ONTARIO CORRECTIONAL INSTITUTE

Proceedings of Tenth Anniversary Symposium

MINISTRY OF CORRECTIONAL SERVICES

Honourable Nicholas G. Leluk
Minister

Dr. George R. Podrebarac
Deputy Minister

PROCEEDINGS OF THE
10th ANNIVERSARY SYMPOSIUM
OF THE
ONTARIO CORRECTIONAL INSTITUTE

March 21, 1984

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Lyndon Nelmes, Superintendent

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Prologue

"I never saw a man who looked
With such a wistful eye
Upon that little tent of blue
Which prisoners call the sky."

Oscar Wilde, "The Ballad of Reading Gaol".

"I know not whether Laws be right,
Or whether Laws be wrong;
All that we know who lie in jail
Is that the wall is strong;
And that each day is like a year,
A year whose days are long."

Idem.

INTRODUCTION

Lyndon Nelmes, Superintendent
Ontario Correctional Institute

There are some who would say - indeed they have said "Why on earth do we need to recognize the first decade of our existence?" The answer really is quite simple. Organizations go through many phases. They are not static. There is always a time to reflect, take stock, look ahead and to share this information and the process and the time with relevant people. This is such a time. Not to do this would, in my opinion, abbrogate our responsibility to ensure the continued effectiveness of correctional care in general and quality care of the mentally disordered in particular. It is very gratifying to see from the numbers present that this need is shared. As for the day's events they can be looked upon as encapsulating the past, present and the future of the Institute to some extent, together with the treatment principles and practices aimed at offenders with special needs. We are indeed extremely fortunate in having in each segment throughout the day, panel members who are very much in tune with the subject matter being discussed and I have no doubt that their presentations, coupled with the dialogue that hopefully will follow, will be both interesting and informative.

Before I touch on the agenda let me clarify one point straightaway. The dictionary definition of symposium underlines the fact that it is a philosophical and friendly discussion on subjects. We hope to have that. There is a second meaning to the word, however, that it is an ancient Greek after-dinner drinking party with music and dances. For those who came for the party I apologize, you're in the wrong place.

As for the agenda itself, the initial segment which takes a retrospective view of O.C.I. and its beginnings, will be moderated by Dr. Reg Reynolds, our Chief Psychologist. I shall leave the comments on the panel composition to Dr. Reynolds. Suffice to say that all three panelists played significant roles before, during and after the opening of this Institute in 1973.

After a suitable break for coffee the focus shifts to the present and under the moderating of Dr. Gerald Heasman, our Chief of Psychiatry, current staff of the Institute, representing a wide variety of professional disciplines, will discuss the here and now - where we're at.

Lunch will follow. The luncheon address, I'm very pleased to say, will be given by the Minister of Correctional Services, the Honourable Nicholas G. Leluk.

The afternoon component begins with our other guest speaker, Dr. Vivian Rakoff. Dr. Rakoff's presentation is really the culmination of a very brief acquaintanceship with the Institute in the two days immediately preceding the symposium. We are, in effect, asking Dr. Rakoff to offer his views and his opinions on the services we provide and we have no illusions that in so doing we show our blemishes as well as our strengths.

Finally, the last segment of the day studies possible future scenarios that could develop in the treatment of the mentally disordered offender. This session will be moderated by Mr. John Duggan, Executive Director, Institutions Division. He will present two speakers on this particular issue: Mr. Gilbert Sharpe, representing the Ministry of Health, and Dr. George Podrebarac, the Deputy Minister of Correctional Services.

Before I hand over to Dr. Reynolds let me just make one observation. The inevitability of organizational change is well documented. Whether the change be as a result of research developments or as a result of other forces, internal or external to that organization. All of us in the profession of corrections are of course not immune to such change. Indeed we often advocate and initiate change. At the same time we are a relatively young profession still wrestling with what works in the complicated area of reducing delinquent behaviour, behaviour that often many years of community, family and personal experiences have shaped. We have considerably less time in which to make an impact. I hope today's contributions will assist us to better appreciate our roles as change agents and the challenges that this role presents, whether we represent corrections, health, other justice components or community perspectives, all of which are reflected in the audience today.

BEGINNINGS:

TREATMENT IN A CORRECTIONAL CONTEXT

HISTORICAL BACKGROUND OF THE ALEX G. BROWN MEMORIAL CLINIC AND THE ONTARIO CORRECTIONAL INSTITUTE

Alfred Gregerson, Assistant Superintendent (Retired)
Ontario Correctional Institute

One of the advantages of belonging to the older age group is that when one is asked to make a statement on the history of one thing or another, one may have the advantage of having lived through that bit of history, rather than having read about it.

It puts events at a distance, which makes it possible to be more objective about them than might have been the case in the heat of the moment. It is useful for a better understanding of the present to have some knowledge of the past in order to make more intelligent decisions about the future. Someone has probably said this before or, if not, someone ought to have said it. As the old Pennsylvania Dutchman put it, "One gets too soon old and too late smart."

I can think of only one logical reason for letting me speak to you today, and that is the fact that I have been around long enough to have been involved in the treatment of the incarcerated offender in Ontario almost from the beginning, but only almost.

In the beginning there was a man with an idea. That man was Alex G. Brown, and the idea was that some offenders might benefit from clinical treatment while serving their sentences.

Alex G. Brown was the Superintendent of the Mimico Reformatory during the late 40's and early 50's. The very title of that institution, "reformatory", indicated that the purpose of the place was to bring about some reformation in the behaviour of its inmates and hints at treatment of some sort. Corporal punishment was still on the books when I joined the service in 1957 and, although that might be called treatment, I never heard anyone calling it clinical.

The treatment seems to have consisted mainly of driving home the fact that the behaviour exhibited by an inmate by committing the offence was unacceptable to society and the loss of freedom and other unpleasantness was therefore a justifiable sanction against him. Loss of freedom and the almost total lack of privacy is punishment indeed, and I have no doubt that such sanction was a sufficiently strong deterrent for some of those inmates to go out and sin no more.

Such procedures could therefore be said to be partially successful. A side effect to correction is that many people do not wish to risk their freedom. I sometimes pointed out to my captive audience in the group sessions that their misery also served as a reminder to others. They were the living proof that crime does not always pay. They did not consistently have to provide such proof as there are always other suckers ready to step in.

Many of Alex G. Brown's colleagues would probably have had considerable difficulty in understanding why he could not just leave well enough alone; just run the institution according to the book and not rock the boat. According to that book, the Superintendent could not leave his residence on the institutional property for more than 12 hours without the permission of the Deputy Minister. The Superintendent was serving a form of life sentence with the odd temporary leave of absence, granted by the grace of Oueen's Park.

It is not possible to impose such restrictions on the head of an institution without influencing his attitudes towards the inmates who were serving much shorter sentences.

The Ontario Plan on Correction came into being, I believe, in 1948 and that did much to humanize the correctional system in Ontario. Maybe this trend did something to stir Alex G. Brown's thinking about what a truly correctional system could be. Anyway, he got his idea about clinical treatment and, if that idea would rock the boat a bit, so be it.

We need people like Alex G. Brown, or even a Morton Schulman or an Allan Borovoy, to rock the boat once in a while or we would be too darn smug about everything. I believe this holds true for every organization, public or private.

Alex G. Brown had a bit of luck, too. The Minister at that time was the Honourable John Foote. John Foote had shown himself to be a true humanitarian long before he became Minister of Reform Institutions. He had earned his Victoria Cross, unarmed, on the beaches of Dieppe in 1942 in that unsuccessful forerunner of the invasion of Europe.

He was an army chaplain who, against the orders of his superior, had stowed away on one of the landing craft because he believed the men there might need his support. They did. During the retreat from the firey hell on the beaches John Foote carried more than 20 wounded soldiers back to the landing craft. But he refused to return when the last boat left. He told the senior officer on that boat that the men

left on the beach needed him more than he would be needed elsewhere. He became a P.O.W. and gave his fellow prisoners much needed support in the time that followed. Later, he became a Minister with first-hand experience in the loss of freedom.

Alex G. Brown won John Foote's support and together they sought out very able consultants for the planning of the first clinic. Two of them were Dr. Gordon Bell, now President of the Donwood Foundation, and Frank Potts, Psychologist, and later Chairman of the Ontario Board of Parole. These men, and probably others as well, became the founders of the clinical treatment of the incarcerated offenders in Ontario. Boat rockers indeed, and maybe dreamers too, but they left their imprint on that clinic for a long time after their association with it.

The spirit was carried on by the staff, even by those who had had little direct contact with them. There was a feeling of togetherness and esprit de corps without which no undertaking can succeed and endure, particularly when the going gets rough; and that happened too, more than once.

The first building was not much to write home about. It was the last remaining building, built in 1906, part of a boy's reform school, but it could house 36 inmates, or patients as they were called then.

Office space was scarce and the staff dining room was in the basement. It was a long, narrow room which originally had housed washrooms and shower facilities for the boys at the school. Ends of the old pipes were still sticking out of the wall, leaving no one in doubt about where and what activities the room had been used for in earlier times. In the summertime, the number of flies in that place was unbelievable, until the reformatory's piggery, about 300 yards away, was finally torn down when the land was sold for industrial development. Too much togetherness can be a nuisance, particularly when it comes to flies.

Alex G. Brown died about a month before the clinic was opened. It was decided to call the place the Alex G. Brown Memorial Clinic. A suitable recognition of a pioneer and a name that did not sound too much like a prison.

As a prison it was not really much either. The doors were open from sun up to sun down. Where one might have expected a fence, a four foot high privet hedge marked the boundary

and the house was surrounded by lawns, flower beds and big old trees.

In spite, or maybe because of, the lack of visible security only two escapes took place from the clinic during the first 16 years. However, it must be noted here that the patients who received treatment for alcoholism were there only during approximately the last 45 days of their sentence. In the period from 1951 to 1956 only inmates with alcohol problems were treated at the A.G.B.

The shortness of stay left little time for introductory procedures, which were confined to an introductory spiel by one of the clinicians on the weekly day of admission. All formal admission procedures were handled by Mimico Reformatory, where the general files were kept in the Records Office. The patients were included in the Mimico count. The clinic was administratively considered under the Reformatory's authority. At times this concept gave rise to some conflict, but generally it worked well.

The correctional staff at the clinic were not dressed in the military style uniforms worn by staff in the regular institutions in those days. They wore an outfit quite similar to the regulation uniform for correctional staff today.

They were not considered "real" correctional officers by a great number of the officers with the brass buttons. That factor tended to make the bond amongst the officers at the clinic stronger, rather than weaken it. Pressure causes counter pressure. However, the rivalry manifested itself more in bantering rather than in real animosity.

In 1956 it was decided to expand the treatment programme to include drug abusers, and for that purpose an additional building was erected adjacent to the first clinic. It was a relatively low cost venture as the bricks for the building came from the brickyard at the Mimico Reformatory. The lumber came from the sawmill at the Burwash Industrial Farm. The labour was done by the inmates from Mimico under the supervision of the tradesmen at the same institution. The Ontario Govenment already owned the land.

That building was made to fit the medium security requirements of the Ministry as the drug addicts were generally considered more dangerous then than they really were.

The building could house up to 24 patients and the treatment period was the last three months of their sentence. In those days all the patients in the drug addiction clinic were heroin addicts and about 75% of them had a criminal pattern, established before they became addicts. Most of the other 25% had resorted to crime to support their habit. In 1959, when I first made a survey of factors I thought might be pertinent to understanding the problem, I found that 56% of the patients were 30 years or older. That picture had changed entirely in the latter part of the 60's, following the change to other drugs of preference such as amphetamines and L.S.D., etc. The older addicts called this new breed of addicts "garbage heads" as it seemed they would gobble anything in the line of drugs.

The old timers were actually more reasonable to work with than the newcomers. They could accept fairly readily that what they did was wrong. Not that they might not do it again, but they knew it was wrong. The newer addicts seemed to think that everybody else was out of step and they resisted the idea that they might have some responsibility to other people.

My idea of treatment is to dig down until you find what is good in a person and that is what one must build on. I have never found a person that I could not find something good in. It is true that in some persons the good you might find will provide only a pitifully small amount to build on, maybe only enough for an old-fashioned outhouse, but such is the game we are in. Winston Churchill once said, "There is a seam of gold in the heart of every man." I believe that to be true, but with people as with gold mines the yield does not always justify the cost of the excavation. The bad traits in a person have probably been pointed out to him ad nauseam, and he may be more surprised than you when you are able to find something to his credit.

In 1961 an interesting bit of legislation was introduced. It made it possible for the courts to sentence chronic alcohol offenders to a period of treatment instead of fine or jail. Such a period was not to exceed 90 days. This form of sentence became known in the jails as a "Bill IX". The A.G.B. was assigned as the treatment centre and the Superintendent there was given the authority to release persons under such sentence at any time within the 90 days. He would seek advice from the clinicians on his staff in regard to the timing of the release.

The idea caught on like wildfire and it again became necessary to expand the facilities. A dormitory building at the Mimico Reformatory was taken over for clinical use. It would hold 120 inmates and, on May 21, 1961, it was opened with much fanfare and 120 patients already there.

Some of the old drunks downtown got wind of the possibility for an early release on a "Bill IX", and when they landed in court on the appropriate charge they would plead for a treatment sentence. The day after their admission they would clamour for a release, and some of them got away with it as they were disturbing the treatment of legitimate patients. That caused some problems until co-operation betweeen the clinic and the courts brought it to an end. The admission under "Bill IX" started to decline after that.

In 1965 a treatment programme for pedophiles was inaugurated at the A.G.B. Until then these offenders had just served their terms, often in protective custody. Prisoners can be a very self-righteous bunch in their treatment of other prisoners whose offences fall outside the accepted norm.

It was a programme we entered into with a great deal of misgivings. It was not that we could not see the need of such treatment. The doubts were more about how the present patient population would react. Staff, including myself, were not certain how their own reactions might be. Many of us were parents and it occurred to us that our own children might fall victim to such crimes. My pride in being fair and impartial took a shakedown and I know that other staff members had similar feelings.

The clinicians helped greatly in helping staff as well as the patients with the change and it went smoother than most of us had dared to hope.

The sex offenders had been used to being kicked in the teeth, both literally and figuratively speaking, and it took a little time for them to find out that the clinic and its staff were for real, but after that had been settled they co-operated rather well. They wanted help, they believed the treatment would help them and those are the first two conditions for successful treatment.

One part of their programme, aversion therapy, took place at the Lakeshore Psychiatric Hospital as we did not then have the proper space for the laboratory equipment at the clinic. This treatment was conducted by two dedicated and able people, Rene Gauthier, a Psychometrist, and Dr. Richard Steffy, a Professor of Psychology at the University of

Waterloo. The team was later joined by Dr. Kurt Freund, Psychiatrist, and specialist in sexual disorders. A very careful follow-up of these patients on release to the community gave a picture on the effectiveness of the treatment.

Connected to the clinic from its beginning was a team of parole and rehabilitation officers. This team was originally led by Don Griggs who later became the Superintendent of the clinics for a period in the 60's, and who ended his career with the Ministry as Vice-Chairman of the Board of Parole.

Each patient was assigned to a parole and rehabilitation officer and, whether he was released on parole or not, a 12-month follow-up was a part of his programme. Most patients were released on the expiry of their sentence and they had the right to refuse participation in the follow-up. Such refusals were rare as most of them found that the assistance offered during the follow-up was to their benefit in many ways.

The follow-up had other uses too as it provided the clinicans with important feedback on their clients in the community and the rates of success or failure could be accurately recorded.

The Parole and Rehabilitation Officers worked with the patients in the clinic in one-to-one encounters as well as in group sessions. They were the bridge between the clinic and the released patient. The caseloads were reasonable, between 30 to 40 per officer. As many as three or four visits in the community to a newly released patient was not unusual in the first difficult month, but these visits took place according to need rather than in accordance with a rule book. The Parole and Rehabilitation Officers were free to act, but encouraged to consult with other clinical staff or with their various contacts in the community. I believe that much was lost on both sides when this arrangement was abandoned on the move to O.C.I.

With the expansion of treatment programmes it became obvious that new facilities were needed. It was fortunate that this need became apparent in the 60's when there was still a bit of loose cash in the government's coffers. The proposal for a new clinic was accepted and the planning started, hot and heavy. This took place while Elo Glinfort was the Superintendent of the clinic, and Art Handelsman was his Deputy. The entire staff participated in the planning in one way or another, and the proposals emanating from these

planning sessions were generally accepted. The O.C.I. today is a reasonable picture of what was suggested.

One event happened which was not a part of the planning at the clinic. A few months before the move to the new facilities in Brampton, both Elo Glinfort and Art Handelsman were promoted to other positions. Such promotions had happened before to senior members of the clinic, and each time it had created a period of uncertainty and unrest in the staff.

John Duggan became the new Superintendent, who would take us into the promised land of O.C.I. A relatively new position as Programme Director was filled by Dr. Richard Meen, a Psychiatrist of note. The Programme Director's position was a rather powerful one and Dr. Meen is a powerful man. Speculation ran wild about how such a team could work. It was dubbed "the two-headed monster". It is a credit to those two gentlemen's political skills and diplomacy that it worked out well. The Senior Management Team was also joined by Bill Taylor, who later became the Superintendent of Guelph Correctional Centre.

Promotions abounded in those days, with the expansion of the staff. It seemed that everybody became Directors or Assistant Directors of something or another. Meetings became the order of the day. I am not against meetings. They can be very useful, and in the set-up of a new institution such as O.C.I. they were necessary, but I beleive that meetings can be habit-forming and meetings for the sake of meetings is a wasteful use of time.

The O.C.I. was officially opened on September 20, 1973, and on the 1st of October we moved in with the last 60 patients from the A.G.B. These patients were relabelled and called residents. They adjusted fast to their new label and their new surroundings. After all they were used to being moved around; it took a little longer for the staff to readjust.

The clientele treated at the O.C.I. was to be the same as at the old clinic with the addition of inmates with certain psychological disorders. The O.C.I. also had a unit, which was originally labelled a diagnostic unit, but, due to the medical connotation of this term, it was renamed assessment unit, and for five years it served as an assessment unit for young first offenders with a sentence of nine months or more, sentenced anywhere in southern Ontario.

After a month or so at the assessment unit these residents were either sent to other institutions or admitted to the treatment units. The data collected on these young offenders during the five year period has been a tremendous source of information for further research.

The treatment approach was altered somewhat from the pattern at the A.G.B. We no longer had specific programmes for symptomatic problems, such as alcoholism, drug addiction, etc., although some special services were rendered for specific needs. The approach became more holistic, but that would be for a clinician to explain.

Each unit was run by a team consisting of a clinician, a correctional unit manager and assistant unit manager, but that system was later abandoned in favour of having the units managed by a C.O.4 with the clinical guidance of a clinician.

John Duggan and Dr. Meen did not stay with us for long, or so it seemed. Tom McCarron took over as Superintendent and Louise Dutka became Treatment Co-ordinator. Superintendents and other senior staff members at the A.G.B. and the O.C.I. seem to fall into a tradition of moving up to more senior positions, which may hint that we usually got the best of the litter, if I may regress to my farm background for a moment. After Tom McCarron, came Bernie Doyle, who, contrary to the usual tenure, stayed with us for more than four years before he also fell victim to the promotional tradition and the oil money in Alberta, where he took over the southern half of their correctional system. Lyndon Nelmes is still the Superintendent, but Queen's Park better watch out.

The type of treatment in a correctional treatment centre such as A.G.B. and O.C.I. would not be possible without the whole-hearted co-operation and participation of a well-trained correctional staff. The selection and ongoing training is of utmost importance. Mutual trust, respect and co-operation between clinical and correctional staff makes such programmes possible, and the A.G.B. and the O.C.I. have shown it can be attained.

The boss is the boss and he needs the support of a loyal crew, whether he is the captain on a ship or the head of an institution. Neither can be run by a committee.

May the good ship O.C.I. always have an able captain and a loyal crew with plenty of esprit de corps, and she will sail on for many years to come. She is needed. I kid you not.

O.C.I. BEGINNINGS: AN ADMINISTRATOR'S OVERVIEW

John Duggan
Executive Director, Institutional Division
Ministry of Correctional Services

It was in the spring of 1973 that I learned that I was to become the Superintendent of the Alex G. Brown Memorial Clinic. I had a major mandate to oversee the closing of that facility and to prepare for the opening of the Ontario Correctional Institute later that year. And it was at the time of my appointment that I met Richard Meen for the first time and I'd like to say that I felt then as I do now that I was in fact extremely fortunate to have been given such an accomplished and personable partner with whom to work. The appointment of Bill Taylor as Deputy Superintendent completed the formation of the new Senior Management team. The subsequent two years in which the three of us worked together with many of the people gathered in this room have been amongst the most enjoyable and rewarding of the 26 years that I have had in this field.

It was indeed with a great deal of enthusiasm and some little trepidation that we commenced our tasks. The staff of the Alex G. Brown Clinic were justly proud of the history of that institution. It had been in the vanguard of correctional programming in Ontario for more than 20 years. They had developed as you have heard an expertise in the treatment of offenders with sexual drive and alcohol problems and had been extremely active in the planning of this new facility in Brampton. They knew very little about these new people who had been appointed to the clinic and were actually anxious and, I suspect, more than a little apprehensive with regards to the future.

From my perspective, and from that of Dick Meen, it was most essential that we establish clearly in our own minds just how we saw the new institution functioning. It was to this end that a great deal of time and energy was given in the early days. We hammered out issues around treatment philosophy in a correctional environment and the ways by which the joint needs of treatment and security could be met and how we would overcome the feelings of resistance and ambivalence that were somewhat apparent at that time. Looking back, it seems that we were able to reconcile those areas with little difficulty. At the time we had our share of frustrations. I think we were able to reconcile them because our basic philosophical stance on corrections was somewhat similar.

Indeed, it was in preparation for today's discussion with you that I came across a letter sent to me by a Regional Director in the United Kingdom system with whom I had worked and who I had known for many years on the occasion of his retirement. In this letter he spoke of his days under Alexander Patterson, who was a leader in penal reform in the United Kingdom in the 1930s. He was a pioneer in the development of the Borstal system in the United Kingdom. This gentleman wrote of how that experience under Alexander Patterson guided him in his days through the prison service and how he was in fact going to re-publish an appreciation of Sir Alexander. He also said in his letter:

> "You may be wondering why I've chosen this means of marking my retirement. I can only say that it is my way of passing on the torch. I don't think I ever managed to make any original contribution to penal theory or practice but I believe wholeheartedly with Patterson and with Vidler that the Borstal system has no merit apart from the Borstal staff. It is men and not buildings who will change the hearts and ways of misguided lads. And I think the best service I can perform is to insure that their example and their precepts are not allowed to die."

He went on to say:

> "If there is one quality essential to a successful worker in the field of penology it is compassion. I have therefore added to the small anthology two poems which I read and learned early in my life and which had very often come to my mind as embodying this quality. They are the Bridge of Sighs by Thomas Hood and the Celestial Surgeon by Robert Louis Stevenson."

Those precepts about which that gentleman wrote are, I believe, still amongst the most important for those of us in this field to possess. And they are as valid today as they were many, many years ago.

We undertook a very careful analysis of the staff of the Alex G. Brown and the staff we recruited to the O.C.I. and we tried very hard to match their strength against the backdrop of what was the emerging role of the Ontario Correctional Institute. It became clear to us that we would eventually

operate five treatment units as well as an assessment unit and that as its core the institute would provide specialized programmes that would incorporate assessment, treatment, education and research. It was also accepted that the dual nature of the Institute as it had been set up, with a Programme Director and a Superintendent, would extend throughout the institution with each unit being headed by both a correctional officer and a clinical person.

Prior to the move three committees were established to oversee and to facilitate the management of the institute. The first was a Senior Management Committee. Its responsibility was to advise the Superintendent upon all matters pertaining to the Institute including the effect of implementation of policy as directed by the Ministry of Corrections. It determined the aims of the Institute and the resources required to implement such aims. It co-ordinated inter-departmental activity, planning and reorganization, staff welfare and training and the use of task groups set up by and reporting to the committee for various specific purposes. Before any proposals affecting policy were put into effect in the Institute they would also be discussed and ratified by this Senior Management Committee. I was the chairman of that committee and the members were the Programme Director, the Deputy Superintendent, the Assistant Programme Director and the Office Manager.

The second committee was entitled the Operations Group and was primarily concerned with the tactical management of the Institute. It ensured that policies that were applicable to it were put into affect. It also assisted the Senior Management Committee in the formulation of policy by collecting and presenting to them information which would be of help in this area. It was also responsible for facilitation of the efficient working of all departments and encouragement and development of effective communication between them. That committee was headed by Bill Taylor, the Deputy Superintendent, with the three Assistant Superintendents and the Office Manager as members.

The third standing committee was the Clinical Programme Committee. It considered treatment and assessment policy in the light of total programming. Initially it was set up in two parts. There was a clinical staff meeting that was attended by all clinical staff and a department heads meeting that would assist in the provision of uniform and cohesive decisions around policy. The transition from the Alex G. Brown to the O.C.I. in fact went smoothly in the final analysis. After the excitement of the opening day we got down to the business of running a brand new institution.

We soon had two treatment units operating and the third planned for opening early in 1974. These two units were using programmes based somewhat upon the treatment of drug abuse, alcoholism and certain sexual offences that had been utilized in the Alex G. Brown Clinic. We were also operating an assessment unit receiving young offenders who were first incarcerates between the ages of 16 and 24 in the early stages of their sentence. This unit in particular presented some difficulties in its design. We didn't make the control module into a fish tank but we did make some other changes in relation to the assessment unit and we did that within the first year of our operation.

During the initial period, problems surfaced around the major issues of custody and control. We were picking up some clear indications that restrictions were in fact being too rigidly enforced. This led us after some evaluation of the situation to a relaxation that allowed for a greater degree of freedom of movement within the confines of the Institute. And yet we felt we were able to maintain good overall standards of necessary security. It allowed for a healthy atmosphere within the Institute and right from the beginning I felt that the rapport between residents and staff was a positive one.

A reflection of this, I think, can be seen today. For example I well remember being told prior to and at the time of the opening that the Institute was far too lavish in its physical plant and its furnishings and that it would be a wreck within 12 months. I well remember, almost two years later when I left, reflecting on how well it looked; and over the years, up to this day, I believe that this Institute itself bears testimony to the regard which all those staff and residents who live within it hold towards it.
As the new boys on the Brampton block it was important that we establish ourselves with our neighbours to the East and West, namely, the Vanier and the Brampton Adult Training Centre. This was achieved in a variety of ways, from meetings with the respective Superintendents and staffs, to the launching of such ideas as joint maintenance of grounds and facilities, ventures which were to meet with varying degrees of success. We also launched the first tentative ventures into co-operative programming with use of such facilities as the television studio which is now defunct and educational programmes.

Two other areas had to be addressed. Our communication with the field and our communication with the community. With

regard to the first, we explored a variety of methods without, I must confess, a great deal of success. I believe this to be an area that perhaps is still worth some close attention. We were more successful with the second and our first year of operation saw many successful forays into the community and likewise a stream of visitors to the Institute. Highlights in my memory, for example, were the first two Christmas concerts held at the O.C.I., which I found to be quite remarkable in many, many ways, not the least of which was the mixing of both families of residents and staff. I also recall such events as the visit of the Royal Canadian Mounted Police, only this time it was the band and not the constables. And we even got Rosemarie thrown in as an encore. Other concerts were from such varied cultural events as the Pig and Whistle television show and Diamond Lil and her girls, who were extremely popular.

I alluded earlier to the importance of research and the recognition of its place in the Institute right from the beginning. However, this and such matters as our contracts with the Clarke Institute, the delivery of health care, etc., are topics that I felt sure Dr. Meen would deal with and, of course, he has. Suffice to say that, as Superintendent, I recognized their importance and their value in the overall scheme of things. They and the whole area of business and finance are issues that demanded attention in high degree. Such matters as the word processing system and in later years the effective use of computers were testimony to some of the initiatives and experiments that were carried out in this area at the O.C.I. Similarly, this Institute was among the first in the Ministry to contract out its delivery of catering services to private industry.

Upon looking back over the past decade, I cannot help feeling some pride in having been allowed the privilege of joining with what I felt were a unique group of people in launching the O.C.I. into the correctional parliament. I like to think that we got off somewhat on the right foot and generally in the right direction. However, it is to the future that we must look, for it is there indeed that the challenge lies. Heaven only knows that the 1980's have presented us in the correctional field with more than our fair share of challenges already. But, of course we must learn from the past, our successes and our mistakes, and I welcome this chance to participate in just such an exercise.

One final note: upon reflection, it seems to me that if there has been a fault in our use of the O.C.I., it is that we have perhaps not spoken its praises loudly enough. We

have not spoken enough of the good things that we have developed and learned. I firmly believe that there are few institutions, if any, in the correctional field in America that can stand comparison.

O.C.I. BEGINNINGS - PROGRAMME DIRECTOR'S PERSPECTIVE

Dr. Richard Meen
Psychiatrist

The opportunity to share some of my thoughts, memories, recollections and feelings about the beginning of the O.C.I., as related to treatment in a correctional context, has produced a time warp in my thought processes over the past few weeks, as I vividly relived some of the joys, angers, frustrations, inadequacies, competencies, laughs, struggles, pain and pride of being an intregral part of the launching of this institute. Not belonging to that group of the population that keeps diaries and journals the comments that I'm about to make come from memory alone and, therefore, are subject to the errors induced by time, affect and other superimposed experiences. I will sincerely attempt not to make fact fiction and fiction fact.

Away back in 1969, having just completed my post-graduate training in psychiatry at the University of Toronto, I was offered a part-time position as a consultant psychiatrist at the Vanier Centre for Women, one-half day per week. I of course said no way. Did I spend all of that time and energy to finish up working in a prison? I knew from my training that the people with personality disorders who finished up doing time were untreatable and guaranteed a budding, young therapist nothing but failure. With great aplomb and manipulation an "accidental meeting" was arranged between myself, Aideen Nicholson and Glen Thompson. I became hooked and obviously was an easy mark. The years at the Vanier Centre and the women's section at the Don Jail provided me with the clinical experience that removed my nihilistic attitudes regarding the value and need for psychiatric intervention within the correctional setting.

Then along came Mr. Don Sinclair asking me to consider working full-time for the Ministry as Programme Director of the A. G. Brown Memorial Clinic, an open setting connected with the Mimico Correctional Centre for the treatment of drug abusers, sexual offenders and alcoholics. This clinic was about to move its location from Mimico to the McLaughlin strip in Brampton and once again I said no. But for different reasons: I was frightened. I was frightened of losing my clinical identity, and my clinical skills, by assuming full-time administrative responsibility and

subsequently getting lost in the system. This was a great risk, I felt at that time, for clinical people. But here was a setting I knew would permit the effective use of clinical knowledge and skill to work in such a way that something other than assessment could be provided for this group of "untreatables".

Closer examination of the programme of the A.G. Brown Clinic revealed to me an exciting endeavour, original thinking and an enormous clinical challenge. But more importantly the emphasis was on change, growth, visionary thinking and the opportunity to provide treatment without the restraint of traditional psychiatric thought. I couldn't resist that opportunity and was hooked once again. I believed, and continue to believe, that some offenders can be treated in such a way that they can learn, understand, and compromise themselves to such a degree that they can live within our communities without abusing the limits of property and fellow citizens to such an extent that they need to be removed.

John Duggan was named Superintendent and together we began to work. As in any treatment modality resistance is a major issue. I can assure you that in this case it was not of minor significance and was evident at many levels. John and I were both outsiders. John came from another correctional system and I from psychiatry. The family of the A. G. Brown had together planned, programmed and built the new clinic and here were two unknowns given the reins. We were received with ambivalence. We knew we had to establish a model that we believed in, and stand fast. We were both aware of the fact that, historically, clinical and correctional staff were essentially like oil on water and that with our model we wanted to make that fact fiction. Many hours were spent by the two of us just getting to know each other. The way we thought, the way we felt, the way we reacted and the ways in which we disagreed. This was the first step in the treatment programme. We had inherited a building, a building that neither of us would have built if we were designing it ourselves. The local community demanded a fence, thus converting an intended minimum security space, into a medium one. I demanded the stainless steel bars, embedded in concrete in the admitting area, be removed. If I remember correctly, I also suggested that the control office in the admitting unit, beautifully designed with all walls made out of shatter proof glass, clearly mod, would make a great storage tank for fresh fish. Senses of humour varied. But we were on our way.

The decision was made to provide two services in this building, which by the way had not been named yet. An assessment unit for first offenders and a five unit treatment programme. Treatment in a correctional context required not only a new physical environment, but rather a new attitudinal environment. One that would not enhance and support the pathology of the clients and the system itself, but at the same time would not pretend it was a psychiatric facility treating mentally disordered individuals. The mental health system had been well established and had much experience with that group. An environment was required that permitted clinical skills and correctional skills to compliment each other in such a way that both could be maximized and the inmate reap the benefit in some positive way.

The name of this facility therefore became a vital issue since it would set the tone of the entire programme. The word clinic was ruled out because of the immediately perceived implication toward the medical model. Correctional was kept because of the obvious need to change something that was wrong. And institute implied an organization established to promote scientific, professional and educational objects. The late Dr. Ken McKnight from the Department of Psychiatry, University of Toronto, described it as "the jewel in the crown of corrections" and so it was christened. This clearly gave John and I a workable mandate and a philosophical base upon which we could build.

One of my first goals was to establish a clinical staff with credibility, not only within corrections and with clients, but also with academic institutions within the region. The Ontario Correctional Institute fortunately sits neatly between the University of Toronto, University of Western Ontario, McMaster University and Waterloo Unviersity. Clinical staff were hired full-time, part-time and consultant, to complete the required clinical staff complement. The clinicians reported clearly within their own disciplines to their chiefs no matter whether it was social work, psychology, teaching, nursing or psychiatry, and thus formed clinical departments which were expected to provide their own peer supervision in order to provide competent supervised delivery of service.

Psychiatry, of course, in that era was a major problem. But thanks to the real interest of the forensic unit of the Clarke Institute and the University of Toronto a contract was

struck such that the O.C.I. was guaranteed a quality service on a consulting basis.

Medical services in the prison setting were notoriously inadequate and in many ways inappropriate, and did not meet our expectations. Consequently, a health service staff evolved that had as its focus health care and teaching, rather than an illness. A head nurse with public health experience and hospital outpatient care expertise was recruited and a contract was signed with a local Brampton group of general practitioners rather than hiring a full-time institutional physician. With the addition of a Research Director a full complement of clinical staff were then available and in place.

This staff along with the correctional staff were then asked to develop programmes. Each unit was given clinical services from all disciplines as well as being headed, as the institute itself was, by a correctional staff and a senior clinician in tandem; not an easy model by any stretch of the imagination.

Classification officers around the province worked diligently in the larger jails classifying inmates as they were sentenced in order to place them appropriately somewhere within the correctional system for the period of their incarceration. They made a decision rapidly as to whether they were mad or bad, co-operative or unco-operative, and the bailiff whisked them off on their way. It was felt that perhaps the first offender deserved a little better shake and the O.C.I. developed a 48 bed assessment unit in order to obtain a thorough history and clinical assessment of each young first offender, make recommendations as to the kind of management and care that would be most useful, suggest placements and make some indication as to the possible prognosis. This unit had a rapid turnover of clients, they offered no treatment per se except that which is inherent in the very process of assessment itself.

The treatment units received referrals from across the province and from our own assessment unit, of sentenced males who were sexual offenders and/or drug abusers and/or alcoholics, plus a small group then sentenced under the L.C.B.O. Act called Bill 9. The initial screening of these referrals was made by my assistant and myself, not for the purpose of decision making, but to confirm the availability of sufficient data such that a reasonable decision could be made as to the suitability of admission with special regard

being paid to the motivation of the client for treatment and his accessibility. The files were then submitted to the correctional/clinical teams of the treatment units for their decision as to whether to admit or deny. This of course made the Superintendents of many of the correctional centres in the province just a little hot, and the four regional administrators even hotter, and it gave John Duggan migraines. However, I can only recollect on three occasions being ordered by head office to admit someone that we had previously refused.

Upon admission the inmate went immediately into his programme. There were short-term programmes, 90 days or less; long-term programmes of two years less a day or less; programmes based on psychotherapeutic intervention technique; or using behaviour modification techniques; there was milieu therapy and drug therapy; there was individual therapy and group therapy; there were programmes with very specific vocational goals as ends unto themselves. The important fact was that each team wrote its own programme utilizing all the resources it could muster. The programmes were well documented and all members of the clinical/correctional personnel at all levels of the hierarchy were involved before the final go-ahead was given.

Besides the individual unit programmes there was an institutional programme. Essentially this was to provide an environment in which growth and learning could take place encouraging a sense of responsibility in both the inmates and the staff. This created a few problems especially when workers were needed. Work placement of inmates was seen as an extension of treatment goals and not the reverse. Treatment, whatever it may mean, was not viewed as a reward. The programme was also not a nine to five one but seven days a week with the emphasis being on clinicians providing a resource when it was needed, not when it was convenient. One of the greater advantages of this institutional programme was the use of male and female correctional officers with an all male clientele. Today, of course, that may seem old hat and accepted as a given, but not so ten years ago. The presence of the female correctional officer introduced a parameter in dealing with sexual offenders and drug abusers that made available all sorts of obvious dynamics never before available in this type of setting. I'm sure that some of the senior correctional officers lost a few night's sleep over this aspect of the programme.

Even though the O.C.I. was a medium security setting with publicly high profile clientele, the pass system was utilized

quite successfully, with many offenders leaving the Institute daily on work and educational passes.

The individual units were encouraged to interact. There were several group passes organized in which offenders from various programmes intermingled outside the Institute, developing life skills that would serve them well once released. A camping programme is a perfect example of this implementation of that philosophy.

In the beginning we did not know how to use our audio-visual equipment very well. One useful experiment, however, was the weekly sessions, produced in the large studio and made available on all the monitors, of the inmate representatives from all the units confronting Mr. Duggan and myself as to what we thought was going on in "the joint". This effectively reduced some of the mis-communications so rampant in any institutional life.

Discharge planning must begin at the time of admission in any treatment programme. The aftercare and probation and parole officers are an integral part. Community liaison, and in the field preparation for the return of the offender to his home, was not taken lightly but on the other hand was not pursued as energetically as it could have been. All members of this initial programme were expected to reach out to the community beyond the walls of the Institute. Many travelled far and wide around the province lecturing to groups of magistrates, other clinicians, other correctional officers, students in community colleges and the like. This programme attempted not to perceive itself as untouchable, it attempted to defend itself against isolationism and thus tunnel vision.

Field placements for university students were encouraged from all the clinical disciplines. A training programme for community college correctional officer students was also available. Students asked questions and kept us all on our toes. They may have been a security risk but they were worth their weight in gold.

A correctional setting in my opinion is an ideal palce for the treatment of many disorders rampant in our community. I entered the Ontario Correctional Institute believing that. I left it knowing it. There is a Greek proverb that states the beginning is half of every action. One of the overwhelming hurdles in the treatment of the offender is that one

constantly feels that they are at the beginning and already half spent. I agree with Dr. Samenow and the concept that criminals think funny: not that they are mentally ill but they just think differently. Most programmes involved with providing treatment also think funny, in the same way as their clients. They have double standards, they split their egos, they require immediate gratification, they communicate indirectly, their loyalties are shallow, they are not affected in any major way by the environment around them.

To summarize my opinions, regarding the beginnings of the Ontario Correctional Institute and treatment in a correctional setting, is very easy. I believe it was an attempt to start to stop thinking funny.

THE PRESENT:

MANAGEMENT AND TREATMENT OF THE

MENTALLY DISORDERED OFFENDER:

PHILOSOPHY AND PRACTICE

"The correctional officer is a central actor in this drama. He can be brushed off as a brutal Neanderthal type or he can be enlisted as an agent of change and find a new dignity for himself. We can no longer afford the futility of polarization." David Fogel, 1973.

THE ONTARIO CORRECTIONAL INSTITUTE:
ITS RESULTS
ITS MANNER OF WORKING
ITS PROBLEMS

Dr. Gerald Heasman, Chief of Psychiatry
Ontario Correctional Institute

We have begun this symposium, to mark the 10th Anniversary of the Ontario Correctional Institute, by hearing from those who knew and worked in its predecessor, the Alex G. Brown Clinic. Their work to enlarge and extend that facility led to the opening of this Institute in the latter part of 1973. Now, we move on to consider what we have become in these last ten years.

Before we go any further let me tell you the answer to the question that is in all your minds. Do all of our efforts achieve anything at all? Or is it all a futile waste of time, money, personnel and energy?

In 1983, Dr. Stasiak, our Director of Research, undertook, with only one temporary assistant, the mammoth task of attempting to determine this. To quote him:

> "... a random sample of residents was created (from) those) who were transferred or released from the O.C.I. during the period January 1, 1977, to December 31, 1981. These residents received treatment and were released from the O.C.I. upon satisfaction of sentence, (being granted) Ontario parole, or were transferred to another facility for discharge planning. The sample did not include residents who were transferred out of the O.C.I. for other reasons prior to expiry of sentence or (being placed on) parole.
>
> "A comparison group was also created of inmates who had applied for treatment at the O.C.I. or who were involuntarily sent to the O.C.I. for classification during the same five year period. Residents in that group had been judged suitable for treatment, but were not accepted for administrative reasons, such as, no appropriate vacancy, not enough time in sentence for treatment, withdrawal from waiting list, etc.

> "There were 577 residents in the treatment sample and 238 in the comparison group. As of September 1982 for the treatment group and June 1982 for the comparison group, 49.6% of the treatment group and 67.7% of the comparison group recidivated."

Thus, in spite of the fact that the treatment group were followed for three months longer than the comparison group, 18% fewer of the treatment group had recidivated during this period of five years. This study is not yet finished, but if, on completion, the picture remains the same, it will at least tend to suggest that while, as Martinson said, "nothing" works, "something" can, and does.

If you now accept that perhaps "something" does work, what is it, and how does it work?

A short answer might be to paraphrase what William Menninger wrote in 1943 of psychiatric hospitals:

> The Ontario Correctional Institute should afford specific and continuous treatment, specific in that it is directed toward meeting the needs of the individual, and continuous in that every contact the inmate makes throughout every day should guide him toward the same therapeutic goal.

To achieve this, our first task is to define the nature of the individual's needs and what the problems are which lie beneath these, whether they be defects in relations with others, reality sense, judgement, instinctual urges or severe inhibitions. Treatment must help the resident develop a more adequately functioning self, a better grasp of reality, more forethought and a greater awareness of the consequences of his acts. Life experiences within the community of his unit and the comments of both staff and other residents are used to pressure him into making changes in himself. In short, our aim is to make treatment move forward on all fronts depending on the inmate's needs.

In this effort, we are operating within a social system in which both residents and staff influence one another, as described by Maxwell Jones in 1953. Our continuous task is to make that influence as constructive as possible for the greatest possible number. The resident is invited to be a partner in the process with us, to give up the "jail house" attitude of "doing my own time" and work with us, working with him, trying to change himself. To do this he has to be

able to learn to live with others with respect, care and responsibility.

A therapeutic community needs a therapeutic team. It is, therefore, vital to our work that we, both correctional and clinical staff, keep our hearts, minds and doors open and live and work together with that same mutual respect, care and responsibility we expect from the residents, sharing knowledge, skills and experience. It is not easy, we are a big diverse family, but it can be done and it is an enriching experience. By it we can all learn as we work, keep our minds active, survive the endless difficulties that are placed in our way, resist burn out, and avoid the correctional dichotomy of custodial and clinical staff, the former having only custodial, and the latter only treatment, responsibilities. Everything is both treatment and custody: both treatment and correctional staff have custodial and treatment responsibilities. If we present a united attitude to the resident, that, of itself, can a powerful force for change.

Security is frequently said to make treatment impossible in a correctional institution. It can do so, but our task is to use it for the benefit of the offender. We are fortunate in the design of this building, which allows security with a sense of freedom and sets the stage for developing a constructive style of security, which relies on relationships and responsibility.

Many of our clients would not stay in treatment on the street. They have problems with authority, so that having to accept staff in both authoritarian and treatment roles can be puzzling at first, although it may eventually help them overcome their antipathy to authority. From this, the resident may begin to accept his criminality and then take constructive responsibility for it.

For the correctional staff, an enforced counselling relationship with the resident provides the basis for an on the job training, through which they learn about the humanity of those who commit crimes. This training is enhanced by their daily contact with social workers, psychologists, nurses and psychiatrists. It is my opinion that this cannot but increase the knowledge and ability of correctional workers and the correctional system as a whole. To this extent, we train correctional officers as well as treat offenders.

So, now we have a therapeutic team, but to have a therapeutic community one has to involve the offender. How do we do that?

One of the very first people the new resident sees within about an hour or two of arriving at the Ontario Correctional Institute is the nurse in the health centre. Enquiring about his health, she takes particular care to ask about all previous assessments, both physical and psychiatric, and there and then seeks permission to obtain summaries of all these past records. We consider these records important because they usefully increase our longitudinal view of the man, provide us with the opinions of others and enable us to bring to light discrepancies between the history he gives and that recorded at the time.

Of equal importance, the nurse gives the new resident a statement to read. It points out that he will be expected to work with the staff as a member of a team seeking ways in which he will help himself. He is told that if we are to help him help himself, we will have to understand him. For us to do that he is going to have to tell us, openly and frankly, about himself and his problems. We, in turn, because we do not work alone, but as members of a team, will be sharing this information with others in this Institute so that they, too, may work as members of the team. In fairness and honesty, we also warn him that, if it becomes necessary, we shall share what he has told us with others within the correctional system as a whole, including the Parole Board. However, except as required by law, the information he gives us will not be shared with others outside the correctional system, without his consent in writing. He is encouraged to ask questions about this statement and finally asked to acknowledge, by signing it, that he has seen it, had an opportunity to ask questions and understood it to the best of his ability.

On the treatment units the aim is to put Menninger's ideas to work within the therapeutic community of the unit. The mechanism for this is the core programme, common to all treatment units, together with other off-unit programme elements chosen to meet the specific needs of each resident.

One such off-unit service available to the resident is that of the psychiatrists. We offer much the same type of treatment as the offender would obtain if he was to go to any psychiatric out-patient clinic, except that, unless there are reasons for treatment to be at the hands of a psychiatrist, we tend to delegate his treatment back to his unit staff. In addition, because we are a secure institution, we can also

offer the equivalent of voluntary in-patient treatment. If the individual has a mental illness and is certifiable, but unwilling to accept treatment here, we arrange transfer to a psychiatric hospital. We do not compel psychiatric treatment against the individual's will. Where appropriate, we arrange for residents who are being released to be seen by family practitioners, private psychiatrists or psychiatric facilities for further treatment and follow-up. In other cases we explain how to go about seeking a referral to a psychiatrist.

Our policy with regard to the use of medications is to use them only when necessary for the treatment of medical conditions. We do not use them to control behaviour which is not the result of psychiatric illness. The decision as to whether or not to precribe medications, and the consequences of that decision, are the sole responsibility of the physician. Perpetuating the habituated person's habit, by prescribing unneeded medications for the duration of his incarceration, does not treat his habituation. Controlling his psychosis with an anti-psychotic medication, and demonstrating to him the benefits of such treatment so that he may continue with it, is worthwhile.

An important aspect of our role is that we are a point of liaison between the correctional system and the health system. We attempt to start the resident on a process of self-acknowledgement and responsibility which we hope will continue following release. We sometimes think of ourselves as a cheap psychiatric hospital. Over the years we have established our credibility and through us there is a frank and full exchange of information between the correctional and health systems.

Our work is not without its problems. Some of these stem from the correctional system itself.

Correctional systems are continually asking themselves whether or not incarcerated offenders should be treated. How can this be when they employ physicians, nurses, social workers, psychologists and psychiatrists? In its broadest sense, treatment is the interaction between two human beings. Whether or not this happens is not a matter for consideration. It cannot be prevented from happening. It is the outcome of this interaction, that is in question. In those interactions which are thought of as "formal treatments", an effort is made to ensure that the outcome is of benefit to the recipient.

Correctional systems deal with the angry, the bitter, the envious, the jealous, the neglected, the disillusioned, the incompetent, the foolish. Will these feelings and traits be increased or decreased by incarceration? In the final analysis, unless society is going to execute all offenders or incarcerate them forever, it has a choice: treat the offender, or accept being raped again. Gunn (1978) and his co-workers found that one third of those incarcerated would be considered "cases" if they were seen in a psychiatric clinic. These persons are entitled to the offer of treatment during incarceration. The health system cannot absorb them all. The Ontario Correctional Institute is one of the few facilities in the world which is attempting to make that offer. The nature and extent of the treatment will depend upon what is possible with the given offender. It may be the most pragmatic everyday common sense, or the most sophisticated modern medical technique.

However, a treatment centre for offenders in a correctional system is atypical, because it is at variance with established correctional tradition, and hence, questionable. In a health system this would not be so. When problems arise, systems, like living organisms, return to the norm. Unlike a health system, the norm for a correctional system is not treatment. The pressure on this correctional institute, to justify its very existence, is far greater than that on any of its sister institutions.

Doubt, of itself, as to the worth of our continued existence, is no bad thing, but if we are not allowed the resources with which to attempt to answer those doubts, it becomes destructive. If personnel and mechanisms are not provided and built in, solely for the purpose of carrying out evaluative research, then time, energy and personnel are taken away from formal treatment programmes. The consequence of that can be no effective treatment, no adequate research and a self-fulfilling prophesy of failure.

The number of staff, both clinical and correctional, have been significantly reduced since the Ontario Correctional Institute was opened. Those that remain are now fully occupied with the mere provision of services. The number of residents has been increased. Our ability to choose who we accept for treatment is limited. We have to accept inmates who have insufficient time to allow of any treatment. All this hinders the fulfillment of the mandate this institute has been given.

I am not advocating that the Ontario Correctional Institute be transferred to the Ministry of Health. Treatment, it should be remembered, is not a matter of where one is, but of how one is treated, by whom and for how long. I believe it is time that correctional systems, and society as a whole, accepted fully their ethical responsibility to treat offenders. I believe that Ontario has one of the better correctional systems. We at the Ontario Correctional Institute would like to work with you to make it one of the best, by being allowed to do the job we have been asked to do.

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THE EVOLUTION OF O.C.I. PROGRAMMES UNDER PRESSURES OF FISCAL AND POPULATION CONSTRAINTS

Louise Dutka, Programme Co-ordinator, Chief of Professional Staff Ontario Correctional Institute

I would like to present an overview of the Ontario Correctional Institute during the past decade. The organizational and programmatic changes that I will reflect are a result of severe financial constraints which have been experienced, not only by this Ministry, but within the government as a whole.

In September 1973, the Ontario Correctional Institute commenced operation with a 5-pronged mandate for the treatment of the offender. The mission included assessment, treatment, custody, education and research. This Institute was a tangible indicator of the Ministry of Correctional Services' belief that treatment while in custody was something to be valued.

At that time the 48-bed Assessment Unit provided a full psycho- social, educational, vocational and custodial assessment for all 1st incarcerates between 16 - 24 years of age with a sentence of 9 months or more. The five 30 bed treatment units had specific treatment programmes designed for both the short term and long term offender. A management team of correctional and clinical managers headed up each unit along with an assistant correctional unit manager, 8 line staff and deployed clinical resources. The line correctional officer was seen as the prime change agent. The resident population consisted of voluntary applicants from across the province who were paper screened and selected for admission.

Motivation for change, ability to cope with an open setting and sufficient time remaining in sentence were among the criteria considered in the selection process. All units had heterogeneous populations in relation to criminal offences. This was something rather unique in correctional facilities.

In 1978, changes began to occur as a result of severe financial constraints. The Ministry of Correctional Services' Task Force Study made a number of recommendations which had a marked effect on the Ontario Correctional Institute.

(1) The 48-bed Assessment Unit for first incarcerates was phased out.

(2) The bed capacity at Guelph Assessment & Treatment Unit was reduced by 50% and residents who were in that setting were screened for suitability as Ontario Correctional Institute candidates. The 41 residents selected for transfer were promised that they could remain together as a group, and on the 31st day of October, 1978 the previous Assessment Unit became the 6th Treatment Unit.

(3) The following criteria for admission were sent out from the office of the Executive Director of Institutional Programmes:

a) "Inmates who appear to be mentally disturbed, i.e., suicidal, severely depressed, showing disordered thinking or unusual emotional reactions and who can be accommodated in the open setting of Unit 6. And,

b) Inmates recommended by judges for psychiatric assessment after sentencing. In addition, common criteria for admission to the Guelph Assessment & Treatment Unit or the Ontario Correctional Institute included "criteria" offenders, i.e., inmates with indications of arson or sexual problems such as indecent exposure, rape, incest, indecent assault, etc."

While, internally, we were adjusting to our changed role, we were facing constraints which resulted in a cutback in correctional and clinical staffing. In addition we accommodated the Guelph Assessment and Treatment Unit transfers without the additional clinical staff recommended by the Ministry of Correctional Services Classification Task Force. With the demand being made on our decreasing human resource, there was a need to look at our organizational mode model both administratively and programmatically.

After considering various organizational models, an internal Senior Management decision was made to discontinue the clinical- correctional management model on the units and, instead, to have a correctional manager only. Along with this, the Social Work staff were deployed to units to assume Case Management Supervisory Services as proposed in a model developed by Mr. Murdock McSween, O.C.I.'s Chief of Social Work. Units ceased to have unit specific programmes and all

additional clinical services were moved from their unit bases.

In place of this model, the Core/Specialized model of programme was introduced. In this model, each resident of the treatment units is guaranteed involvement in the core programme and residents are required to participate in order to remain (active) in the Institute. Core Programme activities include routine health care and selected psychological and social assessments; unit meetings in which problems of daily group living are discussed; peer review meetings in which residents receive feedback from their peers as to their progress in the programme and the quality of their relationships with other residents; small group discussions focused on individualized programme planning; individual counselling with Case Management staff; work, library services, recreation and discharge planning.

Beyond the core programme, assessment, treatment and vocational/educational training opportunities are available to meet the specific deficits residents may have. These have been labelled as Specialized Services and are available by referral.

As well, there is a large volunteer programme, which is comprised of both individual and agency service providers, offering a wide variety of services for residents; both while in the Institute and upon release.

By mid-1979, it became evident that the Unit 6 beds were being underutilized, while at the same time the Ministry was experiencing an increase in its incarcerated count. Internally, we were experiencing difficulty with the direct admission of voluntary applicants to the treatment units. In general, the inmates coming to the Institute were seen as more aggressive, less self-controlled, and more mentally/emotionally disturbed. Given these circumstances, a decision was made to move the Unit 6 residents to a 30-bed unit, to commence using the 48-bed unit for intake and to provide discharge planning for short term admissions.

In 1981, the Ministry implemented a centralized classification system, in which classification officers were placed in jails and detention centres, thus allowing for intake work to be done as early as possible in the inmate's sentence. Information is collected by individual interviews and by making community contacts to clarify facts, which are

presented in the interview process, by speaking with police, probation and parole officers, agencies and perhaps significant others. Inmate Classification & Transfer Branch, a centralized classification body, is responsible for the final decision-making. The following criteria for admissions is found in the Manual of Standards & Procedures for our intake unit which is referred to as Unit 6. It reads as follows:

1) Inmates who appear to be mentally disturbed, i.e. suicidal, severely depressed, showing disordered thinking or unusual emotional reaction, who can be accommodated in the open setting of Unit 6.

2) Inmates recommended by Judges for psychiatric assessments and where a consultant psychiatrist is not available at the Institution to which he may be selected for initial classification.

3) Inmates convicted of arson charges or with indication of sexual problems, i.e. indecent assault, indecent exposure, rape, incest, etc., and who do not need a cell setting.

4) Inmates who are referred by the Ontario Parole Board as special cases and who do not need a secure setting.

The next major change for the Ontario Correctional Institute occurred in mid-1983, when all superintendents were requested to submit a proposal for increasing the bed count without using any additional human resources. The proposal from the Ontario Correctional Institute was to increase our total count by 22 beds: 6 intake beds and 16 treatment beds. This proposal has now been implemented.

May I just reflect, for your information, the complement of human resources, with which we currently work. The total staff complement is 161. The majority of staff, 90 in total, are correctional officers consisting of line level and mid-management There are 20 Clinical staff comprised of social workers, psychologists and nurses. In our educational/vocational section we have 4 staff plus shared resources with the Vanier Centre for Women. The balance of staffing is clerical and maintenance. We also have a contract with the Clarke Institute of Psychiatry for psychiatric services; and contracts for general physician services and a part time sexologist.

The Administrative Senior Management group is comprised of the Superintendent, his Deputy, a Chief of Professional Staff/Programme Co-ordinator, a Senior Assistant Superintendent, Corrections and an Assistant Superintendent, Services.

During the past decade, the human resources, which are the foundation of this Institute, have continued to uphold the original mandate of assessment, treatment, custody, education and research, as well as adding specialized classification. This has been done despite the numerous changes which have taken place. I would suggest, in closing, that this is a strong indicator that those who work in this Institute have put forth every effort to keep the concept of treatment for the incarcerated offender alive.

THE CORRECTIONAL OFFICER AS THE PRIMARY AGENT OF CHANGE

Ian Capewell, Correctional Officer
Ontario Correctional Institute

The Correctional Officer/Case Manager may, at first sight, appear to be a paradoxical pairing of two separate functions existing in the same person. I think of them as aspects of the same function; each complimenting the other, each having skills which can be interchanged to the mutual benefit of both. For example, a Case Manager tries to build trust, self-esteem and give a caring response. A Correctional Officer encourages good work habits, self-discipline and the following of rules and procedures. The ability to listen, a Case Manager skill, can be very useful to the Correctional Officer, offering discipline and direction. Correctional Officer skills can be equally useful to the Case Manager. An analogy between the role of Correctional Officer/Case Manager and parenting is not inappropriate since both require that discipline and caring be offered to aid and encourage the growth of another.

At the Ontario Correctional Institute the role of Correctional Officer/Case Manager is a formal expectation, and as such forms a vital bridge between correctional and professional staff, requiring co-operation and mutual support. During the next few minutes I will outline how I fulfill my role as Case Manager and try to highlight problems which may be met by all staff here sooner or later, although everyone may not deal with them in the same way.

When a resident is assigned to a Correctional Officer's caseload, the process of setting goals for the resident to achieve during his incarceration begins. The resident brings with him what may appear to be a multitude of problems. The first step is to break down these problems into manageable areas; manageable in terms of what programmes are available, the resident's motivation and the amount of time he is likely to spend at the Ontario Correctional Institute. The process of identifying these areas starts on Unit 6 as part of the assessment/classification process, then continues on the treatment unit, culminating in the first Case Conference. A Case Manager is a resident's primary resource person on a unit and frequently the first person to hear that he has a particular problem. In essence he is the resident's liaison with the resources of the Institute.

The Case Management Team consists of the Case Manager and the Case Co-ordinator as constant members, as well as any other staff who may be having significant dealings with the resident. Each member of the team gathers information about the resident, prior to his first Case Conference, using a variety of sources, such as the resident's file, interviews with the resident and observations by unit staff. The input of the resident in this initial information gathering is important, since he not only supplies his history, but also is asked to identify problem areas from his point of view. At the Case Conference the Team shares information, ideas and impressions about the resident. This process helps to identify problems for which programmes are available at the Ontario Correctional Institute that can be dealt with in the unit itself, or need to involve an outside agent, i.e., a volunteer.

In order for the Case Management Team to work effectively, all departments at the Ontario Correctional Institute have to exist in a synergistic relationship. A free flow of information and dicussion about each resident is essential if the resident's treatment objectives are to be met. For example, a resident may be a management problem on the unit. During discussion with other unit staff as to the best approach, the resident's Case Manager will be expected to supply input based on his knowledge of the resident and the resident's treatment objectives. If the same resident is in one-on-one therapy, his therapist becomes an excellent resource person to ask for assistance in planning a course of action for the problem.

Some common problems emerge for which therapeutic intervention is available. Once the problem areas have been identified, two crucial questions to be answered are: (1) can the resident function in the identified programme, and (2) does he have the motivation to start working on his problems? Some residents require a fair amount of work just to get them ready to attend a particular programme. Goals are normally established to provide optimal challenges to the resident. Helping the resident deal with his fears around a particular programme is an important function of the Case Management Team. The identified problems are discussed with the resident by the Team and an attempt is made to reach a consensus. It should be noted that the nature of the offence is not equally important in all cases. It is most significant with sexual or violent offenders. In these cases the nature of the crime can point out certain problem areas.

I think it is fair to say that we try to identify cause whilst being aware that the effect is what has brought the resident to the Ontario Correctional Institute.

Implementation of the treatment goals can be affected by the amount of time a resident has to spend at the Ontario Correctional Instiute. The Psychology Department offers a number of excellent programmes that address some of the common resident problems. These programmes, with some exceptions, re-cycle on a fixed-time basis. A resident may have to wait a while before he can be admitted to a particular programme. If he is a short-term resident he may miss the programme completely. When there is a long wait to enter a programme the Team is thrown back on its own resources in terms of maintaining the resident's motivation and trying to find alternative methods to fill in the gap. Treatment is the active component of a resident's stay here; many come here only for that reason. As a Case Manager I will always be hoping for more programmes. Some units develop their own programmes tailored to the identified needs of a particular type of resident. I, personally, try to get my caseload into one-on-one therapy with a therapist whenever it is appropriate, principally because it provides the resident with a therapeutic relationship outside the unit, and also allows me to discuss the most helpful courses of action at the unit level with the therapist. These discussions can be so informative that they almost constitute informal staff training. Beyond the obvious advantages to the resident of one-on-one therapy, the time that the resident spends in therapy allows the building up of a base of reports, tests, etc., which may be useful in deciding if a resident should return to the Ontario Correctional Institute if he is re-incarcerated.

You may be wondering how Correctional Officers at the O.C.I. find time to perform their duties as Correctional Officer/Case Manager. During each eight hour shift the two Correctional Officer's on duty will perform all of their regular correctional responsibilities in addition to their case management duties. Scheduling these expectations requires the co-operation and understanding of staff. Often a plan is established at the start of the shift which allows each officer to fulfill their Case Management duties, whilst the other performs the correctional function. In effect, each officer books blocks of time during the shift, the

amount depending on whether he has to interview a resident, write up a case conference or counsel a resident with a problem. This can only work if it is approached in a spirit of mutual co-operation and sensitivity to each other's needs. There is no hard and fast rule around how much time is spent on case management duties. Custodial duties have priority. Security of residents and staff always takes precedence. As a Correctional Officer performs his duties he may well be observing the residents with a Case Manager's eye. As a Case Manager he may have to consider correctional implications such as when a resident indicates in a counselling interview that he feels suicidal.

The Correctional Officer/Case Manager is in a unique position in relation to the resident and therefore it can be very easy for the resident to become dependent on his Case Manager. Many residents are more than happy to abrogate responsibility for their actions. They seem quite happy to have decisions made for them. A method often used to alleviate this problem is to give the resident as much control as possible over the elements of institutional life which are important to him, such as canteen and security rating. In addition, residents are often encouraged to self-refer through their Case Manager. This gives them a greater commitment to their programme. Discussion around the reason for a referral can sometimes unearth new areas of concern. In short, attempts are made to get the resident to accept as much responsibility as possible for what happens to him here.

A major area of concern is what happens to the resident after release. He leaves an environment where he is encouraged to discuss problems and try to work towards solutions, and where he may talk with staff and receive guidance and support. He then goes out to a basically indifferent world where the only place he may find anything remotely resembling what he has left behind will be when he visits his probation officer once a month, or if he is engaged with an outside therapist. This transition from a fairly constant interaction with staff to a limited community interest is one of the things that gives residents who have poor community and family connections the most problems. How he applies the things he learns here to the real world determines if any real change will take place. If this application has to take place in an atmosphere of relative indifference, we should not be surprised if the resident returns or just gives up.

Community Resource Centres can go a long way to helping the resident set-up community connections. One of the major problems with Community Resource Centres, however, is that residents with socially unacceptable crimes tend to be excluded from admission. Even if these residents are accepted, their fear of transfer to another institution for assessment prevents them from applying. It might be more helpful if the Ontario Correctional Institute had its own Community Resource Centre or had access to existing Community Resource Centres through direct referral. One would hope that all outside agencies having contact with the resident will seek information from the Ontario Correctional Institute in order to provide some kind of continuity so that the resident's motivation can be maintained for the difficult first few months of release.

The job of Correctional Officer/Case Manager can be challenging and frustrating, but very rewarding. One of the major frustrations is that a Correctional Officer rarely knows how his caseload is doing after release. Almost the only time that post-release information is available is at re-incarceration. Rarely does a resident telephone the Ontario Correctional Institute with a progress note. The rewards come when the Institute has been able, through the effort and involvement of all departments, to make an impact which the resident has then been able to sustain into society. While there are many staff at other institutions who do similar things in an informal way, the great strength of the Ontario Correctional Institute is that it has formalized this role and provided the support services to make it work.

THE SOCIAL WORKER AS AN INDIRECT AGENT OF CHANGE

Margaret Wright, Chief of Social Work

Most of you will be familiar with what social workers do and how correctional institutions work. We function somewhat differently here, largely because we have a different mandate. While, as in all correctional facilities our first concern is with custody we are also actively concerned with change. We have organized the delivery of our social work service in order to effect the maximum impact possible on the residents hoping to receive that service.

In most other settings social workers are involved in the provision of direct services. That is, they do one to one, group or family counselling. While the social workers in this Institute do provide some direct services, they are primarily concerned with helping the correctional staff to provide case management services. Each treatment unit has one social worker whose job description refers to him or her as a case management supervisor. The more popular title for social workers in this Institute is Case Co-ordinator. Case management supervisor means that the social worker supervises the correctional staff in the clinical areas involved in their contact with their case load of residents. Case Co-ordinator means that the social worker is responsible for making sure that all residents on the treatment units are referred to and involved in the specialized services that they should be referred to and involved in and that they are making some progress towards goals that have been mutually agreed upon and contracted for by the resident, the case manager and the Case Co-ordinator.

Within the first two weeks of a resident's arrival on a unit he has a formal meeting with the unit social worker and his case manager. They discuss why he is in this Institute, what the classification committee has identified as his needs, what he wants from our programme and what we can attempt to provide. On Units 2 to 5, the resident will have a peer review within the first few weeks as well. He will sit in a group with most of the residents from his unit as well as with his case manager and the social worker beside him. He will tell his peers what his charges are, something about his background and about his reasons for being here. His peers will ask him questions about what he has told them and they will make comments about what they think he should try to do while he is here. This process of peer review and case

conference following will take place approximately every eight weeks. As he becomes involved in programmes, the case conference meeting (with the resident, the case manager and the social worker) will include discussion of progress reports from work areas, specialized services and discussion about possible recommendations for the Temporary Absence Programme and other future programme referrals.

Unit 1 does not have peer reviews but does have all other components of the Institute's programme. Residents classified to Unit 1 are considered to be unlikely to benefit by peer confrontation or group programmes. On occasion, residents who have been on Unit 1 for a period of time are moved to another treatment unit if their situation has changed and they appear both able and willing to be involved in groups.

Why do we structure our system in this way? A quotation from Seymour Halleck and Ann D. Witte in "Is Rehabilitation Dead" from Crime and Delinquency, October 1977, may serve to illustrate the point.

> "Imprisonment is more than merely punishment; it is immersion in a different kind of life. It is unlikely that anyone can leave a prison with exactly the same attitudes, emotions and responses that characterized him before he went in. At least some of what the offender learned in prison is likely to affect his subsequent behaviour. To the extent that we seek control of the contingencies that influence learning in prison, we are knowingly or unknowingly involved in efforts to change the offender. We can change him in a way that we think is good or bad for him and good or bad for the rest of us. Whenever we do anything to an offender that we believe will result in behaviour that is favourable to his own needs or the needs of society we are involved in rehabilitation."

Simply put, anything that we do to an inmate in a correctional setting because of the nature of total institutions, is treatment. In our view, staff interactions with inmates, or residents are key factors in good or bad treatment. Good treatment is that which enables the resident to return to his community with a greater probability of successful reintegration while bad treatment is that which makes the man more angry and bitter and more likely to recidivate.

Social work practice principles lead us to see the social worker as a change agent. The change, however, is planned not chance or haphazard. Social work training emphasizes the client in the context of his environment or social system. The purpose of the training is to enhance the problem solving and coping capacities of people, to link people with systems that provide them with resources, services and opportunities, and to promote the effective and humane operation of these systems.

One of the major factors in the social context in which we work is the inmate subculture. This term refers to the unwritten rules of a correctional institution which put the inmates on one side and the staff on the other. There is a hierarchy of inmates based on an antisocial value system. Weaker inmates and those with sex offences are at risk for abuse and scapegoating. In this Institute we recognize that our interventions have to be aimed at the resident's immediate social system as well as at his own personal problem areas. Our unit programme is based on the premise that residents will be open with each other about their difficulties. This includes openness about charges even when they are sex offences. Dr. Heasman has mentioned the concept of the therapeutic community. Our emphasis in this Institute is on involvement of all aspects of institutional life in the treatment plan. Because of the structure of the programme we know our residents well. We are able to offer them a correctional atmosphere in which the negative aspects of the subculture are minimized and in which they can safely interact with each other with a view to resolving their differences and their personal difficulties.

SPECIALIZED SERVICES: A SCARCE RESOURCE MEETING PRESSING NEEDS

Dr. Reg Reynolds, Chief of Psychology
Ontario Correctional Institute

My task today is to talk to you about the specialized treatment services provided for individual inmates incarcerated at the Ontario Correctional Institute. To do so is to talk about the dedication of staff and volunteers in a number of widely different professional disciplines. Each of these people shares in a dream, an ideal correctional system towards which each, in his or her own way, is striving. Would you share with me, for a moment, in imagining such an ideal correctional system?

In the best of all possible worlds, inmates would be assessed and then streamed by a classification system to those levels of supervision and programme which would best meet their needs for correction. They would then be given access to programmes which would contribute to their renunciation of future criminal behaviour. It is anticipated that these programmes would enhance the inmate's future community adjustment and socialization by promoting physical health and well-being, adequate academic education, vocational competence and skill, constructive use of leisure time and basic community standards of interpersonal, social and family competence and involvement. Finally, this ideal correctional system would be able to demonstrate that it was performing its functions as it should, and was steadily growing in its effectiveness in reducing the chances of recidivism. And please note that this dream is not a tender-minded or soft-hearted view, but, rather, a hard-nosed approach which seeks to raise the standards of behaviour of offenders to at least a basic minimum for acceptable community living.

During its brief existence, the O.C.I. has sought conscientiously to make the above dream reality. It has taken a group of inmates who are in large part academically disadvantaged and provided them with appropriate levels and types of academic training. It has received inmates whose work skills and employment records have been far short of normal expectation for effective community living and self-maintenance, and has sought to provide them with vocational assessment and counselling and training, some work experience, and life skills training. It has received

inmates whose health has been ignored and sometimes ravaged, and it has sought to help them achieve a better level of physical fitness. It has received people whose human qualities and skills, and whose social lives have been under-developed and under-socialized, and has provided them with the basc skills by which to become healthier and happier contributing members of the community.

In attempting to achieve these objectives, the O.C.I. has been extremely fortunate in being provided with an opportunity to select appropriate inmates for its interventions from among the population served by the Ministry's specialized classification unit. It has done this to ensure that those offenders selected for treatment will at the same time be suitable for the specialized programmes available here, willing to participate in them, and have a high risk of future criminal recidivism.

The O.C.I. offers its specialized programmes to inmates in response to referals arising from either the classification committee meeting, which is held while the inmate is still on the admission unit, or from the case conference, which is held approximately two weeks after transfer to one of the treatment units, and every six weeks thereafter.

The educational department provides residents a wide range of educational training and development opportunities. The Basic Adult Literacy programme helps those who wish to bring their reading up to functional level. The Adult Upgrading programme helps prepare residents for re-entering manpower upgrading classes at community colleges around the province. It also prepares residents for apprenticeship equivalency examinations. The high school programme allows students to earn a secondary school graduation diploma. The trade training and apprenticeship programmes help residents acquire marketable job skills. And assorted life skills courses assist with the social adjustment needed to cope with life on the street.

Through the co-correctional programme, O.C.I. residents may attend the adjacent Vanier Centre for Women and enroll in the following courses: Family Studies, Graphic Arts, Commercial, Hairdressing/Barbering and academic English. Dry cleaning and janitorial services training may also be taken.

The O.C.I. has been selected as one of two pilot project sites for a new Ministry of Correctional Services initiative, computer-based education. Selected residents are registered

on the PLATO system and may receive instruciton via micro-computer courseware in reading, mathematics, writing, science, and life skills. Computer fundamentals classes are also available.

The Vocational and Life Skills Department provides instructional courses in shop management (including shop safety and maintenance, and inventory control), mechanical and architectural drafting, upholstering, welding, and woodworking. Training received in these programmes may led to certification of competence in a particular area, or hours spent in the programme may be credited towards an apprenticeship.

The Chaplaincy Department coordinates a variety of community groups which provides services for inmates. These includes the Bridge, the Christian Church on the Hill, and the Full Gospel Businessmen's Association. They also provide pastoral counselling, coordinate pastoral visitors, organize Growth Days, conduct Bible Study classes, and hold workship services for inmates and staff.

The Recreational Department provides cultural development and recreational education, including instruction in arts and crafts, a fitness and nutrition programme, an exercise therapy and physiotherapy programme for inmates with special needs, and training and instructional clinics covering most sports and leisure activities.

The Psychiatry, Nursing, Social Work and Psychology Departments provide an array of therapeutic programmes designed to promote mental health and to foster emotional development. These latter programmes include individual, group, marital, and family therapies; behaviour therapy and biofeedback; and a variety of interpersonal skills training programmes such as anger and aggression control training, assertion training, interpersonal problem solving skills training, relationship and human sexuality, and stress management training.

And, finally, there are a number of inter-departmentally sponsored programmes such as Straight Talk on Problems, in which resources are pooled in order to provide a programme covering alcohol and drug abuse, consumer education, legal education, leisure education, and family relationships.

Although the O.C.I. has never had the capacity to evaluate these programmes with any degree of precision, as Dr. Heasman

has noted, Dr. Stasiak, who constitutes our Research Department, has compiled statistics which show that about one-half of the inmates who would have recidivated within six months of discharge do not do so, as a result of admission to one or other of the O.C.I. treatment units.

To date, the Psychology Department is the only cost centre within the Institute which has been attempting to evaluate the effectiveness of the specialized treatment programmes which it offers, in the sense of reducing recidivism in the high risk population which we serve. The results have been most encouraging. Before and after measurement of process variables related to our interpersonal skills training programmes, for example, have been found to be uniformly positive. That is, test results show an improvement from before to after therapy: Assertion Training produces an increase in measured Assertiveness, and Stress Management Training produces decreases in distress. Furthermore, preliminary results of our post-release follow-up of inmates admitted to these programmes indicates that treatment is associated with a decrease in recidivism. This is particularly noteworthy with respect to individual psychotherapy and our biofeedback programme. Demonstration of the success of individual psychotherapy as a treatment for criminality is particularly gratifying to me because it confirms what I have always believed: good psychotherapy has the capacity to influence people for the better. The success of the biofeedback assisted behaviour therapy programme is also gratifying because it is demonstrating its effectiveness in reducing recidivism in a group of inmates who have been specifically selected for their tendency to violence.

There is no doubt in my mind, particularly since I have had a preliminary look at the follow-up statistics on inmates who have graduated from our various treatment programmes, that the task which O.C.I. has been given, of developing programmes for use by staff in other institutions, is well within our grasp and will eventually be achieved. I can only regret that there is always more demand for service than we will ever be able to provide. Clinical staffing within the Institute, after all, has been held to about one quarter of the minimum recommended in national standards for a mental health institution of its size - with the result that only small amounts of time can be diverted from treatment into programme evaluation. Nevertheless, I can assure you that the job will eventually be done. Not as soon as we might

have liked, and not as soon as it would have been done had fiscal constraints not severely limited our research capacity, but it will be done.

HEALTH CARE IN THE MINISTRY OF CORRECTIONAL SERVICES: SUCCESSES AND CHALLENGES

Hon. Nicholas Leluk, Minister of Correctional Services
Province of Ontario

Is is indeed a pleasure for me to participate in this 10th Anniversary celebration of the Ontario Correctional Institute. In its short history O.C.I. has played a major role in our Ministry's health care delivery. In addition to providing assessment and treatment for some 220 inmates on any given day, it also provides special support services for the entire ministry.

During last summer's International Congress on Prison Health Care in Ottawa, I received some very complimentary remarks about our Ministry's health care system. Since we have a fairly large system with facilities spread across this province, our ability to respond to the needs of the 65,000 inmates incarcerated annually requires the co-ordination and efficient utilization of all our existing resources. One of the keys is communication and from the beginning information gathering and dissemination has been an important task at the O.C.I. Indeed, it was the recognized need to expand the programmes of the Alex G. Brown Memorial Clinic which spawned the establishment of the Ontario Correctional Institute. In 1971 Ministry staff decided that the existing clinic in Mimico required newer facilities. Built in 1952 it had been designed to treat offenders who were completing their sentence. The treatment was limited to offenders with alcohol and drug abuse problems as well as those who had committed sexual offences.

Ministry staff throughout the province were assessing more and more inmates who had these and other mental problems. With this increased knowledge came the realization of an increased need for a larger facility with a broader programme mandate. By the end of 1972, planning seminar held at Niagara-on-the-Lake confirmed the need and recommended that the new facility provide assessment, treatment, research and education capabilities within a correctional setting. The O.C.I. was officially opened in September 1973 with a 48 bed assessment uint and 150 treatment beds. To this day it remains a major compoenet of this Ministry's health care services. Dr. Paul Humphries, our senior medical consultant, is faced with a large and difficult task. It is his

responsibility to see that our 48 institutions and three work camps provide the health care services that 6,800 inmates require on any given day; and that includes a wide range of professional services.

It is important to remember that these services are not just provided in large, modern facilities like this one, blessed with an abundance of programming and medical service space. Smaller jails throughout the province, some over 100 years old, also house inmates who require medical attention. Yet, despite limited resources, we provide excellent medical services.

I believe an emphasis on utilizing local professional community members has done much for all of our institutions. A partnership with local professionsla gives us flexibility and insures our inmates the best possible medical care. They actually become part of a physician's community practice. There is no better example of this partnership than here at O.C.I. Full-time medical staff employed by our Ministry work with community professionals retained through formal contractual agreements. The Queen Square doctors in Brampton and the Clarke Institute of Psychiatry provide outstanding services. This kind of arrangement has allowed us to operate a relatively independent health care system. We recognize that the local physicians and services, with all their advantages, are a useful resource indeed. We must be prepared to make the most of every source of reliable quality service available. It is maximum utilization through innovation.

I hope that I do not overstate the point too much when I say that the provision of medical services in a correctional setting has its own unique limitations. Government legislation and agencies offer many avenues of redress for complainants who challenge the system. If there is one resource that corrections have in abundant supply it is that of disgruntled and unhappy inmates. I am afraid that I cannot forsee any decline in their numbers nor can I predict any lessening of their attempts to abuse and manipulate the system.

In an era of an ombudsman, advocates and a Charter of Rights, correctional staff will require imagination, resilience and the patience of Job. In my three years as Minister I have admired the high calibre of ouir staff. I am convinced that they can and will meet the challenge.

The environment of the medical and correctional professional is changing very quickly. Issues that would have been dismissed out of hand yesterday will b ecome the m oral mine fields of tomorrow. Issues such as force feeding, forcible medication of a reluctant inmate, freedom of information and internal searches are balanced precariously on a tightrope. A policy decision weighted unfairly towards individual rights on the one side, or towards society's right for protection on the other, will have great consequences. Neither medical staff nor correctional administrators will be able to divorce themselves from these decisions.

I have mentioned just a couple of the thorny issues which permeate health care policy. Our manual of Standards and Procedures presently contains two sections covering these issues. However, a committed has been working for over a year now on addressing these policies or problems and updating our policy. It is my understanding that when its work is completed in a few months time, the manual's health care section will be expanded to five sections. The preliminary proposal includes sections on standards for nursing care, policies for health care, policies for dental care, policies for control of Ministry drugs and the new Ministry formulary. Much time and effort has been put into this review, but it is warranted. The end product I am sure will become our ultimate bible and must withstand intense public scrutiny.

I mentioned at the outset how greater knowledte of inmate's mental health initiated the development of this particular facility. It remains an ongoing process, and as we continue to increase our knowledge, new methods of assessment and treatment will emerge. Computerized technology will be an enormous help in the future as we improve our methods of data transmission and storage. As our health care flagship, O.C.I. can expect to be in the vanguard of future research, development and evaluation.

In just ten short years this institute has built a solid reputation by having dedicated staff develop inoovative programmes.

One of these innovations has been the original approach to staff responsibilities here at O.C.I. Over the years there have been ongoing philosophical differences between security and rehabilitative roles. It is part of an age old conundrum. Does the existence of programming compromise security; will increased security nullify the work of programmes?

O.C.I. has addressed this issue by allowing staff members to assume roles in both these functions. Correctional officers become members of case management teams and play an important role in the rehabilitation of inmates. It is just good sense to use the individuals who spend most of their time with the inmates, and make them part of the team. Correctional officers are accessible to the inmates for advice and they can provide valuable input to the treatment staff on the team.

O.C.I. has benefitted greatly from this approach, and I think the resulting experience is worth sharing throughout the Ministry. Undoubtedly there would be difficulties in replicating this completely in a small jail or a detention centre, but the
blueprint is there, and I would expect O.C.I. to play a prominent role in any future Ministry expansion in this field.

Many of you will be aware that Dr. G. F. Heseltine has recently submitted his report on provincial mental health policy and programming to my colleague, the Honourable Keith Norton, Minister of Health.

In the section pertaining to forensic psychiatry he has made what we consider to be some exciting and worthwhile recommendations. The implications of these for this Ministry are substantial, and I know that Dr. Humphries has discussed with Dr. Heseltine, the potential role that O.c.I. could assume in a co-ordinated forensic effort. The opportunity to increase the level of co-operation and sharing in forensic psychiatry leads me to believe that an exciting future awaits all the participants.

The Young Offenders Act will certainly have an impact on the future activities of almost everyone in this room. Along with Dr. Heseltine's report and our own review of our manual and procedures, I think we can safely predict many changes for both this Institution and the Ministry at large.

The English philosopher Alfred North Whitehead once said, "the art of progress is to preserve order amid change and to preserve change amid order." The history of O.C.I. suggests you have the abililty to walk this fine line. Your first ten years will be of benefit not only to yourselves, but to others who have watched with great interest.

Increased knowledge initiated O.C.I.s establishment; it is now underlining the need for its continued growth and maturity. I congratulate you on your worthy accomplishments and wish you well as you face the complex challenges of the next ten years.

AN EVALUATION FROM A PSYCHIATRIC POINT OF VIEW

Dr. Vivian M. Rakoff
Director and Psychiatrist-in Chief
Clarke Institute of Psychiatry

Since my mandate was to report on my thoughts, and my findings, over the last two days, I find myself in a very difficult situation, because, unlike some of the speeches before me, I have to depend entirely upon my own efforts for my text. I have no group of speech-writing elves working between midnight and dawn to produce a coherent, thoughtful and balanced (which I guess is the political task) manuscript. Since, fortunately, I am not running for office, in the near future, I am going to permit myself some honest indiscretions. I must thank Mr. Nelmes for his generosity in his opening remarks this morning, for anticipating me and giving me a kind of permission when he suggested that I was free to comment on the warts of the institute. Because, not being carved in marble to some Platonic ideal, there <u>are</u> warts in the Institute.

But I certainly don't want to concentrate on the blemishes because that would be carping and totally out of perspective. I thought to myself, as I said Platonic, that this is a funny place to be using such a word. Then I realized it was planted in my head, yesterday, as I sat in the teachers' room working on one of those computer-aided educational programmes in elementary arithmetic. It's called "Plato", and there is Plato's face on one of those "pac-man" print-outs on the screen when you begin the programme. And I thought to myself, how extraordinarly fitting that this modern evocation of the Socratic technique of learning, by simple question and simple answer accumulating to complex knowledge, should be right with me in this place for such disadvantaged people. I recognized that a civilization has the most remarkable continuity, that one couldn't anticipate if one didn't find it in the oddest nooks and crannies.

This place is, although only ten years old, the heir to a perennial thrust in our entire therapeutic and political tradition. It didn't grow suddenly in the slightly dismal northland of Toronto. It was anticipated by John Howard a long time ago, when in 1777, speaking of the inmates of prisons and jails, he said, "No care is taken of them, although it is probable that by medicines, and proper

regimen, some of them might be restored to their senses and to usefulness in life". So that, in our tradition, the penal and the therapeutic, while not always totally intertwined, have had a way of running parallel with one another. The therapeutic is, to some extent, an impulse and an aspiration of the entire penal system when it leaves behind the notion of imprisonment as punishment, which I recognize is also a perennial component of our penal and judicial system. But you all, as a group and inidividually, know a great deal more about that side of things than I do and I'm not planning to give a lecture here on jurisprudence.

Just to tell you what I am basing my comments on, I have spoken to, and met with, the Deputy Superintendent; attended the Superintendent's morning meeting; and toured the facility. I was impressed and bemused, because in most places the vandalism is on the inside. But I saw you have rotting turrents on the outside walls and I said to myself, "Well they can't blame anybody whose inside for the fact that the brick work isn't so good on the outside. You may have had a delinquent contractor about 12 years ago but he is not in one of your units. I visited a Classification Committee, I met with the nurses and the community physician and I, of course, met with my colleagues, the psychiatrists, who come to you from the Clarke Institute. I don't think the Minister is still here, but he is aware of this and I would like to emphasize the fact that they come from the Clarke Institue. My impulse is totally polemical. I met with the case managers, the psychologists, I spoke to people concerned with recreation activities and the co-ordinator of your volunteer services. I also spoke with the social workers, the teachers, shift supervisors, the unit supervisors and I had the moving and painful experience of sitting in on a peer review group and was fortunate, afterward, to have the opportunity to meet with a number of the residents of this place. I then had a short talk with the Research Director and I finally talked with the programme co-ordinator. So that you can gather a fairly rich programme was laid on for me.

Now let me get abreast of my basic perception of what I saw here. I saw here what has been referred to and described all morning, and you all know about, but perhaps it may not be bad to hear it again through the eye of a total stranger. I saw a fundamentally humane institution devoted to an impulse of correction and therapeutics that represents, as I said, probably the very best component of our penal system. I met with devoted, educated staff. I saw an energetic commitment

to programmes. I met with inmates who were probably well schooled and manipulative but also sincere when they told me that this place was remarkable because they were treated as human beings; that it gave them some hope for the future. And, indeed, the word hope was picked up by one of the unit managers when I asked what the satisfactions were in working here. "Hope" was his single word answer. Someone in social work said that this was, despite the frustrations and the difficulties, a job that she anticipated with pleasure when she woke up in the morning; that there was a great deal of freedom, more than is usual, to use one's brain to devise new activities, to find interesting things to do. In the computer room, when I spoke to the teachers, I got the impression that the absolute importance of the small skills that they had to inculcate gave this very difficult job an edge over that which could be found in most institutions. These were the most positive things that I saw. So I guess, as a fundamental institution, the place rates "B+" or "A-", which is terrific when you consider that only God rates an "A". And when you look at the world he created you realize that an "A" ain't so good. Just listen to the morning news.

This place, like the morning news, has a kind of Wordsworthian text,

"And much it grieves my heart to think
What man has made of man."

You deal with the casualties of individual pathology, of family pathology, of social disorder, of confused heritages. You have, essentially, got an impossible task to perform. Because the ideal purpose of your task is, after all, completely correctional, totally therapeutic, no recidivism: new made souls out into the world. And I know, and you know, that this doesn't happen.

So having said all that let me address myself to the warts. I hope that you will take them in the context of my sense that this is an extraordinary and marvellous place. I am very glad I live in a province where primitive notions of cost effectiveness are not used to measure the imponderable, and totally external to cost, issues of altruism; which is really what this society, as a whole, is about. There is ultimately, no such thing, in health care, or in therapeusis, as cost effectiveness. There is only social expectation and commitment because health care is like an old cliche about opera: there is never enough money for it.

Expectations are constantly on the rise. But in speaking to people in this institution I started to get a repetition of very similar complaints. And the complaints were, let me summarize them, of the following kind: inevitably, not enough staff, never enough staff, but I consider there to be a great deal of reality in that complaint. I heard the figures this morning, and I run an institution and I know about administration and I'm not some addle brained idiot or anarchist. But I say to myself, "Hm, six administrators and twelve therapists. That's a funny balance." It may be an unavoidable balance, but it's one that I think one must question. I may have the figures wrong by one or two in each direction, so let me cover myself by saying a hell of a lot of administrators and very few therapists.

Let me go further, a constant complaint from all groups was that the numbers of inmates have now become excessive. They have gone from 180 to over 200, straining the system beyond its capacity. There were also complaints about the kind of inmates who were coming here. Involuntary people are now shipped here. Their placement is not well thought out. They cannot, and do not want to, take part in the complex and burdensome programme that is demanded of them in O.C.I. I heard a patient yesterday, and I've never heard such talk before because I have led a sheltered life, he said, "I'd rather do my time in the bucket because in the bucket you do your own time and I don't like it here and if I get parole I'll go out and if I don't get parole I'm going to ask to go to the bucket". My feeling was that if I heard one such statement in my two days here, the statistical likelihood was that I hadn't run across the only one in the institution. There must be other such people here, who, for psychiatric and correctional purposes, should probably not be here. Furthermore, people of all disciplines and all categories said that it is wrong practice to send people here just before they are due for discharge or parole, for what should be a complex long-term remedial programme. So there is a feeling that this is a programme that requires commitment both from staff and from the patients, the inmates, the residents, those who are here for correctional purposes. It takes time and you can't short-change the residents or the staff in their efforts.

The other problem that I heard repeatedly, was that while people are convinced of the value of what they do, while in common-sense terms the work here is worthwhile, you have to fight off the hard faced men of money all the time to justify

where you are and what you are doing. In human terms trying to help confused, criminal, difficult, young people is something that is worth doing. If you say it isn't worth doing you have given up hope in advance. Nevertheless, there is a point at which the hard-nosed men, the hard-faced men (and now I am one of them) after ten years say, "Well, how do you know what you are doing is any good?" It is at this point that research activity is not an academic frill on what you do. It isn't some silly luxury, thought out by fellows like me who sit in the Clarke Institute and visit you for two days in ten years. No, if you haven't got a research programme going you cannot justify your continued existence, and research is not just something that is written down on a piece of paper by somebody some evening between dinner and the late night movies. It is an ongoing activity, that costs money. The money that it costs is salaries for people whose time can be dedicated to setting up the studies, collecting the data, looking at control samples and being prepared, therefore, to provide everything which would justify the continuation of this extraordinary place. This is, as you know, an extraordinary place. There aren't many like it in the world as a whole and there are certainly no others like it that I can think of in Canada, unless I am mistaken. And because you are a unique institution you are under constant surveillance by an entire system and by the tax paying public. You have to be able to show that what you do is worthwhile. So the case for research, which I make as an academic, is, nevertheless, a highly pragmatic one, that, in all friendliness, I urge on the powers that be, both here and in the Ministry. Research is not an error, it is the only way in which this programme is likely to continue in the future.

Having said that, I would like to make some specific points about psychiatry, which, of course, is what I was invited to speak about. You have very few of my colleagues here from the Clarke Institute of Psychiatry, but you have clinicians in the form of psychologists and supervisory social workers. And from them I, of course, heard an expression of the tension that surrounds the beginning of this place. Dr. Meen this morning spoke of half the task being in its beginning. That quotation can be extended, that the shape of a thing is determined, almost forever, by the way it begins. Now, although you made jokes about there being a two headed monster, and this was all resolved, in fact the initial symmetry of the establishment of O.C.I. is no longer there. When O.C.I. began the representative of the therapeutic structure was parallel to, and in organizational

terms the equal of, the representative of the correctional or penal part of this institution. Obviously, you don't have to be a brilliant politician or a great organizational psychologist to recognize that two headed monsters have a hell of a time surviving. So that, in due course, the institutional status of the therapeutic has been somewhat reduced vis-a-vis the institutional status of the correctional. And again, one realizes that people are here not because of their "psychiatric disorder", the ticket of admission here is only partially that they might benefit from the therapeutic programme. The ticket of admission here is fundamentally the involuntary one of having been found guilty of a crime. Therefore, the fundamental structure of this institution is determined by crime, justice, retribution and imprisonment. In fact we must recognize that the therapeutic, with the best will in the world, represents an altuistic add-on. I understand that. Nevertheless, given the ideal which was referred to by the Minister, and by Mr. Nelmes, there should be a blend of the therapeutic and the institutional, the security and the correctional. However, I heard from the therapeutic staff, of course not surprisingly, that the impulse that determines security, that renders this place more a prison than a therapeutic facility, dominates. There are difficult moments when research and treatment are subject to apparently arbitrary fiat from above. There is an absence of collegial discourse when decisions are made about matters which in other places would be perceived as fundamentally therapeutic or investigational. Thus, the tendency of the organization to run down into the correctional mode seems to be stronger than perhaps it should be. And this, of course, is contained in the initial history. It will happen inevitably when there is a shortage of staff. This will happen if there are too many inmates. This will follow when there isn't enough money for research. This will follow when the therapeutic programmes cannot be validated. Then, of course, you are going to do that which you know how to do. And this place has more institutional memory of control by the correctional mode, than it has of the therapeutic. When the chips are, not down, but taken away, you're going to do that for which there is a habit. It's not a bad thing to do. If it were so bad why is it done all over the province? It is the repertoire of immediate behaviour that is available to the institution, when it cannot do other things. It will be the political and organizational reflex to retreat to security rather than retreat to therapy. If this were a psychiatric institution it would be the other way round. The problem we have at the Clarke Institute is people running away or doing other more

terrible things because we're not as good as you are at security. The reason we're not as good as you are with security is that the fundamental ticket of admission to the Clarke Institute is not crime and punishment, but therapy and pain.

To explore that for a moment, because I am a psychiatrist. In an institution such as this, one is aware of (and the Minister made passing mention of it) the coming together of two very different social impulses. They could be perceived as almost inimical to one another, mutually contradictory. They can also be seen as requiring great co-operation. The law, which is the great generic parent of this place, operates in general on statements of great universality, where individual acts are constantly judged by great social consequence. Medicine, which is the granddaddy, the parent, of all the therapeutic professions (however they have split off and grown into their own identity), operates on a totally different premise. It operates on the need of the single person. It operates on individual pain and therapy. Even where that is sometimes not possible, because we don't know enough, the response to individual pain is what determines the medical impulse. Example: by law a country has declared war. That soldier is my enemy. In law, I may now kill him. When he is wounded and he is brought by the medics back to my side, ideally, a completely different structure takes over. He is not my enemy, he is not virtuous or wicked, he is not responsible or irreponsible, all that he is, is wounded and in pain. At that point, the physicianly impulse is only a response to the pain. If you rule in moral judgment in law, we rule in medicine precisely on the statement that we are not concerned with moral judgment. We are only concerned with caritas, with charity. Now these are two necessary and proper social structures and blending them becomes extremely difficult because very different kinds of judgment are involved when one comes to consider success or lack of success. A great deal of medicine, to come to this sideways, addresses the problem of recidivism. The chronic cardiac patient is a recidivist. He doesn't get better. The diabetic is a recidivist. He is usually under life sentence of insulin, daily, which is a kind of hard labour. Schizophrenia is to some extent a recidivist disorder. The patient may be ill intermittently for years, returning to the involuntary prison of his psychosis, condemned to days in the solitary confinement of delusion and thought disorder. The manic depressive patient is a recidivist who, from time to time, lapses into the terrible oubliette of his depression or his mania. He is sentenced to a kind of corrective

treatment by drugs, psychotherapy, and in certain instances unapologetically, if necessary and the pain is too great, to electroconvulsive treatment.

Most of medicine now deals with recidivism, because the easy disorders have probably been dealt with by the revolution of antibiotics and relatively painless surgery and medications that take away fevers and most of the diseases of infection. We are left with chronic disorders and we do not reject the patient. We don't say to the patient of view to this place one must take into account that a humane responsiveness, with associated research, is sufficient validation of the activity. I was very glad that there has been a small study done by Dr. Stasiak which indicates as a pointer that the work here operates in both areas of concern. That there is a therapeutic result and there is an institutional result. That, in fact, recidivism is reduced. From my last remarks I don't want you to think that I am saying that recidivism is irrelevant, far from it. But, I am saying this is not the only thing and, if you're going to use recidivism and cost effectiveness to judge this place, you would probably have to close it down, because you haven't got enough evidence to justify its continuation. The kind of evidence that must be brought, and I'm speaking as a psychiatrist here, to justify the continuation of this place has got to be an unashamed statement that, prima facie, on the surface, this is a good place, because it corresponds to a social and a therapeutic impulse which we all value. We are not, fundamentally, members of a punitive society. We use punishment when it is unavoidable. The ideal to which we aspire as a community, and which we represent on the therapeutic side, and those of you who have given your lives to corrections represent on the legal side, is that our institutions reflect a kind of communal charity towards one another.

At the risk of being very solemn, I got home last evening and I was talking to someone and they said, "Well, where have you been?" I told them where I had been and they said "My God". "That's probably the proper expletive", I said, because I saw as much accumulated pain, just walking through the corridors, as one usually sees in a huge multi-faceted hospital in a couple of weeks. And they said, "Well what do you think of it?" And I said, "It's rather spendid". "What word would you use for it?", they asked after a lot of banter. So I used a word that I don't easily use, that doesn't come easily to my lips, because, in case some of you haven't noticed, I am not a Plantagenate, nor a Hohenzollern, from some long

lineage. I said "I think this is probably a noble activity." It is a noble activity. I would hate to see it dissolved or eroded by small-mindedness in some bureacratic office somewhere. This is a splendid experiment that deserves more support, but, as I said, judging from my own home base in medicine, psychiatry, in academe, the wart is that you don't have enough time or money or people to effectively justify your programmes and to be able to expand them so that they can be a kind of gift that you give to all the other institutions of our society.

FUTURE SCENARIOS:

CRIMINAL JUSTICE AND

THE MENTALLY DISORDERED

OFFENDER

THE CRIMINAL CODE AND THE MENTALLY DISORDERED OFFENDER

Gilbert Sharpe, Project Chief
Mental Disorder Project
Department of Justice (Canada)

I thought what I would try to do today is to review with you proposed changes to the Criminal Code of Canada and to the Canadian Penitentiary Service's Legislation in the area of the mentally ill offender. Perhaps I could start with the latter project. Some of you from O.C.I. will recall our being here last year when we presented an overview to the staff. At that time we were preparing our report which came out last fall. Subsequent to this we do have recommendations that have gone to Ottawa but have not been approved as yet for release so that rather than telling you what we have specifically proposed I think I'll speak of some of the issues, many of which I'm sure you are well aware.

Basically, our federal task is to look at all areas under federal jurisdiction that involve mentally ill individuals. That includes not only the Criminal Code but the Penitentiaries Act and the Young Offenders Act. For those of you who have not seen our report I will very briefly go through the issues that we examine. We start with the very first part of the process, the psychiatric Remand for an individual who when first picked up and charged with an offence, is seen to be mentally ill and in need of, at least initially, some kind of assessment. Presently, the Criminal Code only permits remands for the purpose of assessing their current fitness, although those of you who are involved in the remand process know full well that you are often asked to look at other matters, such as: the mental state of the offender at the time the offence was committed for the purpose of insanity (Section 16 of the Code), the prognosis as to how long it is likely to be before the individual recovers and what the likely disposition should be if the person is found to be insane or unfit to stand trial. One possibility set out in the report is that the Criminal Code be amended to specifically take into account the expanded purposes that are currently being considered.

Chapter 3, Fitness to Stand Trial deals primarily with the issue of what criteria one should use to assess fitness. It had been suggested by the Federal Law Reform Commission in its 1976 report that specific criteria should be set out in the Code. Probably, the most critical issue to groups like

the retardation associations involves whether there should be an obligation on the Crown to delay trying the fitness issue until the Crown establishes a prima facie case of guilt. There have been allegations that often an individual with a developmental handicap who is a nuisance in the community may ultimately be charged with an offence, be found unfit to stand trial, and then be held indefinitely on a warrant of the Lieutenant Governor.

This is an abuse pointed out by some of the civil rights groups. Examples have been cited of individuals who have an alibi, but who are unable to get to trial to establish it, or individuals against whom the evidence as to the commission of the offence is very thin. We have taken this into account in making our ultimate recommendations on fitness.

The defence of Insanity deals with the matter of Section 16. As those of you in the criminal law area are aware the test of insanity has been somewhat narrowed in recent years so that the concept of appreciation of moral wrongfulness is really not part of the test any longer. Arguably this may well keep psychopaths out of the mental health stream insofar as they would qualify for the insanity test. There have been all kinds of examples that we have used and we have set out of many different formulations of the insanity test: versions of McNaughton that have come out of Britain and out of our own Law Reform Commission, various versions of Durham out of the United States, and some, frankly, that we made up, that seem to be a combination of language that was used in recent times in some of the jurisprudence. To those of you who are interested in this area I would commend our report to take a look at the formulation of the insanity test and how you feel it perhaps should be altered.

There are terms in Section 16, like natural imbecility, that do not make any sense. Some have even argued that disease of the mind is not a concept that should be retained in the Code and that one should perhaps move to a more modern concept like mental disorder. These are factors that we took into account in making our recommendations to Ottawa.

There has been some suggestion that the nature of the verdict should be changed from not guilty by reason of insanity to guilty but mentally ill, or guilty but insane. Personally, I have a lot of difficulty in moving to that. I know that the Americans in a number of States have dealt with that formulation, but apart from anything else, I think that

if, as a society, we are going to remain with the concept of responsibility, if someone lacks that responsibility because of their mental state they should not be found guilty. I cannot see how one can impose any kind of a verdict of guilty on that type of individual. We could probably accomplish the same result by implementing the Federal Commissions recommendation of hospital permits or hospital orders as a sentencing option.

The next area that we deal with is Disposition and Review. The current Criminal Code provisions when someone is found insane or unfit are, frankly, quite unfair and I think offensive to the Charter of Rights, amongst other things. They require that the person be held in strict custody until the pleasure of the Lieutenant Governor is known. Therefore, even if the individual has been out on bail and has been working in the community, as soon as he is found insane or unfit he must be taken into custody and confined. Even though the Lieutenant Governor has three options in the Code available to him, i.e. to safely keep, to discharge on condition or to discharge absolutely, he always orders safely keep because he has no useful information at that early stage upon which he could take the chance of ordering some form of discharge. Although we have tried (in the Ministry of Health, working through the Attorney General) to obtain Crown briefs so that there might at least be some evidence available on which an informed decision could be made, thus far we have been unsuccessful.

One suggestion that is made in this paper is that the role of the Lieutenant Governor be abolished and that the court make the initial disposition, as they do now in imposing sentences. After a period of time, three months, six months or whatever, the multi-disciplinary Review Board which is currently advisory to the Lieutenant Governor might make a decision in the case, much as the regional boards currently involved in civil committal reviews deal with these issues. There could then possibly be an appeal from the decision of the Board to the courts. This is just one of the many issues that are discussed under Disposition and Continuing Review.

The area, I suppose, of greatest interest to this group is Chapter 8 of our paper entitled "The Convicted Mentally Disordered Offender". In that chapter we deal with a number of issues.

The first, and in many cases probably the most significant, is concerned with allowing judges to sentence people to a

term in a psychiatric hospital if they are sufficiently mentally ill and if the hospital and the individual are agreeable to that route. This could theoretically result in fewer very sick people being in the correctional system in that they would be sent directly to hospital. This option has been used with some variation in Britain and has worked fairly well there. It could result in a person only being in hospital sufficiently long to cure him of the illness. He would then be discharged on a form of parole, or if the patient is a particularly dangerous individual, after a time in hospital, he could then be moved to the prison system to serve out his sentence. That is an option of which we are frankly in favour and most of the people with whom we consulted across the country were supportive of it as well.

The other significant issue involves Section 546 of the code. I was frankly amazed in consulting with O.C.I. last spring that very few people here had even heard of that option. That is a provision whereby someone who is serving a sentence in a provincial correctional facility can, on order of the Lieutenant Governor, be moved to a mental health setting and held there. In fact he can be held there beyond the expiry of his sentence, ultimately to be turned over to the Minister of Health. The Federal Solicitor General last year suggested that this could be considered a solution to the gating problem insofar as someone who is mentally ill and dangerous and who is about to be released on mandatory supervision could be diverted into the provincial mental health stream to be held there until they are no longer dangerous or mentally ill. That is something that we are not too keen on, frankly, since I think that there are Charter of Rights problems apart from anything else. In fact, that provision was slated for repeal a few years ago by the Department of Justice following extensive consultations with the Uniform Law Commissioners. In any case, it is something that you should perhaps have a look at and see whether there is some sense to expanding it in a way that might also protect the rights of the offender.

There is a fair bit of material in our report on the Young Offenders Act (YOA). When the YOA was originally tabled I believe that the Solicitor General indicated the mental disorder aspects of it were not going to be changed until a report from our project could be forthcoming. Therefore the current YOA does have provisions relating back to the adult provisions in a mutatis mutandis manner that may create some problems when the YOA comes into being on April 1st. I think it would be very helpful if you could monitor any

difficulties that may be encountered with mentally ill young people, particularly with the age going up to 18 come April 1st, 1985. It is my understanding that it is still the intention of the Federal Solicitor General to amend the YOA within the next year or so, consistent with our recommendations as to specific provisions to deal with mentally ill young people.

Speaking very briefly now from a provincial perspective, we have had some discussions with Pinel, which is the Quebec version of Penetang, and with the Quebec government, and found that under Section 19 of the Federal Penitentiaries Act, which allows for a province to agree with the "Feds" to take mentally ill offenders, Quebec has a multi-million dollar agreement to look after offenders in their institution. There seems to be a great deal of satisfaction on the part of both the province of Quebec and the federal government with this arrangement. We are hoping to work towards something similar in Ontario and perhaps expand the use of mental health beds in our provincial facilities to use them for federal, and perhaps also provincial inmates who have mental disorders. I understand that the current mechanism that is often used involves putting such an individual on both a Temporary Absence Medical Pass under the Correctional Services Act and a Civil Committal Certificate under the Mental Health Act to provide the provincial mental health facility with the authority to hold the person.

That presents all kinds of difficulties, arguably additional difficulties now that we have proclaimed Sections 66 and 67 of the Mental Health Act. I think it would be far better if we could work towards some type of amendment to both the Federal Penitentiaries Act and the Provincial Correctional Services Act that would provide the provincial mental health facility with continuing authority to hold the person following the transfer, to deal with them and then to move them back.

PERSPECTIVES ON TREATMENT IN CORRECTIONAL SERVICES

Dr. George Podrebarac, Deputy Minister
Ministry of Correctional Services

Earlier in the day you heard our Minister, the Honourable Nicholas Leluk, refer to the Ontario Correctional Institute as a remarkable Institution, and comment on its outstanding contributions over the past 10 years. I would like to heartily endorse his comments, and to say to you that I am extremely pleased to be here this afternoon on the occasion of its 10th anniversary.

I want to, at the outset, compliment you very much for holding this day. I know for some of you it was perceived to be somewhat of a risky event. I am glad that you have taken the risk. On my first trip to this Institution, not too long ago, I left here amazed, impressed and also convinced of what Dr. Rakoff has said: that you have here a noble activity. In fact I said to some of my colleagues as I left, and I said it to the Globe and Mail reporter who left, that we should be flashing our kimono a little more, and I am glad we're flashing it today.

So often, throughout the Ministry, we hear that O.C.I. is the "flagship". What does that mean? Is it a flagship in classification or assessment or treatment or education or research, or is it in the combination of all these responsibilities? I suspect that it is the latter, but for this presentation let us consider initially some of these components.

As you know, I have been asked to comment on future scenarios. However, since we are so often accused of rediscovering the wheel, I feel that it is necessary to consider present and historical perspectives as well. Douglas K. Griffin stated in his 1976 doctoral dissertation titled "An Analysis of Staff Perspectives in Five Correctional Centres", that in Corrections in Ontario over the past century a full cycle has been completed. He said that aspects of correctional practice which were thrown out at the close of the last century are returning to favour. These are an emphasis on work programmes, a view of the offender as a social incompetent and unfortunate, and consideration of co-educational institutions. Some of the Ministry's annual reports also have familiar rings to them. Listen to portions of an inspector's report made in 1879:

> "I made an inspection of the gaol on the 11th day of January (Milton, Ontario) when no less than 26 persons were found in custody, all of whom, except two persons of unsound mind, had been committed for vagrancy. These 24 tramps were very nearly all young, able bodied men, and capable of the hardest kind of labour.... I pointed out that as these tramps were in custody they must be immediately placed at breaking stone or cutting wood."

It was noted at that time that the primary problem with providing employment to prisoners in institutions had historically been that of objection of trade unions, and other workers outside the institutions, who complained of unfair competition. The inspector, however, rejected such complaints out of hand. He stated that:

> "The arguments advanced against the utilization of prison labour, our antagonism toward ordinary skill labour, are founded on false and erroneous premises and have not the slightest force."

From a classification point of view I offer you these comments from the 1872-73 report:

> "The sane and the insane, the suspected and the convicted, the hardened criminal and the child, the guilty and the innocent are mingled together in the same wards and corridors."

And a report from 1871 states:

> "When we consider that, of the 2,695 prisoners committed for terms under two months, fully one-third of them were sentenced from twice up to six times during the year, if a properly organized central prison had been in operation they would, or at any rate should, have been sentenced for periods varying from 2 to 12 months.... I have frequently reported on the desirability of sentencing such prisoners for longer periods, in order that the requisite means may be used, and influences exercised for their reformation, which, under the present system of sentencing for short periods, cannot be done."

These earlier reports also addressed overcrowding. The following statement was made in 1910:

> "A lack of proper accommodation in Toronto Gaol is most deplorable. The conditions so long complained of do not permit of proper classification of the prisoners. The overcrowding is not only unsanitary, but extremely detrimental to proper discipline and management."

In a 1941 report from Burwash the value of the staff is addressed in the following statements:

> "Reasonable plant and equipment are necessary, but in the final analysis the efficiency of the institution depends on the calibre of the staff... The staff are undoubtedly better than at any time in the past, but they cannot be improved to the proper degree until definite standards are set and specific qualifications required and enforced."

A little later, we observe a recognition of the value of treatment approaches:

> "There is necessary a new type of prison official, not simply a gaoler but a man fitted by experience and training for projects of human reclamation."

Probably, the introduction of the concept that prisoners need treatment has proved to be one of the most far reaching in its effects in the Ontario system. Along with the new concept, there was introduced the need for specialized staff. Simple detention, farm work and industrial work could be supervised by correctional officers, or guards; so could punishment of a physical nature, such as deprivation of certain foods, or solitary confinement. But, with the introduction of the concept that prisoners suffered from pathologies came the need for new specialized staff, who did not seem to fit into the traditional hierarchy. This of course leads directly into one of the fascinating philosophical considerations which we have today and that is the identities associated with the relationship between the security and the programme personnel.

We have heard today about the noble pursuit in this building. We have heard today about relationships. We have heard today about the pathologies in the treatment. We have heard today about the linkages between the professional staff and the correctional officers. But if you are a flagship, if you are the proud possession of this Ministry and if you are anxious of the future as we all should be, then I think that what we have to start doing is looking at the question of the relationship between staff.

Because what is an institute? Is it a what? Is it a thing? Is it a place? Is it a who? It's people. But when I look at the O.C.I. as a flagship of this Minsitry, when I look at the security question and put it off against the programme role, I am reminded again of Griffin.

Two of the variables that Griffin looked at with respect to correctional officers and programme staff were status and staff competency. Here's what the C.O.'s had to say about their perception of status in 1976 in the five following correctional centres, Burwash, Mimico, Rideau, Burtch and Millbrook.

1. They said that our status is low and it's deteriorating.

2. They said that our experience it not valued as much as those who have formal training.

3. They said that officer's opinions don't count very much in an institution.

What did the treatment staff say? They said that their informal status was high but the formal status was not very clearly defined.

Comments also clustered around staff competency. The correctional officers said that they knew the inmates and they knew how to handle them. In fact, they knew how to handle them in almost every situation. They also said that the treatment staff were ineffectual when it came to dealing with the typical inmate. And they said that it would be better if the treatment staff worked with those very few exceptional inmates.

I could go on and on in this regard, but the fact is that we do have professionals throughout the system with a great deal

of knowledge and ability to assist the inmates, and we do have correctional staff whose major responsibilities are to provide security, who spend a great deal of their time in direct contact with the inmates, and who also have a great deal of knowledge, experience and ability to help the inmates. Just because the training may have given them different skills does not mean that either group is any less effective. My questions therefore are as follows:

- Are these roles mutually exclusive or can they be complimentary to each other?
- How much information can and should be exchanged between the two groups?
- At the O.C.I., how much information is being shared between the two groups, and how is this accomplished?

When the O.C.I. first began, it had a Superintendent and a Programme Director. My understanding is that both of these positions had a great deal of credibility and responsibility. However, after the Programme Director left that position, it was changed to the position of Co-ordinator of Treatment Services. Again, I have to ask:

- How was this decision made?
- What were the results of this decision?
- Have the results been studied?
- In a task force report concerning the O.C.I. prepared in 1978, it was recommended that the position of Co-ordinator of Treatment Services be replaced by that of a full-time Programme Director. Was this carried out, and if not, then why not?
- Also that task force report recommended the sytem of dual management of units be terminated and a single manager appointed for each unit. The Unit Managers should be the most appropriate for the job regardless of disciplinary affiliation. Were these recommendations carried out, and if so, what have been the results?

I am stressing these issues because I feel that the roles of the two groups are extremely important, and I would like to know the most effective mechanisms to permit them to work in a co-operative, supporting manner. O.C.I. has addressed this since its very beginning, both in its internal organization and development, and I would be most interested in knowing the views of the staff, and in learning what the O.C.I. experience has to offer to the Ministry as a whole in this most valuable area.

Until a few years ago, one of the O.C.I.'s responsibilities was the "assessment of all male first incarcerates between the ages of 16 and 24 with sentences of nine months or more from the central, western and eastern regions".

I am certain that there must be a wealth of information and experience as a result of that mandate, and again I would like to ask how much of that has been used by the Ministry, and what is available to assist us as we continue to improve our classification system.

For a few years, you have had access to a computer here at O.C.I. How much has it been used to its best advantage? Has it been for all of the five major responsibilities of the O.C.I., namely classification, assessment, treatment, education and research, or has it been used more exclusively in just one or more of these mandates? Can it be made more effective, and if so, what is required to facilitate this?

With the excellence of the professionals working at the O.C.I., what have been the goals and objectives of research? Is the research directed at producing answers and information that will be of value to O.C.I. and the Ministry, can it and should it be encouraged to make greater contributions in this direction, or is all that can possibly be done under present constraints, already being done? I raise these questions because in 1978, the Task Force on the O.C.I. made the following statement:

> "It is the judgement of the Committee that the Ontario Correctional Institute can best serve the Ministry by assuming responsiblity for developing and providing specialized treatment and educational programmes for all inmates of the Ministry who are behaviourally disordered and, through research and education, providing all Ministry centres with knowledge which will be helpful to both centres in working more effectively with the inmates assigned to them."

That Committee also recommended increased participation in the following:

- Research work aimed at the development of predictive and evaluative measures of personality, behaviour and psychopathology.
- Research work aimed at identifying high risk individuals for recidivism and testing methods to reduce same.

- Research evaluation of short-term emergency intervention methods.

Because these comments and recommendations could have so much value for us, I again would be interested in knowing how many of these endeavours have been achieved and how was the knowledge obtained and put to use.

It is an accepted fact that within our Ministry there is an increased need for mental health services. There are increased ethical dilemmas and legal requirements placed upon staff. So often we approach our conventional problems using conventional, accepted practices. There is no reason to believe that these challenges are going to decrease in the future, and the question is, how are we going to respond?

As you are aware, we shall be taking on greater responsibilities for a segment of the young offenders. A significantly increased number of them will come directly under our supervision. The new legislation indicates that we will not be able to mix young offenders with adults, males or females, or those that received a disposition with those who have not. With these thoughts in mind it is impossible to ignore that we will require more buildings, more staff, more staff training, and more programmes. These next few years of growth and change should be immensely exciting to this Ministry.

Earlier, the Minister commented on the report by Dr. G. F. Hesseltine to the Minister of Health, the Honourable Keith Norton. In his report, he recommended establishing for the province a comprehensive network of forensic psychiatric services including assessment, treatment, teaching and research, a provincial advisory committee on forensic psychiatric services, and a provincial centre of excellence in forensic psychiatric services.

In the light of these present activities, the role of the O.C.I., and its ability to respond, is going to be of immense importance to the correctional system of Ontario as well as to the proposed co-ordination of forensic psychiatric services.

There are some issues that probably require additional attention at this time. For example, one of these is the waiting list for admission to the O.C.I. It is a realism which we have lived with for some time. This then leads to some questions in my mind:

- Does the O.C.I. wish to have an ongoing waiting list?
- Has the O.C.I. been asked to develop mechanisms or to make changes that would decrease the present waiting list?
- Does the O.C.I. have ideas or plans that would decrease the waiting list short of additional building?
- Would the O.C.I. like to take both males and females, or would the O.C.I. like to increase its co-operative programmes and endeavours with the Vanier Centre for Women?
- Would the O.C.I. like to become a support system for young offenders with mental health problems? If so would this include both males and females, or just males?
- If the O.C.I. decides it would like to be a support to these young offenders, it could require additional building. Should this be the case, would the O.C.I. like to include buildings and segregation cells for the adult population, and change its mandate to include a different kind or kinds of clients, and if so what would these be?
- Does the O.C.I. anticipate that at some time it might have to changes its admission and treatment criteria to make it more of an emergency assessment and treatment facility for mentally ill offenders? In other words, it would regularly take emergency referrals from other institutions as a regular routine rather than as an exception.

As we now move into the future, the role and response of the O.C.I. to the kinds of issues which I have tried to identify today will be of immense importance to the Ministry of Correctional Services of Ontario. As I review the tremendous contribution made by the O.C.I. over the past 10 years, I have no doubts about the abilities or willingness of its staff to continue to be our programme "flagship" as we proceed into this most challenging era.

I talked about the issues and deliberately about questions, I am extremely confident that we will get answers in the form of direction. And it is you who will be giving us those answers.

You have already taken up the challenge of creating a comprehensive programme evaluation model, which I hope we can use across this province. You have labelled it PEDCORP - Participative Evaluation and Development of Correctional Programmes. I thank you for picking up on that. Evaluation, though, creates trauma in people, makes them afraid, makes them ask the source of the motivation. The motivation for

evaluation of the O.C.I. and all Minstry programmes is a very simple one. It's not to decide or to prove that somebody's bad. The dedication of evaluation is not to prove but to improve.

We look forward to your advice, direction and encouragement to proceed as a flagship in the waters of Corrections in the days ahead. You will help set our future and I cannot think of a better group to provide that direction.

In closing, thank you for your past and ongoing endeavours, and for inviting me to be with you today on your 10th anniversary.

CLOSING REMARKS

Lyndon Nelmes, Superintendent
Ontario Correctional Institute

I would like to thank Mr. Sharpe and Dr. Podrebarac for their respective contributions. Looking into the future is, to say the least, fraught with danger, but strategic thinking and planning is absolutely essential if we are to remain relevant in what we do.

This brings us to the end of our day's programme, and I would like to take this opportunity to thank all those who participted in presenting the various segments, and to thank you for making this day a very worthwhile experience.

There are many thoughts going through my mind right now that need time to sort out. Perhaps one recurring thought, from an administrative point of view, however, is worthy of mention.

Programme activities for inmates/residents in any correctional setting, can only flourish within a supportive framework, i.e., one that reinforces and strives for the promotion of individual responsibility, equity and opportunities for growth. In essence, the environment must be organizationally healthy and therefore conducive to positive change. This often involves risk-taking. It touches on eroding some of the barriers that total institutions inevitably surround themselves with. It talks to attitudinal changes - to creating a sense of independency as opposed to nurturing dependence. Those of us directly involved in correctional administration need to constantly remind ourselves of the inherent dangers in becoming more concerned with the paper in our files than with the people in our care. Bureaucratic rigormortis can and does set in occasionally. Being aware of these possibilities can provide us with the impetus to develop institutional environments that provide fertile (not futile) opportunities for change. We indeed can learn from each other.

On that note, thank you all for coming today. Have a safe journey home, and I now close this symposium.

Epilogue

"For nothing worthy proving can be proven,
Nor yet disproven: Wherefore than be wise,
Cleave ever to the sunnier side of doubt."

Alfred, Lord Tennyson, "The Ancient Sage".

"The reasonable man adapts himself to the world: The unreasonable one persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man."

George Bernard Shaw, "Reason".

"He which hath no stomach for the fight
Let him depart; his passport shall be made,
And crowns for convoy put in his purse."

William Shakespeare, "Henry V".

"Give us the tools, and we will finish the job."

Winston Churchill.