: COMMITTEE OBSERVATIONS AND RECOMMENDATIONS

5.1. INVEST UPSTREAM TO ENSURE THAT PEOPLE WITH MENTAL DISORDERS AND ADDICTION PROBLEMS DO NOT END UP IN PRISON DUE TO A LACK OF COMMUNITY RESOURCES

[W]hen you're dealing with mentally ill offenders..., the best way to prevent future criminality is to treat that mental illness, but we're talking about a prison system and not a health system. The best way to ensure that these folks don't come into conflict with the law, I suppose, is to make sure they're getting adequate services and the treatments they need in the community before they enter corrections.⁴⁶

This excerpt from testimony by the Correctional Investigator accurately sums up the feelings shared by many witnesses we heard from in Canada, Norway and England. While our inquiry did not specifically address community mental health and addiction prevention initiatives, the Committee believes they are a key aspect of the issues it is concerned with. This first section therefore considers addressing the issues of mental health and addictions among inmates from a prevention perspective.

At the outset, the Committee wishes to state that it supports the decision by federal, provincial and territorial ministers responsible for the administration of justice who, at a meeting in Fredericton, New Brunswick on October 29 and 30, 2009, "acknowledged the need to address the increasing challenges related to mental health issues in the criminal justice system," and agreed this topic would be a standing agenda item for their future meetings.⁴⁷ Cooperation among the various levels of government is central to an integrated mental health system that will prevent those suffering from mental disorders and addiction problems from ending up in prison inappropriately because of such problems.

5.1.1. The Need for Investment in a Mental Health and Addiction System and an Appropriate National Strategy in Collaboration with the Provinces and the Territories

It is estimated that every year, "about one in every five people living in Canada will experience diagnosable mental health problems or illnesses." Research tends to show that these problems generally develop during childhood and adolescence (70% of cases).⁴⁸ These data are alarming, particularly as according to the Mental Health Commission of Canada (MHCC), "no jurisdiction in the country can lay claim to having a genuine mental health system in place. Rather, what generally exists is a fragmented patchwork of

46 *Evidence*, June 2, 2009.

47 Canadian Intergovernmental Conference Secretariat, press release, 2009 http://www.scics.gc.ca/cinfo09/830974004_e.html.

48 Mental Health Commission of Canada, *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada*, November 2009.

programs and services, many of which face a constant struggle to find adequate resources to meet ongoing demands.”⁴⁹

According to the MHCC, “[a] mental health system must also be comprehensive. Being comprehensive means addressing the full range of factors that influence mental health and well-being for everyone living in Canada.”⁵⁰ It has to take into consideration the economic, social, environmental, cultural, family and individual factors that contribute to good mental health, including access to proper housing and stable income, and it must seek to reduce the factors that increase the likelihood of a person’s developing mental disorders, such as poverty, abuse of drugs and alcohol, violence and social isolation.

In order to prevent people with mental health or addiction problems from committing crimes as a result of these problems and being incarcerated in provincial or federal correctional institutions, we also have to ensure that community mental health services are both available and effective.

Like some of our witnesses, the Committee believes that to reduce the burden on CSC resulting from mental health and addiction issues, it is imperative that:

- Funding to the provinces and territories be increased for services and programs that tackle the structural and social determinants of mental health, primarily access to adequate housing and stable income;
- The capacity of the public health and social services network to meet the public’s mental health needs, in particular by facilitating access to treatment and support services, be strengthened; and
- Early detection of mental health and addiction issues be improved.

The Committee agrees with those witnesses who felt that it would be more cost-effective, in the long term, to invest in the risk and protection factors that affect the mental health of all Canadians, rather than continually increase funding for mental health services provided in correctional institutions. As noted by a witness in London, we must stop regarding imprisonment as a free resource, while associating costs with crime prevention.⁵¹ On the contrary, research has shown that imprisonment is an expensive measure that is generally not suited to the care of people suffering from mental disorders. Imprisonment can facilitate the appearance of mental disorders, or contribute to their recurrence and the aggravation of symptoms, particularly as a result of the stress generated by the danger of intimidation and violence within institutions, separation from family and loved ones, and concerns related to eventual release.

49 Ibid., p. 15.

50 Ibid., p. 16.

51 Excerpt from testimony by Sir Alan Beith, Chairman of the Justice Committee in the United Kingdom, at the meeting in Westminster Palace.

In light of these considerations, the Committee recommends:

RECOMMENDATION 1

That the federal government, in cooperation with the provinces and territories, make a commitment to and a serious investment in the mental health system, in order to ease the identification of and access to treatment for people suffering from mental health and addictions before they end up in the correctional system.

In London, the Committee became aware of a recent report entitled *Childhood Mental Health and Life Chances in Post-war Britain*. Insights from three national birth cohort studies that illustrates the importance of investing in measures to support parents and families, and preschool programs for children with emotional and behavioural disorders.⁵² This analysis of the three birth cohorts (1946, 1958, 1970) indicates that mental health disorders not treated in childhood or adolescence greatly affect life trajectories. The results demonstrate, among other things, that these individuals generally have a lower level of education than the population as a whole, have difficulty throughout life in finding and keeping a job, and are more likely to come into contact with the criminal justice system in adulthood.

Given the significant potential savings for the penal system and the reduction in the crime rate resulting from the early detection of mental health problems and the implementation of appropriate programs and treatment before adulthood, the Committee recommends:

RECOMMENDATION 2

That the federal government study the report entitled *Childhood Mental Health and Life Chances in Post-war Britain. Insights from three national birth cohort studies* and develop a national strategy, in collaboration with the Mental Health Commission of Canada and in keeping with provincial and territorial areas of jurisdiction, to deal appropriately with mental health problems experienced in childhood and adolescence, so as to reduce markedly the adult crime rate.

5.1.2. The Need for Greater Investment in Diversion Initiatives

Like many countries, Canada cannot ignore the connection between mental illness, addictions and the criminal justice system because of the growing number of individuals with such disorders who enter the criminal justice system and end up in correctional institutions. That said, it is important to emphasize that most people with mental health disorders do not come into contact with the criminal justice system. Moreover, an individual with such a disorder who commits a crime does not always match the

52 Marcus Richards and Rosemary Abbot, *Childhood Mental Health and Life Chances in Post-War Britain. Insights from three national birth cohort studies*, 2009.

stereotypical image of a criminal. In some cases, offences are the direct result of mental illness or a need to satisfy a drug dependency. Studies have clearly shown that mental health problems that go untreated increase the risk of contact with the criminal justice system, and that offenders with serious mental health issues are more likely to be charged and to reoffend more quickly thereafter.

The Committee agrees with a number of witnesses that diversion from the standard justice process is a favourable approach in these cases because it promotes early intervention, and makes it possible to reduce the frequency of these individuals coming into conflict with the law. As such, diversion is a key factor in reducing the criminalization and imprisonment of people with mental health and addiction issues.

Diversion programs can take various forms and can be used at various points within the criminal justice system. Police officers, prosecutors and courts have been using diversion techniques for many years now. As the first point of contact between an offender and the criminal justice system, police officers can play a key role in efforts to intervene in such cases. They are well placed to act quickly and refer an individual to a hospital, a psychiatric facility or a community resource.

The Committee also notes that Lord Bradley's report stresses the need to implement and use diversion measures, and notes that strong partnerships are another key to success in creating pathways to treatment. It recommends, among other things, that police officers work closely with Crown prosecutors and court staff to share information with them, if applicable, on the offender's mental health and addiction issues.

The Committee agrees with Lord Bradley and many witnesses that diversion is a key component of a system that respects the right of individuals to receive the healthcare services they need. In order to detect mental disorders and addiction issues and intervene as early as possible, the Committee believes it is essential to train police officers, Crown prosecutors and other participants in the criminal justice system to recognize symptoms of mental health and addiction problems and refer individuals to the appropriate community and healthcare resources.

The Committee accordingly recommends:

RECOMMENDATION 3

That the federal government work with provinces and territories in order to ensure that police officers, Crown prosecutors and other key players in the criminal justice system be trained to recognize the symptoms of mental health problems, mental illness and drug and alcohol abuse so that they can direct offenders to the appropriate treatment services.

The Committee realizes that some offenders will not satisfy the prerequisites for diversion, and must be remanded to a provincial correctional facility pending a court appearance. In such cases, these offenders should automatically undergo a psychiatric assessment to identify any mental disorders or addiction problems. Such an assessment

would provide court staff with information to conduct a full review of each case and ensure that the offender receives the appropriate treatment and services. Assessments of mental disorders, including addictions, followed by treatment, would also help to address the revolving-door syndrome we heard much about.

In light of these considerations, the Committee recommends:

RECOMMENDATION 4

That the federal government work with the provinces and territories on early identification of mental health and addiction issues affecting offenders in remand, and secure access to treatment services for them in order to address conditions that are so often precursors to escalating crime and incarceration.

5.1.2.1 Drug Treatment and Mental Health Courts

Specialized courts such as mental health and drug treatment courts have been operating in Canada for some time now.⁵³ The Committee supports the work of such courts, which emphasize a therapeutic approach to treating offenders with mental health or addiction issues. Within a judicial setting, offenders taking part in these programs are referred to the appropriate primary or specialized healthcare services.

Drug treatment courts strive to reduce substance abuse, crime and recidivism through the rehabilitation of the offender. These courts facilitate treatment by providing an intensive, court-monitored alternative to incarceration. To access such treatment, an offender must plead guilty to the charges against him. In order to secure community support, the multidisciplinary team responsible for the case ensures that the offender has safe housing and, where appropriate, is in stable employment, attending school or receiving vocational training. In return, the offender undertakes to appear regularly before a judge who reviews his or her progress, and imposes sanctions or rewards good behaviour, as appropriate.

Mental health courts are also designed to meet the manifold and complex needs of offenders appearing before them.⁵⁴ Witnesses told us that the success of such courts and of participating offenders depends on close cooperation with community partners. According to these witnesses, the multidisciplinary teams attached to these courts have special sensitivity to the fragility of their clients and the stigma all too many of them face.

53 Canada currently has six drug courts receiving federal government funding: Toronto (December 1998), Vancouver (December 2001), Edmonton (December 2005), Winnipeg (January 2006), Ottawa (March 2006) and Regina (October 2006). There are other such courts not funded federally: for example, the drug court in Calgary is funded by the City of Calgary.

54 Mental health courts have been established in Ottawa, Montreal and Toronto.

The Committee is concerned about what appears to be an insufficient use of mental health courts and its impact on the provincial and federal correctional systems. Offenders suffering from mental health problems serve a greater part of their sentences in institutions than those who are not mentally ill but were convicted for the same offence. As was explained to the Committee, this can be due to a variety of reasons. For example, offenders suffering from a mental illness often have difficulty adapting to the prison environment, thereby increasing the risk of inappropriate or violent behaviours. Additional time in prison can therefore lead to more time spent in segregation, increase the cost related to the use of expensive psychiatric medicine, the risk of altercations with correctional officers, and suicide.

The Committee was disappointed to learn that a lack of funds is hampering the establishment of drug treatment and mental health courts across the country, and believes that the use of specialized courts should be increased and that sufficient funding be provided in order to ensure that offenders with drug addiction and mental health issues receive the appropriate treatment at the right time. The Committee accordingly recommends:

RECOMMENDATION 5

That the federal government support the creation and funding of more drug treatment courts to divert offenders with addictions to treatment centres and mental health courts to divert those with mental health needs to appropriate services.

The Committee heard repeatedly that drug and alcohol addiction frequently coexists with mental health disorders within the inmate population, and that successive or parallel services are ineffective in treating concurrent disorders.⁵⁵ Best practices in the field reveal that it is better to treat such disorders simultaneously. While the Committee did not hear evidence about community courts, it believes their approach, offering simultaneous treatment of mental health and addiction disorders, could prove useful in treating those suffering from concurrent disorders.

Community courts, like those in British Columbia and the United Kingdom, are based on the US model of community justice, which seeks to develop partnerships within the community and address the factors underlying criminal behaviour. For example, these courts deal with homelessness, mental health and drug and alcohol dependency. They provide for options similar to those of drug treatment and mental health courts with respect to, among other things, the requirement that the offender appears periodically before the judge in order to improve the likelihood of rehabilitation.

55 James Livingston, *Evidence*, October 29, 2009.

In light of these considerations, the Committee recommends:

RECOMMENDATION 6

That the federal government support the creation and funding of more community courts to divert offenders with concurrent mental health and addiction issues to appropriate health facilities.

5.2 RECOGNITION OF THE ADVANTAGES OF PARTNERSHIPS IN THE DELIVERY OF MENTAL HEALTH AND ADDICTION SERVICES WITHIN THE CORRECTIONAL SYSTEM

Many witnesses felt that without developing partnerships, CSC cannot alone handle the challenge of managing offenders with mental health or addiction issues. Such partnerships could include provincial and territorial administrations responsible for health and social services, community health resources and non-governmental organizations that can provide support for offenders and help them resolve their social and financial problems by, for example, finding them suitable housing and stable employment.

In Canada and abroad, the Committee observed promising practices in treatment and support for offenders with mental health and addiction issues both within institutions and in the community. The next section canvasses the various partnership models that were brought to the Committee's attention during its study. It also contains related recommendations to improve the quality of healthcare services and support provided to federal inmates with mental health and addiction issues.

5.2.1. Healthcare Service Delivery Models in Norway, England and Wales

In most countries, including Canada, the delivery of healthcare services in prison is the responsibility of the correctional administration, rather than the health administration. In recent years, however, there has been a trend towards transferring the responsibility to health administrations. Norway, Australia, France and, more recently, England and Wales have adopted this approach.

5.2.1.1 The Norwegian Approach

Since 1988, healthcare services within the correctional system in Norway have been the responsibility of the Ministry of Health and Social Welfare, rather than the Ministry of Justice. Healthcare services for offenders are thus independent of the administrative and economic control of the correctional administration.

In 1994, the Norwegian government gave municipalities responsibility for delivering primary health care in prisons, hiring medical staff (nurses, doctors, physiotherapists) and referring cases requiring specialized care. As a rule, reimbursement for these services

comes from government subsidies.⁵⁶ Since 2002, specialized health care in Norwegian prisons has been the responsibility of regional health administrations.

In Norway, offenders with serious mental illness are cared for not in prison, but in psychiatric hospitals run by the regional health administrations. Only offenders with less serious mental conditions are treated in prison by healthcare professionals from the municipality in which they are detained.

Municipal health administrations contract with local psychiatric hospitals and clinics for the delivery of appropriate health care. Under these contracts, the clinic or hospital provides specialized health services to offenders for which the municipality is responsible; the clinic or hospital assigns a psychiatric nurse, a psychologist or a psychiatrist to the prison.

That said, according to witnesses heard from in Norway, the system is not perfect. Municipal administrations are not always successful in securing the regular attendance of psychiatric staff in the prisons; in many cases, offenders who receive specialized treatment in psychiatric hospitals or clinics are returned to prison too soon. As a result, their mental health problems quickly resurface. Some experts feel that, in order to avoid this vicious circle, municipal administrations should develop additional contracts with hospitals and clinics that are able to handle offenders requiring specialized care.

Lastly, witnesses we spoke with in Oslo emphasized that Norwegian inmates have the same rights to healthcare services as the rest of the population (services are based on the principle of equivalence). Moreover, offenders have the legal right to free private health care if they do not receive appropriate and timely healthcare services within the correctional system. It is therefore in the interests of the Norwegian public administrations that in these cases have to pay for private health services to ensure that offenders receive the services they require in a timely manner.

5.2.1.2 England and Wales

Since April 2006, the National Health Service (NHS), which is responsible for providing health services to all British citizens, has had complete responsibility for the provision of healthcare services in prisons in England and Wales. The granting of this responsibility was motivated by the government's desire to improve care within the correctional system and to emphasize that inmates, as an integral part of the community, should have access to healthcare services equivalent to those provided to all other British citizens.

The reform process began in 2000 with the transfer from the ministries of Justice to the Ministry of Health the responsibility for developing public policy on health care in the

56 Document provided to the Committee, Anne-Grete Kvangig, Health Branch, *The treatment of offenders with mental health problems*, November 23, 2009.

prisons. It followed the publication of numerous reports highlighting significant shortcomings in the delivery of healthcare services in prisons in England and Wales.

According to evidence gathered in England, the transfer of responsibility to the NHS has led to an improvement in the quality of care provided to inmates. Moreover, it has done much to facilitate the recruitment of healthcare professionals—including psychiatric nurses—within the correctional system.

According to the Director of Offender Health, Richard Bradshaw, the reform has also facilitated the transfer to psychiatric hospitals of inmates requiring specialized care. He also said that the prison and health authorities are working closely together to create healthcare wings and mental health centres with high security components in order to avoid managing mental health cases in prison.

5.2.1.3 Benefits of Transferring Responsibility for Healthcare Services within the Correctional System to Provincial Health Authorities

The approaches taken in Norway, England and Wales differ in detail, but they do offer some advantages with respect to access to high-quality care within the correctional system, and continuity of care for offenders in the community.

More specifically, the Committee heard that transferring responsibility for health care in the correctional system to health administrations:

- 1) **Highlights the principle that inmates should enjoy a level of care equivalent to what is available in the community.** According to some witnesses, the transfer confirms that inmates are full citizens: they should therefore have the same opportunities for access to health care as the general population. This approach is obviously beneficial not only for inmates, but also for prison staff and for society as a whole, since most inmates rejoin the community at some point.
- 2) **Integrates training and research in the correctional setting with normal practice.** Some witnesses we met with in England and Norway told us that the transfer makes it possible to more readily integrate inmate health with broader public health issues. In England, the training provided to health professionals and recent health promotion initiatives reflect this important change. These initiatives recognize the importance of using the time in detention to promote inmate health and thus the health of the population in general.
- 3) **Prevents the isolation of health professionals.** The health professionals we met in Norway and England all told us that belonging to a health administration rather than a correctional administration contributed to their feeling of belonging to the health network, and thus prevented professional isolation. For example, a witness we spoke with in England maintained that working in prison was once regarded as a form of

professional isolation; it is now perceived as part of an exciting multidisciplinary approach that offers numerous opportunities for development.

- 4) **Solves the correctional system's difficulties in recruiting health professionals.** In addition to offering competitive salaries to health professionals working in the correctional system, Norway, England and Wales have taken an approach that makes the prison environment more interesting for health professionals. According to witnesses we spoke with, since health professionals report to the administration that is also responsible for the health of all citizens, they can readily combine working in the prisons with working in hospitals and in the community. A health professional who agrees to work within the correctional system is thus not confined to that system, and can easily transfer to a hospital or community setting if he or she chooses.
- 5) **Contributes to more integrated delivery of health care services in the institutional and community settings.** In the opinion of many witnesses, integrating the care provided in the closed environment of a prison and in the open environment of a community facility makes it much easier to provide a continuum of care for offenders, particularly after their release into the community. Moreover, transferring inmates to hospitals or specialized clinics is much easier, since the administrations responsible for health care in prison are also responsible for health care in the community. In a system like Canada's, continuity of care becomes more difficult, particularly because of the sharing of responsibilities for health among the federal, provincial and territorial governments, and the isolation of the mental health professionals employed by CSC.
- 6) **Clearly establishes the role of health professionals within the correctional system.** Many witnesses acknowledged that it can be difficult for health professionals employed by a correctional administration to give priority to rehabilitation and treatment objectives, as opposed to disciplinary objectives. According to these witnesses, the strategy adopted in Norway and England has the advantage of favouring a therapeutic approach in the correctional setting, which is better suited to the treatment of mental disorders and addictions. In Canada, CSC must contribute to protecting public safety by taking an approach that balances assistance to and control of offenders, in accordance with section 3 of the CCRA. In practice, health professionals can find it difficult to reconcile helping and controlling offenders in an environment that calls for multiple security factors to be considered. According to the Correctional Investigator, CSC psychologists "are primarily engaged in risk assessment as opposed to treatment and rehabilitation."⁵⁷ This leads him to conclude that the

challenge facing CSC in relation to the shortage of human resources for delivering mental health care “is one of focus and priority as much as it is one of numbers.”⁵⁸

The Committee acknowledges that the adoption of a system similar to the one in Norway or England and Wales presents specific governance challenges in Canada because health care responsibilities are shared among the federal, provincial and territorial governments. We nevertheless believe that transferring responsibility for the delivery of health care within the correctional system to the provincial and territorial health administrations offers significant advantages, and deserves the attention of all levels of government in this country. The Committee therefore recommends:

RECOMMENDATION 7

That the federal government initiate discussions with provincial and territorial governments with a view to establishing partnerships and service agreements with hospitals for the delivery of health care services so that federal inmates have the same access to health care as other Canadians. Such partnerships would also provide continuity of mental health care when inmates are released into the community.

5.2.2 Strengthening the Capacity of Correctional Service Canada to Meet the Needs of Federal Inmates by Developing Partnerships as an Interim Measure

The Committee realizes that transferring responsibility for health care within the federal correctional system may take time. To strengthen its capacity to meet the needs of federal inmates and ensure that they can return to the community as law-abiding citizens, the Committee believes that as an interim measure, CSC should work to develop partnerships with hospitals and mental health services in the community. In addition to improving the quality of care, this approach would favour continuity of care for inmates following their release in the community.

5.2.2.1 The Need to Develop Agreements with Provincial and Territorial Health Authorities under which Inmates with Serious Mental Health Disorders would be Treated in Psychiatric Hospitals, rather than in Conventional Correctional Institutions

“A correctional facility is by definition a restrictive, coercive environment”⁵⁹ that affects the mental health of those detained. According to the evidence we heard, the prison setting can generate or exacerbate psychiatric disorders because of the stress associated with loss of freedom, restrictions on private space and contacts with friends and family, and the violence generally characteristic of prisons. On the latter point, studies

58 Ibid.

59 Government of Canada, *The Human Face of Mental Health and Mental Illness in Canada*, 2006.

clearly show that the prison environment generates competition for scarce resources, develops relationships of dominance and submission, and compels individuals to associate with others whose behaviour may be unpredictable.

For all of these reasons, the correctional environment often constitutes an obstacle to therapy; by contrast, the health care environment is much better suited to treating people in crisis who have serious mental illnesses.

To improve its capacity to meet the psychiatric needs of offenders in its charge, CSC has set up RTCs. While these do offer a more appropriate environment for treating people with a serious mental illness, they cannot meet the demand.

In its Quebec Region, CSC can also rely on an agreement with the Institut Philippe-Pinel (Pinel) in Montreal. Federal inmates requiring specific psychiatric care may thus be treated by health professionals associated with Pinel who visit them in detention, or while hospitalized following a transfer. Under this agreement, CSC has reportedly improved the quality of psychiatric care provided to inmates with serious mental illnesses. The agreement benefits the inmate, CSC and society in general. In the Committee's opinion, it should serve as an example for more such partnership agreements.

Lastly, agreements also currently exist in Nova Scotia between correctional services and the provincial health administration for the delivery of health care to inmates sentenced to less than two years' imprisonment. Apparently, these agreements have done much to improve health care in these correctional settings.

In light of all these considerations, the Committee recommends:

RECOMMENDATION 8

That Correctional Service Canada establish agreements with provincial psychiatric hospitals—that have suitable facilities to accommodate offenders without compromising public safety—to transfer some offenders who are posing a threat to themselves or others and who cannot be treated at regional treatment centres, along with financial compensation. These agreements should also allow correctional staff to be assigned to the facilities during a transfer in order to ensure public safety.

5.2.2.2 The Need to Develop Agreements with Provincial and Territorial Authorities and Community Organizations to Correct Shortcomings in Continuity of Care

Despite its efforts and accomplishments, CSC still experiences significant difficulties in terms of ensuring continuity between services provided within the correctional system and provincial services. This constitutes a major obstacle to the successful reintegration of offenders into the general population.

The Committee agrees with a number of witnesses it heard from that the development of partnerships with provincial health and social services authorities, and community organizations that can provide support to offenders, would likely improve the continuum of care for offenders with drug addictions and mental illnesses. It would also promote the resettlement of these inmates. According to Brenda Tole, retired warden, Alouette Correctional Centre, government and non-government organizations are generally very enthusiastic about creating partnerships with correctional services. Appearing before the Committee, Ms Tole noted:

Our experience is that a lot of those organizations, ministries, or other government agencies are quite willing to partner. They see the population as part of their community and they are quite willing to engage and do that. It's just that correction tends to be an entity upon itself and sticks to itself and is quite closed.⁶⁰

She maintained that such partnerships benefit the correctional services, inmates and society as a whole, because they facilitate the successful reintegration of offenders into the community. She also noted that partnerships are useful not only in the health field, but also in education, job readiness and vocational training.⁶¹

To strengthen CSC's capacity with respect to continuity of care, while contributing to public safety and the resettlement of offenders in its charge, the Committee recommends:

RECOMMENDATION 9

That the federal government develop coordination of services between Correctional Service Canada and provincial and territorial health authorities to provide a continuum of care through warrant expiry.

RECOMMENDATION 10

That Correctional Service Canada explore and arrange community partnerships for training federal offenders (through Habitat for Humanity, for example).

5.3 THE NEED TO BETTER RESPOND TO THE SITUATION OF ABORIGINAL OFFENDERS

In 1996, the Royal Commission on Aboriginal Peoples described the special situation of Aboriginal peoples in Canada. The growing overrepresentation of Aboriginal offenders in Canada's penitentiaries supports the Commission's view that the justice system does not adequately respond to their particular needs. As the following data show, the situation of Aboriginal people remains critical.

60 *Evidence*, March 16, 2010.

61 Brenda Tole, Retired Warden of Alouette correctional Centre for Women, *Evidence*, March 16, 2010.

- The incarceration rate for Aboriginal people increased from 815 per 100,000 in 2001/02 to 983 per 100,000 in 2005/06;⁶²
- At the end of March 2009, Aboriginal people comprised 17.3% of federally sentenced offenders, compared with 2.7% of Canada's adult population;⁶³
- One federal offender in five is of Aboriginal origin.⁶⁴

The plight of female Aboriginal offenders is even more alarming:

- They represent 31.4% of the female inmate population;⁶⁵
- The number of Aboriginal women in detention has been rising steadily over the last ten years. From 1999-2000 to 2008-2009, it increased from 84 to 157, or 86.9%.⁶⁶

The circumstances of the care and treatment of Aboriginal offenders are both complex and multidimensional, presenting a substantial challenge for CSC. For example, Aboriginal offenders:

- Have a higher rate of recidivism than other offenders;⁶⁷
- Are often overrepresented among offenders in segregation;⁶⁸
- Have a much higher incidence of mental disorders and addiction issues than non-Aboriginal offenders;⁶⁹
- Are younger upon admission into custody than non-Aboriginal offenders;⁷⁰
- Serve more of their sentences in the institution before initial release, as compared with other offenders;⁷¹

62 *Annual Report of the Office of the Correctional Investigator 2008-2009*, June 29, 2009.

63 Correctional Service Canada, *Aboriginal Corrections, Quick Facts*, January 2010.

64 *Annual Report of the Office of the Correctional Investigator 2008-2009*, June 29, 2009.

65 Public Safety Canada, *Corrections and Conditional Release Statistical Overview*, Public Safety Canada Portfolio Corrections Statistics Committee, December 2009.

66 Ibid.

67 *Annual Report of the Office of the Correctional Investigator 2008-2009*, June 29, 2009.

68 Ibid.

69 Michelle M. Mann, *Good Intentions, Disappointing Results: A Progress Report on Federal Aboriginal Corrections*, Office of the Correctional Investigator, October 11, 2009.

70 Public Safety Canada, *Corrections and Conditional Release Statistical Overview*, Public Safety Canada Portfolio Corrections Statistics Committee, December 2009.

71 *Annual Report of the Office of the Correctional Investigator 2008-2009*, June 29, 2009.

- Are more inclined to have gang affiliations;⁷² and
- Have more health problems, including FASD and PTS syndrome.⁷³

A number of systemic and contextual factors are also causal in terms of offences committed by Aboriginals: placement in residential facilities, the intergenerational cycle of violence, unemployment, low education levels, poverty, low pay and poor housing.⁷⁴

5.3.1 Correctional Service Canada's Commitment to Aboriginal Offenders

Under sections 79 to 84.1 of the CCRA, CSC is required to respect the cultural differences and specific needs of Aboriginal offenders in the discharge of its mandate, and more specifically in the delivery of services and programs. Commissioner's Directive (CD) 702, issued in 1995⁷⁵ and revised in 2008⁷⁶, also sets out procedures for the rehabilitation and reintegration of Aboriginal offenders through effective casework. Under CD 702, CSC undertakes to adopt a holistic approach towards Aboriginal offenders in order to promote understanding of traditional Aboriginal spirituality. This approach also encourages cultural dances and ceremonies and the consumption of traditional and country foods.⁷⁷

To address the numerous challenges related to Aboriginals within the federal correctional system, CSC has developed the following initiatives:

- Strategic Plan for Aboriginal Corrections 2006-2011 (approved in 2006);⁷⁸
- Strategy for Aboriginal Corrections Accountability Framework (implemented in 2009-2010);⁷⁹
- Template for Results Reporting and Monitoring.⁸⁰

72 Michelle M. Mann, *Good Intentions, Disappointing Results: A Progress Report on Federal Aboriginal Corrections*, Office of the Correctional Investigator, October 11, 2009.

73 Marc-Arthur Hyppolite, CSC Senior Deputy Commissioner, *Evidence*, November 5, 2009 and Michelle M. Mann, *Good Intentions, Disappointing Results: A Progress Report on Federal Aboriginal Corrections*, Office of the Correctional Investigator, October 11, 2009.

74 Ibid.

75 Correctional Service Canada, *Aboriginal Corrections*, Quick Facts, January 2010.

76 Michelle M. Mann, *Good Intentions, Disappointing Results: A Progress Report on Federal Aboriginal Corrections*, Office of the Correctional Investigator, October 11, 2009.

77 According to CSC Commissioner's Directive no 702, traditional foods are authorized in federal correctional institutions provided they are used in connection with a celebration or ceremony. Country food (all harvested wildlife, composed primarily of seal, whale, caribou and arctic char) is also allowed and is to be provided at least monthly to Inuit, as a dietary requirement.

78 Correctional Service Canada, *Aboriginal Corrections*, Quick Facts, January 2010.

79 Correctional Service Canada, *Response from the Correctional Service of Canada to the 36th Annual Report of the Office of the Correctional Investigator*, 2 November 2009.

80 Ibid.

Although more than four years have elapsed since the approval of the Strategic Plan for Aboriginal Corrections, the gap continues to widen between program and casework results for Aboriginal offenders and other offenders. The OCI remains dissatisfied with CSC's efforts. It maintains that "previous good intentions reflected in CSC policies and strategies have been inadequately operationalized, leading to disappointing results."⁸¹ In his 2008-2009 Annual Report, Howard Sapers notes:

Over the years, my Office has made a series of findings and recommendations to challenge the Service's thinking and its resolve to make significant and sustainable progress in the area of Aboriginal corrections. Many of our recommendations have yet to be fully implemented. As a consequence, the gap between Aboriginal and non-Aboriginal offenders continues to widen, the situation for Aboriginal people under federal sentence deteriorates, and the Service revises and updates frameworks and strategies without apparent results.⁸²

5.3.2 The Need to Improve Correctional Service Canada's Capacity to Work Effectively with Aboriginal Offenders

The steady gap between outcomes for Aboriginal and non-Aboriginal offenders raises serious questions about CSC's ability to take responsibility for the former.⁸³ Like a number of witnesses, the Committee believes the situation is not only critical, but is demanding of urgent attention. This situation is all the more critical because the inmate population is likely to increase with the passage of federal legislation designed to create more severity in sentencing. To increase CSC's capacity to respond to the needs of Aboriginal offenders, the Correctional Investigator has long been proposing a change in its governance structure. He has urged the Minister of Public Safety to direct CSC to appoint a deputy commissioner for Aboriginal corrections in order to pay special, targeted attention to Aboriginal offenders. The Minister has yet to accept this suggestion. The Committee believes this recommendation should be implemented, together with all those made by the Correctional Investigator in his 2008-2009 annual report. The matter is further addressed in section 5.15 of this report.

The Committee is also concerned that existing CSC programs for treating mental disorders and addiction issues constitute an inadequate response to the cultural and spiritual needs of Aboriginal offenders. The Committee accordingly encourages CSC to review its current programming with a view to incorporating a more traditional and religious component for these offenders. In the Committee's view, attaching increased importance to the Aboriginal context in existing programs could make them more effective in reaching Aboriginal offenders. Lastly, the Committee hopes that CSC will take the opportunity to implement more programs for Aboriginal people in order to assist in their recovery.

81 Michelle M. Mann, *Good Intentions, Disappointing Results: A Progress Report on Federal Aboriginal Corrections*, Office of the Correctional Investigator, October 11, 2009.

82 *Annual Report of the Office of the Correctional Investigator 2008-2009*, June 29, 2009.

83 Howard Sapers, *Evidence*, 2 June 2009.

During the visit to the Okimaw Ohci Healing Lodge, a good many witnesses drew the Committee's attention to the crucial role of elders and spiritual advisers in the success of programs for Aboriginal offenders. They encourage offenders to repair broken links with their culture, their families and their communities. The Committee hopes CSC will make greater use of the services of elders, and invite Aboriginal communities to participate in the development and delivery of programs for Aboriginal offenders.

The Committee accordingly recommends:

RECOMMENDATION 11

That Correctional Services Canada (CSC) review its current mental health and addictions programming to ensure that it meets the cultural and religious needs of Aboriginal offenders, who make up a disproportionate percentage of the Canadian inmate population, and a disproportionate percentage of inmates facing mental health and addiction issues; that CSC implement, together with local Aboriginal communities, more mental health and addiction programs addressing the specific needs of Aboriginal offenders. In addition to contributing to the development of these programs, local Aboriginal communities should also contribute to the delivery of these programs to ensure maximum success.

While the Committee is aware that CD 702 allows cultural ceremonies, like sweat lodge ceremonies, it maintains nevertheless that CSC should increase the use of such healing methods. The Committee therefore recommends:

RECOMMENDATION 12

That Correctional Service Canada expand the use of sweat lodges and other Aboriginal healing methods and refrain from using denial of same as a disciplinary measure.

Lastly, although the Committee realizes that traditional and country food⁸⁴ is sometimes permitted in institutions, it maintains that CSC should encourage this practice. The Committee therefore recommends:

RECOMMENDATION 13

That Correctional Service Canada encourage healthy dietary practices for all offenders and where practical consider diet options for Aboriginal offenders including traditional and country food.

84 The definition of traditional and country foods is provided in footnote 77.

5.3.3 Correctional Service Canada's Obligation to Work with Aboriginal Communities (ss. 81 and 84, CCRA)

Under section 81 of the CCRA, the Minister of Public Safety may enter into an agreement with an Aboriginal community for the provision of correctional services to Aboriginal offenders, and for payment of the cost of such services.

A number of witnesses consulted during our study stressed the importance of participation by Aboriginal communities in the correctional process. According to them, the reintegration of Aboriginal offenders is possible only if Aboriginal communities take an active part in CSC initiatives.

Since the healing lodges authorized under section 81 of the CCRA promote a traditional holistic approach to service delivery, the Committee is disappointed that 18 years after the coming into force of this section of the Act, there are only four independent Aboriginal healing lodges in Canada. It is all the more alarming to note that there are no healing lodges for Aboriginal offenders operated by Aboriginal communities. The Committee finds it difficult to understand why CSC has been so slow to act in this regard, and hopes that the \$33 million capital outlay for Aboriginal corrections in 2009-2010 will lead to the establishment of new healing lodges.⁸⁵

Section 84 of the CCRA also requires CSC to involve Aboriginal communities in planning for the release of inmates to such communities. The Committee is disappointed in the fact that more frequent use is not being made of section 84 to have Aboriginal communities take part in the parole process.

Like many of its witnesses, the Committee is convinced that transferring responsibility to Aboriginal communities will likely contribute to the recovery and well-being of Aboriginal offenders with mental health disorders and addiction problems. According to Ms. Tole, "You can't get much worse than what we're doing. In terms of managing that population, we really can't."⁸⁶

In light of these considerations, the Committee recommends:

RECOMMENDATION 14

That Correctional Service Canada make greater use of agreements concluded with Aboriginal communities under sections 81 and 84 of the *Corrections and Conditional Release Act*, and establish the required capacity.

85 Marc-Arthur Hyppolite, *Evidence*, November 5, 2009.

86 *Evidence*, March 16, 2010.

5.4 THE NEED TO IMPROVE CORRECTIONAL SERVICE CANADA'S CAPACITY TO MEET OFFENDERS' HEALTHCARE NEEDS

Much can be learned from the Aboriginal approach to health. In accordance with this holistic approach, mental health is an integral part of a person's physical, emotional and spiritual well-being. Thus, investment in the general health of all inmates would help improve their mental health and overall well-being. It is also essential to realize that the health of inmates is an important public health issue: most will return to the community at some point, and correctional staff move back and forth between the institution and the community.

The Committee also believes, in accordance with international law, that inmates, as human beings, are entitled to enjoy the best possible state of health.⁸⁷ It should be noted that the sanction of imprisonment is deprivation of freedom, and not the loss of fundamental human rights.⁸⁸ The Committee therefore recommends:

RECOMMENDATION 15

That Correctional Service Canada ensure that offenders have the same medical care as citizens generally.

RECOMMENDATION 16

That Correctional Service Canada ensure that access to medical care is provided to offenders in a timely manner.

RECOMMENDATION 17

That Correctional Service Canada work towards a psychologist/patient ratio of no more than 1:35 at all federal institutions.

RECOMMENDATION 18

That Correctional Service Canada add substance abuse counsellors at every federal institution.

RECOMMENDATION 19

That Correctional Service Canada add psychiatric nurses and nurses at every federal institution.

RECOMMENDATION 20

That Correctional Service Canada ensure timely access to dental care at every federal institution.

87 Lars F. Moller, Brenda J. van den Bergh, Alex Gatherer, Health in Prisons Project, World Health Organization (WHO), Regional Office for Europe, "L'usage de drogues en prison : une grave menace pour la santé publique," in *Dépendances*, September 2008, No. 35.

88 Ibid.

RECOMMENDATION 21

That Correctional Service Canada place a renewed focus on individualized treatment for all offenders with diagnosed mental health conditions, including addiction issues.

RECOMMENDATION 22

That Correctional Service Canada work towards ensuring that adequate one-on-one counselling services are commenced forthwith upon diagnosis, and delivered in a timely fashion and in sufficient weekly amounts as prescribed by the treating psychologist or counsellor.

RECOMMENDATION 23

That the federal government require offenders who have assaulted staff members or other offenders with biological substances to undergo, in the interest of the health and safety of those assaulted, all the necessary tests to diagnose the presence of any infectious diseases.

5.5 IMPLEMENTATION OF THE CORRECTIONAL SERVICE OF CANADA'S MENTAL HEALTH STRATEGY

According to the Correctional Investigator, CSC has, since 2004, been slow to implement all components of its mental health strategy, and the delivery of mental health care has not changed significantly since that date. Like most witnesses, the Committee supports all the objectives of the strategy, and believes that implementing it in full would enable CSC to respond appropriately to the needs of federal offenders in its institutions and in the community. The Committee believes that action by CSC in this regard is critical, and therefore recommends:

RECOMMENDATION 24

That the federal government invest additional resources for the full implementation of the Correctional Service of Canada's mental health strategy.

Objective 1 Mental health screening and assessment of offenders upon admission

This objective is fulfilled by CSC's Institutional Mental Health Initiative (IMHI). The IMHI was given temporary funding of about \$21 million in Budget 2007, and permanent funding of some \$16 million in Budget 2008. It has only very recently been implemented, however, and the Committee is concerned that screening and assessment upon admission may still be inadequate. Evidence given to the Committee while touring the correctional institutions confirmed that full psychological screening, when needed, is not taking place for all offenders upon admission into custody. Testimony by

James Livingston, indicates that published standards and directives unanimously support systemic assessment and screening for mental health problems.⁸⁹

Given the importance of screening for mental disorders upon admission to an institution, the Committee believes CSC should give priority to Objective 1. By doing so, it will thus be in a better position to correct the numerous shortcomings in the delivery of mental health services, and improve the quality of care. The Committee therefore recommends:

RECOMMENDATION 25

That Correctional Service Canada (CSC) make mental health screening upon admission a priority and that the federal government continue to fund this component of the mental health strategy. CSC should also require a full psychological assessment of an offender if recommended by a health care professional after the aforementioned screening.

Objective 2 Primary mental health care in all institutions, including counselling, support, treatment and maintenance

This is also an IMHI objective; it was funded in Budget 2008, and has been given the same permanent funding as objective 1. Its goal is to promote and maintain good mental health for all offenders, using a multidisciplinary approach. Mental health guidelines pursuant to this objective were distributed to all staff on December 21, 2009 in an effort to prevent suicide attempts, provide timely care and help offenders deal with mental illness in the correctional environment. The Committee wishes to emphasize that it supports CSC's efforts in achieving this objective.

Objective 3 The development of intermediate mental health care units for offenders suffering from mental health disorders that require mental health care within the institutions

The Committee finds it difficult to understand why this third objective has yet to be funded. In the absence of the resources needed to develop intermediate mental health care units, CSC is unable to meet its obligation to provide offenders with adequate mental health care. Moreover, numerous witnesses decried the lack of intermediate mental health care within the federal correctional system.

The Committee is concerned about the plight of inmates who receive no care, or limited care, because CSC must concentrate its mental health resources on inmates suffering from more serious or chronic mental illness. Such cases demonstrate the importance and urgency of developing intermediate units for inmates who do not meet the criteria for admission to an RTC. The intermediate units could also assist CSC by

89 James Livingston, *Evidence*, October 29, 2009.

providing a safe transition for inmates who have to go back to the institution after spending time in an RTC.

Given these findings, the Committee recommends:

RECOMMENDATION 26

That Correctional Service Canada establish and fund intermediate mental health services and intermediate care units, depending on offenders' needs in each correctional facility, in order to care properly for offenders with mental health problems who do not meet the admission criteria of regional treatment centres and in order to provide care for offenders transferred from a regional psychiatric centre; and so that offenders do not feel compelled to enter voluntary administrative segregation to protect themselves from other offenders.

Lastly, during its visit to Whitemoor, in the United Kingdom, the Committee toured a unit for offenders with personality disorders. All the caseworkers we met were encouraged by the progress of the offenders receiving care in this specialized unit, which takes a multidisciplinary approach to this type of mental illness. While some witnesses mentioned the high operating costs of the program and found that it was still too early to assess its overall effectiveness, the Committee believes it would be useful to establish such a unit in Canada to treat offenders with such disorders. Accordingly the Committee recommends:

RECOMMENDATION 27

That Correctional Service Canada implement innovative, multidisciplinary units for personality disordered individuals, based on the Whitemoor, U.K., model.

Objective 4 Enhance Correctional Service Canada's regional treatment centres

This objective seeks to improve the services provided in CSC RTCs so that they are of the same calibre as those provided in forensic psychiatric hospitals in the community. While this objective is as important as the others, funding for it in Budget 2007 was limited. The Committee supports this objective as being consistent with the right of offenders to attain the best possible state of health. In the hope that this objective will receive permanent funding, the Committee encourages CSC to pursue the efforts made so far to secure the accreditation of its RTCs, to ensure professional development of its staff and to maintain newly signed contracts with psychiatrists.

Objective 5 Enrichment of mental health support in the community

This objective of CSC's mental health strategy seeks to ensure continuity of care for offenders, with no interruption, from the institution into the community. It is pursued by CSC by means of the Community Mental Health Initiative (CMHI), which seeks to ensure the establishment of new positions for mental health professionals in 16 such facilities, the provision of specialized services for offenders in the community through mental health consultancies, and mental health training sessions for front-line staff. Five-year funding for

this initiative was included in Budget 2005, but ended in March 2010. CSC is still trying to obtain permanent funding for this objective, believing that if the government is slow to provide funding, the result will be:

- Significant staff retention challenges, since approximately 50 employees are funded through the CMHI budget;⁹⁰
- Reduced capacity in the community, which would take time to rebuild, given the need to establish new contracts and hire new staff;⁹¹
- Reduced services for high risk and high needs offenders in the community.⁹²

The Committee encourages the government to provide permanent funding for the initiative at the earliest possible date, in order to avert the risks listed above.

Moreover, the Committee recommends:

RECOMMENDATION 28

That Correctional Service Canada cover the cost of all medication prescribed to treat mental illness of offenders on conditional release in the community through warrant expiry.

Objective 6 Provision of mental health training for all mental health professionals and correctional staff

This objective relates to CSC efforts to establish a program to train staff and mental health professionals to recognize the symptoms of mental illness, and provide effective and timely care. Although over 1,600 CSC employees and community partners were trained in 2008-2009, the Service must persevere in efforts to train all its employees.⁹³ The Committee wants to encourage CSC to continue its training efforts in order to strengthen its capacity to meet the needs of offenders with mental health disorders.

5.6 AN APPROACH TO DEAL WITH DRUGS IN PRISON THAT PUTS TOO MUCH EMPHASIS ON CONTROL, AS OPPOSED TO TREATMENT OF ADDICTIONS

The CSC drug strategy emphasizes three key elements: prevention, treatment and care, and control. According to CSC, the strategy seeks to cut supply and demand by preventing the entry of illicit drugs into its institutions, preventing drug use, and providing

90 Correctional Service Canada, *Community Mental Health Initiative*, no date. (Documentation provided to the Committee by CSC in October 2009).

91 Ibid.

92 Ibid.

93 Correctional Service Canada, *Continuum of Care Model—Summary of Mental Health Services and Outcomes*, October 2009.

substance abuse programs for inmates. The strategy also seeks to create a safe environment for staff and inmates. On August 29, 2008, the Minister of Public Safety announced an expenditure of \$122 million over five years to support CSC efforts in this area.

CSC maintains that the purpose of the strategy is to encourage inmate rehabilitation by implementing substance abuse programs. However, Ivan Zinger, Executive Director and General Counsel, OCI, informed the Committee that the funding approved for this strategy was all directed towards drug control efforts—teams of drug detector dogs, intelligence activities, ion scanners and x-ray machines—to the detriment of substance abuse programs and harm reduction initiatives.⁹⁴ The Committee would like CSC to take an approach that balances control, rehabilitation and prevention in combating drug use. Moreover, according to Sandra Ka Hon Chu of the Canadian HIV/AIDS Legal Network, CSC's desire to eliminate all drugs from its institutions is praiseworthy, but unrealistic.⁹⁵ The Committee also noted in Norway and England that drugs are a sad reality in the correctional environment.

According to Ms. Ka Hon Chu, the CSC's approach is harmful to inmate health, public health and the implementation of initiatives to reduce the problems caused by drugs.⁹⁶ In her opinion, CSC should establish a needle exchange program in all federal correctional institutions. She considers this program to be more effective in reducing the transmission of infectious diseases than the methods currently used by CSC, that is providing bleach to inmates for disinfecting needles and methadone treatment. She also urged the Committee to recognize that relapse is almost inevitable in prison and that, when relapse occurs, offenders are more likely to share contraband syringes, increasing the risk of contracting and spreading blood-borne diseases.

Dr. Peter Ford also points out that the spread of blood-borne diseases in correctional facilities has very serious public health consequences, because offenders are at some point released and could spread their diseases into the community.⁹⁷ He added that “[t]he long-term health costs of this are very considerable. It costs about \$20,000 to treat somebody with hepatitis C” and that “[c]orrections is going to find itself looking after people with terminal liver failure, and this is a very expensive prospect.”⁹⁸

In light of these considerations, the Committee recommends:

94 Ivan Zinger, *Evidence*, June 2, 2009.

95 Sandra Ka Hon Chu, Senior Policy Analyst, Canadian HIV/AIDS Legal Network, in her brief “Do the Right Thing”: An evidence-based response to addiction and mental health in federal prisons” to the Committee, October 2009.

96 *Ibid.*

97 Dr. Peter Ford, Physician, *Evidence*, November 5, 2009.

98 *Ibid.*

RECOMMENDATION 29

That the federal government explore all program options available to reduce the skyrocketing rates of HIV/AIDS and hepatitis C that pose a serious threat to public health both in prison and when offenders are released back into the community, and that assessments be undertaken to evaluate which program options are most effective at reducing the spread of infectious diseases in the context of the Canadian correctional system.

RECOMMENDATION 30

That Correctional Service Canada encourage and expand the use of 12 Step programs to deal with addiction issues, including the increased use of outside community groups to assist.

RECOMMENDATION 31

That Correctional Service Canada encourage the creation of drug treatment units in federal institutions.

RECOMMENDATION 32

That Correctional Service Canada allocate additional financial and human resources for drug treatment, harm reduction and prevention.

RECOMMENDATION 33

That Correctional Service Canada allocate additional funding to drug treatment programs at all federal correctional facilities.

RECOMMENDATION 34

That Correctional Service Canada establish programs to treat offenders who have both mental health and drug abuse problems simultaneously.

RECOMMENDATION 35

That Correctional Service Canada (CSC) continue to examine ways of strengthening drug interdiction monitoring activities and, in keeping with the recommendations made by the CSC Independent Review Panel, that CSC take a more rigorous approach to drug interdiction in order to create safe and secure environments where offenders can focus on rehabilitation.

5.7 THE PHYSICAL INADEQUACY OF SOME INSTITUTIONS

During its visits to federal institutions, the Committee noted the frequently poor conditions in which CSC staff work and federal offenders are detained, mainly as a result of the obsolescence of correctional institutions.⁹⁹ Of the 57 institutions operated by CSC, a good many were built in the 1800s and early 1900s—Kingston (1832), Dorchester (1880), Saskatchewan (1911), Stony Mountain and Collins Bay (1920-1930)—or in the mid-1900s—Joyceville (1950) and Archambault (1960s). Only four correctional institutions have been built since the mid-1990s. The average age of the institutions is about 45 years.¹⁰⁰

Apart from the high maintenance costs of the aging infrastructure, the Committee heard that these structures also pose a risk to the safety of staff and inmates and can hamper the delivery of correctional programs and services.

5.7.1 Penitentiaries that are Decrepit, Crowded, Noisy and Devoid of Natural Light

According to witnesses, the architecture of correctional institutions built in the 1800s and early 1900s is often a hindrance to modern correctional interventions, and is unsuited to the complex profile of today's inmate population, characterized by, among other things, a growing number of inmates who have committed violent crimes or are affiliated with criminal gangs. Witnesses also noted that some institutions today hold four or five subgroups of incompatible inmates that have to be kept apart for security reasons.

Here is what the Correctional Investigator had to say about the care of inmates with mental health disorders in CSC's older institutions:

Many of the older penitentiaries in this country, some of which were built in the mid to late 19th century, simply lack the design and infrastructure capacity to meet the needs and challenges of a rapidly expanding population of mentally disordered offenders. Staff cannot do their best, nor are offenders suffering from mental illness well served when they are housed in conditions that are decrepit, crowded, noisy, and devoid of natural light. The impact of these conditions of confinement on offenders whose thinking, learning, and/or emotional responses are impaired, delayed, or damaged can have deleterious and degrading effects on their mental functioning over time.

We no longer live in a time when penitentiaries are designed to be solitary and confining places with minimum human contact. Modern correctional practice requires modern infrastructure. Places of confinement should not purposely add to the pain of incarceration, nor should their design hinder the delivery of correctional interventions.¹⁰¹

99 Although most of the problems noted during the study related to correctional institutions built before the 1950s, problems were also reported in institutions built within the last two decades.

100 Don Head, "Modernization of Physical Infrastructure," *Let's Talk*, Vol. 33, No. 1, May 2008.

101 *Evidence*, October 6, 2009.

The architecture of some institutions also interferes with creating a proper balance between passive security (electronic barriers, camera surveillance, checkpoints and so on) and active security (encouraging interaction with inmates to get to know each other better, and thus prevent incidents and actively contribute to their rehabilitation). This is a serious consideration, because interaction with inmates is an important factor in the safety of both inmates and staff. Some witnesses also maintained that frequent, positive interaction with inmates increases the likelihood that inmates will talk to staff about plots or problems between inmates. Ruth Martin, a physician who works with inmates, also noted that “[o]pen communication with staff and administration can reduce the development of a negative subculture.”¹⁰²

During its study, the Committee also learned that most inmates are placed on waiting lists before gaining access to the programs and treatment specified in their correctional plan. This is attributable to, among other things, a lack of caseworkers and lack of space for program delivery that meets staff and inmate security requirements. This is all the more serious in that most inmates do not have timely access to appropriate programs. Those admitted late generally have their release into the community postponed; others are released without the benefit of all the programs and treatment considered essential to their rehabilitation.

Given the inefficient, inadequate and expensive infrastructure of many of CSC’s correctional institutions, the CSC Review Panel, tasked by the government in 2007 with reviewing CSC’s operational priorities, strategies and business plan, recommended that the federal government invest in the construction of a new type of regional penitentiary complex.¹⁰³ These complexes would include minimum, medium and maximum security sectors and share correctional services and space for the delivery of programs, and mental health and medical care.

In his testimony, the Panel Chair, Robert Sampson, spoke of the need to address the physical infrastructure in order to meet the needs of a prison population dealing with mental health or addiction problems.¹⁰⁴ Appearing before the Committee, CSC Commissioner Don Head¹⁰⁵ supported Mr. Sampson’s position, pointing out that changes to the institutions’ infrastructure were needed to facilitate the delivery of related programs.

Our visits to correctional institutions convinced us of the need for infrastructure changes in order to facilitate correctional measures. These changes are also essential to

102 Ibid.

103 The Panel’s recommendation reads: “The Panel recommends that CSC pursue undertaking capital and operating investments in a new type of regional, penitentiary complex that responds to the cost-efficiency and operational-effectiveness deficits of its current physical infrastructure.” Correctional Service of Canada Review Panel, *A Roadmap to Strengthening Public Safety*, report submitted to the government on October 31, 2007.

104 Robert Sampson, Chair, Correctional Service of Canada Review Panel, *Evidence*, June 11, 2009.

105 *Evidence*, June 11, 2009.

ensure conditions of detention that are conducive to the recovery of inmates with mental disorders and addiction issues.

In light of these observations, the Committee recommends:

RECOMMENDATION 36

That the federal government support the renewal and modernization of the federal correctional system's aging infrastructure.

RECOMMENDATION 37

When building new facilities, that Correctional Service Canada provide toilets and windows in every cell with access to sunlight and fresh air where possible.

RECOMMENDATION 38

When new infrastructure is built, that Correctional Service Canada ensure that therapeutic considerations are taken into account.

5.7.2 The Need for New Specialized Mental Health Units

At the Shepody Healing Centre in the Dorchester Institution, the Committee observed a glaring lack of space for the delivery of mental health care. Dr. Louis Thériault, who has been a psychiatric consultant for more than 10 years at the Centre, noted that it is simply unable to meet the growing demand for additional beds or co-dependency units.¹⁰⁶ In his presentation, he reminded the Committee of the importance of having access to appropriate spaces to manage individuals experiencing mental health problems who are in crisis. Similar problems were observed in the other psychiatric care units the Committee visited.

The Committee therefore recommends:

RECOMMENDATION 39

That the federal government build more expanded psychiatric care units. It must also ensure appropriate sub-units, and space both for private interviews and to deliver one-on-one counselling.

The former Deputy Commissioner for Women at CSC, Elizabeth Van Allen, also noted a shortage of space at the new regional institutions for women in terms of the delivery of programs and services for offenders with complex mental health challenges. She stated:

We have a challenge with our infrastructure's capacity to deal with our mental health offenders. For our women in minimum and medium security, we have a good program in

106 Speaking notes, December 16, 2009.

place. Our structured living environments work well. ... It's more difficult when we have to deal with women who have behavioural challenges stemming from more complex mental health needs. Unfortunately, working with these women requires a more secure environment. We have five regional facilities. The secure units are relatively small, and that poses challenges. That's an area we will have to work on in the coming years.¹⁰⁷

The Committee also noted that CSC does not have any independent psychiatric facilities for federally sentenced women. Such facilities would make it possible to accommodate female offenders with complex mental health challenges, in keeping with Ms. Van Allen's concerns. The Committee therefore recommends:

RECOMMENDATION 40

That the federal government take action to address the fact that Correctional Service Canada currently has no stand-alone psychiatric facility to accommodate and treat women serving sentences of two or more years who are affected by complex mental health issues.

The Committee is also concerned that the regional mental health centre located around the Archambault facility cannot accommodate high-security offenders. As a result, a number of offenders with mental health problems are sent to the Special Detention Unit (SDU), where conditions are harmful to their mental health. In the Committee's opinion, offenders at Archambault should have access to services similar to those available at the regional psychiatric centre in Saskatoon. The Committee therefore recommends:

RECOMMENDATION 41

That Correctional Service Canada modernize the Archambault Regional Mental Health Centre by building, outside the current location, a maximum security psychiatric facility to treat all mental health problems. This facility could be similar to the Regional Psychiatric Centre in Saskatoon and the treatment philosophy could be based on the approach used at the Shepody Healing Centre in Dorchester or at Ila institution in Norway.

5.8 CREATING AN ENVIRONMENT CONDUCIVE TO REHABILITATION

The atmosphere in the correctional facilities visited in Norway differs from that in most of the facilities visited in Canada. Members of the Committee noted that some facilities are more like schools than prisons given the colour of the walls, the paintings and sculpture on display, the poetic messages on hallway walls and the friendly interaction between guards and offenders. Even at maximum security facilities, the guards do not use security equipment as a rule—Kevlar vests or extendible batons—when interacting with offenders. The guards do however still have access to a full range of highly sophisticated security equipment for use when needed. The equipment is stored in a locked room near the detention units.

107 *Evidence*, November 5, 2009.

At CSC medium and maximum security institutions, offenders usually follow a strict schedule with various services provided (meals etc.). At the facilities in Norway, including maximum security ones, offenders live in units where they have to get along with others and do household duties such as cleaning, vacuuming and cooking. This is similar to the approach at CSC minimum security facilities. The approach gives offenders the opportunity to assume responsibility for their self-care, to apply basic life skills and to counter inmate apathy.

On the whole, the Committee was impressed by the approach used in the correctional system in Norway. It was also surprised to learn that instances of violence against prison guards are extremely rare in these institutions. This is an approach favoured by Ms. Tole, retired warden of Alouette Correctional Centre in British Columbia. Appearing before the Committee, she pointed out that a more structured environment can be much more unsafe for correctional staff:

It is a fallacy that the more structured the environment, the safer it is. It isn't. The more confined, structured, and authoritarian the environment is, the more difficulty they have in living within that environment, and they tend to produce much more in the way of management problems. As a result, it's not a safe environment. It's unfortunate when institutions move more and more towards that—more technology, more security, more restrictive movement—because what you actually generate is a very dysfunctional population that presents a threat to the staff.¹⁰⁸

Most of our witnesses also agreed that offenders fare better when they have positive and frequent interaction with qualified personnel. Amber-Anne Christie, a former inmate and research assistant with Women in 2 Healing, stressed that the environment and the physical design of correctional facilities are significant factors in offender rehabilitation. She stated before the Committee:

The way the prison [Alouette] was being run was more like a rehabilitation centre than a prison. It was amazing. Not only was there a library and a gym there, there was a native elder there to talk to. As well, there was drumming and dancing every Tuesday night. As a mother myself, I have to say that it helped me to remember the things I was giving up, and I know that the other inmates dealt with their problems and reacted differently because there was a baby there.

I was released from prison in October 2005, and I have not been back since. I will be the first to say that this exact prison changed my life. I had been in many prisons before, but this prison treated me like I was a person and not a number.¹⁰⁹

According to Dr. Ruth Martin, enhancing offenders' self-confidence, engaging them in decision-making and focusing on their strengths rather than their weaknesses are essential to the success of correctional services.¹¹⁰

108 *Evidence*, March 16, 2010.

109 *Ibid.*

110 *Ibid.*

Finally, since the atmosphere and physical design of correctional facilities are decisive factors in offender rehabilitation, especially for those with mental health and addiction issues, the Committee recommends:

RECOMMENDATION 42

That Correctional Service Canada develop a values-based vision as part of its mission to encourage healthy living in the correctional setting and mutual respect among offenders and staff. These values would be posted in all common areas and updated regularly by inmates and staff.

RECOMMENDATION 43

That Correctional Service Canada ensure adequate access to physical exercise and outdoor exercise.

RECOMMENDATION 44

That Correctional Service Canada ensure that all psychiatric units meet acceptable standards, including cell size, lighting, common areas, etc.

RECOMMENDATION 45

That Correctional Service Canada reduce barriers between correctional officers and inmates to establish, where possible, an atmosphere most conducive to rehabilitation.

RECOMMENDATION 46

That Correctional Service Canada have petition boxes installed in correctional facilities to allow inmates to submit confidential written requests to institution wardens, who would be responsible for responding to every reasonable request.

The international community has made a commitment to protecting the human rights of offenders by instituting a number of international human rights instruments, such as the Convention against torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Standard Minimum Rules for the Treatment of Prisoners (SMR).¹¹¹ The SMR are likely the most broadly recognized international standard regarding offenders' rights. In becoming a signatory to them in 1975, Canada undertook to apply the minimum rules in the management of its correctional clientele. In so doing it also recognized that offenders retain all their human rights, except their right to freedom of movement, and that they must at all times be treated humanely and with respect for their human dignity.

111 Human Rights: A Compilation of International Instruments, Vol. I, Part 1, Universal Instruments, Section J, No. 34.

Rule nine of the SMR states:

Where sleeping accommodation is in individual cells or rooms, each prisoner shall occupy by night a cell or room by himself. If for special reasons, such as temporary overcrowding, it becomes necessary for the central prison administration to make an exception to this rule, it is not desirable to have two prisoners in a cell or room.

In accordance with this rule, CSC internal policies provide that single cell occupancy is the most appropriate method for offenders for correctional purposes.¹¹² Yet CSC does not choose its correctional clientele and it sometimes departs from this principle, as many other correctional administrations do here and elsewhere. Such departures have an impact though, as studies have demonstrated that the overpopulation of institutions results in:

- Increased tension and violence and compromised safety of personnel, offenders and visitors;
- Greater risk of the spread of infectious diseases;
- Accelerated progression of certain illnesses; and
- Reduced ability of correctional administrations to meet offenders' needs, including health care, treatment, education and training.

Appearing before the Committee, the Correctional Investigator stated that the rate of "double occupancy" in CSC institutions has increased significantly in recent years and is currently about 10% of the federal inmate population.¹¹³ As of February 15, 2009, 1,313 offenders were double bunked in 657 cells.¹¹⁴ Here is what the Correctional Investigator told the Committee about overpopulation:

The Correctional Service of Canada right now has empty cell capacity of maybe between 800 and 1,000, scattered across the country. So if you were to take a very high-level look and you say, gee, we've got empty cell space, so if more people come into a penitentiary, we must be able to accommodate them, you might be able to draw that conclusion.

The reality is that with the mix of the offender profile, with the issues to do with gangs, with the mentally ill, with the special concerns of women or Aboriginal offenders, that capacity isn't in the right place at the right time; it's not available. We have overcrowding, particularly at medium security, where the vast majority of offenders spend the vast majority of their time.¹¹⁵

112 CSC Commissioner's Directive No. 550, Inmate Accommodation, March 2001.

113 Howard Sapers, Correctional Investigator of Canada, Standing Committee on Justice and Human Rights, May 25, 2009.

114 Ibid.

115 *Evidence*, June 2, 2009.

In light of these observations and with the recent adoption of federal legislation that could increase the federal inmate population, the Committee recommends:

RECOMMENDATION 47

That the federal government uphold the United Nations' Standard Minimum Rules for the Treatment of Prisoners, to which the Government of Canada is a signatory, which states: "Where sleeping accommodation is in individual cells or rooms, each prisoner shall occupy by night a cell or room by himself," as it is widely accepted that double bunking and overcrowding exacerbates mental health and addiction problems faced by inmates, as well as their ability to rehabilitate and reintegrate into society.

5.9 GAPS IN THE TRAINING OF CORRECTIONAL STAFF

Staff training is recognized in the CSC Mental Health Strategy as an essential factor in providing services and programs that meet the needs of offenders with mental health issues. In his 2008-2009 report, the Correctional Investigator states that CSC has made progress recently in this regard by creating a new online mental health training kit for front-line workers.¹¹⁶ CSC also informed the Committee that it had recently introduced a two-day mental health training session for staff working at parole offices and halfway houses. Despite these promising initiatives, many witnesses, including CSC employees, stated that CSC has not done enough in this regard.

The Committee did not fully review the content of the training currently available to CSC employees. The evidence indicates however that correctional officers who work with federally sentenced offenders on a daily basis cannot recognize the symptoms of mental health problems and illness, despite their best intentions. They have difficulty dealing with the inconsistent behaviour associated with mental health disorders and cannot respond appropriately to the offenders in question.¹¹⁷ Some witnesses, including the Correctional Investigator, noted that the compulsive and irrational behaviours associated with mental health disorders are often interpreted as acts of violence and are addressed through security measures rather than treatment.¹¹⁸ As highlighted in the next section, administrative segregation is often the default response in such cases.

Given the importance of training for managing correctional clientele, the Committee was surprised to learn that corrections officers at RTCs do not receive specialized training. The Committee agrees with the Correctional Investigator that CSC must recognize the importance of mental health training by immediately providing suitable training for staff at RTCs.

116 *Annual Report of the Office of the Correctional Investigator 2008-2009*, June 29, 2009.

117 See for example the testimony of Howard Sapers, June 2, 2009.

118 Ivan Zinger, *Evidence*, June 2, 2009.

In the Committee's opinion, CSC should also provide improved training as soon as possible for staff working with offenders in traditional facilities on a daily basis. Staff training should focus on the recognition of verbal and behavioural signs of mental health disorders and on responding accordingly to offenders' needs.

In view of these observations and since staff training is fundamental to the effective and humane management of offenders with mental health and addiction issues, the Committee recommends:

RECOMMENDATION 48

That Correctional Service Canada make its mental health training activities a priority so that all employees working with offenders in an institution or in the community can gain familiarity with the symptoms of mental illness and treatment methods for offenders with mental health problems.

RECOMMENDATION 49

That Correctional Service Canada introduce specialized mental health training for correctional officers, program officers and parole officers who work in mental health units or regional treatment centres.

Finally, given the limitations of traditional training that usually includes printed training material, Glenn Thompson, Secretary of the Board, Mental Health Commission of Canada, suggested that an electronic training tool be created that CSC employees could consult at any time. He stated:

Nowadays there should be something online for the correctional services staff that they can refer to any time, on the job or even in their home environment, training materials that are electronically available. People don't remember everything from a two-week course or a three-month course, or whatever it might be, and they need to refer back and think about it as their experience goes along. Today, they maybe had to supervise a person who had a schizophrenic condition. They may want to go and think about that and read about it and find out more about what other people have learned to do in that kind of situation.¹¹⁹

The Committee agrees with Mr. Thompson that such a tool could improve the correctional officers' responses. The Committee therefore recommends:

RECOMMENDATION 50

That Correctional Service Canada create mental health training material that is available electronically so that correctional employees can consult it at any time, at work or even at home.

119 *Evidence*, December 10, 2009.

5.10 INAPPROPRIATE USE OF ADMINISTRATIVE SEGREGATION

While administrative segregation is seen as an essential tool for crisis management, the Committee learned that CSC uses it too often to deal with offenders with mental health issues.

5.10.1 Statutory Framework

The CCRA authorizes CSC to use two types of segregation: disciplinary and administrative. Disciplinary segregation is a severe form of punishment that can be used for offenders found guilty of a serious disciplinary offence.¹²⁰ This is the most severe punishment authorized under the CCRA. It is limited to 30 days but can be extended to 45 days in the case of multiple disciplinary offences.¹²¹

Administrative segregation is a last-resort measure intended to prevent an offender from associating with other offenders.¹²² An administrative segregation order must be based on one of the following three grounds:

- To prevent behaviour that could jeopardize the safety of any person or the security of the penitentiary, including employees and other inmates;
- To allow for an investigation that could lead to a criminal charge or a charge of a serious disciplinary offence under subsection 41(2);
- To provide services to the inmate whose safety would be jeopardized in the general inmate population.¹²³

Unlike disciplinary segregation, there is no limit on the duration of administrative segregation, although the CCRA provides that an inmate must be returned to the general inmate population as soon as possible.¹²⁴ Some witnesses argued that administrative segregation often runs on for too long. In his 2008-2009 report, the Correctional Investigator expresses concern over the high number of offenders placed in administrative segregation for 60 days or more. It has been demonstrated repeatedly that risks to health increase over time. The Committee agrees with the Correctional Investigator that “[t]he practice of confining offenders with mental disorders to prolonged periods of isolation and deprivation must end. It is not safe, nor is it humane.”¹²⁵ Moreover, an extended period of

120 Disciplinary offences are set out in Section 44, CCRA.

121 Section 44, CCRA, and section 40, *Regulations Respecting Corrections and the Conditional Release and Detention of Offenders*.

122 Sections 31 to 37, CCRA.

123 Subsection 31(3), CCRA.

124 Subsection 31(2), CCRA.

125 *Annual Report of the Office of the Correctional Investigator 2008-2009*, June 29, 2009.

segregation can also delay an offender's rehabilitation and release due to the interruption of correctional programs.

It should be noted that the case of an inmate placed in administrative segregation must be reviewed regularly pursuant to section 33 of the CCRA and sections 19 to 23 of the Corrections and Conditional Release Regulations (Regulations). The Regulations provide that, the day after the inmate is placed in segregation, the institutional head must confirm the confinement order or order that the inmate be returned to the general prison population. This requirement also applies for offenders in voluntary confinement. When the institutional head confirms the administrative segregation order, a segregation review board within CSC must conduct a hearing within five working days of the order and every 30 days thereafter. The CSC regional head or designated regional staff member must also review the inmate's case after 60 days in administrative segregation to determine if segregation is still justified.

5.10.2 Administrative Segregation as a Default Option

Offenders with mental health problems who have irrational, impulsive and compulsive behaviour are often involved in altercations with staff and other inmates. In such cases, the staff's inability to recognize symptoms of mental illness leads to decisions based more on security and repression than on treatment and intervention.

The Committee is concerned that CSC has not acted more quickly to establish intermediate care units to treat these offenders in units suited to their needs. The Committee agrees with its witnesses that establishing such units would address serious weaknesses in the current management of this population. Such units would provide a safe place for offenders requesting segregation because they do not feel safe among the general population. These units would also help offenders who do not meet the regional treatment centre admission criteria and have to remain in the correctional facility, where mental health resources are limited. For offenders returning from a stay at a regional treatment centre, such units would also provide for a gradual and safe transition from the therapeutic and clinical setting of the regional treatment centre to the general inmate population. According to the Correctional Investigator, the use of segregation as a substitute for intermediate mental health care cannot be justified in any case.¹²⁶ The Committee therefore recommends:

RECOMMENDATION 51

That Correctional Service Canada give priority to admitting into intermediate care units (newly created by Committee recommendation 26) offenders with mental health problems who would normally be subject to administrative segregation to protect them from other offenders.

126 Douglas Quan, "Put end to isolation of mentally ill offenders", CanWest News Service, March 25, 2010.

The Committee is also very concerned about offenders placed in segregation as a way of managing their self-destructive behaviour (suicide attempts and self-mutilation). Depriving an offender of human contact is considered detrimental to rehabilitation and in fact exacerbates suicidal and self-mutilation behaviour. The Committee encourages CSC and its employees to use intervention methods first to calm offenders.

The Committee agrees with the Correctional Investigator who states in his June 2008 report, *A Preventable Death*, that administrative segregation should never be used as punishment or as a way around disciplinary segregation. Since administrative segregation is not a punitive measure, the offender must have the same rights, privileges and detention conditions as other offenders.

The Committee therefore recommends:

RECOMMENDATION 52

That Correctional Service Canada use administrative segregation in only the most limited circumstances, under very strict regulations and as a last resort.

RECOMMENDATION 53

That Correctional Service Canada ensure that when administrative segregation is used, it is in its mildest form, on a graduated basis and of the shortest duration possible in order to achieve the desired outcome.

RECOMMENDATION 54

That Correctional Service Canada recognize that administrative segregation is not conducive to the treatment of offenders with mental health diagnoses and that human contact is essential to their rehabilitation and, where possible, facilitate their treatment with a health-care approach.

5.10.3 Seeking Innovative Solutions

The Committee noted that, in both Norway and England, segregation is seen as a necessary evil in dealing with a crisis. However, in England, offenders are systematically evaluated before being placed in segregation to identify underlying mental health issues. This is a promising approach that seeks to promote the well-being of offenders with mental health issues. England and Wales also have a centre providing close supervision of dangerous and troublesome offenders who refuse to or have difficulty obeying prison rules. These centres are an alternative to placing these offenders in segregation for extended periods. During its visit, the Committee observed that these centres take a humane approach in managing difficult cases, with an emphasis on offender rehabilitation. During its study, the Committee also learned that some prisons in England and Wales never use segregation to manage their inmate population.

Johanne Vallée, CSC Deputy Commissioner, Quebec Region, noted that a regional advisory committee was created in that province to find alternatives to long-term segregation. A peer program was also created as an alternative for offenders who do not want to leave segregation. Dr. Ruth Martin pointed out that at some centres offenders are placed in special units rather than segregation. In these units, the offenders benefit from the daily assistance provided by counsellors, psychiatric nurses and community workers.

The Committee is convinced that correctional facilities that use innovative alternatives to segregation provide an environment that is more conducive to the rehabilitation of offenders with mental health issues. Indeed, all offenders would benefit from a therapeutic environment conducive to their well-being and good mental health. The Committee therefore encourages CSC to find alternatives to segregation in the correctional system.

In view of these considerations, the Committee recommends:

RECOMMENDATION 55

That Correctional Service Canada (CSC) examine the use of segregation for offenders with mental health problems in order to develop alternative solutions for this clientele. In order to do so, the CSC must take into account the opinions of wardens, front-line workers, including correctional officers, and best practices in other countries that have reduced the use of segregation.

5.10.4 Independent Adjudication to Address Accountability and Transparency Problems at Correctional Service Canada

The Canadian Charter of Rights and Freedoms (hereafter the Charter) applies to and plays an important role in the correctional system, especially for the protection of inmate integrity. Various provisions of the Charter have been incorporated into the CCRA in order to uphold offenders' human rights. Under the CCRA, CSC must provide for the humane custody and treatment of its correctional clientele. This guarantee is especially important in the correctional setting where the clientele is most vulnerable.

Several major studies¹²⁷ and numerous recommendations have called on CSC to use an independent adjudication process to review the placement of inmates in administrative segregation. Yet neither CSC nor the Minister of Public Safety has acted on

127 After the CCRA was passed, Madam Justice Arbour investigated the segregation of federal inmates and issued a report in 1996 on certain events at the Prison for Women in Kingston. In 2000, the Sub-committee on the Corrections and Conditional Release Act of the House of Commons Standing Committee on Justice and Human Rights published a report entitled *A Work in Progress—The Corrections and Conditional Release Act*. In 2004, the Canadian Human Rights Commission published its report, *Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women*. In 2004, the Office of the Correctional Investigator published a working paper entitled *Shifting the Orbit—Human Rights, Independent Review and Accountability in the Canadian Corrections System*. In 1966, the United Nations made recommendations regarding the segregation process in the International Covenant on Civil and Political Rights.

these recommendations. The Committee is disappointed that CSC has ignored the recommendations of corrections experts. We believe that an independent mechanism is necessary not only to ensure the transparency of CSC decisions, but also to identify any violation of these offenders' human rights. The Committee fears that there may be abuse without such a mechanism. The Committee therefore recommends:

RECOMMENDATION 56

That Correctional Service Canada immediately conduct an independent review of all cases of long-term administrative segregation and have an independent outside agency validate and assess the review of these cases.

5.11 RECOGNIZING THE IMPORTANCE OF CORRECTIONAL PROGRAMS FOR THE REHABILITATION AND SAFE REINTEGRATION OF OFFENDERS

It is widely recognized that it is in society's interest as a whole for correctional services to respond appropriately to the needs of offenders in their custody. These needs pertain to mental health problems, addictions and any other problem affecting their ability to function in the community as law-abiding citizens. In this regard, research has shown that correctional programs that address criminogenic factors are effective in reducing recidivism, which makes them a strategic investment. CSC's internal documents show that, for every dollar invested in correctional programs, CSC saves four dollars in incarceration costs.¹²⁸

CSC currently relies on a number of correctional programs, including programs for anger management, violence prevention, sex offenders and addictions. According to the evidence heard in Canada, Oslo and London, CSC is a leader in this field. Moreover, a number of the prison programs offered in Norway, England and Wales are based on CSC programs.

As stated above, while all CSC institutions offer correctional programs, a number of offenders do not have timely access to them due to insufficient human or financial resources or lack of space. At all the institutions visited, there are long waiting lists for programs. According to the Correctional Investigator, there were 13,353 men and women in federal correctional institutions as of May 10, 2009, 3,190 of whom were in basic correctional programs. "This means that in every region of the country there were dozens and dozens of offenders waiting for program assignment, with unmet needs in terms of their correctional plan."¹²⁹

128 Ivan Zinger, *Evidence*, June 2, 2009.

129 Howard Sapers, *Evidence*, June 2, 2009.

5.11.1 The Need to Immediately Increase Funding for Programs

CSC currently spends about \$37 million per year on correctional programs: this covers training, quality control, management and administration costs.¹³⁰ Correctional programs addressing criminogenic factors account for just 2 to 2.7% of the total correctional budget. A number of witnesses lamented this state of affairs, pointing out that without increased funding it will be difficult for CSC to provide inmates with access to programs that can address the social inadequacies at the root of their criminal behaviour.

Appearing before the Committee in Ottawa, CSC Senior Deputy Commissioner Marc-Arthur Hyppolite stated that CSC had recently received additional funding¹³¹ for the implementation of a new Integrated Correctional Program Model (ICPM), which has been in trials in the Pacific Region since 2010. Like other witnesses who appeared before the Committee, Mr. Hyppolite seemed confident that the upcoming implementation of this framework will enable CSC to improve access to correctional programs for all federal offenders and reduce dropout rates. CSC has every hope that the ICPM will:

- Give inmates access to programs much earlier in their sentence;
- Allow CSC to accept more offenders into programs on an ongoing basis;
- Help CSC ensure that offenders participate in and successfully complete programs in a timely manner.

The Committee hopes that this CSC initiative will be successful in giving offenders timely access to the programs included in their correctional plan. The Committee maintains however that this initiative alone is insufficient. Like a number of our witnesses, the Committee concludes that without a significant increase in the budget for correctional programs, CSC will not be able to effectively respond to help offenders reintegrate safely in the community.

Since CSC spending on correctional programs addressing factors contributing to crime is currently inadequate, the Committee recommends:

RECOMMENDATION 57

That Correctional Service Canada substantially increase its budget for correctional programs addressing factors contributing to crime, including drug and alcohol abuse and mental health problems.

In order to maximize investments in correctional programs and offender rehabilitation, the Committee is also of the opinion that CSC should use peer counsellors more extensively. This approach relies on the participation of offenders to bring about

130 Ivan Zinger, *Evidence*, October 2, 2009.

131 He noted that CSC intends to invest up to “\$5 million next year and \$5 million the following year”, *Evidence*, November 5, 2009.

change in other inmates with similar problems. This method can be very effective for rehabilitation. Using peer counsellors might also improve CSC's ability to meet offenders' needs relating to mental health and addiction. The Committee therefore recommends:

RECOMMENDATION 58

That Correctional Service Canada provide for the training and increase the use of peer counsellors.

5.11.2 A Need to Expand the Range of Programs Offered to Federal Inmates

The Committee supports all the programs currently offered in the federal correctional system. The evidence gathered from inmates, corrections officers and professionals indicates however that CSC should expand its range of correctional programs. Similarly, the Committee agrees that the period of incarceration must be fully utilized to engage offenders in obtaining the necessary tools for their successful reintegration in the community as law-abiding citizens. The Committee therefore recommends:

RECOMMENDATION 59

That Correctional Service Canada increase the use of craft rooms and workshops and expand the range and number of creative, recreational, arts and music programs as well as other therapeutic programs.

The offenders who took part in the Committee's study reported very positive experiences with some CSC programs. Some noteworthy programs brought to our attention included those based on animal therapy such as the Horses as Healers program at the Okimaw Ohci Healing Lodge, located in the Necaneet First Nation, in Maple Creek, Saskatchewan, and the farm prison program currently offered at six correctional facilities operated by CSC.¹³²

Research shows that attachment to an animal has an overall favourable impact on the person physically, psychologically and emotionally.¹³³ Programs based on animal therapy can reduce depression and anxiety, develop self-esteem, and assist in the learning of compassion and various social skills including respect for others, discipline and a sense of responsibility. In the correctional setting, interaction with animals can also be a calming influence for inmates and staff, fostering an atmosphere that is more relaxed and conducive to rehabilitation. The results of an evaluation of the dog training program at the Nova institution for women showed that it: "builds the offenders' self-esteem, produces

132 CSC has also offered a dog training program, *Pawsitive Directions Canine Program* (PDCP), at the Nova women's institution since 1996.

133 See Wendy G. Turner, *The experience of offenders in a prison canine program*, Federal Probation, Vol.71, N° 1, June 2007; Fournier et al., "Human-Animal Interaction in a Prison Setting: Impact on Criminal Behaviour, Treatment Progress, and Social Skills", *Behaviour and Social Issues*, 16, 2007, p. 89-105.

positive changes in the institutional environment, and changes the community's perception of women inmates at Nova Institution."¹³⁴

A literature review conducted by CSC concludes that animal therapy programs not only help participants by improving their behaviour and learning about discipline, as well as their sense of cooperation and respect for others; they also help the staff of correctional institutions since the presence of animals makes the atmosphere more relaxed and encourages communication among inmates.¹³⁵ Finally, society as a whole would benefit from these programs since the participating inmates would learn skills that would serve them well in the labour market and would reduce the rate of recidivism.¹³⁶

Animal therapy programs have proven effective and all participating inmates believe that these programs have undeniable benefits at the human level. For this reason, the Committee has difficulty understanding why CSC decided to terminate the farm prison program at penitentiaries by March 31, 2011. Like many of our witnesses, the Committee is convinced that CSC is on the wrong path in this regard and maintains that CSC should actually increase the number of programs based on animal therapy.

In view of these considerations, the Committee recommends:

RECOMMENDATION 60

That Correctional Service Canada restore its prison farm program, which is an excellent rehabilitation tool, also serving as animal therapy.

RECOMMENDATION 61

That the federal government, acknowledging the imperative nature of preparing inmates for reintegration into the community, recognize the unique rehabilitative needs of offenders struggling with mental health and addictions, and put a greater focus on rehabilitation programs that have offenders working with living things, which research has shown has a calming and restorative effect on inmates, and helps them develop qualities that offenders often lack, like a sense of self worth, respect and empathy, as well as essential life skills like a sense of responsibility, dependability and teamwork, and that Correctional Service Canada explore and implement the use of pet therapy programs and other therapeutic use of animal husbandry.

134 Kelly Richardson-Taylor and Kelley Blanchette *Results of an Evaluation of the Pawsitive Directions Canine Program at Nova Institution for Women* Research Branch, Correctional Service Canada, September 2001.

135 Office of the Deputy Commissioner for Women, *Pet Facilitated Therapy in Correctional Institutions, 1998*: <http://www.csc-scc.gc.ca/text/prgrm/fsw/pet/pet-eng.shtml>.

136 Earl O. Strimple, "A History of Prison Inmate-Animal Interaction Programs", *American Behavioural Scientist*, Vol. 47, No. 1, September 2003.

Women inmates in provincial and federal facilities are often mothers. According to CSC, about two-thirds of women in their custody have children under the age of five, and most of them are single mothers. The incarceration of these women has a huge impact on their children. Research has shown that “young children who are forcibly separated from their mothers suffer long-term developmental and emotional damage.”¹³⁷

To counter the harmful effects of imprisonment on children, a number of countries have developed mother-child correctional programs. Under a number of programs, children born in prison remain with their mother for a certain period of time. Other programs allow children to stay with their mothers in detention under certain conditions. CSC established a mother-child program in 1996-1997. For a long time, this was a pilot project; CSC officially established it in 2001.

Commissioner’s Directive No. 768 states that the mother-child program is designed to create a supportive environment that fosters and promotes stability for the mother-child relationship. Under this directive, CSC identifies two levels of participation in the program: full-time residency and part-time residency, where the child stays with the mother on weekends, holidays or school vacations. The upper age limit for full-time residency is four years (at the fourth birthday) and twelve years (at the thirteenth birthday) for part-time residency. Exceptions to this rule may be considered upon written request; the request must be approved by the Deputy Commissioner for Women and the Regional Deputy Commissioner.

Under the Commissioner’s Directive, the institutional head is responsible for ensuring that all decisions are made in the child’s best interests, including safety and physical, emotional and spiritual well-being. The former Deputy Commissioner for Women, Ms. Van Allen, also pointed out that the institutional head usually consults with child protection authorities before making any decisions relating to inmates’ children.

Although the program is currently available at the five institutions for women, just one inmate was registered as of November 5, 2009.¹³⁸ Ms. Van Allen pointed out that few women have participated in the program since its inception. The Committee hopes that CSC will maximize the use of this program in the future in order to encourage and support women in its custody in terms of assuming their responsibilities as mothers while they are inmates.

In speaking with inmates, the Committee also noted that a number of them were fathers. CSC should also encourage and support these fathers in terms of their responsibilities as parents either by providing parenting skills programs or by encouraging visits from their children.

137 World Health Organization, *Women’s health in prison. Correcting gender inequities in prison health*, 2009, paragraph 21.

138 *Evidence*, November 5, 2009.

In the opinion of the Committee, all of these practices would serve to recognize the importance of the parent-child relationship in terms of the well-being and mental health of mothers, fathers and children alike. That said, for all decisions regarding children, CSC must also continue to guarantee that their safety, health and development are not jeopardized.

In view of these considerations, the Committee recommends:

RECOMMENDATION 62

That Correctional Service Canada create a parenting skills program for offenders in institutions by creating partnerships with community and government organizations. This approach could include educational training for children of various age groups, conflict management, weekend family visits, improving children's reading skills and increasing the number of prison units accommodating mothers and their children.

Finally, the Committee is aware that CSC currently administers five programs for sex offenders: three national programs, high intensity, moderate intensity and low intensity; the Tupiq program that is tailored to Inuit culture; and the program for women sex offenders. Some witnesses argued that the current programs are not suitable for sex offenders with concurrent problems such as mental health issues. The Committee therefore recommends:

RECOMMENDATION 63

That Correctional Service Canada develop and deliver core programs for sex offenders who have developmental delays, bi-polar disorders or other similar limitations that currently make access to present core programming inappropriate.

5.12 ENSURING A SAFE TRANSITION BACK INTO THE COMMUNITY AND REDUCING THE RISK OF RECIDIVISM

In his introductory remarks, Mr. Livingston, noted that “the transition between custody and community can be acutely stressful, psychologically distressing” for inmates with mental health problems. To offset this and to facilitate the rehabilitation of these inmates, research has shown that correctional services must provide them with transition plans that clearly identify available community resources and, if applicable, that ensure that offenders have a sufficient supply of medication to last until they are able to see a community health service provider.

The statistics we received for the Quebec region indicate that the recidivism rate following release is twice as high for offenders with mental health problems as for other offenders.¹³⁹ To counter this trend, CSC must ensure that offenders receive treatment and

139 Johanne Vallée, CSC Deputy Commissioner, Quebec Region, *Evidence*, March 23, 2010.

programs suited to their needs along with sufficient support in the community. Here is what Graham Stewart, former executive director, John Howard Society of Canada, had to say in this regard:

If we don't make a change, if we can't bring together the proper treatment, if we don't have the proper reintegration support for people re-entering the community, you can be sure that being as vulnerable as they are, having the difficulty they have day by day in their lives, they will be back at the door in short order—and not necessarily for serious crimes.¹⁴⁰

To increase offenders' chances of success and in the interest of public safety, the Committee concludes that CSC should immediately expand its community correctional services. It should also work on developing links with outside public programs that could offer treatment services and adequate support to offenders on conditional release.

In light of these considerations, the Committee recommends:

RECOMMENDATION 64

That Correctional Service Canada increase the number of half-way beds for men and women to ensure adequate beds in every province and territory.

Like many witnesses, the Committee is of the opinion that the transition from detention to the community would be greatly facilitated by correctional practices that encourage the participation of families, friends and community groups in the correctional setting. In the opinion of the Committee, the participation of persons and groups able to provide appropriate community services and to support offenders as they take control of their lives and health is an important factor in the successful reintegration of offenders. The Committee therefore recommends:

RECOMMENDATION 65

That Correctional Service Canada encourage and increase family visits and re-connection to family, friends and community.

RECOMMENDATION 66

That Correctional Service Canada expand the interaction with community programs, resources and groups to vastly increase both the community involvement in, and the type, number and quality of programs within, the correctional institutions (e.g., sports teams, drama programs, teachers, etc.).

140 Graham Stewart, *Evidence*, October 27, 2009.

RECOMMENDATION 67

That Correctional Service Canada expand the access of offenders wherever possible and desirable to community resources, programs and visits, in the community.

5.13 PROBLEMS RECRUITING AND RETAINING HEALTH PROFESSIONALS IN THE CORRECTIONAL SETTING

The information gathered by the Committee during its study indicates that CSC has a critical shortage of personnel to meet the needs of federal inmates with mental health and addiction issues. As a result of this shortage, which varies in intensity among regions in Canada,¹⁴¹ offenders do not receive appropriate care; often they must wait for the services and programs included in their correctional plan. This could delay their release date, or worse, the offender could be released without the treatment and programs needed to increase their chances of success in the community.

According to the evidence gathered, CSC finds it especially difficult to attract and retain health professionals. This can be attributed to various factors including:

- The general shortage of health care workers;¹⁴²
- The complex and difficult environment of penitentiaries due in part to the profile of the correctional clientele;
- The location of institutions;¹⁴³
- The more limited opportunities for development and ongoing training;¹⁴⁴
- The reluctance of physicians, psychiatrists and psychologists to give up private practice and become employees;¹⁴⁵

141 See testimony of Marc-Arthur Hyppolite, Senior Deputy Commissioner, SCC, November 5, 2009, and Howard Sapers, Correctional Investigator of Canada, Office of the Correctional Investigator, June 6, 2009.

142 Gail Czukar, Executive Vice-President, Policy, Education and Health Promotion, Centre for Addiction and Mental Health, *Evidence*, October 29, 2009.

143 It should be noted that many CSC workplaces are located outside major urban centres. Correctional Services Canada, *Strategic Plan for Human Resource Management, 2009-2010 to 2011-2012*, 2010. See also Don Head, Commissioner, CSC, *Evidence*, June 11, 2009.

144 Howard Sapers, *Evidence*, June 2, 2009.

145 Testimony of a psychiatrist met at a mental health treatment centre.

- Professional isolation;
- Compensation that is not competitive.¹⁴⁶

The Committee learned that CSC has attempted to address these issues through partnerships with university departments of medicine, psychology, social work and criminology. These partnerships allow students to do work terms and conduct research at correctional facilities while offering CSC staff opportunities to share their experience by teaching university courses.

Committee also had the opportunity to visit the Regional Psychiatric Centre (RPC) in Saskatchewan and speak with the staff there. This is the only example of a public/private partnership in the federal correctional system. The RPC is built on land owned by the University of Saskatchewan and is the result of cooperative planning between the Province of Saskatchewan, the University of Saskatchewan and CSC.¹⁴⁷ The RPC differs from other regional treatment centres in the importance it attaches to teaching and research. According to evidence we gathered, the RPC is a sought-after employer and CSC does not have any difficulty recruiting mental health professionals for this Centre.

Despite CSC's success in recruiting mental health workers for some institutions, the Committee agrees with its witnesses that, without additional human resources, CSC will not be able to meet the challenge of managing correctional clientele with mental health and addiction problems. This clientele could also increase as a result of the anticipated increase in the federal correctional population following the enactment of legislation that imposes stiffer sentences for certain offences.¹⁴⁸ To ensure that the correctional clientele that requires mental health and addictions programs and treatment receives the appropriate care, the Committee believes that CSC must develop and implement a new recruitment and retention strategy.

Given the importance of having specialized personnel to provide health care in general and mental health care in particular, the Committee recommends:

RECOMMENDATION 68

That Correctional Service Canada develop an attraction and retention program for psychologists, nurses, psychiatric nurses, occupational

146 The CSC Commissioner used the example of Alberta to illustrate the challenge of not offering competitive compensation. He stated: "They were making about \$88,000 a year. They left to go to work at the Alberta hospital, where they immediately started at \$108,000, and one year later went to \$118,000. I can't compete against those kinds of options that are out there." *Evidence*, June 11, 2009.

147 The RPC is established under a memorandum of understanding. See Correctional Service Canada, "Mental Health Care in Correctional Settings", *FORUM on Corrections Research*, Vol. 2, No. 3, 1990, <http://www.csc-scc.gc.ca/text/pblct/forum/e023/e023ind-eng.shtml>.

148 Craig Jones, *Evidence*, October 27, 2009.

therapists, social workers and other necessary professionals, including paying market salaries.

RECOMMENDATION 69

That Correctional Service Canada provide for dedicated budgets for the ongoing training of health professionals in order to make the environment more attractive to them.

5.14 A NEED TO IMMEDIATELY IMPLEMENT THE RECOMMENDATIONS OF THE REPORT, *A PREVENTABLE DEATH*, BY THE OFFICE OF THE CORRECTIONAL INVESTIGATOR

The tragic death of Ashley Smith in 2007 was upsetting to the correctional community and the public in general. It called attention to the urgent need to improve both the quality of mental health care services provided in correctional facilities in Canada and CSC's ability to do this.

The Correctional Investigator's report regarding Ms. Smith, *A Preventable Death*, highlights CSC's failures with regard to this inmate in particular, as well as many systemic problems in general. The Correctional Investigator lamented the lack of mental health resources and the lack of an independent external review mechanism for cases of segregation. He also pointed to the lack of coordination between correctional services and federal, provincial and territorial health care. The Report of the Ombudsman and Child and Youth Advocate of New Brunswick pertaining to the services provided to Ashley Smith also pointed to the gaps in health care provided to offenders with mental health problems.

In August 2009, CSC responded to the recommendations of the Correctional Investigator, describing in general terms what it intended to do to address the weaknesses identified. In 2010, an updated progress report was released in which CSC expressed its support for eight of the 15 recommendations pertaining to it. While the Committee considers this a positive sign, it maintains that CSC must immediately implement all the recommendations made in the independent and impartial study conducted by the Correctional Investigator. The Committee therefore recommends:

RECOMMENDATION 70

That Correctional Service Canada immediately implement all of the recommendations made by Howard Sapers, Correctional Investigator, in his report entitled "*A Preventable Death*," released in June 2008.

5.15 FOLLOW UP ON RECOMMENDATIONS OF THE ANNUAL REPORT OF THE CORRECTIONAL INVESTIGATOR 2008-2009

The Committee wishes to begin by acknowledging the important work the Correctional Investigator does to ensure that offenders receive fair and humane treatment in the federal correctional system. In his latest report, he makes 19 recommendations and addresses systemic problems in CSC's application of corrections legislation and policies.

The concerns raised by the Correctional Investigator are similar to the issues the Committee has identified in its study. Mental health, self-harm, health services, correctional programs, types of segregation, Aboriginal offenders, federally sentenced women, deaths in custody and gaps in dynamic security are among the various concerns raised in his report. It is unfortunate that CSC has not yet implemented all the Correctional Investigator's recommendations, which in the Committee's opinion would increase CSC's ability to deal with the many issues relating to the makeup of its prison population. The Committee therefore recommends:

RECOMMENDATION 71

That Correctional Service Canada implement all recommendations of the Office of the Correctional Investigator 36th Annual Report to Parliament (2008-2009) not contained herein.

CONCLUSION

The purpose of this study was to review CSC's policies, practices and programs in meeting the needs of federally sentenced offenders with mental health and addiction issues. This study was necessary considering that:

- The demand for mental health services in the federal correctional system has increased considerably in recent years;
- The unmet needs of offenders with mental health and addiction problems are both urgent and troubling;¹⁴⁹
- Offenders who do not receive the treatment and programs they need are more likely to reoffend after their release which could compromise public safety.

In light of the evidence we heard, the Committee must conclude that CSC is not able at this time to offer adequate treatment and support to the majority of inmates with mental health and addiction issues in its custody. As a rule, although inmates admitted to RTCs receive adequate support, often they have to leave this therapeutic environment too early due to a lack of space. As a result, many offenders once again find themselves in a state of psychological distress shortly after being returned to the general prison population. This generally leads to administrative segregation in conditions that are further harmful to their mental health. Successive or extended periods of segregation also reduces their access to much needed correctional programs and services. Offenders with mental health problems who do not meet the admission criteria of RTCs also find themselves in a difficult situation. CSC simply does not have the capacity to treat them and most of them receive limited clinical attention. This appears to be the case with the majority of inmates with mental health problems who are in CSC custody.

The Committee agrees with the Correctional Investigator and a good many of our witnesses that CSC should give priority to providing sufficient and quality care, treatment and programs to offenders with mental health and addiction issues in order to support their rehabilitation. The human and financial resources available to CSC must be sufficient to address this urgent need. It is especially critical that prompt action be taken to improve CSC's results in this regard given the anticipated increase in the federal correctional population.

Finally, the Committee recognizes that every effort must be made to prevent the criminalization and incarceration of persons who commit offences due to mental health issues and addictions. Resolving this problem goes far beyond the CSC's mandate; it requires significant investments in prevention and diversion. The federal, provincial and

149 *Annual Report of the Office of the Correctional Investigator 2008-2009, June 29, 2009.*

territorial governments must work together and invest in, together with community partners, a system based on mental health promotion, prevention and early detection and access to care and quality treatment in the community. This approach recognizes that the correctional environment is not ideal for treating offenders with mental health issues and addictions. However, when incarceration is considered the appropriate response to the crime and as necessary for ensuring public safety, the Committee firmly believes that action must be taken for their rehabilitation and for the implementation of a range of programs to ensure their successful reintegration in the community.

LIST OF RECOMMENDATIONS

RECOMMENDATION 1

That the federal government, in cooperation with the provinces and territories, make a commitment to and a serious investment in the mental health system, in order to ease the identification of and access to treatment for people suffering from mental health and addictions before they end up in the correctional system.

RECOMMENDATION 2

That the federal government study the report entitled *Childhood Mental Health and Life Chances in Post-war Britain. Insights from three national birth cohort studies* and develop a national strategy, in collaboration with the Mental Health Commission of Canada and in keeping with provincial and territorial areas of jurisdiction, to deal appropriately with mental health problems experienced in childhood and adolescence, so as to reduce markedly the adult crime rate.

RECOMMENDATION 3

That the federal government work with provinces and territories in order to ensure that police officers, Crown prosecutors and other key players in the criminal justice system be trained to recognize the symptoms of mental health problems, mental illness and drug and alcohol abuse so that they can direct offenders to the appropriate treatment services.

RECOMMENDATION 4

That the federal government work with the provinces and territories on early identification of mental health and addiction issues affecting offenders in remand, and secure access to treatment services for them in order to address conditions that are so often precursors to escalating crime and incarceration.

RECOMMENDATION 5

That the federal government support the creation and funding of more drug treatment courts to divert offenders with addictions to treatment centres and mental health courts to divert those with mental health needs to appropriate services.

RECOMMENDATION 6

That the federal government support the creation and funding of more community courts to divert offenders with concurrent mental health and addiction issues to appropriate health facilities.

RECOMMENDATION 7

That the federal government initiate discussions with provincial and territorial governments with a view to establishing partnerships and service agreements with hospitals for the delivery of health care services so that federal inmates have the same access to health care as other Canadians. Such partnerships would also provide continuity of mental health care when inmates are released into the community.

RECOMMENDATION 8

That Correctional Service Canada establish agreements with provincial psychiatric hospitals—that have suitable facilities to accommodate offenders without compromising public safety—to transfer some offenders who are posing a threat to themselves or others and who cannot be treated at regional treatment centres, along with financial compensation. These agreements should also allow correctional staff to be assigned to the facilities during a transfer in order to ensure public safety.

RECOMMENDATION 9

That the federal government develop coordination of services between Correctional Service Canada and provincial and territorial health authorities to provide a continuum of care through warrant expiry.

RECOMMENDATION 10

That Correctional Service Canada explore and arrange community partnerships for training federal offenders (through Habitat for Humanity, for example).

RECOMMENDATION 11

That Correctional Services Canada (CSC) review its current mental health and addictions programming to ensure that it meets the cultural and religious needs of Aboriginal offenders, who make up a disproportionate percentage of the Canadian inmate population, and a disproportionate percentage of inmates facing mental health and addiction issues; that CSC implement, together with local Aboriginal communities, more mental health and addiction programs addressing the specific needs of Aboriginal offenders. In addition to contributing to the development of these programs, local Aboriginal communities should also contribute to the delivery of these programs to ensure maximum success.

RECOMMENDATION 12

That Correctional Service Canada expand the use of sweat lodges and other Aboriginal healing methods and refrain from using denial of same as a disciplinary measure.

RECOMMENDATION 13

That Correctional Service Canada encourage healthy dietary practices for all offenders and where practical consider diet options for Aboriginal offenders including traditional and country food.

RECOMMENDATION 14

That Correctional Service Canada make greater use of agreements concluded with Aboriginal communities under sections 81 and 84 of the *Corrections and Conditional Release Act*, and establish the required capacity.

RECOMMENDATION 15

That Correctional Service Canada ensure that offenders have the same medical care as citizens generally.

RECOMMENDATION 16

That Correctional Service Canada ensure that access to medical care is provided to offenders in a timely manner.

RECOMMENDATION 17

That Correctional Service Canada work towards a psychologist/patient ratio of no more than 1:35 at all federal institutions.

RECOMMENDATION 18

That Correctional Service Canada add substance abuse counsellors at every federal institution.

RECOMMENDATION 19

That Correctional Service Canada add psychiatric nurses and nurses at every federal institution.

RECOMMENDATION 20

That Correctional Service Canada ensure timely access to dental care at every federal institution.

RECOMMENDATION 21

That Correctional Service Canada place a renewed focus on individualized treatment for all offenders with diagnosed mental health conditions, including addiction issues.

RECOMMENDATION 22

That Correctional Service Canada work towards ensuring that adequate one-on-one counselling services are commenced forthwith upon diagnosis, and delivered in a timely fashion and in sufficient weekly amounts as prescribed by the treating psychologist or counsellor.

RECOMMENDATION 23

That the federal government require offenders who have assaulted staff members or other offenders with biological substances to undergo, in the interest of the health and safety of those assaulted, all the necessary tests to diagnose the presence of any infectious diseases.

RECOMMENDATION 24

That the federal government invest additional resources for the full implementation of the Correctional Service of Canada's mental health strategy.

RECOMMENDATION 25

That Correctional Service Canada (CSC) make mental health screening upon admission a priority and that the federal government continue to fund this component of the mental health strategy. CSC should also require a full psychological assessment of an offender if recommended by a health care professional after the aforementioned screening.

RECOMMENDATION 26

That Correctional Service Canada establish and fund intermediate mental health services and intermediate care units, depending on offenders' needs in each correctional facility, in order to care properly for offenders with mental health problems who do not meet the admission criteria of regional treatment centres and in order to provide care for offenders transferred from a regional psychiatric centre; and so that offenders do not feel compelled to enter voluntary administrative segregation to protect themselves from other offenders.

RECOMMENDATION 27

That Correctional Service Canada implement innovative, multidisciplinary units for personality disordered individuals, based on the Whitemoor, U.K., model.

RECOMMENDATION 28

That Correctional Service Canada cover the cost of all medication prescribed to treat mental illness of offenders on conditional release in the community through warrant expiry.

RECOMMENDATION 29

That the federal government explore all program options available to reduce the skyrocketing rates of HIV/AIDS and hepatitis C that pose a serious threat to public health both in prison and when offenders are released back into the community, and that assessments be undertaken to evaluate which program options are most effective at

reducing the spread of infectious diseases in the context of the Canadian correctional system.

RECOMMENDATION 30

That Correctional Service Canada encourage and expand the use of 12 Step programs to deal with addiction issues, including the increased use of outside community groups to assist.

RECOMMENDATION 31

That Correctional Service Canada encourage the creation of drug treatment units in federal institutions.

RECOMMENDATION 32

That Correctional Service Canada allocate additional financial and human resources for drug treatment, harm reduction and prevention.

RECOMMENDATION 33

That Correctional Service Canada allocate additional funding to drug treatment programs at all federal correctional facilities.

RECOMMENDATION 34

That Correctional Service Canada establish programs to treat offenders who have both mental health and drug abuse problems simultaneously.

RECOMMENDATION 35

That Correctional Service Canada (CSC) continue to examine ways of strengthening drug interdiction monitoring activities and, in keeping with the recommendations made by the CSC Independent Review Panel, that CSC take a more rigorous approach to drug interdiction in order to create safe and secure environments where offenders can focus on rehabilitation.

RECOMMENDATION 36

That the federal government support the renewal and modernization of the federal correctional system's aging infrastructure.

RECOMMENDATION 37

When building new facilities, that Correctional Service Canada provide toilets and windows in every cell with access to sunlight and fresh air where possible.

RECOMMENDATION 38

When new infrastructure is built, that Correctional Service Canada ensure that therapeutic considerations are taken into account.

That the federal government build more expanded psychiatric care units. It must also ensure appropriate sub-units, and space both for private interviews and to deliver one-on-one counselling.

RECOMMENDATION 40

That the federal government take action to address the fact that Correctional Service Canada currently has no stand-alone psychiatric facility to accommodate and treat women serving sentences of two or more years who are affected by complex mental health issues.

RECOMMENDATION 41

That Correctional Service Canada modernize the Archambault Regional Mental Health Centre by building, outside the current location, a maximum security psychiatric facility to treat all mental health problems. This facility could be similar to the Regional Psychiatric Centre in Saskatoon and the treatment philosophy could be based on the approach used at the Shepody Healing Centre in Dorchester or at Ila institution in Norway.

RECOMMENDATION 42

That Correctional Service Canada develop a values-based vision as part of its mission to encourage healthy living in the correctional setting and mutual respect among offenders and staff. These values would be posted in all common areas and updated regularly by inmates and staff.

RECOMMENDATION 43

That Correctional Service Canada ensure adequate access to physical exercise and outdoor exercise.

RECOMMENDATION 44

That Correctional Service Canada ensure that all psychiatric units meet acceptable standards, including cell size, lighting, common areas, etc.

RECOMMENDATION 45

That Correctional Service Canada reduce barriers between correctional officers and inmates to establish, where possible, an atmosphere most conducive to rehabilitation.

RECOMMENDATION 46

That Correctional Service Canada have petition boxes installed in correctional facilities to allow inmates to submit confidential written requests to institution wardens, who would be responsible for responding to every reasonable request.

RECOMMENDATION 47

That the federal government uphold the United Nations' Standard Minimum Rules for the Treatment of Prisoners, to which the Government of Canada is a signatory, which states: "Where sleeping accommodation is in individual cells or rooms, each prisoner shall occupy by night a cell or room by himself," as it is widely accepted that double bunking and overcrowding exacerbates mental health and addiction problems faced by inmates, as well as their ability to rehabilitate and reintegrate into society.

RECOMMENDATION 48

That Correctional Service Canada make its mental health training activities a priority so that all employees working with offenders in an institution or in the community can gain familiarity with the symptoms of mental illness and treatment methods for offenders with mental health problems.

RECOMMENDATION 49

That Correctional Service Canada introduce specialized mental health training for correctional officers, program officers and parole officers who work in mental health units or regional treatment centres.

RECOMMENDATION 50

That Correctional Service Canada create mental health training material that is available electronically so that correctional employees can consult it at any time, at work or even at home.

RECOMMENDATION 51

That Correctional Service Canada give priority to admitting into intermediate care units (newly created by Committee recommendation 26) offenders with mental health problems who would normally be subject to administrative segregation to protect them from other offenders.

RECOMMENDATION 52

That Correctional Service Canada use administrative segregation in only the most limited circumstances, under very strict regulations and as a last resort.

RECOMMENDATION 53

That Correctional Service Canada ensure that when administrative segregation is used, it is in its mildest form, on a graduated basis and of the shortest duration possible in order to achieve the desired outcome.

RECOMMENDATION 54

That Correctional Service Canada recognize that administrative segregation is not conducive to the treatment of offenders with mental health diagnoses and that human contact is essential to their rehabilitation and, where possible, facilitate their treatment with a health-care approach.

RECOMMENDATION 55

That Correctional Service Canada (CSC) examine the use of segregation for offenders with mental health problems in order to develop alternative solutions for this clientele. In order to do so, the CSC must take into account the opinions of wardens, front-line workers, including correctional officers, and best practices in other countries that have reduced the use of segregation.

RECOMMENDATION 56

That Correctional Service Canada immediately conduct an independent review of all cases of long-term administrative segregation and have an independent outside agency validate and assess the review of these cases.

RECOMMENDATION 57

That Correctional Service Canada substantially increase its budget for correctional programs addressing factors contributing to crime, including drug and alcohol abuse and mental health problems.

RECOMMENDATION 58

That Correctional Service Canada provide for the training and increase the use of peer counsellors.

RECOMMENDATION 59

That Correctional Service Canada increase the use of craft rooms and workshops and expand the range and number of creative, recreational, arts and music programs as well as other therapeutic programs.

RECOMMENDATION 60

That Correctional Service Canada restore its prison farm program, which is an excellent rehabilitation tool, also serving as animal therapy.

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That the federal government, acknowledging the imperative nature of preparing inmates for reintegration into the community, recognize the unique rehabilitative needs of offenders struggling with mental health and addictions, and put a greater focus on rehabilitation programs that have offenders working with living things, which

research has shown has a calming and restorative effect on inmates, and helps them develop qualities that offenders often lack, like a sense of self worth, respect and empathy, as well as essential life skills like a sense of responsibility, dependability and teamwork, and that Correctional Service Canada explore and implement the use of pet therapy programs and other therapeutic use of animal husbandry.

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That Correctional Service Canada expand the access of offenders wherever possible and desirable to community resources, programs and visits, in the community.

RECOMMENDATION 68

That Correctional Service Canada develop an attraction and retention program for psychologists, nurses, psychiatric nurses, occupational

therapists, social workers and other necessary professionals, including paying market salaries.

RECOMMENDATION 69

That Correctional Service Canada provide for dedicated budgets for the ongoing training of health professionals in order to make the environment more attractive to them.

RECOMMENDATION 70

That Correctional Service Canada immediately implement all of the recommendations made by Howard Sapers, Correctional Investigator, in his report entitled “A Preventable Death,” released in June 2008.

RECOMMENDATION 71

That Correctional Service Canada implement all recommendations of the Office of the Correctional Investigator 36th Annual Report to Parliament (2008-2009) not contained herein.

APPENDIX A LIST OF WITNESSES

40th Parliament, 3rd Session

Organizations and Individuals	Date	Meeting
<p>As an individual</p> <p>Ruth Martin, Clinical Professor, Department of Family Practice and Collaborating Centre for Prison Health and Education, University of British Columbia</p>	2010/03/16	2
<p>As an individual</p> <p>Brenda Tole, Retired Warden of Alouette Correctional Centre for Women</p>		
<p>Women in 2 Healing</p> <p>Amber-Anne Christie, Research Assistant</p>		
<p>Correctional Service Canada</p> <p>Andrée Gaudet, Associate Director, Montreal-Metropolitan District</p> <p>Christine Perreault, Regional Coordinator, Institutional Mental Health, Quebec Region</p> <p>Johanne Vallée, Deputy Commissioner, Quebec Region</p>	2010/03/23	4
<p>Canadian HIV/AIDS Legal Network</p> <p>Sandra Ka Hon Chu, Senior Policy Analyst</p>	2010/04/01	7
<p>Correctional Service Canada</p> <p>Kate Jackson, Director General, Clinical Services</p> <p>Jennifer Oades, Deputy Commissioner for Women</p> <p>Heather Thompson, Regional Director, Health Services, Prairie Region</p>		
<p>Momentum Healthware</p> <p>Bruce Penner, General Manager, Canadian Operations</p>		

APPENDIX A LIST OF WITNESSES

40th Parliament, 2nd Session

Organizations and Individuals	Date	Meeting
Office of the Correctional Investigator Howard Sapers, Correctional Investigator Ivan Zinger, Executive Director and General Counsel	2009/06/02	24
Correctional Service Canada Don Head, Commissioner Leslie MacLean, Assistant Commissioner, Health Services	2009/06/11	27
Correctional Service Canada Review Panel Rob Sampson, Chair		
Office of the Correctional Investigator Nathalie Neault, Director of Investigations Howard Sapers, Correctional Investigator	2009/10/06	32
As an individual Graham Stewart, Former Executive Director of the John Howard Society of Canada	2009/10/27	36
John Howard Society of Canada Craig Jones, Executive Director		
Canadian Mental Health Association Frank Sirotich, Program Director, Community Support Services	2009/10/29	37
Centre for Addiction and Mental Health Gail Czukar, Executive Vice-President, Policy, Education and Health Promotion		
Forensic Psychiatric Services Commission of British Columbia James Livingston, Researcher, Mental Health and Addiction Services		
As an individual Peter Ford, Physician	2009/11/05	39
Canadian Association of Elizabeth Fry Societies Kim Pate, Executive Director		

Organizations and Individuals	Date	Meeting
Correctional Service Canada Lisa Allgaier, Director General, Aboriginal Initiatives Directorate Marc-Arthur Hyppolite, Senior Deputy Commissioner Elizabeth Van Allen, Deputy Commissioner for Women, Women Offender Sector	2009/11/05	39
Department of Justice Margaret Trottier, Senior Analyst, Drug Treatment Court Funding Program Edmonton Drug Treatment and Community Restoration Court Doug Brady, Executive Director Government of Ontario David Moffat, Assistant Crown Attorney, Ministry of the Attorney General Rideauwood Addiction and Family Services James Budd, Senior Director, Corporate Services Royal Ottawa Health Care Group Helen Ward, Clinical Director, Forensic Service, Champlain	2009/12/08	42
Mental Health Commission of Canada Glenn Thompson, Secretary of the Board	2009/12/10	43

**APPENDIX B
LIST OF BRIEFS**

40th Parliament, 3rd Session

Organizations and individuals

Collins, Peter

Canadian HIV/AIDS Legal Network

**APPENDIX B
LIST OF BRIEFS**

40th Parliament, 2nd Session

Organizations and individuals

Canadian Association of Drug Treatment Court

Canadian HIV/AIDS Legal Network

John Howard Society of Canada

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant Minutes of Proceedings ([Meetings Nos. 1, 2, 4, 7, 8, 24, 25, 26, 27, 33 and 46](#)) is tabled.

Respectfully submitted,

Kevin Sorenson, MP

Chair

Mental Health and Drug and Alcohol Addiction in the Federal Correctional System

Dissenting Opinion by Government Members of the Standing Committee on Public Safety and National Security

December 13, 2010

It is well known that the committee began this study in response to the death of Ashley Smith.¹ An incident such as this is first and foremost a human tragedy that has deeply affected her family, and is of concern to all Members of Parliament. We reiterate our sincere condolences to the family.

Following Ms Smith's death, the government immediately asked the Commissioner of the Correctional Service of Canada (CSC) to launch an investigation into her case and to include any issues of compliance with the law, and the policies and procedures of CSC.

Government members, from the beginning, have supported the Committee of Public Safety and National Security's (the Committee) efforts to study this issue and to produce a report. We feel obliged however, to make known publicly, our position on these matters, how we disagree with what this opposition dominated committee has put forward, and what we propose as an appropriate way forward.

At the outset, it should be noted that Government members of the Committee take no issue with the Committee's findings that correctional institutions should not be serving as hospitals by default. And that, in general, prison is not a suitable environment to treat the mentally ill. That said, the government has been taking responsible steps to ensure that mental health issues in our prisons are properly addressed.

In Budget 2007, the government committed \$55 million (over five years) towards a Mental Health Commission. The creation of the Mental Health Commission of Canada was a key recommendation of a Standing Senate Committee report on mental health, mental illness and addiction in Canada. It is the cornerstone of our government's strategy to address mental health issues in Canada.

Significant additional resources have already been provided to CSC specifically. In 2007, CSC received \$21.5 million (over 2 years) to support key elements of its Institutional Mental Health Strategy.

CSC's Mental Health Strategy includes:

- a comprehensive mental health screening at intake for offenders;
- enhanced primary mental health care in institutions;
- consistent standards at treatment centres;
- intermediate mental health care units; and
- preparation for reintegration and transition into the community.

In the 2008 Federal Budget, CSC received permanent funding of \$16.6 million annually for institutional mental health services, commencing in 2009/10. The

¹ Pursuant to Standing Order 108(2). Minutes of the Committee, April 28, 2009

funds are directed towards screening and assessment, primary care and in-patient care within institutions.

A factor made clear during the Committee's hearings was that an exacerbating challenge to dealing with mental illness is drug use. This is a concern for correctional organizations throughout the world and is a well known contributing factor to criminal behaviour.

We strongly disagree with the majority of the Committee on how to address this matter. Illicit drugs in federal prisons compromise the safety and security of correctional staff as well as our communities. Providing needles, even if it is done under the guise of harm reduction, means putting a potential weapon in the hands of convicted criminals. Further, drugs undermine the success of rehabilitation programs

80% of offenders entering CSC institutions have identified problems with substance abuse. To combat this issue, CSC has in place an Anti-Drug Strategy, the key elements of which are:

- prevention;
- intervention; and
- enforcement

The Committee learned that starting in 2008/09; CSC began expanding its drug detector dog program by hiring 10 new teams of drug detector dogs during fiscal year 2008-09 and aims at hiring a total of 80 new teams by 2012-13. By 2011, CSC will have hired 165 new security intelligence officers, analysts and administrative support staff both in institutions and in the community to strengthening intelligence operations.

In order to improve the searching of all visitors entering an institution, 30 new x-ray machines and 20 ion scanners were replaced or installed. Furthermore, CSC is enhancing perimeter security by staffing additional towers and watch points to combat drugs being thrown over fences and walls.

We recognize that the recruitment and retention of mental health professionals continues to be a challenge. We are in agreement with the Correctional Investigator, Howard Sapers, that this requires ongoing attention. In support of the implementation of the Mental Health Strategy, CSC has implemented several management practices such as the provision of mental health training to both mental health professionals and correctional staff.

With all of these considerations in mind, with an eye to building on the improvements made by this government thus far, and with an understanding that

public safety must be of paramount consideration in these matters, it is recommended by the government members of this committee that;

- 1. In light of permanent funding provided in budget 2008 and commencing in 2009/10 that CSC continue to work towards implementation of its Mental Health Strategy with an emphasis on intermediate care.**
- 2. It is recommended that Correctional Services Canada continue to examine ways of strengthening drug interdiction monitoring activities.**
- 3. That Correctional Services Canada consult with stakeholders, including provincial agencies, with a view to amending existing policies, and developing new policies to better reflect the priorities of the Anti-Drug Strategy.**
- 4. In keeping with previous recommendations made by the Independent Review Panel, and with the Government's continued commitment to tackling crime, that a more rigorous approach to drug interdiction be implemented in order to create safe and secure environments where offenders can focus on rehabilitation.**
- 5. That the government continue to support the renewal and modernization of Correctional Services Canada's aging infrastructure.**

Bloc Québécois Supplementary Opinion

The Importance of Innovation

The report

The Bloc Québécois would like to begin by thanking all the individuals, groups and institutions in Quebec, Canada and elsewhere for sharing with the Committee their experiences in managing and treating addiction and mental health in a correctional setting.

While the Bloc Québécois in no way disagrees with this report, we believe that it does not always go as far as it should. We think that this is rooted in a reluctance to take an innovative approach to the problems presented.

Taking the next steps

In Norway and London, it was repeatedly said that small correctional facilities were able to establish a good working environment that fostered rehabilitation and a friendly atmosphere between inmates and guards. The report states that the “atmosphere in the correctional facilities visited in Norway differs from that in most of the facilities visited in Canada.” We believe it would be very useful to establish a pilot project involving the administration of a small correctional facility with a maximum of 70 inmates to test new methods for treating offenders.

On the subject of fostering innovation, we believe that Correctional Service Canada (CSC) should establish a structure for developing new methods, consistent with its mission, to deal with harm reduction related to substance abuse. Although recommendation 32 proposes that more resources be allocated for this purpose, we believe that in addition to spending more, it would be wise to look at ways to spend better.

The report also makes several recommendations concerning segregation, particularly recommendations 52, 53, 54 and 56, all of which suggest that administrative segregation be used in limited circumstances. However, none of the recommendations offer specifics on how CSC can achieve this goal. The Bloc Québécois proposes that the *Corrections and Conditional Release Act* (CCRA) be amended to provide for an independent adjudication process for all forms of long-term segregation. This proposal is based primarily on the

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

Lastly, the Bloc Québécois would have liked the Committee to give further consideration to having the governments of Quebec and the provinces treat offenders with substance abuse and mental health problems. Recommendations 7 and 8 pave the way by proposing federal-provincial agreements on prisoner transfers and on care following release into the community. Unfortunately, the Committee did not take this proposal to its logical conclusion. The provincial level has the medical expertise, and such an approach would likely facilitate continued medical care between incarceration and the return to the community. This transfer should be accompanied by the necessary funding, of course.

While the Bloc Québécois undertook the Committee report and this supplementary report in good faith, it has few illusions that the current government will act on the recommendations. A government that does not hesitate to imprison innocent people and believes that punishment is the only answer cannot fully understand the importance of changing the approach to treating offenders with substance abuse and mental health problems.

Supplementary Opinion of the New Democratic Party of Canada

Submitted by Don Davies, M.P.

New Democrat Critic for Public Safety and National Security

Vice-Chair, Standing Committee on Public Safety and National Security

The New Democratic Party of Canada strongly supports this Report and the recommendations contained herein. We urge the government to implement the recommendations as urgently as possible, as the issues of mental illness and addictions in our federal corrections system are serious, important and pressing. The New Democrats believe that dealing with mental health and addictions issues is a critical component to make our communities safer for everyone.

During the Committee's study of the issues raised in this Report, we heard from many witnesses with extensive experience in the fields of mental illness and addictions, particularly as these occur within the federal corrections context. We also travelled to many federal correctional facilities in Canada as well as those in the United Kingdom and Norway. As New Democrat Critic for Public Safety and National Security, I have also visited and inspected additional federal prisons in Canada and Asia on my own.

During its study of this issue, the Committee consulted with and heard expert testimony from a wide array of professionals who work in the corrections field. These experts included prison guards, parole officers, prison wardens, doctors, nurses, psychologists, staff representatives, prison chaplains, addictions specialists, organizations that work with current and former offenders, and offenders themselves. These individuals made a large number of important recommendations to the Committee. They reflect the proposals and experience of these diverse groups, all of whom have the same general aim: to provide better delivery of services and care for offenders suffering from mental health and addictions issues.

Although many of their recommendations were adopted in this Report, a number of important measures are not contained herein. The testimony received by the Committee during its many hours of hearings is part of the public record, and we hope that the government and the Correctional Service of Canada will give serious consideration to implementing their suggestions where appropriate.

In particular, action needs to be taken to end the use of segregation as a method of dealing with mental illness. While there are some laudable recommendations contained within this Report that seek to improve segregation protocol and practice, the tragic cases of Ashley Smith and other mentally-ill individuals in our federal prisons clearly show that there is an urgent need for decisive steps to eliminate the segregation of mentally-ill offenders. The New Democrats would support more concrete and more decisive measures to end the use of segregation as a response to mentally-ill offenders. The Committee heard evidence that segregation is harmful for all offenders, but particularly for those with mental illness. It exacerbates unwanted behaviour, and deepens the mental illness that is present. Instead, we need to adopt a health-based model for dealing with mentally-ill offenders that recognizes their needs for human interaction, therapy, and treatment for their illness.

New Democrats recognize the real and demonstrated connection between mental illness and addictions, and incarceration for many individuals. By taking effective steps to improve mental health treatment and recovery from addictions, we believe that many individuals will be helped and community safety will be enhanced.

