



*Submission to the Standing Committee on Public Safety and
National Security investigating Federal Corrections,
Mental Health and Addictions*

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Introduction

I address my remarks to two audiences today: first to you, the members of this special committee, and second, to the historical record.

Let me say, first, that I appreciate the opportunity to bring before this Committee the views of The John Howard Society of Canada. You will know that we are a non-profit charitable society governed by volunteers committed to “effective, just and humane responses to the causes and consequences of crime.” Our 65 front line offices deliver evidence-based programs and services intended to ensure the safe and effective re-integration of prisoners at the end of their sentences. We also deliver numerous services to young persons to divert them from the criminal justice machinery. We subscribe to the view that crime is a community issue and that an intelligent response ought to involve the community. So thank you – Committee members – on behalf of our front line, our volunteers and our boards of directors for the chance to bring our message to you.

Mission Statement of The John Howard Society of Canada: "Effective, just and humane responses to the causes and consequences of crime."

My second audience is the future. I suffer no illusions that I will be able to alter the course of this government’s crime agenda – which legislative components contradict evidence, logic, effectiveness, justice and humanity. The government has repeatedly signalled that its crime agenda will not be influenced by evidence of what does and does not actually reduce crime and create safer communities. So if we can’t persuade on evidence of effectiveness, justice or humanity, we will speak to future historians, criminologists and parliamentarians to show them that there were dissenting voices when this government’s crime agenda was being deliberated.

The Context: Creating a Perfect Storm

A little context is in order. Prisons are dumping ground for Canada’s mentally ill. It was not supposed to be that way when, in the 1970s and 80s, the provinces closed their mental hospitals and transferred care to communities. As is now understood, the resources for community-based care never appeared, and as increasing numbers of people went off their meds – or fell through the cracks created by cutbacks to provincial social services – a larger number of these have been criminalized and ended up in federal custody. The federal prison system is the only component of the state structure that cannot say “Sorry, we’re full.” So today we face a crisis of mental illness and substance abuse in our federal prisons.

Simultaneously, governments have been pursuing a utopian experiment in social engineering called “drug prohibition.” This policy transforms a public health issue – drug abuse and addiction – into a criminal justice matter and has the effect of filling prisons with people who need medical attention, psychiatric care and substance abuse treatment. The government has recommitted to this madness with the National Anti-Drug Strategy.

Ignoring the experience and evidence from the United States, the National Anti-Drug Strategy adds, for the first time, mandatory sentences for drug crimes. The historical experience of the United States illustrates that “getting tough” on drug offenders simply stuffs prisons and jails with low-level users – many of whom show clear evidence of mental illness that, in most cases, preceded the onset of their substance abuse problems.

Drug prohibition has had other consequences too. It has produced a hardened cohort of violent young men schooled in ruthless gang violence over drug profits – and this is what

“If you had to invent a way to deepen mental health problems and create a health crisis, an overcrowded prison, and particularly the bleak isolation of its segregation unit, would be it.” ~ Juliet Lyon, Prison Reform Trust, online at <http://www.prisonreformtrust.org.uk/subsection.asp?id=438>

has given rise to CSC’s “changing offender profile.” These young men are not necessarily mentally ill – though many of them suffer the effects of prolonged drug abuse – but they do create legitimate

management problems for Correctional Services Canada. And prisons have become, in the words of one aboriginal gang member, “gladiator schools” for young men as they cycle in and out of the criminal justice system.

So our federal prisons have become “gladiator schools” where we train young men in the art of extreme violence or warehouse mentally ill people. All of this was foreseeable by anyone who cared to examine the historical experience of alcohol prohibition, but since we refuse to learn from history we are condemned to repeat it. And that brings us to the present.

Recommendation of The John Howard Society of Canada

I call on the federal government to engage the *Mental Health Commission of Canada* in the development of a National Strategy that would achieve collaboration and coordination among federal/provincial/territorial criminal justice, correctional and mental health systems to (a) promote the seamless and cost-effective delivery of services to offenders with identifiable mental disorders; and, (b) to initiate innovative community-based service delivery models for these offenders and focus resources in particular on those mentally disordered offenders with co-occurring substance abuse problems who are living in disadvantaged social circumstances (e.g., homelessness, unemployment), a population which poses the greatest challenges for effective service delivery and social reintegration.

A national strategy to address mental health in the correctional system must grapple with the reality that the great majority of persons in the correctional system suffer from concurrent disorders: they have a mental health condition *as well as* a substance abuse disorder – which means that both conditions have to be treated simultaneously.

As Don Head told this committee on May 29, 2006, “about 80% of offenders have substance abuse problems, either alcohol and/or drugs. About 12% have a current mental

health diagnosis and the challenges that go with that.”¹ We can infer from the Commissioner’s testimony – knowing what we do about the nature of concurrent disorders² – that the actual burden of mental illness is probably much higher than 12%, that it is probably closer to 80%.³ We know this because first onset of mental disorders usually occurs in childhood or adolescence, although treatment typically does not occur until a number of years later. It’s for this reason that psychiatric disorders are called “chronic diseases of the young.”⁴ The literature is quite clear that “substance misuse is often the result of an underlying mental health problem or illness” – sometimes a consequence of untreated trauma or brain injury – and that mental illness often precedes the onset of a substance abuse disorder by as much as 10 years.⁵

In other words, there is often a temporal sequence to mental illness and the onset of a

substance abuse problem, and the sequence is almost always that a mental illness or disability of some kind takes hold before the onset of a substance abuse problem.⁶ What makes this population such a treatment

“The large increase in the [US] prison population has not made us safer. The expansion of prisons [since the 1980s] has resulted in incarcerating large numbers of non-violent offenders who then become recidivists in greater numbers than they would have had they been punished outside of prison. Apparently, non-violent offenders are learning the wrong lessons in prison.” ~ Judge Michael A. Wolff, “Evidence-Based Judicial Discretion: Promoting Public Safety through State Sentencing Reform (The 14th Annual Justice William J. Brennan Jr. Lecture on State Courts and Social Justice, February 20, 2008).

challenge is that they self-medicate with substances that exacerbate the underlying disorder. Their subsequent behaviour while incarcerated *is the illness manifesting itself* in the highly artificial environment of a prison.⁷

Even worse “substance misuse can contribute to the development of mental health problems and illnesses.”⁸ But ultimately it makes little difference which comes first – the

¹Don Head, Testimony, Standing Committee on Public Safety and National Security, Monday, May 29, 2006 online at <http://www2.parl.gc.ca/content/hoc/Committee/391/SECU/Evidence/EV2224680/SECUEV04-E.PDF>

²“Concurrent disorders” generally describes a situation in which a person experiences a psychiatric disorder and either a substance use disorder and/or a gambling disorder. Concurrent disorders presents in many different forms. For example, someone living with schizophrenia who has problems with cannabis use has a concurrent disorder, and so does a person who has problems with alcohol use and has a clinical depression. See http://www.camh.net/About_Addiction_Mental_Health/Concurrent_Disorders/index.html

³Wilson Compton, *et al.*, “Psychiatric disorders among drug dependent subjects: Are they primary or secondary?” *The American Journal on Addictions*, 9 (2000), pp. 126-34.

⁴Daniel E. Falk, Hsiao-ye Yi1 and Michael E. Hilton, “Age of Onset and Temporal Sequencing of Lifetime DSM-IV Alcohol Use Disorders Relative to Comorbid Mood and Anxiety Disorders,” *Drug Alcohol Depend.* 2008 April 1; 94(1-3): 234–245.

⁵Ronald Kessler, *et al.*, “Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Study,” *Archives of General Psychiatry*, 54(April 1997), p. 313.

⁶Ronald C. Kessler, *et al.*, “Age of onset of mental disorders: A review of recent literature,” *Curr Opin Psychiatry*. 2007 July; 20(4): 359–364.

⁷There is some evidence to support the idea that people with schizophrenia and other psychotic disorders use substances to reduce general dysphoria, and possibly negative symptoms. Social environment and experiences are also likely to be factors in the development of substance misuse in this group. See P. Phillips and S. Johnson, “How does drug and alcohol misuse develop among people with psychotic illness? A literature review,” *Social Psychiatry and Psychiatric Epidemiology*, Volume 36, Number 6 / June, 2001.

⁸Skinner, W., O’Grady, C., Bartha, C., & Parker, C. (2004). *Concurrent substance use and mental health disorders: An information guide*. Toronto: Centre for Addictions and Mental Health.

substance abuse disorder or the underlying mental illness – because they have to be treated in an environment that is primarily designed for security and incapacitation.

Furthermore, concurrent disorders cannot be effectively treated independently of each other: they must be addressed together and simultaneously, which challenges conventional treatment modalities.

The problem that confronts you – and all Canadians – is that the government is seeking to grow our rate of incarceration which means that all the challenges currently facing our correctional system are about to get more severe. And that brings us to the issue of what happens to persons with concurrent disorders in prison.

What to Expect: Crowding, Tension, Stress and Violence

If the government achieves its objectives, estimates are that the current population will grow by as many as 3,000 new beds for men and as many as 300 for women. These are conservative estimates because – so far – no one has made public the anticipated costs and consequences of the crime agenda.⁹ But we can make some general projections based on the American experience.

1) Crowding increases tension between inmates

Among the first noticeable effects of crowding is elevated blood pressure, both systolic and diastolic. Elevated blood pressure is a gateway to metabolic syndromes, including diabetes and heart disease. So the first obvious effect will be to create the conditions for chronic health conditions downstream. The second immediate effect is that crowding elevates the incidence of viral and bacterial transmission between inmates. So crowded

"Our findings suggest that harsher prison conditions cause higher rates of post-release criminal behaviour, behaviour which is also measurably more violent."

~ M.K. Chen & J.M. Shapiro, "Does Prison Harden Inmates?" p. 19, online at <http://sentencing.nj.gov/downloads/pdf/articles/2007/Jan2007/document08.pdf>

prisons are sicker prisons. Crowded prisons are also less habitable environments because

malodorous air pollutants heighten negative psychological affect, and cause behavioral disturbances (e.g., self-regulatory ability, aggression) and depressive symptoms. Currently, the federal system is running at about 10% double bunking. No one, to my knowledge, has assessed the population health burden of the crime bills once they come into force, but it would be prudent to assume that our prisons – which are already incubators of HIV and Hepatitis C – will begin to breed numerous other infectious diseases as they fill up. To my knowledge no one has assessed the consequences of this elevated level of infectious conditions for labour requirements across the federal system.

⁹Heather Scoffield, "Data suggests crime legislation that eliminates two-for-one credit for time served in jail would cost more than \$100-million a year," *The Canadian Press Monday*, Oct. 19, 2009.

2) Tension increases stress levels among inmates and staff

As tension increases, staff feel less safe and limit their personal contact with inmates. They adopt a more cautious posture and keep a greater distance from inmates on the ranges. This contributes to increased tension, because it creates a self-escalating cycle as staff and inmates perceive elevated anxiety in each other's non-verbal behaviour. Disputes that might have been resolved with conversation take on a combative quality, and staff – in order to protect themselves – wear heavier apparel like stab-resistant vests. Behaviour symptomatic of mental illness is sometimes treated in prison as a disciplinary rather than a medical matter.¹⁰ This cycle rapidly degrades the quality of work for staff and guards, which is an outcome that this committee should examine closely because – among other problems – it will eventually drive good correctional officers out of the profession.

As CSC will admit, they already have problems attracting and retaining staff. Rapid growth in the rate of incarceration can only exacerbate this problem.

3) Stress levels correlate with self-harm and suicide attempts

As stress levels rise, we can expect to see more incidents of self-harm and of suicide-attempts. As Alison Liebling has written, prisoner suicide is not exclusively or predominantly a psychiatric problem.¹¹ There are multiple psychological pathways to suicide in prison – one of which is the social isolation that accompanies the management of a rapidly growing population. Furthermore, there are at least three identifiably different kinds of prison suicides in the literature: life-sentence prisoners; the psychiatrically ill; and the “poor copers.” These latter are generally younger and non-violent.¹² Liebling claims that women far outnumber men in terms of numbers of incidents of self-injury per head of population, up to as many as 1.5 incidents per week and that twenty or thirty incidents of “cutting” during one sentence is not unusual among women prisoners. She claims that the rate of suicide among women prisoners is “seriously underestimated.”¹³

The Service is already struggling to deal with inmate suicides. As the Correctional Investigator told you earlier this month,

“front-line staff members are not always well-supported or trained to manage and respond to offenders exhibiting mental health and/or addiction problems. Offenders may exhibit their illness through disruptive behaviour, aggression,

¹⁰Kimmet Edgar and Dora Rickford, *Too Little Too Late: An Independent Review of Unmet Mental Health Need in Prison*, The Prison Reform Trust, 2009, online at <http://www.prisonreformtrust.org.uk/temp/TOOspLITTLEspFINALspVERSIONlo.pdf>

¹¹Alison Liebling, “Prison Suicide and Prisoner Coping,” in Michael Tonry, ed., *Crime and Justice*, Vol. 26 (The University of Chicago Press, 1999), p. 329.

¹²Liebling, “Prison Suicide and Prisoner Coping,” p. 301.

¹³Liebling, “Prison Suicide and Prisoner Coping,” p. 307.

violence, self-mutilation and refusal to follow prison rules. They may “act out” in ways that prison officials consider manipulative or otherwise contrary to correctional authority. In too many cases, underlying mental health behaviours are met by security-driven interventions – use of force, segregation, cell confinement. It is especially critical that specialized training be provided for correctional officers working in mental health units and the psychiatric centres.”

4) Elevated stress correlates with population management problems

As populations become harder to manage and control, staff turn to segregation and other forms of offender control – and invariably these fall disproportionately on those least able cope with the pace of change and who act out from desperation and frustration. Again, symptoms of mental disorder manifest as behavioural misconduct which are disruptive to the good order of the institution – and mentally ill persons find themselves singled out for special, usually harsher, treatment – but also for the hostile attention of other inmates. So crowding turns into elevated stress, which turns into heightened tension which manifests as violence.

As the population continues to grow and crowding becomes a more serious issue, we can expect to see an increase in violence – both toward staff and between inmates. A 2008 multi-level analysis in the journal *Criminal Justice and Behavior* concluded that “aggressive inmates were found to commit more assaults in prisons that were crowded and had a greater percentage of” [inmates under 25].¹⁴

Given that mentally ill prisoners are often the targets of aggression, we should expect to see more violence directed toward them.

Conclusions: A Difficult Time for the Correctional Service of Canada

If the government is committed to growing Canada’s rate of incarceration, it will impose great costs on the Correctional Service in the short term – costs which will be felt in the safe management of the population, in staff and inmate stress levels, and in the overall incidence of violence. The Service will have to fill many vacancies in its therapeutic complement – social workers, psychologists and substance abuse specialists – if it wants to prevent the worst effects of overcrowding on inmates with concurrent disorders. As the Correctional Investigator told you,

“many institutions are currently not staffed, funded or equipped to deal adequately with the needs of mentally disordered offenders.... Interdisciplinary mental health teams are supposed to be on-site, but in many facilities these teams exist in name only.”

¹⁴Karen Lahm, “Inmate-on-inmate assault: A multilevel examination of prison violence,” Vol. 35, No. 1 (2008), pp. 120-137.

The Service has indicated that it will employ temporary accommodations to address its crowding issues – but it's not clear what impact this will have on the safe and non-violent operation of its current facilities. On the basis of currently available information, the prospects are not good. As the Correctional Investigator told you,

“special needs,” “transition” or “structured living” units ... have become particularly ubiquitous population management strategies [and are] primarily measures of convenience and expediency as they have very little to do with providing clinical treatment or rehabilitative programming.”

As you know, substance abuse programs are seriously over-subscribed and waiting lists are long.

We could be heading into a very difficult time for the Service. It is urgent that the government grow the Service's capacity to address these issues with the same alacrity that it seeks to grow the rate of incarceration.

Thank you for your time and attention to this urgent matter.