HRED

PARLIAMENT
REPUBLIC OF TRINIDAD AND TOBAGO

SIXTH REPORT OF THE

JOINT SELECT COMMITTEE ON

HUMAN RIGHTS, EQUALITY AND DIVERSITY

THIRD SESSION OF THE ELEVENTH PARLIAMENT (2017/2018)

on

an Inquiry into the impact on Mental Health and Family Life of the Remandees at the Remand Prisons

Committee Mandate

The Joint Select Committee on Human Rights, Equality and Diversity was established under House of Representatives Standing Order 106 and Senate Standing Order 96 and shall have the duty of considering, from time to time, and reporting whenever necessary, on all matters related to:

(a) compatibility of Acts of Parliament with human rights, and any matters relating to human rights in Trinidad and Tobago (but excluding consideration of individual cases);
(b) Government compliance with national and international human rights instruments to which Trinidad and Tobago is a party;
(c) the promotion of measures designed to enhance the equalization of opportunities and improvement in the quality of life and status of all peoples including marginalized groups on the basis of gender, age (elderly, youth, children) disability and the creation of an inclusive and more equitable society through greater social justice and sustainable human development within Trinidad and Tobago."

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Publication

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[1] Mr. Esmond Forde appointed to the Committee in lieu of Mr. Randall Mitchell on December 01, 2017
[2] Mr. Saddam Hosein was appointed to the Committee on November 27, 2017

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List of Abbreviations

COPCAM	Council of Prison Chaplains and Ministers
CCP	Carrera Convict Prison
COSTAATT	College of Science, Technology and Applied Arts of Trinidad and Tobago
CPWO	Chief Prison Welfare Officer
CSO	Central Statistical Office
ENA	Enrolled Nurses Assistant
ECRC	Eastern Correctional Rehabilitation Centre
GGP	Golden Grove Prison
MOH	Ministry of Health
MSP	Maximum Security Prison
POS	Port of Spain
POSP	Port of Spain Prison
PMO	Prison Medical Officer
PWO	Prison Welfare Officer
SOP	Superintendent of Prisons
TTPrS	Trinidad and Tobago Prison Service
TTPS	Trinidad and Tobago Police Service
UWI	University of the West Indies
UNDP	United Nations Development Programme
VOM	Vision on Mission
WP	Women's Prison
WHO	World Health Organisation
YTC	Youth Training Centre
YTEPP	Youth Training and Employment Partnership Programme

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EXECUTIVE SUMMARY

1.1. The Committee resolved at its meeting held on May 19, 2017 to inquire into the impact on the mental health and family life of remandees at the Remand Prisons and agreed that the following two (2) objectives would guide the inquiry:

a. **To evaluate the programmes and services to mitigate, against the effect of detention on remandees at the Remand Yard Prison; and**
b. **To determine the impact on mental health and family life of remandees at the Remand Yard Prison.**

1.2. The Committee agreed that the Ministry of Health, Vision on Mission (VOM), Trinidad and Tobago Prison Service (TTPrS), Council of Prison Chaplains and Ministers (COPCAM) and the Association of Psychiatrists of Trinidad and Tobago were to be invited to a public hearing on November 03, 2017.

1.3. The Committee obtained both oral and written evidence from various stakeholders and would like to express gratitude to the 133 remandees who participated in the questionnaire sent by the TTPrS to the Maximum Security Prison (MSP), the Women's Prison, the Remand Prison and the Port-of-Spain Prison.

1.4. Some of the significant issues raised during the public hearing were:

- There was an absence of statistics or studies done in Trinidad and Tobago to prove whether the prison system and the environment is a breeding ground for mental health illnesses;
- There is no mental health screening for remandees upon entering the Remand Prison;
- The initial medical assessment of remand prisoners favours screening for physical illnesses over mental illnesses;

- The challenges faced by Prison Infirmary Officers when seeking compliance from remandees to conduct screening tests;

- The procedures currently in place in the Remand Prison to detect, diagnose and treat a remandee who is mentally ill;

- The need for a standard procedure to assess the mental health of the remandees;

- The need to improve upon internal administrative procedures of the prisons specifically in the areas of case management and information sharing on the remandees;

- The lack of resources and time which may inhibit a psychiatrist from conducting a complete testing to accurately diagnose the mental health illness of the remandees;

- The need for the Prison Rules, 1943 to be amended to allow for all remandees to attend the programmes available at the prison facilities;

- The $54 million upgrade for the Remand Prison which would include the design plans for a purpose-built remand prison which can allow for increased space for the remandees and more developmental programmes and services;

- The need to increase the current number of 84 Prison Infirmary Officers;

- The impact of the uncertain release date on remandees which affects their mental health;

- The backlog in mental health evaluation for persons sent by the Court to the St. Ann's Hospital for assessment;

- The need for robust pre-release programmes for the remandees which include the services which are given to convicted prisoners who have been released;

- The need for facilities which promote bonding of the family unit of the remandee; and

- The need for increased programmes which allow the family to visit the remand prison.

1.5. The Committee submits its findings and recommendations with respect to the inquiry into the impact on the mental health and family life of remandees at the Remand Prisons in Chapters 4 and 5.

INTRODUCTION

Remand Prisoner

1.1. A Remand Prisoner is, *"any person charged with a criminal offence who has been ordered by the Court to be detained in custody while awaiting trial or sentencing*[3]*… These include:*

I. *Inmates awaiting trial in the High Court;*
II. *Those whose cases have been adjourned at the Magistrates' Court;*
III. *Inmates who have appealed their sentences and are awaiting the determination of their appeals;*
IV. *Prohibited immigrants and deportees."*

Human Rights of Remandees

1.2. The United Nations Human Rights Office of the High Commissioner define human rights as, "*rights inherent to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status.*[4]"

1.3. The United Nations Standard Minimum Rules[5] for the Treatment of Prisoners (the Nelson Mandela Rules) are the *"essential elements of the most adequate systems of today, to set out what is generally accepted as being good principles and practice in the treatment of prisoners and prison management."* The Rules state that:

- *"An untried prisoner shall be allowed to inform immediately his family of his detention and shall be given all reasonable facilities for communicating with his family and friends, and for receiving visits from them, subject only to restrictions and supervision as are necessary in the interests of the administration of justice and of the security and good order of the institution."*(Rule 92)

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[3] The Final Report of the Cabinet Appointed Task Force on Prison Reform and Transformation. 2012. p94 and 433. http://ttprisons.com/downloads/taskforcereport.pdf

[4] UN Human Rights Office of the High Commissioner ,http://www.ohchr.org/EN/Issues/Pages/WhatareHumanRights.aspx

[5] United Nations Standard Minimum Rules for the Treatment of Prisoners(the Nelson Mandela Rules)(UN-Doc A/Res/70/175)https://documents-ddny.un.org/doc/UNDOC/GEN/N15/443/41/PDF/N1544341.pdf?OpenElement p8

- *"So far as possible, the personnel shall include a sufficient number of specialists such as psychiatrists, psychologists, social workers, teachers and trade instructors. The services of social workers, teachers and trade instructors shall be secured on a permanent basis, without thereby excluding part-time or voluntary workers."* (Rule 49)

1.4. The revised Standard Minimum Rules were adopted unanimously by the UN General Assembly on December 17, 2015.

Legislation

1.5. Sections 4(b) and (d) of the Constitution of Trinidad and Tobago states that *"the right of the individual to equality before the law and the protection of the law"* and *"the right of the individual to equality of treatment from any public authority in the exercise of any functions"*.[6]

Trinidad and Tobago Prison Service (TTPrS)[7]

1.6. TTPrS is committed to the protection of the society and crime prevention by facilitating opportunities for habilitation/ rehabilitation of offenders, while maintaining control under safe, secure and humane conditions[8]. TTPrS has responsibility for the Remand Prison which houses male and female persons whose matters have not yet been decided.[9]

Budgetary Allocations

1.7. The budgetary allocation for TTPrS for the fiscal years 2012 to 2017 under Recurrent Expenditure and Development Programme Expenditure is provided in Table 1.

[6] The Constitution of Trinidad and Tobago 1: p33.
[7] The Judiciary of Trinidad and Tobago. http://www.ttlawcourts.org/index.php/about-the-judiciary-1/overview-53
[8] Administrative Report of the Ministry of Justice 2013, p11.
[9] Administrative Report of the Ministry of Justice; 2013, p11.

Table 1
Budgetary Allocation, Trinidad and Tobago Prison Service

Budget Allocation	2012 (Actual)	2013 (Actual)	2014 (Actual)	2015 (Revised Estimates)	2016 (Estimates)	2017 (Estimates)
Estimates for Recurrent Expenditure[10]	$266,168,011[11]	$547,794,18	$579,565,339	$641,337,800	$1,143,707,200	$918,713,400
Estimates for Development Programme	$14,025,968[12]	$15,151,277	$ 9,241,358	$ 22,318,750	$ 23,000,000	$20,500,000

Statistics - Remandees

1.8. According to the Fifth Report of the JSC Human Rights, Equality and Diversity on the Human Rights of Remandees at Remand Prisons, the number of remandees at the remand prison as at January 2017 was 1,074[13].

1.9. Table 2 provides the number of persons on remand as well as the percentage of the prison population that consisted of persons on remand for the years 2000, 2005, 2008 and 2016. It also shows the remand population rate per 100,000 of the national population.

Table 2
Statistics of Remand/Pre-Trial Prisoners in Trinidad & Tobago[14]

Year	Number in pre-trial/remand imprisonment	Percentage of total prison population	Pre-trial/remand population rate (per 100,000 of national population)
2000	1,475	31.8%	116
2005	1,573	42.2%	121
2008	1,595	41.9%	121
2016	2,235	c. 60%	164

[10] Total = Goods and Services + Personnel Expenditure + Minor Equipment Purchases
[11] Estimates, Details of Estimates of Recurrent Expenditure for the Financial Year 2014-2017. https://www.finance.gov.tt/category/final-estimates/page/2/
[12] Estimates of Development Programme for the Financial Year 2014-2017. https://www.finance.gov.tt/category/final-estimates/page/2/
[13] Fifth Report of the JSC Human Rights, Equality and Diversity on the Human Rights of Remandees at Remand Prisons, p24. http://www.ttparliament.org/reports/p11-s3-J-20170929-HRED-r5-REMA.pdf
[14] World Prison Brief, The Institute for Criminal Policy Research, http://www.prisonstudies.org/country/trinidad-and-tobago#further_info_field_pre_trial_detainees

Programmes and Services

1.10. The daily life of a remandee[15] includes, *"participation in classes or programmes attend such during those scheduled periods. These occur during both the morning and evening periods. Inmates attend programmes such as anger management, or take classes including C.X.C O'Level Mathematics, Social Studies and English. Religious classes take place on Saturday, with the exception of Juma for Muslim prisoners which occur on Fridays between 12 p.m. and 1 p.m."*

Conduct of the Inquiry

1.11. Before the public hearing, the Committee was briefed by Dr. Dominic Obiajulu Nwokolo, a member of the Association of Psychiatrists of Trinidad and Tobago, on the objectives pursued by the Committee for the inquiry.

1.12. The public hearing was held on November 03, 2017. During this time the Committee questioned the officials on the various matters based on the inquiry objectives.

1.13. Prior to the public hearing, the Committee provided questionnaires to the Ministry of National Security for distribution to Remand Prisons. (**see Appendix III and IV**). A total of 133 questionnaires were completed from the following Prison Facilities:

- Remand Prison, Golden Grove – 15 responses;
- Remand Yard, Port of Spain Prison – 53 responses;
- Remand Section of the Women's Prison – 15 responses; and
- Remand Section of the Maximum Security Prison – 50 responses.

1.14. Additionally, the Committee sought responses from various stakeholders and in response written submissions were received from Vision on Mission, the Ministry of Health, the Trinidad and Tobago Prison Service, the Association of Psychiatrists of Trinidad and Tobago, Professor Ramesh Deosaran, Research and Development Impact

[15] Inspector of Prisons 2012 Report. p91-92.

Fund, UWI, the Judiciary and the United Nations Development Programme (UNDP). These responses provided a frame of reference for the supplementary questions pursued at the hearing.

1.15. The Table 3 below provides a list of the officials that were invited to the public hearing.

Table 3
Officials Attendance List

Name	Position
Ministry of Health	
Mr. Richard Madray	Permanent Secretary
Dr. Roshan Parasram	Chief Medical Officer
Dr. Hazel Othello	Medical Chief of Staff – St. Ann's Hospital
Professor Gerard Hutchinson	Head of Clinical Medical Services, UWI
Trinidad and Tobago Prison Service (TTPrS)	
Mr. Vel Lewis	Permanent Secretary
Mr. William Alexander	Commissioner of Prisons (Ag.)
Mr. Sherwin Bruce	Assistant Commissioner of Prisons (Ag.)
Mr. John Lopez	Prisons Supervisor (Infirmary)
Mr. Sheridan Joseph	Ag. Prisons Supervisor (Ag.)
Vision on Mission	
Mr. Wayne Chance	Executive Director
Mr. Gordan Husbands	Director
Association of Psychiatrists of Trinidad and Tobago	
Dr. Dominic Obiajulu Nwokolo	Registered Psychiatrist

1.16. The **Minutes** and **Verbatim Notes** are attached as **Appendix I** and **Appendix II respectively**.

1.17. The Sixth Report was approved on March 07, 2018.

EVIDENCE

Statistics of Mental Health of Remandees

3.1. Table 4 shows the total number of remanded inmates who have been diagnosed with mental health issues at the remand facilities for the period 2012 to 2016.

Table 4
Remandees with Mental Health Issues 2012 to 2016

No. of remandees	Gender	Offence	Mental Disorders
215	Males	*Include but not limited to:* Murder Wounding with Intent Grievous Bodily Harm Possession Of Marijuana Possession Of Cocaine	*These vary from:* Bipolar Disorder Insomnia Delusional Disorders Depression Schizophrenia Drug-Induced Psychoses Substance Abuse
30	Females		

3.2. Table 5 shows the number of suicides committed in remand facilities for the period 2012 to 2016.

Table 5
Suicides committed in Remand Facilities 2012 to 2016

Remand Facility	Remandees
Port-of-Spain Prison	2
Remand Prison, Golden Grove	1

3.3. Table 6 shows the number of remandees who were ordered by the Court to receive mental health evaluations during the period 2013 to 2016.

Table 6
Remandees Ordered for Mental Health Evaluations 2013 to 2016

Trinidad and Tobago Prisons Service	Year (s)				Total
	2013	2014	2015	2016	
Remandees	**8**	**5**	**9**	**13**	**35**
Total	**8**	**5**	**9**	**13**	**35**

3.4. According to TTPrS, the percentage of the total remand population that are under psychiatric care is 4.03%[16].

[16] According to the Fifth Report of the JSC Human Rights, Equality and Diversity on the Human Rights of Remandees at Remand Prisons, there were 1,074 remandees at remand prisons as at January 2017.

Objective 1: To Evaluate the Programmes and Services to Mitigate, Against the Effect of Detention on Remandees at the Remand Prisons.

Programmes and Services at the TTPrS for Remandees

3.5. The TTPrS coordinates programmes with various non-governmental organizations (NGOs) to promote and maintain existing ties between remandees and their families such as the Angel Tree Programme and the Father's in Action Programme. A comprehensive list of the NGOS which cooperate with the TTPrS is provided in **Appendix V**.

3.6. Mental health services are provided to prisoners on the third Wednesday of every month at Maximum Security Prison and on the second Wednesday of each month at the Women's Prison.

3.7. Prison Rule No. 298 (7), entitled 'First Division Prisoners – Privileges', states, "*They shall be permitted to be visited twice a week between the hours of 10 a.m. and 2.p.m. by not more than three relatives or friends or legal advisers, at the same time for a period of 15 minutes. The Commissioner may in any special case or for special reasons prolong the period of the visit or increase the number of visits or allow them to be visited by more than three persons at the same time. Such interviews to be in the presence and hearing of a prison officer, except in the case of legal advisers when the interview shall be in the sight, but not in the hearing of such officer.*" The TTPrS has implemented initiatives to allow for the remandees to utilize the special visits provided for under the rule to implement a series of weekend visits for remanded mothers and fathers with their children.

Staff and Training at TTPrS

3.8. There are currently two permanently hired mental health professionals on staff. However, this number is insufficient and there is a need for more persons to treat with the 1,074 (as at January 2017) remandee population.

3.9. Table 7 shows the staff complement at the Infirmary of the Prison Facilities who are trained to deal with mental health issues that may occur amongst the prison population.

Table 7
Persons trained to treat with Mental Health Issues

Category of Staff	Remand Yard	Women's Prison	POS Prison	Other Stations	Total
Prison Officer with Enrolled Nurses Assistant (ENA) Training in psychiatry	05	06	06	63	80
Psychiatric Nurses	01	-	02	01(Welfare)	04
Psychologists from St. Ann's[17]	-	-	-	03 (MSP)	02
Psychiatrists from St. Ann's	-	-	-	02	03
Total	06	06	08	69	**89**

3.10. During the period 2009 to 2012, 15 Prison Officers from the TTPrS participated in the ENA Programme with the Ministry of Health. The programme contained a psychiatric component within its curriculum focusing on the Social and Psychological Aspect of Patient Care.

3.11. However, it was highlighted that COSTAATT will start a training programme in February 2018 which will include a component on Psychiatric Management and will target potential infirmary officers.

Programmes and Services available for Families

3.12. The Prison Welfare Department of the TTPrS does not have programmes that support families, however they provide individual casework, group-work, mediation services and family intervention depending on the necessity for each remandee's case.

[17] The Psychologists and Psychiatrists from St. Ann's Hospital are not Prison Officers and are professionals assigned to deal with all psychiatric and psychological issues.

The Prison Welfare Department may also refer on a case by case basis external agencies such as:

- Ministry of Health- medicals
- Mediation Services
- Ministry of National Security
  - Immigration Division – Passports
  - Probation Services Department
- Unemployment Relief Agencies
- Ministry of Labour and Small Enterprise Development
- Micro Enterprises – Grant and Business Support Services
- Youth Training and Employment Partnership Programme (YTEPP)
  - Election and Boundaries Commission – ID Card Services
- Ministry of Works and Transport – Renewal of Licenses, Ferry Services
- Ministry of Social Development and Family Services – Access to Grants
- Ministry of Rural Development and Local Government – Community-Based Environment Protection and Enhancement Programme (CEPEPP)
- Ministry of Agriculture, Land and Fisheries – Youth Apprenticeship Programme in Agriculture (YAPPA)

Challenges of Mental Health Screening for Remandees

3.13. According to the Judiciary, the challenges faced in the court-ordered mental health screening process are:

- ***High Court***: the waiting time to get an appointment for remandees for mental health screening is six (6) to eight (8) months;
- ***Magistrates' Court:*** remandees are usually sent to the St. Ann's Hospital for a fourteen (14) day period to be evaluated. The hospital may request further time for evaluation for a period not exceeding fourteen days at a time.
- ***Medical Discharge***: The persons remanded for mental health evaluation are often discharged from the St. Ann's Hospital without bail being granted to them by the Court.

3.14. The Ministry of Health, indicated that as at November 03, 2017 there is a backlog of thirty-eight (38) patients at St. Ann's Hospital who were referred from the High Court for mental health screening.

Avenues for Remandees to Communicate with their Families

3.15. Remandees are allowed to communicate with their families via monitored phone calls at the Maximum Security Prison and the Remand Prison, Golden Grove and are allowed to utilize phone cards up to a maximum of TT$400.00, which are purchased by their family members.

3.16. At the Women's Prison there are two phone lines dedicated for the Remandees' family to call around 2:00 p.m., to speak with their loved ones. The calls are usually of a 15 minute duration. Remandees are also entitled to two scheduled visits of 15 minutes per week.

3.17. A child over the age of 16 can visit a remandee however, they must be accompanied by their guardian and be in possession of picture identification upon entry.

3.18. The process map for a child under the age of 16 to visit a remandee, based on Circular entitled, "Visits of Inmates by Children" dated February 23, 1987, (See Circular in **Appendix VII**) is shown in Chart 1.

Chart 1
Process Map for Visits of Children under 16 years

STEP 1

- **The remandee requests the Superintendent of Prisons (SOP) for child to visit.**

STEP 2

- **The SOP forward request to Chief Prison Welfare Officer (CPWO) to investigate the merits/demerits of the request and submit recommendations**

STEP 3

- **CPWO will assign a Prison Welfare Officer (PWO) to investigate and submit a report related to request.**

STEP 4

- **PWO will interview remandee to gain relevant data to request and communicate the request to the caretaker of the child, ascertain the legal situation of the child and receive the permission from the caretaker of the child for the visit.**

STEP 5

- **If permission is received, PWO will arrange for an interview with the caretaker and then the child with the permission of the caretaker.**

STEP 6

- **The caretaker will be advised to sign legal disclaimer absolving the TTPrS of liability for any psychological, psychiatric or social which may result from the visit and provide legal documents authenticating the paternity/maternity of the remandee.**

STEP 7

- **A report will all relevant documentation on the investigation of the PWO will be forwarded to the Chief Prison Welfare Officer, who will forward it with his comments to the SOP.**

Waiting Time for a Mental Health Evaluation

3.19. The average waiting time for a remandee to receive a mental health evaluation is as follows:

- ***New Client:*** Same day evaluation when attending the psychiatric clinic;
- ***Returning Client:*** Appointment-only basis within an agreed timeframe; and
- ***Psychological Testing Clients:*** clients referred to by the Court are scheduled appointments accordingly for psychological evaluation in either single session or multiple sessions. Upon completion the report is compiled after approximately 12 to 14 days.

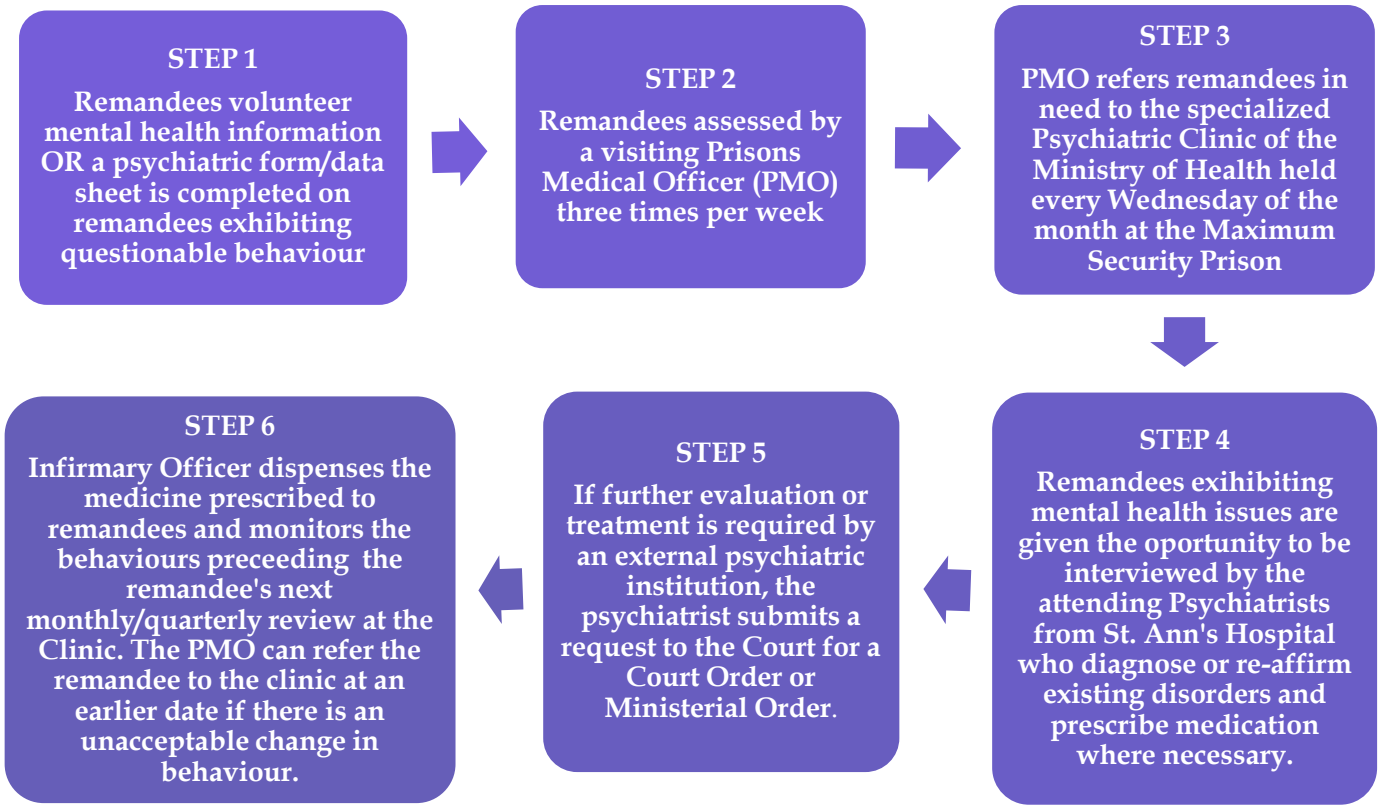
Objective 2: To Determine the Impact on Mental Health and Family Life of Remandees at the Remand Prisons.

Mental Health Evaluation and Treatment Procedure

3.20. According to the WHO, mental health is defined as a state of well-being in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to contribute to their community.

3.21. The Chart below shows the step-by-step procedure for the evaluation and treatment of a remandee with a mental health issue at the TTPrS.

Chart 2
Procedure for Evaluation and Treatment of a Remandee with Mental Health Illness



Training of Prison Officers

3.22. In September 2009, 20 Prison Officers completed a six-month Certificate Emergency Care (CEC) Programme and then completed the Certificate Emergency Care Management II Programme administered by COSTATT. In 2015, eight additional Prison Officers completed both programmes. The CEC Management II Programme exposed students to basic training in psychiatry.

3.23. The training programmes were administered to the Officers based on the availability of the programmes and the need for the Officers in the Prison system to have training in the field. It should be noted that Psychiatrists form the Regional Health Authorities (RHA) were not involved in the development and implementation of the Emergency Care Programme at COSTATT for members of the protective services.

Income

3.24. According to the submission from the TTPrS there is no provision for the remandees to earn an income while imprisoned.

Mental Health Effects of Remand time on Remandees

3.25. According to the Ministry of Health and the Association of Psychiatrists of Trinidad and Tobago detention on remand can produce the following effects:

- Social isolation form families and social networks
- Aggression, fear and bullying
- Lack of purposeful activity
- Loss of control and power to make changes
- Major Depression with or without psychotic symptoms
- Minor depression
- Acute psychotic episodes
- Uncertainty about the future
- Poor physical conditions and diminished hygiene
- Stigmatization and social exclusion
- Problems with reintegration
- Schizophrenia
- Self-harming behaviours
- Suicidal attempts
- Insomnia

Effects on Family Life of Remandees

3.28. According to Professor Deosaran, in his submission to the Committee, remandees or convicted prisoners are often the main breadwinners in the family and leave behind their spouses and children when they are imprisoned who then must support themselves.

3.29. According to Professor Deosaran, in a separate research in 2006, it was found that an estimated 3000 children were left behind by remandees.

Mental Health Studies/Research done in Prisons

3.30. According to the Ministry of Health (MOH) no local studies have been conducted by the MOH on mental illness at the Remand Prison.

3.31. However, an unpublished study was undertaken by Professor Gerald Hutchinson, Professor John Rose and Professor Tony Bastick in 2016, entitled, "The prevalence of Mental Health difficulties in prisoners in Trinidadian Prisons Referred for Anger Management."

3.32. The aim of the study was to evaluate the prevalence of mental health disorders in a sample of inmates of Trinidadian prisons who volunteered to attend Anger Management Groups. The survey was conducted using the SCL- 90[18] which was administered to inmates in groups within the prison system. In total 135 prisoners completed the survey (9% of the prison population).

3.33. The results of the study indicated that the group of inmates who completed the survey had scores of psychiatric symptomatology that were closer to a psychiatric

[18] The Symptom Checklist-90-R (SCL-90-R) instrument helps evaluate a broad range of psychological problems and symptoms of psychopathology. The instrument is also useful in measuring patient progress or treatment outcomes. https://www.pearsonclinical.com/psychology/products/100000645/symptom-checklist-90-revised-scl-90-r.html#tab-details

inpatient population than a general community population. The results suggested that there is considerable unmet psychiatric need among the population served by the TTPrS and a greater mental health focus in health services for the prison be considered to meet the need.

3.34. The Statistical Report **(See Appendix IV)** compiled by the Committee based on the questionnaires completed by 133 remandees (12% of the remandees population of 1,074 as at January 2017), highlighted the following impacts of becoming a remandee:

- In Chart 8 **(page 94),** 21 of the remandees indicated that they were "separated" from their significant other while they were in remand facilities. In contrast, 12 of the remandees indicated that their remand time had no effect on their relationship with their significant other.

- In Chart 9 **(page 94),** 12 remandees indicated they "Lost communication" with their family while in the remand facilities, 17 indicated their remand time had a "Negative" effect on the relationships and 20 stated that it was "Financially and mentally stressful."

- In Chart 10 **(page 95),** 25 remandees indicated they "Lost communication" with their children while in remand, 17 indicated their remand time had a "Negative" effect on the relationships while only four (4) indicated their remand time had no effect on the relationship with their children.

- In Chart 12 **(page 96),** 58 remandees indicated that they have observed all of the behaviors (anxiety, depression, rebellious, suicide, restlessness, violence) in other remandees while in the remand facilities. The most observed behaviour however, is depression, which was observed by 52 remandees.

- In Chart 13 **(page 97),** 11% of the remandees indicated that "Depression" was the effect of their time in remand prison, 9% indicated that remand prison has "Negative" effects on their mental health, while 48% of the remandees did not respond to the question.

FINDINGS AND RECOMMENDATIONS

Objective 1: To Evaluate the Programmes and Services to Mitigate, Against the Effect of Detention on Remandees at the Remand Prisons

4.1. The Committee was informed that the programmes offered to the remandees by the TTPrS are not mandatory and administered on a voluntary basis which coincides with the Committee's survey **(Appendix IV)** which highlighted 54% of the 133 remandees participated in the programmes at the remand facilities.

4.2. The Ministry of National Security has developed a programme to monitor and treat remandees with mental health challenges, however, it was noted during the public hearing that there is room for expansion and strengthening of this programme.

4.3. The Committee noted that while the TTPrS has a cadre of internal and NGO programmes (**Appendix V**) available to remandees as well as the, *"Procedure for Evaluation and Treatment of a Remandee with Mental Health Illness"* provided in **Chart 3**, the programmes offered are insufficient to cater to the specific needs of persons with mental health illnesses.

4.4. The Committee was pleased with the following initiatives of the TTPrS:

- Father's Day activities for the remandees and their family;
- Remandees meeting with their child upon consent by the Prison Welfare Department; and
- The Futsal Programme.

4.5. The TTPrS indicated that they have a pre-trial resettlement programme which prepares the remandee for the eventuality of an extended remand period and bridges the gap between the remandee and their family to ensure that the person still has housing or their business upon release.

4.6. The Committee noted the challenges to introduce a pre-release programme at the remand facilities including the:

- Uncertainty of the remand period of the remandee; and
- Perception that the remandee will be admitting guilt by attending the programme.

4.7. The Committee was informed of the use of the "Special Visits" in accordance with Prison Rule No. 289(7), where the children of remandees can visit and weekend visits are a reward for good behaviour.

4.8. The Committee found that, according to the Ministry of Health, no evaluation of the programmes and clinic services have been done to determine the effectiveness and impact on the remandees at the Remand Prisons.

4.9. VOM highlighted, during the public hearing, barriers faced for VOM to reach the ideal success rate of former remandee reintegration and resettlement into the wider society including:

- Remandees who enter the prison who have not been adequately diagnosed or assessed for mental or psychiatric discord; and
- Remand facilities do not holistically address the mental health challenges of the remandee while within the prison system.

4.10. VOM, during the public hearing, indicated that there is a need for improved case management and information–sharing by the TTPrS with VOM in order to improve follow-up with affected remandees.

4.11. The Committee was informed that at the TTPrS the current ratio of mental health professionals to mentally ill remandees is 2:78 as seen in Table 7.

Recommendations

4.12. The Committee recommends that a comprehensive assessment of the mental health clinic services be done by the TTPrS in collaboration with the Ministry of Health and an appropriate programme be implemented to address the mental health issues of remandees at the prison by 2019.

4.13. The Committee recommends that the TTPrS recruit one psychologist and one psychiatrist by the end of fiscal year 2018 to be permanently stationed at each prison facilities to provide for the needs of the remandees in addition to the mental health professionals provided by St. Ann's Hospital.

4.14. Given the insufficient number of programmes and services for mental health illnesses, the Committee recommends that the Ministry of National Security seek assistance from the Ministry of Health to expand the number of programmes available for mentally ill remandees.

4.15. The Committee recommends that the TTPrS coordinate information-sharing on released remandees with VOM to facilitate follow-up treatment for released remandees with mental health illnesses.

Objective 2: To Determine the Impact on Mental Health and Family Life of Remandees at the Remand Prisons.

Mental Health

4.16. The Committee noted that there was an absence of a standard procedure to frequently monitor and evaluate the mental health of all remandees in the prison facilities.

4.17. The Committee noted that, the TTPrS utilises a psychiatric form/data sheet **(See Appendix VIII)** to compile information from remandees. However, in instances when remandees are unwilling to volunteer their information or untruthful about the answers posed in the psychiatric form/data sheet, it is difficult to accurately detect presenting signs/symptoms.

4.18. The Committee was informed that international studies have correlated overcrowded prisons with the development of mental illness. This provides a contributing factor towards the development of mental illness in local remandees, given that remandees have one hour of airing per day, twenty-three (23) hours in confinement and experience poor physical conditions at remand facilities outlined in the Fifth Report of the Joint Select Committee on Human Rights, Equality and Diversity on the Human Rights of Remandees at Remand Prisons.

4.19. The Committee noted that while an unpublished study was undertaken on *"the prevalence of Mental Health difficulties in prisoners in Trinidadian Prisons Referred for Anger Management,"* with a professor from UWI and other international professors, no studies have been done locally on the percentage of the remand prison population who are

patients of mental health illnesses or the correlation between the prison environment and the number of remandees who are diagnosed with a mental illness.

4.20. The Committee found that the TTPrS experienced challenges when new remandees are unwilling to be examined by the Prison Medical Officers (PMO) and there are incidences of non-compliance during the physical screening by the PMO within 24 hours upon entry to a remand facility. Indeed, the Committee's survey indicated that 77% of remandees did not undergo a mental health examination upon entry to a remand facility.

4.21. During the public hearing, the Association of Psychiatrists of Trinidad and Tobago highlighted the following difficulties of mental screening within the prison population:

- Ganser Syndrome which presents in incarcerated persons not telling the truth;
- Unwillingness of the remandee to share; and
- Unresponsive behaviours of the remandee when placed before a psychiatrist.

4.22. VOM indicated measures that can be adopted by the Ministry of National Security and the Ministry of Health to mitigate the effects of detention on remandees. **(Appendix VI)**

Family Life

4.23. During the public hearing, the Committee was informed that prisoners are a high-risk population for the development or worsening of mental health problems and research is needed to determine the impact of detention on the mental health and family life of remandees at Remand Prison.

4.24. The Committee's survey noted that 72% of the remandees indicated that they were parents however, the Committee was informed that there is an absence of research done by the TTPrS to collect information on the effects of the remandees' detention on their familial relationships.

4.25. Although the TTPrS indicated that the percentage of the total remand population that are under psychiatric care is 4.03%, the Committee is concerned that the absence of local studies and the absence of a formal mandatory assessment of a remandee upon entry by a trained team of mental health professionals, highlights:

- the difficulties to effectively monitor remandees with pre-existing mental health illnesses prior to entry to a remand facility and to accurately assess whether or not a remandee has developed mental health illnesses while at a remand facility;
- the current detection/ diagnostic procedures at the remandee facilities are not ideal to detect a mental illness; and
- that there is a high probability that remandees with mental illnesses may be overlooked and the data related to the percentage of the total remand population under psychiatric care is under-stated.

<u>Recommendations</u>

4.26. The Committee recommends that the Ministry of National Security allocate resources to the TTPrS for research to be conducted to determine:

- **the effects of prison facilities on the mental health of remandees/inmates;**
- **the impact of detention on family life of remandees at Remand Prison; and**
- **the effect of overcrowding and confinement on the mental health of remandees.**

4.27. The Committee recommends that the CSO together with the Ministry of Health initiate studies into the incidence and relapse rates of mental health illnesses in remand prisons by the end of fiscal year 2018.

4.28. The Committee recommends that the PMO conduct a physical health evaluation and a mental health evaluation with a well-trained psychiatrist, upon the entry of the newly committed to prison facilities.

4.29. The Committee recommends that the TTPrS and the Ministry of Health should review the recommendations proposed by VOM in Appendix VI.

4.30. The Committee recommends that the Ministry of National Security collaborates with the Ministry of Health to provide a training module by fiscal year 2019 for "layman" prison officers to recognise common indicators of mental health illnesses in the prison population and refer the incidences to the relevant channels or departments.

Your Committee respectfully submits this Report for the consideration of Parliament.

Sgd.
Dr. Nyan Gadsby Dolly, MP
Chairman

Sgd.
Mrs. Glenda Jennings Smith
Vice-Chairman

Sgd.
Mr. Esmond Forde, MP
Member

Sgd.
Mr. Kazim Hosein
Member

Sgd.
Mrs. Vidia Gayadeen-Gopeesingh, MP
Member

Sgd.
Mr. Dennis Moses
Member

Sgd.
Mr. Saddam Hosein
Member

Sgd.
Dr. Dhanayshar Mahabir
Member

March 07, 2018

Appendix I
Minutes

EXCERPT OF THE MINUTES OF THE FOURTEENTH MEETING OF THE JOINT SELECT COMMITTEE ON HUMAN RIGHTS, EQUALITY AND DIVERSITY, HELD IN THE J. HAMILTON MAURICE ROOM, MEZZANINE FLOOR, TOWER D PORT OF SPAIN INTERNATIONAL WATERFRONT CENTRE, 1A WRIGHTSON ROAD, PORT OF SPAIN ON FRIDAY NOVEMBER 03, 2017

Present

Dr. Nyan Gadsby-Dolly, MP	Chairman
Mrs. Glenda Jennings-Smith, MP	Member
Mr. Dennis Moses	Member
Mr. Kazim Hosein	Member
Mrs. Vidia Gayadeen-Gopeesingh, MP	Member
Dr. Dhanayshar Mahabir	Member

Secretariat

Ms. Candice Skerrette	Secretary
Ms. Khisha Peterkin	Assistant Secretary
Mrs. Angelique Massiah	Assistant Secretary
Ms. Aaneesa Baksh	Graduate Research Assistant
Mrs. Delrene Liverpool-Young	Legal Officer I

Absent/Excused

Mr. Randall Mitchell, MP	Member [Excused]

Trinidad and Tobago Prison Service (TTPrS)

Mr. Vel Lewis	Permanent Secretary
Mr. William Alexander	Commissioner of Prisons (Ag.)
Mr. Sherwin Bruce	Assistant Commissioner of Prisons (Ag.)
Mr. John Lopez	Prisons Supervisor (Infirmary)
Mr. Sheridan Joseph	Ag. Prisons Supervisor (Ag.)

Ministry of Health

Mr. Richard Madray	Permanent Secretary
Dr. Roshan Parasram	Chief Medical Officer
Dr. Hazel Othello	Medical Chief of Staff, St. Ann's Psychiatric Hospital
Professor Gerard Hutchinson	Head, Clinical Medical Services, UWI

Association of Psychiatrists of Trinidad and Tobago

Dr. Dominic Nwokolo	Registered Psychiatrist

Vision on Mission

Mr. Wayne Chance	Executive Director
Mr. Gordon Husbands	Director

Public Hearing

9.1 The meeting reconvened at 10:32 a.m. in the J. Hamilton Maurice Room.

9.2 The Chairman welcomed and thanked the officials for attending. Introductions were made.

9.3 The Chairman invited opening statements from:

- Mr. Richard Madray — Permanent Secretary, Ministry of Health
- Mr. Vel Lewis — Permanent Secretary, Ministry of National Security
- Mr. William Alexander — Commissioner of Prisons, Trinidad and Tobago Prison Service
- Dr. Dominic Nwokolo — Association of Psychiatrists of Trinidad and Tobago
- Mr. Wayne Chance — Executive President, Vision on Mission

Summary of Discussions

10.1 The following issues arose during discussions with the officials *(for further details, please see the Verbatim Notes)*:

i. There were no statistics or studies done in Trinidad and Tobago to prove whether the prison system and the environment is a breeding ground for mental health illnesses. However, studies were done internationally which show that overcrowding is a catalyst for mental health illnesses;

ii. There is no mental health screening for remandees upon entering the Remand Prison;

iii. The disparity in the initial medical assessment of the remand prisoners which favours screening for physical illnesses over mental illnesses;

iv. The challenges faced by Prison Infirmary Officers when seeking compliance from remandees to conduct screening tests;

v. The procedures currently in place in the Remand Prison to detect and diagnose or treat with a remandee who is mentally ill;

vi. The need for a standard procedure to assess the mental health of the remandees and to develop a medical profile on each remandee;

vii. The need to improve the level of the mechanisms at the prisons specifically in the areas of case management and information sharing on the remandees;

viii. The creation of a module with the input of the certified Psychiatrists Association of Trinidad and Tobago, which can be taught to all Prison Officers to allow for a higher detection rate of the mental health illnesses of the remandees;

ix. The training of the Infirmary Officers to include the COSTAAT module and training by Psychiatrists from the St. Ann's Hospital;

x. The lack of resources and time which may inhibit a psychiatrist to conduct a complete diagnoses of exclusion on the remandees to accurately diagnose the mental health illness of the remandees;

xi. The need for the Prison Rules to be amended to allow for the remandees to attend the programmes available at the prison facilities;

xii. The $54 million upgrade for the Remand Prison which would include the design plans for a purpose-built remand prison which can allow for increased space for the remandees and more developmental programmes and services;

xiii. The recommendation that a policy be developed to mandate the attendance of remandees in programmes provided by the prison service;

xiv. The need to increase the current number of 84 Prison Infirmary Officers;

xv. The need for stakeholder input and collaboration to deal with the challenges faced by the prisons;

xvi. The impact of the uncertain release on remandees which impacts on mental health;

xvii. The backlog in the mental health evaluation for persons sent by the Court to the St. Ann's Hospital for assessment; and

xviii. The need for robust pre-release programmes for the remandees which include the services which are given to convicted prisoners who have been released;

xix. The need for a data on the factors that contribute to the effects of remandees/ prisoners on family life;

xx. The mental health effects on the child of a remandee can have a negative impact;

xxi. The lack of adequate bonding of the family unit of the remandee; and

xxii. The need for increased programmes which allow the family to visit the remand prison.

10.2 The Chairman invited all of the head of each entity to make a closing statement.

10.3 The Chairman provided a summary of the discussions and thanked the officials in attendance.

Request for Written Submissions

11.1 During the public hearing, written submissions were requested on:

Ministry of Health

i. Whether psychiatrists of the Ministry of Health were involved in the development and/or implementation of the COSTAAT programme?

ii. Have any local studies been conducted on mental illnesses at Remand Prisons throughout Trinidad and Tobago? If yes, please provide a copy.

iii. What is the average process and waiting time for a remandee to receive a mental health evaluation sent by:
   a. the Court; and
   b. the Remand Prison, Golden Grove; Remand - Women's Prison and Remand Yard, Port of Spain Prison.

Trinidad and Tobago Prison Service

i. Details of the training programme held at St. Ann's Hospital inclusive of:
   a. a summary of each course;
   b. a summary of the practicum,
   c. the frequency of the programme inclusive of training dates and last training date; and
   d. the number and category of staff trained.

ii. A copy of the questionnaire sheet used to assess remandees;

iii. In your written submission **(page 4)** it was stated, *"There are two permanently hired staff to treat with mentally ill inmates…"* However, in the public hearing **(page 35 of Hansard)** it was stated, *"… we have three Prison Medical Officers, we have four psychiatric nurses, three psychologists and two attending psychiatrists from St. Ann's. We have a total of about 84 Infirmary Officers with basic training in identifying and basic management of people presenting with mental illnesses…"*

a. Provide the number and category of staff that assist with the diagnosis and treatment of mentally ill remandees at Remand Prison, Golden Grove; Remand - Women's Prison; and Remand Yard, Port of Spain Prison;
b. Indicate whether it was 84 Infirmary Officers or 84 Prison Officers that received basic training to identify remandees with mental illnesses;
c. Details of the current training given to Infirmary Officers;

iv. The number of psychiatrists and psychologists assigned to:

a. Remand Prison, Golden Grove;
b. Remand - Women's Prison;
c. Remand Yard, Port of Spain Prison.

v. Provide details of the training Prison Officers received at COSTAAT inclusive of:
a. a summary of each course;
b. a summary of the practicum,
c. the frequency of the programme inclusive of training dates and last training date; and
d. the number and category of staff trained.

vi. List of non-governmental agencies and mental health programmes/services provided by non-governmental organisations.

vii. The process for a child under the age of 16 to visit a remandee;

viii. The process for a child between the age of 16 to 17 to visit a remandee;

ix. A list of each programme inclusive of a summary, provided by the Social Welfare Department to support families.

x. A list of each programme from other Ministries/Departments that are referred by the Social Welfare Department to support families.

University of the West Indies

i. Have any local studies been conducted on mental illnesses at Remand Prisons throughout Trinidad and Tobago? If yes, please provide a copy.

Adjournment

12.1 The meeting adjourned at 1:11 p.m.

I certify that the Minutes are true and correct.

Chairman

Secretary

November 21, 2017

Appendix II
Verbatim Notes

VERBATIM NOTES OF THE FIFTEENTH MEETING OF THE JOINT SELECT COMMITTEE ON HUMAN RIGHTS, EQUALITY AND DIVERSITY HELD IN THE ARNOLD THOMASOS ROOM (WEST), LEVEL 6, (IN CAMERA) AND J. HAMILTON MAURICE ROOM (MEZZANINE FLOOR) (IN PUBLIC), OFFICE OF THE PARLIAMENT, TOWER D, THE PORT OF SPAIN INTERNATIONAL WATERFRONT CENTRE, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON FRIDAY, NOVEMBER 03, 2017 AT 10.33 A.M.

PRESENT

Dr. Nyan Gadsby-Dolly	Chairman
Mrs. Glenda Jennings-Smith	Vice-Chairman
Mr. Kazim Hosein	Member
Mr. Dennis Moses	Member
Mrs. Vidia Gayadeen-Gopeesingh	Member
Dr. Dhanayshar Mahabir	Member
Miss Candice Skerrette	Secretary
Miss Khisha Peterkin	Assistant Secretary
Mrs. Angelique Massiah	Assistant Secretary
Miss Aaneesa Baksh	Graduate Research Assistant

ABSENT

Mr. Randall Mitchell	Member

MINISTRY OF NATIONAL SECURITY

Mr. Vel Lewis	Permanent Secretary
Mr. William Alexander	Ag. Commissioner of Prisons
Mr. Sherwin Bruce	Ag. Assistant Commissioner of Prisons
Mr. John Lopez	Prisons Supervisor (Infirmary)
Mr. Sheridan Joseph	Ag. Prisons Supervisor
Mr. Darius Gopaulsingh	Prison Officer II (Infirmary)
Mr. Lawrence Jaisingh	Director, Health and Policy Research and Planning
Prof. Gerard Hutchinson	Head Clinical Medical Services UWI/EWMSC

MINISTRY OF HEALTH

Ms. Richard Madray	Permanent Secretary
Dr. Roshan Parasram	Chief Medical Officer
Dr. Indar Ramtahal	Medical Chief of Staff (Ag.) – St. Ann's Hospital

VISION ON MISSION

Mr. Wayne Chance	Executive President

Mr. Gordon Husbands Director

ASSOCIATION OF PSYCHIATRISTS OF TRINIDAD & TOBAGO

Dr. Dominic Obiajulu Nwokolo Registered Psychiatrist

10.33 a.m.

Madam Chairman: Good afternoon everyone. It is my pleasure to reconvene the meeting, the 15th Meeting of the Joint Select Committee on Human Rights, Equality and Diversity. This public hearing will be broadcast on Parliament Channel 11, Parliament Radio 105.5 FM and the Parliament's YouTube Channel, *ParlView*.

I would like to welcome with us the officials from the Ministry of Health, the Trinidad and Tobago Prisons Service, the Association of Psychiatrists of Trinidad and Tobago and Vision on Mission. My name is Dr. Nyan Gadsby-Dolly. I am Chair of this committee and at this time I would like to introduce the members of the committee and allow them to introduce themselves starting with the Vice-Chairman.

[*Introductions made*]

Madam Chairman: So now that all the members of the committee have been introduced I would like to invite our representatives here with us to introduce themselves and to just state where they are coming from. Maybe we can start with those from the Ministry of National Security.

Introductions made by Officials of:

Ministry of National Security

Ministry of Health

Vision on Mission

Association of Psychiatrists of Trinidad and Tobago

Madam Chairman: Welcome to all and thank you for being here with us this morning. This morning, our enquiry is into the impact on mental health and family life of remandees at the remand prison.

Mental health is defined as a state of well-being in which every individual realizes his or her potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.

Considering that the tension on remand is likely to be associated with various negative effects on mental health, including social isolation, aggression, bullying and depression, and considering also that the Nelson Mandela Rules of 2015, which are the UN's standard minimum rules for the treatment of prisoners states that they should be given all reasonable facilities to communicate with their family and friends and for receiving visits from them; and having looked at the physical structure of Remand Yard in our last enquiry, this committee now turns to evaluating how remand detention affects the mental health and the family relationships and family life of remandees.

And it is with that in mind that our enquiry this morning focuses on determining the impact on mental health and family life of remandees at remand prison and the evaluating of the programmes and services to mitigate against the effect of detention on the remandees at remand prisons.

I want to thank those who are here with us in our oral hearing and also acknowledge the receipt of submissions from the Ministry of Health, the Trinidad and Tobago Prisons Service. We also received 150 questionnaires completed

by remandees at remand prisons located at Port of Spain and Golden Grove. We received submissions from Vision on Mission, the Association of Psychiatrists of Trinidad and Tobago, Professor Ramesh Deosaran and also the Judiciary, and we do thank all who would have given us the written submissions.

At this time, I would like to invite brief opening remarks from—and we would take it in this order that I am going to call—Mr. Vel Lewis, Permanent Secretary of the Ministry of National Security; Mr. William Alexander, Commissioner of Prisons; Mr. Richard Madray, Permanent Secretary in the Ministry of Health; Mr. Wayne Chance, Executive President, Vision on Mission; and Dr. Dominic Nwokolo from the Association of Psychiatrists of Trinidad and Tobago. So I would call that order again: Mr. Vel Lewis, Mr. William Alexander, Mr. Richard Madray, Mr. Wayne Chance; and Dr. Dominic Nwokolo.

Mr. Lewis: Thank you, Madam Chairman, members of the Joint Select Committee. I thank you for the opportunity to appear before this committee looking into the mental health and family life of persons at the remand prison.

Mental health and family life of remandees have been areas for particular attention from members of our prison service for many years. Many mentally-ill offenders come to the remand prison with a variety of disorders including schizophrenia, depression, bipolar disorder, delusional disorders and drug-induced psychosis. And while some experts would argue that many people who come to the remand prison with a mental illness will ultimately find themselves living in conditions which can make or contribute to their condition worsening, I want to assure this committee and members of the public that the Trinidad and Tobago Prison Service works tirelessly to ensure that this is not the case in Trinidad and Tobago.

Indeed, the prison service and by extension the Ministry of National Security have developed a programme of monitoring and treatment for remandees with mental health challenges. This programme has been put in place with the recognition that mentally-ill offenders need to be offered the care necessary to enable them to function at a level that would allow them to live with other offenders and ultimately to be ready for life whenever they are released back into their communities.

I would hasten to add though that there is a recognition that this programme can be expanded and strengthened and, therefore, the Ministry of National Security will explore further inexpensive interventions and services and continue to dedicate resources to this issue. In this context, I am pleased to participate in this hearing with the hope that by its conclusion we will be in a better position to address more effectively the mental health needs of remandees and to improve the health and quality of life, both of remandees with mental disorders and the wider prison population on the whole. Thank you very much.

Madam Chairman: Thank you Mr. Lewis. Mr. William Alexander.

Mr. Alexander: Madam Chairman, members of the committee, all those present, I would firstly like to publicly acknowledge the hard work of dedicated prison officers who, notwithstanding several challenges, especially recently, have stuck to their task and maintained their oath in holding and treating their clients. We will continue to so do, and I want to encourage those who may be intimidate or feel pain at this time, your commissioner is in your corner. God is on our side.

The Trinidad and Tobago Prison Services Motto: to hold and treat, indicates that we are required by law to commit persons on a warrant into custody and care. This includes persons from differing and diverse backgrounds

and temperament. As a result, they pose several challenges. They include mentally-ill persons, drug addicts, and violent people.

Several theorists, however, have concluded that the custodial environment is not the ideal place for housing and treating individuals with mental illnesses. Based on their conclusions, for several years the psychiatry community has embarked on a deinstitutionalized approach of treating and managing mentally-ill persons. We must recognize environment affects behaviour, and while we deliberate today I want us to be conscious that there is so much and only so much the prison can do.

Notwithstanding that, we at the prison service, in keeping with our motto have developed processes and mechanisms to treat with these challenged persons. We have access to clinics that are available in the public space. We have programmes that we have created to release the stress level. We have also embarked on programmes to reunite the families, so that they get the social support. All in all, I look forward to this session this morning, so that we can exchange and deliberate on issues and ideas to create a better environment for our citizens. Though they may be mentally challenged, they have rights and they have to be treated with dignity. Thank you.

Madam Chairman: Thank you, Mr. Alexander. Mr. Madray.

Mr. Madray: Good morning again. The Ministry of Health has a key role to provide relevant health services to prisoners, including those who have mental health challenges, amongst all others. In doing so, we aim to provide those services as effectively as possible and to support the Ministry of Health, as far as we can, in the fulfillment of that organization's responsibilities. I look forward to this enquiry and we will attempt to respond to your questions as fully as possible. Thank you.

Madam Chairman: Thank you, Mr. Madray. Mr. Wayne Chance.

Mr. Chance: Madam Chairman, other members of the head table, Vision on Mission is a non-profit organization, an NGO, which works in the field of correction within the Trinidad and Tobago Prisons Service. We work in the area of preparing inmates for release to return to their communities, to help them to reintegrate and resettle back into the wider society of Trinidad and Tobago.

We work with the population. We work with—it is very dynamic. The demographics are very broad and the challenge faced by these inmates to have them resettle, both foreign and local, is very compelling. There is a number of barriers we faced in being successful, in terms of the kind of success rate we would like to have, as it relates to this particular area of focus this morning, as it relates to the number of inmates that goes into the prison not properly diagnosed or assessed, as it relates to the their mental or psychiatric discord. And the prisons in its current circumstances do not holistically address those challenges while within the prison system. And for the years or time spent, a lot of times those major areas may not be totally or completely addressed. And, therefore, upon their release it continues to be a major challenge.

So I am happy to be here to exchange ideas, thoughts, and make recommendations, as it relates to addressing this major issue. Thank you very much.

Madam Chairman: Thank you, Mr. Chance, and Dr. Nwokolo.

Dr. Nwokolo: Yes, thank you everybody. I am Dr. Nwokolo, as you said. I am a member of the Association of Psychiatrists of Trinidad and Tobago, a 50-odd membership organization of which, at any point in time, has 20 of

them being psychiatrists and others being doctors working in the same.

Our members are integrally involved in the care of the prison population because the prison services' mental health is a part. It is an extension of the public mental health services of Trinidad and Tobago and these services are offered through the staff of the St. Ann's Hospital who are also members of the Association of Psychiatrists and hence how I came to be charged with this assignment. Seeing that I have worked with the prison services, I have, over the years assisted in the running of the clinics, psychiatrists' clinics in the prison.

Here, we are talking specifically about remandees, who are persons who are facing charges before the court. From our experience, from my experience, no studies have been done locally in these groups as to what is the percentage of mental health illnesses. But, if one is to go by international standards, especially in systems that are similar to us, basically the United Kingdom, one could safely say about 20 per cent to 30 per cent of remandees do have mental health issues.

By similar studies it has been deemed that only about 25 per cent of them, a quarter of them, and possibly up to half in our unique system. Because, having worked with the prisons services I understand that prisons services, they have medical officers working with them who helped in picking up these mental health issues and they have some prison officers who are trained mental health nurses. I do not know the exact proportion. But having seen them in training and met them through the clinic, I know they do have.

So the modus operandi of these clinics is that they are run twice monthly for the main prisons, which are the Remand Yard prisoners who are brought to be seen. And the Remand Yard prisoners are seen and they do come with various conditions, you understand. The 20 per cent to 30 per cent I said that are mentally-ill does not include persons who are substance dependent, people who abuse substances, which we do know. But that is usually not considered a big problem, except as it relates to the impact it has on their mental health too, either through the psychosis that could emanate from the use of such substances, or even the withdrawal. Some do suffer. While they are in remand they are coming off substances and hence the high prevalence of depression and psychosis, particularly.

We know that being remanded must be hard on persons who, prior to that, had enjoyed freedom. So that these brings about stress that they try to adjust to and a few of them do succumb to that.

And also, we do know that some of them have mental illnesses that they were labouring with before being remanded in prison and these sometimes either gets notice because they stop taking their medication or they were never treated in the first place, which is an opportunity I would talk about later.

So, in running this clinic, we do offer the services of treating, diagnosing and following up these persons. There is a small percentage of them that also come to the attention of mental services via the court. Because when these remandees go to court and the judge observes that they have a mental health issue, it is usually deemed important to ascertain the extent of it and if it had any impact on the crime committed or if it does, or if it will, in any particular way, hinder or interfere with the court proceedings, hence they are sent directly to St. Ann's.

The way the prison operates is that most people we see in clinics are treated in the prison because the prison has its own infirmary that stocks mental health medication. So they do report to us and we follow up with treatment with these persons.

If they need admission, because they are either too disturbed to recover properly in prison, I do understand

that the Minister of National Security is usually charged with giving the go-ahead to move them from prison to St. Ann's. But this is not very common or often. The diagnosis we usually see are we do see adjustment disorders with depressed mood, depression, acute sycosis, relapses of schizophrenia and substance abuse.

The positives that one could draw from the remandees is that there are lots of inmates or remandees who interface the mental health services for the first time, thanks to having been remanded. Because, that is for those who suffer untreated mental health issues. We do see those who access treatment for the first time, via the remand process. Okay. Thank you.

Madam Chairman: Thank you, Dr. Nwokolo, for that submission.

At this point, we will move into the questioning stage of our public hearing and just to remind officials and members of the committee to direct your questions through the Chair as we proceed.

Let me ask the first question as we go along. Various submissions have indicated that there are strong reasoning to conclude that the conditions of Remand Yard can lead to mental issues in persons that did not present with those issues before. And there is also an assertion that prisoners are high-risk population for developing mental health problems. So, given the fact that these assertions are being made, is there any data? Is anyone doing any type of monitoring that would indicate that persons in Remand Yard, under the present conditions, are developing a higher level of mental illness than maybe the outside population? Or if they are presenting birth mental illnesses on coming in, that they are being worsen at a faster rate than the outside population because of the conditions within the Remand Yard? Is anyone doing that type of research? Do we have statistics that is related to Trinidad and Tobago? It is an open question to anyone of the representatives.

Mr. Alexander: What I can say, we keep statistics and we do not see any significant changes in numbers between persons who are coming in and who are staying there for a period of time. Because the officers would be interchanging with these persons and sometimes they are the first persons to observe any abnormal characteristics. They would then refer them to the prison medical officer, who would then refer them to the psychiatrist and I must say I was looking through my statistics here and I am not seeing any great jump or cluster to indicate or to support that assertion. But I will say, as I said in my opening remark, environment will impact people and there are some persons who may have an inclination to mental illness and the environment can bring it out, because the restriction, the depression, that they go through could lead to these things. But our statistics are pretty level when it comes to persons being treated in the prison for psychiatric illness or mental illness.

Madam Chairman: So, is there any record that persons who have come in without presenting? In one of the submissions we saw that 80 per cent of the remandees are not tested psychiatrically when they come into the prison. So is there any baseline data that would indicate persons who came in without mental illness problems and would have developed those along the way?

Mr. Alexander: Yesterday we were discussing that there is no such baseline. That is expensive and resource intensive to pursue at this time. But it is something that needs to be done.

I have a position on this that the prison affects the society in a very significant way and if we do not pay attention to the prison. The society would be affected. Remember the persons who come to prisons are those persons who break the law; those persons who have the tendency to be bold and they can discomfort your life, whether as a

result of criminal action, drug use, mental illness, we do not have any way of base-lining everybody that comes into the prison. That is maybe something that we need to look at.

11.00 a.m.

And I am not aware of any research that is being carried out, in the prison that will give you an answer to the question that you asked.

Dr. Ramtahal: Can I say something?

Madam Chairman: Sure.

Dr. Ramtahal: I think the answer to the question is, no. We have no studies of incidence rates of mental illness in the population generally versus incidence rates of mental illnesses in the prison population. For example, incidence rates will refer to things like number of new cases per hundred thousand per year. So that has never been done in Trinidad, such comparisons. The second part is, there are no studies to compare relapse rates of mental illnesses in the general population versus relapse rates of mental illnesses in the prison population. So as far as I am aware, those studies have not been done and the answer is, no.

Mr. Husbands: Madam Chair, if I may? On that same issue.

Madam Chairman: Sure.

Mr. Husbands: This speaks to the whole aspect, in terms of, if we really want to move to a position of corrections, corrections. And in modern corrections, screening instrument tool for mental illness is integral as part of your reception and induction of all prisoners and this is not to lay blame. It is that we have to start thinking, in terms of if we really want to address these mental health issues, there must be a particular mandate that all inmates when they come in, they must be screened for mental illness, by trained professionals and that will require the prison to have a psychological department with psychologists, psychiatrists and the like to do that kind of in depth screening. Because it is not only in terms of illnesses, but for the well-being and how these people are able to adjust. So we are looking at two things really; those who probably would come in with mental illness, but how can we do a diagnostic to see where the mental functioning of individuals, and to see through the screening where they are and then do an assessment to see if they are being impacted negatively and the like. So it speaks to that particular screening tool. So that they can really get that research capability.

Madam Chairman: Okay, thank you. Sen. Moses.

Mr. Moses: Thank you very much, Madam Chair. For mental illnesses that are not apparent at first glance, such as personality disorders or depression, how does the remand facility determine if the remandee is experiencing personality disorders? It is an open question, open in the sense that anyone can answer.

Mr. Alexander: We did not get the question.

Mr. Moses: Okay, for mental illnesses that are not apparent at first glance, such as personality disorders or depression how does the remand facility determine whether the remandee is experiencing personality disorders?

Dr. Nwokolo: As you said, mental illnesses are not easily detectable, especially personality disorders will remain that, because personality disorders are particularly difficult to diagnose. It requires longitudinal view of the person, not a point view, you understand. So that, it is not usually the most problematic of the mental health illnesses, because even treatment for them are not easily available nor effective.

So that what—the persons involved do not really suffer much when it comes to personality disorder. As per depression, depression can be picked up by screening tools, fairly easily. Does that answer it, please?

Mr. Moses: Partially so. I was thinking more, across time; with the passage of time the procedure that would be involved in ascertaining whether the person, the remandee that is, is suffering from any particular disorder; over time not necessarily at a particular point on entry into the facility.

Dr. Nwokolo: And that speaks to, the capability of the officers, because in interacting with fellow prisoners and—a prison officer, they usually know who is problematic or who has particular pattern of behaviour that calls itself to attention, or persons that are withdrawn, refusing to eat, or not bathing, or self-harming. There are ample signs that trained officers could pick up to know that this person should be—warrant some further investigation.

Madam Chairman: And I think that is where the question lies. What is the capability of the prison officers? Are they exposed to that kind of training to be able to pick that up?

Dr. Ramtahal: To answer the question directly, the diagnostics of—like a diagnosis of personalities, for instance is quite a detailed thing that must be done by a team of psychiatrists and especially psychologists who go through long instruments with 500 questions or more. So that is not happening at this stage in the prison service. Whatever diagnostics in the prison services would depend on the clinical acumen of the prison officers who might notice something and who might then report that, if they wish, to a generally trained doctor, who may or may not know much about psychiatric conditions.

So it is far from ideal most of these patients will be missed because they are not getting a formal assessment by a trained team of persons. For example, at St. Ann's Hospital we do have about four psychologists in the forensic department and they do extensive work in diagnostics, regarding personality disorders and we do more of the depression and all of that. So in my opinion, it will be less than ideal what is happening right now.

Mr. Alexander: Could I say something on the topic please?

Madam Chairman: Let us just get the Commissioner to weigh in here.

Mr. Alexander: Let me inform the committee, we have—working in the prison, qualified psychiatrists and psychologists and medical people. We have officers who are psychiatric nurses. As Dr. Dominic said, you will have to observe a person with personality disorder, over a period of time. The goodly doctor just now, spoke about the complicated and technicalities involved in it. But, what we do notice is that an individual over time, because he will be in a cell with some inmate and that inmate will complain "this guy seem to be strange, one minute he seems to be this, next minute he seems to be that" and that, most often, is what starts the process where this person will be interviewed by the infirmary officer, placed before the doctor and if the doctor is convinced that it is not just the vagaries of the imprisonment has him behaving that way, we have a welfare team, who will also get data from the family, because sometimes people come to visit and they will say "that boy very strange you know", and they will give you information that will cause you to cause this inmate to be placed before the psychologist or the psychiatrist. But—so this is what the realities in the prison.

Mr. Husbands: Could I, Madam Chair on the issue, and this begs the issue in that there must be what you call a standard procedure, in terms of if you are going to be interviewing your inmates incarcerated, if you tell me three months, every four months and the like, not in the terms of screening, but having them placed before the doctor, having

them placed before the psychiatrist and the like. Yes, it is a lot of work, but if you are talking about corrections, that is how corrections operate. In terms of processes, in terms of timelines for classification and reclassification; assessment, reassessment so that you can actually develop a profile on each person. It is a lot of work and it is going to be expensive but if you want to move to the point of corrections and addressing those mental issues there is no way of getting away from it. We have to have the instruments, we must have the personnel, the trained personnel at all levels from prison officers and the professionals.

Mr. Hosein: Thank you, Madam Chairman. With your permission I would like to make two small comments and one question. I want to remind myself and all of us sitting in this room here, that we are servants of this beautiful country. And on that note, I want to pay commendations to the Commissioner of Prisons and your team for the excellent work that you are doing despite the constraints.

Mr. Alexander: Thank you.

Mr. Hosein: And I would like to say also, to Mr. Wayne Chance, on Vision on Mission that you all are doing yeoman service to Trinidad and Tobago, and I want to compliment you and your team. I have one question. Who assesses behaviour to establish that it is questionable behaviour at the prisons? You have questionable behaviour and I want to know—I would like to know who assesses this questionable behavior?

Madam Chairman: That will be to the Commissioner of Prisons.

Mr. Alexander: Well, as I had said, we have psychiatrists and psychologists in the prison, but I think, we have a team of persons but in the first instance the person who interacts most often with the inmate is the officer and some years ago we started a training programme at St. Ann's—I manage to recognize Dr. Ramtahal, I do not know if he remembers me—where we on a regular basis, would send persons to St. Ann's, not only to do the theoretical aspect but the practical, working along with mentally unstable people.

But we at the prison have a questionnaire sheet here that was drafted over time and we ask these questions: "Are you a previous psychiatric case? Are you on medication? Were you ever on medication?" And according to the responses here then we send it up for action. So there is a process, what I would like to see is a—there has to be more effort. Recognize that the prison population is increasing, that will impact on the resources. Recognize that there is a down turn in the economy, when there is a down turn in the economy crime increases. The prison population increases, we have to sit down and strategize before that time reaches or before the situation develops into something that we cannot control. Now is the time for all of us, all the stakeholders to put our intellect to use, and improve the situation. It will also help in reoffending, because if we could ideally deal with persons who have issues. They are disgruntled, violent, aggressive, unstable people, all because they think nobody cares about them, nobody is addressing their issues and if we could do that. It will have a spin-off effect in reducing crime.

People want to be felt and appreciated and treated in a humane fashion. This is why sometimes it worries me when persons may unfounded accusations as though prison officers have no heart for people. But that is foolishness. Prison officers go beyond the call of duty, sit down for hours talking with persons, advising them. We have created additional visits outside of what the prison—outside of what the rules call for, because according to the prison rules you are entitled—remanded inmates are entitled to two visits per week, convicted one. We have changed that. In instances where persons are demonstrating good behavior, we give them a weekend visit.

We have Father's Day activities, we have a number of things to reunite the family. A prisoner will come to you and say that he has a 14 year old child that is giving problems and he feels if he speaks with him he will be able to get to him. The welfare comes in, visits the family, makes sure that the family is in agreement, that there is no friction and they meet, and they discuss. There is a number of work that goes on behind the prison walls that the population is not aware of, and we help maintain safety and security in this island of ours. Because if those persons are left unattended and that hate builds up, then we will be in trouble.

So what we are looking for is assistance, stakeholders' consultation. We do not know it all, neither does any single individual. But when we come together I think there is enough talent in Trinidad and Tobago to make this place a beautiful place, a paradise. I know it, I am on the face of the earth for a little while now and I know when persons had this traditional value of neighbourliness, everyone looking out for one another. You pass by me on a weekend, I have an extra pot so that you could get—community spirit we need to rebuild that—

Madam Chairman: Commissioner, if I could just interrupt. I know that we can go from day until tomorrow. But I want to assure you that we do as a country understand the constraints and what we are about in this committee, today is looking at the systems that are in place and how we can improve those systems, so that things would be better for the prison officers as well as for the remandees and the general prison population.

We are all about finding the solutions this morning. If I take the submission from—I am seeing two hands, I think I saw the official from the Ministry of Health first and then we will take Mr. Chance.

Dr. Ramtahal: Mr. Hosein, to answer your question directly. It is grossly unfair and unreasonable to ask a layperson to determine the presence of mental illness in somebody. That is like me asking you if you can look at your neighbour and tell if they have heart disease, if they have Cushing's disease if they have—you know adrenal problems, liver function disease, any other illness. It is one and the same, so I think the system is far from ideal. The determination of mental illnesses requires a well-trained doctor; even GPs miss diagnoses of mental illness and even psychiatrist themselves. So I think it is grossly unfair to leave it up to a layperson in an institution to make such a determination.

Mr. Chance: Okay, in response to your question as it relates to mechanism and hearing the contribution of the Commissioner, there is an excellent contribution and services that the Commissioner and his team provide at the prison system. However, in light of the budgetary and economic constraints to improve the level of mechanisms within the prison, in terms of information sharing, can definitely go a long way in terms of getting the desired result.

For example, case management; how information is shared. If someone is coming out of prison, how information is shared as it relates to that person's mental issues during the prison. Sometimes the information is not passed on, follow-up and case management are not there to prevent and to assist in keeping that person on the straight path, so to speak. To keep him following up with his clinic dates and so forth. So a lot of times we receive persons who come out of the prison system and we will not have a comprehensive – and I know there will be classified information that would not be permitted. But, however, for the information that is necessary to continue to follow up with this client is not all the time hundred percent, and therefore there is breakdown in the system. If these areas can be amended—and these areas do not require major financial injection. It is a matter of information sharing, communication, that could reduce the level of incidents that we are seeing. So I would just call for greater communication in terms of the case management of these clientele.

Madam Chairman: Thank you, Mr .Chance. Sen. Mahabir.

Dr. Mahabir: Thank you, Madam Chair. A brief follow up in relation to what Dr. Ramtahal has said and it is a follow up to a question of Sen. the direct question of Sen. Kazim Hosein. And that is, we were told that the first contact with the prisoner is the prison officer and we know in the police service there is a training module for police officers to deal with law breakers who may be suffering from some mental ailment, and I am simply wondering whether, notwithstanding the comment of Dr. Ramtahal, it is possible for all prison officers to be exposed to some type of training so that—I know they are laypersons.

So that because they are in initial contact on a daily basis they will be able to provide some preliminary assessment and alert the four or five psychiatrists you have that may be in cell number 14, there is a case you might want to see that you may have overlooked. So is it possible for the Ministry of Health's specialist in psychology and psychiatry to provide the training module simply to evaluate individuals by interactions on who may or may not have a problem in the prisons? Or is it, do you think that that is impossible to do? Because that is a potential solution you see. Yes, I see Dr. Nwokolo and then I think Dr. Ramtahal may want to answer.

Dr. Nwokolo: I want to, at least draw attention to the scope of what we are engaged with, and I hope we are not trying to make sure that everybody that ever passes through prison comes out a saint or mentally healthy.

Mental illness is a very broad thing, I will not be surprised if some of us in this room are not mentally ill, and without treatment and we are going about our lives, which is part of human rights. Mental illness is one of those illnesses, which sometimes do not cause distress to the sufferer or anybody and yet other times the only aspect of the mental illness is distress to others as in personality disorders. And this is the hardest to treat of mental illness, because the sufferer feel very good about the way they feel. So they do refuse treatment and even with depression and mental illnesses that cause distress, they are very difficult to treat because sufferers usually have the option to refuse treatment.

And they do refuse treatment, far more than any other illnesses and to at least add my perspective to what Dr. Ramtahal has said about detecting mental illnesses. We are not asking the prison officers to diagnose, and mental illnesses are picked up by relatives who are not trained at all. The layperson can easily detect significant mental differences and we all know it, we all know "how he moving so?" "How he speaking so?" "Why he always cutting himself?" and that goes a long way. I am not against improvement by providing an enhanced screening tool, you understand. But we must be very aware that we are here to offer those who are in distress and imprison, respite.

Not those who are happy, the way they are and not necessarily disturbing everybody, which will overload our already limited system. If resources were unlimited of course I will be the first on that bandwagon – screen all of them, treat all of them, follow them up for life, but we have to really optimize these resources. I just want to at least give that perspective.

Madam Chairman: Somebody else wanted to weigh in on this?

Mr. Husbands: Just one final point and I do not want to sound repetitive. If we are running – getting into the realm of corrections, a screening tool for mental illness, for substance abuse, all those things must be introduced. That is what they call good practice and it works.

Madam Chairman: If I may ask a question? I seem to recall on our previous enquiry that the prison service would have advanced that upon entry to Remand Yard, the prisoners are—the detainees, sorry, are seen by a medical doctor

to deal with their physical state and if that is a routine practice, and it is not done for the mental side of it. I am asking, is it that we place more emphasis on their physical condition than their mental condition? And if this is so should it be so?

Mr. Alexander: When an inmate comes into prison, he comes with a warrant and there is a whole number of actions that have to be taken, from the documentation, checking to see if the warrant is correct, screening of the individual to see if there are any wounds—the infirmary officer is the first point of contact from the medical side. He will speak with the individual, examine him and after that he would make some entries.

All new committals are supposed to be put before the prison medical officer the following day, after the infirmary sees them. But you will appreciate that the numbers of persons that we have that is not always possible, but we try our best for them to be seen by a doctor. Some of them, as the goodly doctor just said, there are people who are very noncompliant for their own welfare and we have a challenge sometimes with that.

An individual will come in and tell you "I do not need you to check me I am healthy, I do not want anybody to tell me open my mouth or eyes"—they just want to be left alone. So it is not as easy as in the public practice. Within the prison you have some rebellious people and you have to find a middle ground. What sense would it make, you trying to restrain an individual to examine his mouth and end up in some confrontation where the inmate is injured, than leaving him alone and do just an external screen? If you ask him to pass urine he may not want to pass any urine.

These are the unique situations in a prison and unless you work in that environment you will not understand these things. It is a constant communication and trying to talk down rather than beat down an individual to get him to co-operate and it takes time. A man who has lived all his life being violent, killing people, raping people is not an easy subject to handle. So sometimes when persons talk about professional, I often ask myself what professional they are talking about. The professional is the prison officer; 30-40 years working—he could watch an individual and tell you what he is up to because of years of experience.

Dr. Mahabir: There has to be a follow up to see, because if you say that the prison officer can watch somebody—

Mr. Alexander: No, no, I am just saying—

Dr. Mahabir:—and know what he is up to—

Mr. Alexander:—do not get carried away with that. I am just telling you—

Madam Chairman: I think he was just being a little bit informal. But we take the point that experience counts for a lot in terms of looking at it—

Mr. Alexander: We have formal processes, rest assured of that. As I said up front we have doctors, we have psychiatrists, we have psychologists, plus we have access to the external clinics.

Madam Chairman: Let me take a comment from Dr. Ramtahal and then a question from Vidia Gayadeen-Gopeesingh.

Dr. Ramtahal: As you know one of the WHO's slogan is "There is no health without mental health". But we say that but we do not take it in. But mental health is just as important or perhaps more important than—well I will not say more important—just as important as all the other areas of health. So, like the person who is assessed by the doctor for physical conditions, the same should happen for the psychiatrist side of it, or the mental side of it. They should be assessed by a trained person and if not it will be missed or most likely it will be missed so that bias—and

that you know, that biased view of mental services and mental health, is quite a historical thing; that has been going on for hundreds of years now, but it is not really getting better with time significantly you know. So persons are not given the psychiatric attention that they should be getting.

Mrs. Gayadeen-Gopeesingh: Thank you, Madam Chair. Dr. Nwokolo, you were speaking about personality disorders and you have listed some as minor depression, acute psychotic episodes, schizophrenia and so. And we would deem it as being functional. What about those issues, mental health issues that are organic? Meaning remandees who have a bleed in the brain or have a tumor. Are those remandees screened at all? Or have—you have said, you have done a certain number of remandees, you have assessed a certain number of them. Have you at any point in time, any of these remandees presented themselves or you have decided "Okay, let us do some random checks and see these behaviours, perhaps they are altered not because of functional but because of organic". Have any of those been screened?

Dr. Nwokolo: First of all, I would like to at least suggest that that distinction of functional and organic has been done away with. All mental disturbances are organic, they have a molecular basis in the brain. We do know that behaviour, environment and training, impact. And coming specifically to those who have what you will now call organic, because of tumors or space-occupying lesions, that goes under the purview of medical and the psychiatrist is trained to pick that up, if somebody is disturbed by their presence and you will be surprised that the biggest brain tumors do not cause any psychiatric problem. Do you understand what I mean and the worst psychiatric problem are in brains that look healthier than yours or mine, under the MRI and things we do. You understand and when they do happen and they come with headaches, cannot move an arm or everything, it will be obvious to a prison officer that this person is not moving the way they should move. They are not coming out for morning, this or that; they will pick them up and they will be in the extreme minority, to be honest, those kind of patients, you understand.

11.30 a.m.

But what I was trying to forward on is what the Prison Commissioner said about the prison population being a unique population, and maybe you might not have heard of it, but they have done studies in the past and they have come up with a syndrome, for instance, called Ganser Syndrome, which occurs in incarcerated persons where they have this need not to give the correct answer. If you are even bold enough to ask them: how many legs does a dog have? They would think hard and say, three, in part of negating or giving an approximate answer.

So a lot of screening tools may not even be very relevant, as he said, because if somebody does not want to share with you, your screening tool is as good as the person answering, and nothing trumps a neutral, natural observation of a difference in a change of behaviour which is what I am trying to say, because we have to know the extent and limitations of what we are going after, and the resources that we do have because any psychiatrist would tell you they have met clients who you come to interview and they answer no questions—they say nothing and they watch you—and at the end you have not gained anything. They do tell you he behaves somehow, he withdraws and he does not—and he comes and he watches you and he does not answer your question. So psychiatry is very intricate.

There is a lot of training that goes into being an observer of prisoners over years, as the good officer said. All patients come to the psychiatrist because they have relatives, people in the street and lay people bring them. Psychiatrists do not go home and screen anybody. They bring them because lay people say something is wrong. We

all are fairly aware of what is normal behaviour, and we tend to quickly pick it up.

Mrs. Gayadeen-Gopeesingh: Yes, but my question is: Do you all do any random screening to see, okay this behaviour is sort of awkward, untoward and it might not be functional but it might be something different?

Dr. Nwokolo: Random screening? No.

Mrs. Gayadeen-Gopeesingh: Yeah.

Dr. Nwokolo: What I am saying is the screening lives with you. If you call the person to come and have breakfast, to go and bathe and they behave other than normal that is the screening. You will see it. You do not call them and say, line up, let me screen you or randomly pick up people. The conditions, mental illnesses, the significant ones do not hide. You will be able to pick up that this person is moving "ah how" as they would say, and call the attention. And, even so, you can only get a fraction of them because some will insist they are well and they do not want nothing to do with it. Even in the prison now, we have a few inmates who are seriously psychotic and will not take any medication. It takes a lot of fight.

Madam Chairman: Could we have Dr. Ramtahal as well as—

Dr. Ramtahal: To answer the question, psychiatric conditions, they are diagnoses of exclusion. That means, technically, when a psychiatrist sees a person with behavioural problems, he is supposed to do all the testing that is possible to exclude all other medical illnesses including tumours, strokes, epilepsy—every other thing—and space occupying lesions, before he could then say this patient has depression or this patient has schizophrenia. That is the way it is supposed to be done. We may not do that here all the time because of resources. So in the little experience I have, the answer to your question is no. That sort of in-depth testing like an MRI or a CAT scan on a prisoner or a remandee is not done.

Mr. Husbands: Again, in modern-day corrections, there is an evidence-based approach to doing things, and the whole aspect in terms of having those sort of tools become very, very significant. It is not done in terms of procedure, it is not done in terms of a routine. Again, yes, we may use our own judgment and we could identify, but there are tools now, particularly the dynamic factor identification tool, a modern tool, in all corrections that pick up cues. It would not identify if you have a personality disorder, but it picks up certain cues that will help the individual to indicate that this person need further assessment, and that is done every three to six months.

Mr. Chance: Earlier on, Mr. Moses had asked a very important question as it relates to the prevention while a person is incarcerated how mental illness can be prevented or if over time in the system can mental illness be developed and what kind of approach or preventative measures or instrument, I guess, in trying to assess as it relates to that issue. Now, if you look at our current remand system, it is almost like an oven for creating mental illness or depression.

Madam Chairman: I want to just stick a pin right there, because that was the crux of my first question, and I want to ask you, having said that, what justifies that statement you have just made?

Mr. Chance: What justifies—?

Madam Chairman: That statement you have just made, that it is almost a greenhouse for producing mental illness. Why would you say that and do you have data to support that?

Mr. Chance: I do not have any kind of data, empirical data, to support that from a scientific perspective, it will be on assumption, but it is something that could be undertaken to be able to validate the perception. But if we look at

what Mr. Husbands is talking about, modern-day prison correctional institution, if we look at our prison current system and situation—our current prison environment, our lack of proper prison infrastructure and modern design—I attended international functions where I listened to a psychologist put perspective and recommendation as it relates to purpose-built prison to address and alleviate some of those issues from as far as colours that is used within the prison to treat with rehabilitation and stabilizing people.

The prisons, in terms of how it socializes inmates—how prisoners are socialized and inmates are socialized, especially if they are there for over a period or lengthy period of time, if they are not socialized in a humane and best practice approach, given the kind of losses, impact and trauma and what have you that inmates undergo while incarcerated, if the system does not support it from a proper infrastructural perspective, it can lead to the development of various disorders.

You have programming and the lack thereof for persons while incarcerated. All of these are factors that can lead to an increase—and I say there is no empirical, but all of these are factors that can lead to persons falling ill to various mental illness or disorder. So those are things that I think, given our present and current circumstance where the Trinidad and Tobago prison is concerned, need to be taken into immediate account if we have to address the current circumstances face by inmates in the Trinidad and Tobago Prisons which have given trigger to this discussion.

Madam Chairman: Thank you so much, Mr. Chance. I will just give Dr. Nwokolo a chance to weigh in on this and then we will take a question from Mrs. Jennings-Smith.

Dr. Nwokolo: Yes, I would just like to inform this body that the conditions in the Remand Yard and Trinidad and Tobago Prisons are 10 times better than the conditions on the ward, most of the wards at the St Ann's Hospital. So if the remandees, hopefully, as they are trying to get better conditions, I hope the good Committee should be able to extend this very heartfelt information that the conditions in the prisons are far better than the conditions at the St. Ann's Hospital. So whatever we are doing, I am telling you, resources are really limited and have to pass through that too.

Madam Chairman: Are we referring to the Remand Prison?

Dr. Nwokolo: Say that again?

Madam Chairman: Sorry, are you referring to the Remand Prison? When you say the condition at the prisons, you are referring to the Remand?

Dr. Nwokolo: The Remand. The conditions at the Remand are better than the condition on ward 8, ward 5 and some of the major wards where people are kept in St. Ann's. It will be remiss of me not to say this at this point.

Madam Chairman: Okay. I know that there is going to be a tendency right now to comment on this which will take us away from substantive—

Dr. Nwokolo: No, no, I just want to drop it, not to comment not to explore it.

Madam Chairman: I know you have dropped it and having dropped it, I want members and representatives to resist the temptation for now to go in that direction, because that actually may be a whole enquiry on its own. Right? So let us rest that just for a minute. It is very interesting that you would have raised that particular point. Let us take the question now from Mrs. Jennings-Smith.

Mrs. Jennings-Smith: Thank you, Madam Chairman. My concern is really on the programmes that are afforded to

a remandee. I want to take us back to who is a remandee. A remandee is a person that we have in our care awaiting the completion of a trial, and from a survey that was done on remandees, it showed that anger and frustration, violence, depression and outbursts are some of the main challenges or behaviour patterns in the prison service.

Now, I looked at some of the programmes and I wondered—and I want some clarity—are the programmes that you all are offering at this point in time are they diagnostic? Were they mandatory or do they go to the programmes as they feel to?

Madam Chairman: This is specific to the remandees' programmes. Right?

Mrs. Jennings-Smith: I am speaking about the remandees and the programmes afforded to the remandees.

Mr. Alexander: The programmes do not have to be mandatory. The demand for the programmes outweigh the availability. That is how much that the inmates want to attend the programmes. So we do not necessarily have to force anybody.

Mrs. Jennings-Smith: I see the majority of remandees, they attend programmes in mediation, religious and School Leaving and little emphasis or little attendance on programmes which relate to sporting activities, cultural activities and the impact of music. Could you tell us, you know, if there is any intention to reverse that pattern?

Mr. Alexander: That is going on right now. We have had 41 remanded inmates successful in their CXC examinations not too long ago. We have Futsal, the first well-organized Futsal Programme in Trinidad and Tobago run by Clayton Morris an ex—what you call them?—Soca Warrior in the prison with remanded persons. That is something now we are trying to create a policy out of another joint select recommendation because the last commissioner, Mr. Stewart, he used to give a wider birth in terms of the remanded persons accessing certain things.

We are in the process of amending the rules. A remanded inmate is supposed to be held by us for the court. The police is responsible for taking them and bringing them. We are not supposed to do much with remanded persons. To beat that what we do, we cause them to write or sign a document agreeing to. They are not even supposed to work according to the rules. We have found a way to cause them to sign. They go to school, they play music and they engage in sport. So that is the response.

Mrs. Jennings-Smith: You have answered my question because certainly it is not mandatory, but based on their feelings if they want to attend—

Mr. Alexander: Voluntarily, they have to—

Madam Chairman: Just a follow-up to that question, you said that there is a greater demand than supply, and I wanted to know if there are any partnerships that Government agencies or ministries can help to alleviate the lack of supply on the end of the process.

Mr. Alexander: Well, the supply I am talking about here is space and facilities. And, fortunately, let me give some kudos to the Minister of National Security, over meetings I was involved and he managed to encourage the Cabinet to find $54 million to renovate the remand facility. So we must give him kudos for that. [*Desk thumping*]

Madam Chairman: In that renovation, would that address the issues of space for the provision of courses?

Mr. Alexander: Yes it will, but let me give you some information also. The last administration had drawn up plans for a purpose-built remand prison and we were going along appreciating and awaiting it and it never came to fruition. That could have make a big difference because a purpose-built remand facility will cause you to do a lot that you

cannot do now in terms of libraries, in terms of classes, in terms of recreation and in terms of families. That is a very serious thing that we look at, being able to reunite families. Somebody locked up in the prison for 10 to 15 years without any kind of close relationship with their family is a serious thing. If you come to one of our Father's Day programmes and see how children hug their fathers, it removes this hostility from their heart.

Madam Chairman: Could I just interject and ask Mrs. Jennings-Smith to finish her question so that you can address that?

Mrs. Jennings-Smith: I have a concern, because I asked you previously as to your programmes with regard to remandees and you just said they spent sometimes 8, 9 and 10 years and you also said that the programmes are voluntary.

Mr. Alexander: Yes, they are.

Mrs. Jennings-Smith: Remember I preceded my question by telling you the percentage of these people, remandees, who are exhibiting tendencies of hatred, violence and those types of things. If you are saying that the programmes are voluntary and they are released back into society, and with the percentage of criminality we have in the society: how do you intend to deal with that differently? Because surely when those persons are released into society, having been in a place where they were given the choice to volunteer if they want to be in a programme of music, culture or whatever to change their mindset and to deal with their tendencies to be angry and hatred and all those things, if you said the programme is voluntary, then—and I see here 1 per cent on a survey that was done—only 1 per cent ticked off on football and those things.

Mr. Alexander: Where that survey was done?

Mrs. Jennings-Smith: I really should not be using that. That is really an in-house survey, but I am going on the point that you said voluntary. Are you confident or are you satisfied that by saying you have voluntary arrangements for persons who are there and a large percentage on hate and anger, are you satisfied that you are meeting the needs of the demands of the external environment that when they are sent back out they are sent back out in a peaceful manner or change or anything like that to impact on crime and criminality?

Mr. Alexander: Let me answer it this way. You used a word "choice", it is not "choice", it is "right". We have to obey the laws of the land, and this is why I said earlier on, all of us have to come together—the parliamentarians, those people who make the laws. Sometimes you talk to the Minister and tell him the necessity for changing a piece of legislation and because of the politics, it stays for years.

The remand people have their rights, but to deal with the essentialities with what you are speaking about there, it is better to convince a man than try to force a man because these persons you have to understand how they live. You talk about bitterness and whatnot, there are areas in Trinidad and Tobago more bitter than any place in the prison. You cannot walk about there. They will shoot you, they will rob you. The connect between the prison and the society cannot be overemphasized, and that takes a lot of consultation in order to deal with it.

What we do, we encourage spirituality. A number of persons, you know, in this world of academics and what have you, tend to discount the spiritual man, but we have seen some hard knots changed, got baptized and are living a different life. There are persons who try to access them with all the academia and all the diagnosis and just something about an individual, connecting a man to his God and he totally changed.

Madam Chairman: Mrs. Jennings-Smith, you have one more question?

Mrs. Jennings-Smith: Just one more. So we spoke a lot about mental and persons challenged with mental illness. In our experiences in the prison's department, could you tell me like out of every 100 prisoners, how many are mentally challenged?

Mr. Alexander: That number is small. I worked in the infirmary for more than 15 years. I was an Infirmary Officer. I took people to Dr. Ramtahal, to El Dorado Road, St. Ann's—where ever there were psychiatric institutions and specialized persons and I have seen persons got their life back together. Some persons were not fortunate, but I think the best cure for the ills of the society is that we have become too cold. Love is still the greatest healer. If we learn to love one another, Trinidad and Tobago could improve.

Madam Chairman: And as we are on that topic of taking people to different places for treatment, how many—you had mentioned that they are trained staff at the prisons who are stationed there to deal with the remand population and so on—trained staff do you have resident at the prisons to deal with the issues? What is the ratio of the staff to the prisoners and the remandees? The remandees we are dealing with? What is the ratio of the staff, trained staff to remandees and what is the ideal? Is there an international benchmark that it should be at? Where are we at? What are the plans if we are not at the ideal to get there?

Mr. Alexander: I will want to refer that question please to Mr. Lopez.

Mr. Lopez: Let me just draw reference to a number you was looking for earlier with the total population—percentage under psychiatric care as it relates to the total population, we have a total of 4.03 per cent.

Madam Chairman: Let me clarify. That is 4 per cent of the remand or the general prison population?

Mr. Lopez: Remand, the remanded population.

Madam Chairman: 4 per cent of the remand population are under psychiatric treatment?

Mr. Lopez: Yes.

Dr. Mahabir: Thank you very much, Madam Chair. Madam Chair—

Madam Chairman: Hold on, I think he has a further answer to give us with respect to the ratio of staff to remandees, and if that is close to the benchmark, any international benchmark, and if it is not, is there a plan to get to that point?

Mr. Lopez: We cannot compare it as against an international benchmark because simply we do not have that information, but the ratio of officers, trained officers to inmates, we have a total of 12 to 73.

Madam Chairman: Trained officers being psychiatrists?

Mr. Lopez: No, we have three PMOs, Prison Medical Officers, we have four psychiatric nurses, three psychologists and two attending psychiatrists from St. Ann's. We have a total of about 84 Infirmary Officers who have basic training in identifying and basic management of people presented with mental illnesses. They identify and they refer to the PMO who subsequently after assessing the patient, refer him to the psychiatrist.

Madam Chairman: I just want to make something very clear in my head. You have 84 prison officers who are trained to detect basic mental illness.

Mr. Lopez: Yes, Ma'am.

Madam Chairman: That training was supplied by the Ministry of Health in the courses referred to a little bit earlier by the Commissioner?

Mr. Lopez: Yes, Ma'am. The basic training we get at COSTAATT is part of the module. That is one of the modules.

Madam Chairman: Okay. So 84 prison officers are trained to pick up that initial—but that is for the whole prison, the whole prison population, in general, not specifically for remandees?

Mr. Lopez: Yes, Ma'am.

Mr. Alexander: To answer part of your question in terms of the adequacy of what we have, I will say no, there is room for improvement. I would like to see the training practicum that we had with St. Ann's restarted. That did a lot in terms of competency.

Madam Chairman: Could you just indicate for us how long it has been in abeyance?

Mr. Alexander: I would have to check that because I have been out of the infirmary for quite a while.

Madam Chairman: Okay. And it was a programme that trained on a yearly basis?

Mr. Alexander: Continuous basis.

Madam Chairman: Continuous basis. Dr. Ramtahal you have an input here?

Dr. Ramtahal: That was a one-off thing done by ourselves and a team from Dalhousie about eight or 10 years ago which went on for a period of maybe a few months and it was then finished. So that was quite a one-off and not really ongoing over the years, over the last 10 years. That was quite about eight or 10 years ago.

Madam Chairman: Is there another programme you are referring to Commissioner then?

Mr. Alexander: No, that is the same programme, but we knew the benefits because after the persons were trained, some of them went on to do further work in psychiatric nursing and things like that. So what I am saying is, we need to meet with the Psychiatric Association and if we could have that programme restarted—that was quite helpful to us—or anybody else who could provide that service.

Madam Chairman: All right. I am just trying to get it very clear. There was a one-off programme eight to 10 years ago that trained prison officers to be able to detect basic mental health problems. How many officers were trained in that programme, an approximate number?

Mr. Alexander: It was quite a lot you know.

Dr. Ramtahal: I cannot remember, but it could be 50 to 100. I am not sure really about that figure.

Mr. Alexander: It was quite a lot.

Madam Chairman: And they underwent this programme for a couple of months, but subsequent to that programme, eight to 10 years ago, where you had, let us say the maximum number 100 trained, what other training has been given? Apart from persons' private training what other training has been given or offered to prison officers to assist in this regard or has any been offered?

Mr. Alexander: Yes, through COSTAATT.

Madam Chairman: What type of training is that through COSTAATT?

Mr. Alexander: That is a programme geared to prepare the Infirmary Officers to function in the medical area, so it would not only be psychiatric in nature.

Madam Chairman: Okay. That is something that they undergo through the prison service, like an in-service type of programme.

Mr. Alexander: That is right.

Madam Chairman: Okay. And it is out of that programme then and whatever the remnants of the programme eight to 10 years ago that you would now have those 84 officers who are within the system and have been trained in that regard?

Mr. Alexander: But it is ongoing. It is ongoing.

Madam Chairman: I think, Mr. Lopez, you may have more of your answer you wanted to give?

Mr. Lopez: No, that was the end of that Ma'am.

Madam Chairman: That is it? Okay.

Dr. Mahabir: Thank you very much, Madam Chair. There is a follow-up—I have a couple of others—with respect to these prison officers. I am glad to hear that the prison officers are subject to a formal training programme. I think that dealing with that population you do need to be formally trained to handle the various idiosyncrasies of the behaviour of that population. I am posing a question to both the Commissioner and Dr. Nwokolo and that is, Dr. Nwokolo indicated that the majority of patients who are suffering from some psychiatric problem are brought in by regular people, brought in by the lay people. I am simply wondering whether Dr. Nwokolo can, as a trained psychiatrist, is that possible to provide a module where not only officers who are working in the infirmary, but officers who are interacting with the inmates on a daily basis can be exposed to some rudiments of your profession so that while they feed them and they speak to them and they take them out, they are able to basically be your first responders and to be able to tell the Infirmary Officers, the 84 of them or the trained psychiatrists, that we think in cell No. 5 there is a patient you have not seen that you may want to evaluate?

Is it possible for you doctor to prepare a module for lay people so that they can be exposed to some of the things that they should be looking for so that all prison officers and then subject to the kind of training that is necessary and that, therefore, the entire remand population can be subjected to some kind of continuous evaluation? That is, I am asking you as a professional, if that is possible, a module that you and your unit can prepare as opposed to COSTAATT, and for the Prison Commissioner whether, in fact, he is of the view that that kind of training for all of his officers should be part of his training module for correction officers in Trinidad and Tobago. That is the first question. Thank you very much.

12.00 noon

Dr. Nwokolo: Yes, it is possible if it could be linked with the training that he spoke about in COSTAATT as a continuous process. It is possible for a professional, a mental health professional to generate such a module, you know, as it is, introduction to psychiatry or detection of mental illness as it may be. If it is for the general prison officers, you understand, it will be useful, such a training module.

Madam Chairman: Dr. Mahabir, I just want to ask a direct question on this. In the development of the programme at COSTAATT, there is a module that deals with that type of situation, mental illness, and so on, so what I want to ask is, seeing that you have asked, could there be input, I would like to ask, how then, what was developed at COSTAATT? Who gave the input there to develop that programme that they currently undergo?

Mr. Alexander: Over the years it started with an institution called Allied School of— [*Inaudible*] at the Port of Spain hospital. We started training our medical people many, many years ago because we saw the need. We used to call it the paramedic programme back in those days where you were taught almost everything, from emergency care, so if

an inmate collapsed you would know how to check the airway, what to go to first, and all that kind of thing, and then it developed over time into this COSTAATT programme. In terms of adding an element I think it would just be up to discussion and need. This is why I keep emphasizing stakeholder interaction in order to meet the challenges, because to live means to say you have to evolve. As new demands come your way you have to deal with them. So I would be very supportive of any additional criteria, training, support that could cause the officer to perform at a more professional level. But I must remind you that infirmary officers are on call 24 hours, seven days a week. There is never a period of time in the prison where there is no access to an infirmary officer. Infirmary officers work from batches around the clock, and the PMO is always on call.

Madam Chairman: Thank you. Dr. Mahabir.

Dr. Mahabir: There is a response, could we get this other point?

Madam Chairman: Sure. Dr. Ramtahal.

Mr. Husbands: Just one quick response to that. I know for a fact the prison service has been going abroad and is part of the IPCA that develops best practices, and that is an avenue where you can actually get a module for the training for staff in that particular field, mental health, whatever field, right, and they can also provide you with the whole module, which could be incorporated in our developmental training.

Dr. Ramtahal: We have about 30-something psychiatrists in Trinidad and Tobago, and we have a department of psychiatry at UWI, an academic department headed by Prof. Hutchinson, who is right here at the back—I just saw him when I turned around there—but I do not know that anyone of us is involved in that COSTAATT programme. So I am not sure what happens there, and I just do not know anything about it.

Dr. Mahabir: May I therefore recommend, since Dr. Nwokolo indicated that the trained psychiatrist can offer some kind of guidance in a training module to all prison officers, may I then recommend that in the welfare of the inmate population, the psychiatrists interact with the prison authorities so that the training which you can offer from a professional level can then devolve onto all officers in the prison service in the interest of the inmates. So that we will be complying with international norms and international best practice, because, you see, I was under the impression that the common man could not be exposed to training to evaluate mental illness, but Dr. Nwokolo was very clear that he can train individuals to look for certain things so that they will be the first responders. You see, what the Commissioner indicated was that the infirmary officers are available 24/7, but someone has to tell the infirmary officer, someone who is seeing the incarcerated individuals to say, we think there is something amiss in a particular person in a particular cell. And this is what I am after, that all officers should be trained so that they will be able to call these infirmary officers on our 24/7 basis.

Dr. Ramtahal: Let me caution you a little bit there. This is just the reductionist view of psychiatry, or the bias view of psychiatry. Nobody asks lay persons to go and look for illnesses of diabetes, hypertension, strokes, Cushing's disease, and all these other medical illness. So somehow psychiatry is viewed differently where some persons seem to think that they are easier to diagnose, or because they are behavioural in nature they are somehow different, and somehow more accessible to the layperson, but there is no programme in this world that asks the layperson to screen for other medical illnesses. I am not aware of that, right, and these are complex illnesses.

Dr. Mahabir: Okay—

Madam Chairman: If I could just interject, in the same way if I am following Dr. Mahabir, in the same way that there is a paramedic course, which is not a full medical degree, I am looking at this as the same type of exposure that can indicate that there is a problem, not necessarily go to the diagnosis state, but indicate that there is a problem and, therefore, that person needs to be referred. So I am thinking that that is the approach that Dr. Mahabir is suggesting.

Dr. Mahabir: That is exactly the approach, and I understand that the psychiatrists as professionals will have their issues with lay people, but, you see, when we are crafting solutions, solutions are not necessarily perfect, we will not pick up all. In fact, we may include some people who are normal, but my view is, unless those who interact on a daily basis, as if we have relatives we interact with them on a daily basis, and if they are not right in terms of what we expect as normal, it is our duty to kind of tell a medical doctor, could you just check it out; I am not diagnosing but I feel something is not right. And I am simply looking at the psychiatrists in Trinidad and Tobago to determine from them whether, and I have to go to my second question, but, really, I think as a solution, not a perfect one, solutions are never perfect, but is it going to be beneficial to the inmates, the remandees?—many of whom are going to be incarcerated for 10 years and more, that the people with whom they interact on a daily basis keep an eye out, because we only have six or seven psychiatrists servicing a population of a few thousands. So the economics of the thing is that, if Dr. Nwokolo can provide that particular training programme then maybe we will be able to catch a bit more people that who are currently being excluded and who may be languishing for 10 years in remand. But my second question is this—so that is for you all, the professionals to consider; that may be a recommendation of the Committee.

But my second question is this, again to Dr.Nwokolo. Dr.Nwokolo, at the behest of the Committee, I, together with members, visited the remand in Golden Grove and the remand in Port of Spain, and on another committee I had the opportunity to visit the psychiatry department in St. Ann's where you are housing those with criminal charges, and I tell you one thing, when I saw the remand conditions at the Golden Grove from what I saw, it was scary. Nine individuals in a cell sometimes. I am speaking to one of them—I do not know how many are in the cell, and they had a few of them from the back come in and it is dark, the lighting is poor, ventilation is inadequate. I want to ask you, Sir, and I would not want to compare both, both of them are equally bad, it is like a rock and a hard place, but with respect to the psychiatrist what effect does overcrowding do to the mental health of someone? This is for Dr. Ramtahal as well, because in your profession you probably do have some studies with respect to space, confines of individuals, and I am coming to craft a solution, but what is the effect of overcrowding, an overcrowding and confinement for 23 hours of the day on the mental health? So I am talking about someone who comes in, he is a lawbreaker or potential lawbreaker, but the condition under which he is housed, I would like to know what contributing factor is that to his mental health and well-being? And what kind of mental problems can arise when he is confined in a space with nine others, eight others for extended periods? What are the studies telling us?

Dr. Nwokolo: Yeah, there are ample studies that have looked into overcrowding, even in prisons, you know, and they positively correlated with development of mental illness, aggressiveness, depression, you know, especially. So it does impact on any population of people, be it socially, people who live in a crowded situation, in refugee camps, they have studies here and there that have positively linked overcrowding with mental health issues.

Dr. Mahabir: Okay. But what kind of issues that would arise directly from overcrowding?

Dr. Nwokolo: Specifically depression, adjustment disorders with depressed mood, agitation and violence, you know,

which are not diagnosis in themselves. But behavioural anomalies like combativeness, fighting, violence, you know, could arise in such situation, and for those who are unable to cope, definitely, could lead to depression.

Madam Chairman: Let me just interject here, though—

Dr. Mahabir: Yeah, sure.

Madam Chairman:—because we asked this question earlier on, and the research you are referring to that there is a correlation between the overcrowding and that, has that research been done in Trinidad and Tobago, or are we referring to international research that has been done—

Dr. Nwokolo: Yes.

Madam Chairman:—that can refer to.

Dr. Nwokolo: It has not, to my knowledge, been done in Trinidad and Tobago, but when it comes to overcrowding, in that sense, human beings are similar, whether it is in Trinidad and Tobago. If it is valid in Guyana or Australia, trust me, overcrowding to that extent will be violating, you know. So when we talk about studies not being replicated there, there are certain studies that are universally self-evident, overcrowding is one such.

Madam Chairman: And let me ask again, just in case it may have slipped and we can get a different answer this time to the same question, is there anything to indicate then, any data to indicate that the occurrence of these types of mental disorders are greater in the prison population, specifically in the remand population than in the general population?—because when we asked it before the impression I got that there was no data actually saying that going into the remand prison, with all the conditions that we know exist there cause you to end up with a greater possibility of having a mental disorder.

Dr. Nwokolo: Yes, there are no data in Trinidad and Tobago. And, certainly, in those countries where they are diligent about data-taking, I will presume they do not have the sort of overcrowding that we have, you understand, but there are no data, local data as to that.

Dr. Mahabir: Madam Chair, could I continue?

Madam Chairman: Sure.

Dr. Mahabir: Then a potential solution, there are mental problems which can arise, I would imagine physical health problems, respiratory problems, and asthma, and so on, but we are looking at the mental health. To the Commissioner of Prisons, you see, for the remand population they are not guilty, they have simply been charged, and, I am wondering, since overcrowding is an acute problem in the Remand Yard—it is acute, I have seen the cells myself, it is not theoretical—how difficult is it for the remand population to have much more time outside as opposed to the one hour per day that the regulations allow them to give? Is it possible that they can be out for more hours in the day to play cricket and football, to walk, to mix and mingle? They have not yet been convicted, but what resources will you need, I should ask, to allow them to spend more time on the outside as opposed to being in their cramped cell?

Mr. Alexander: What we have done is to transfer inmates from the remand prison to the Maximum Security Prison, which is more liveable, it is more modern; you cannot put more than three persons in a cell because bathroom and toilets are constructed within the cell. It is a more humane institution, so what we do, we transfer persons from remand to MSP, and more of that will be done in order to—

Dr. Mahabir: Prison Commissioner, I need to interject, that is not the question I asked.

Mr. Alexander: What is it?

Dr. Mahabir: The question I asked was this, how difficult will it be for you, not to shift them from one prison to the next, but to give them more airing time as opposed to being confined, whether it is in maximum security or in remand, give them maybe four hours as opposed to one hour. Is that going to be impossible for you to achieve?

Mr. Alexander: It is not impossible, but this is why I told you about transferring. If you have 1,400 persons in one space, how much hours you could give each of them? You will have to give them 24 hours, because there are some persons cannot air with some persons, they are from different gangs. There are people who we have to separate, it is not just a matter of airing. So this is why I am saying the way the MSP is constructed there are four different airing yards, so it is easier to keep people outside for longer hours than at the remand.

Dr. Mahabir: A follow-up question, at the Maximum Security Prison then, what is the average amount of time an inmate is allowed in the open air?

Mr. Alexander: Three to four hours.

Dr. Mahabir: Okay. Very well. One final question, Madam Chair. The final question is this, and again to the psychiatrists, we have spoken about the training of prisoners, we say it is possible; we have looked at overcrowding, we know that we could work into a programme so that if they are non-violent and if they are cooperative they can get more hours outside, but now I want to ask the psychiatrists about this notion of living under conditions of uncertainty. In the maximum security prisoners have already been convicted, they know they have to spend 10 years. They have reconciled. It is like closure. In remand you do not know whether you are coming, you are going, or you are staying put. Some of you can leave after a year, some can leave after 12, 15 years. The question I want to pose to the psychiatrists is this: What is the effect of living under this type of uncertainty on the mental health and well-being of a remand population, uncertainty and mental health?

Madam Chairman: And while you are answering it, maybe you can tell us if the answer you are giving is a general answer, if it is based on any kind of data that has been recollected, or if it is correlating with what you would have seen abroad.

Dr. Nwokolo: Yes, that is why I am trying to say that I would not be surprised that different psychiatrists may look at it differently, because psychiatry and philosophy have a very close interrelationship, because some people might watch it that people in remand have hope, people who have been convicted have no hope. People in remand who are innocent and have been caught wrongly will be affected, you understand, whichever way. People who are guilty may still have hope that these magic lawyers might get them out, so they are, certainly, I will expect that those who are convicted already will have a higher percentage of mental health issues, and that is granted that our police is not incarcerating or remanding a higher proportion of innocence people than warrant. So it is a technical question that I am sure you will be hard pressed or find any study to tease these factors apart. So it has to be on, one, the knowledge about human nature overall, and the people in remand have hope. The people who have been told they are lifers, or they have 10 years do not have as much hope. It will now depend on how they cope, or what kind of counselling they get along the way. So that is my view, but we have about three psychiatrists in the room, I will like to hear what they say.

Madam Chairman: That is what I was just going to say, maybe some of the other psychiatrists may want to weigh

in.

Dr. Mahabir: Yes.

Dr. Ramtahal: I could just give an opinion, I mean, I do not know of any study that has looked at that one problem of uncertainty about what is going to happen in the future, if you will be there for 10 years or 10 months, or 10 days. Psychiatric conditions like depression and others are caused by genetic influences and they are precipitated in the main by environmental stresses, so it depends on the person really. It depends on the resilience of the person, which sometimes it is a genetic thing as well, and a combination of the two. So it is hard to give a good answer on that; it depends on the genetic resilience of each person. I cannot really give a good comment on that.

Dr. Mahabir: Maybe Prof. Hutchinson that is a part of the research agenda of the department of psychiatry, because for me it is a critical matter. The reason is this, Trinidad and Tobago houses inmates for periods in excess of 10 years. It is greatly in excess of international norms. And that is a problem that seems to be peculiar to Trinidad and Tobago. So as a fellow professional I think it is something that you can consider: What is the effect of this uncertainty in prison sentencing on the mental health and well-being of the inmate population of Trinidad and Tobago? Your response on whether you think it also is an important study worthy of investigation.

Prof. Hutchinson: Yes, I think the length of time that they spend there I think is a critical factor, and I think it is a factor in all of the things that have been discussed, because the pace of the judicial system seems to be slow, the experience of those conditions is—the uncertainly is really about the length of time you will have to experience those conditions, and I think that is where the challenge to mental health occurs.

Mrs. Jennings-Smith: One thing coming out from the last speaker is the importance of resilience building, environmental stresses, and I want to quote from the Commissioner of Prisons. Earlier on when you introduced yourself and you spoke of the whole institutionalization in treating with access to clinics, and stuff like that, within the prisons department, and relative to programmes to reuniting families, and I want to ask you if there are any non-governmental agencies that partner with the Trinidad and Tobago Prison Service to provide programmes and services to improve the mental health of prisoners on remand.

Mr. Alexander: Many. We have quite many. I have six pages of persons; that is to tell you the quantum of people that are eager to assist. They bring a different dimension. The inmates, after a while they get accustomed to the officer, whoever is around, to see a new face. They get a different perspective to know that somebody else outside there cares about them, and is telling them that; they look forward to it, and we have found that there is a reduction in aggressiveness, in breaches of the prison regulations as a result of that. I was telling an officer: When last did you hear about an escape from the prison or any major riot, or bloodshed? I would want to knock to make sure that that continues. [*Laughter*]

Madam Chairman: As we all do.

Mr. Alexander: Yes.

Madam Chairman: Mrs. Gopeesingh.

Mrs. Gayadeen-Gopeesingh: Yeah. Dr. Ramtahal spoke about environmental stresses also impact on the mental health of the remandees. What is the incidents, perhaps the Commissioner of Prisons may answer that too, what is the incidents of prison rape on the mental health of those remandees? And what is it that the Commissioner of Prisons or

the prison service is doing to try to mitigate or to reduce the incidents of those?

Mr. Alexander: It is a horrible act because, remember, you are interfering with the masculinity or the perception of the "man-ness" of a human being. So those individuals, to start with, a person may get rape and may not even come forward. So what we do, it is something that we do not take lightly and, in many ways, you know they say, "out of evil cometh good", because of overcrowding it reduces it because there are many more persons in the cell and somebody will speak up, as opposed to if two or three persons are in a cell it can more easily occur. We have found that has decreased tremendously. Thirty-something years ago when I joined the prison there were some predators that you had to incarcerate differently. The minute they get mixed in the population they would engage in that behaviour, so you have to lock them down and lock them in a cell by themselves which reduces your capacity to house the population because it is only one individual you could put in a cell. But with the increase of visits, and the inmates are allowed to talk in an open forum with civilians, to be labelled a rapist in the prison will have certain consequences for you. Prisoners frown on two persons in jail, rapists and child molesters. When they come into the prison we have to house them separately. That is strange, somebody will rob you, chop you, shoot you, but they will hate you for raping another individual.

Mrs. Gayadeen-Gopeesingh: And does that really impact, Dr. Nwokolo, does that impact on the mental health of a remandee?—the rape, does that impact on the remandee?

Dr. Nwokolo: Definitely, they are human beings. Rape and such assaults of one person will always have mental health consequences, adverse consequences. I say definitely that rape and such assault on persons' personal integrity will have adverse mental health consequences. It is universal.

Mrs. Gayadeen-Gopeesingh: And one diverging view I am taking now, I believe the Judiciary, the court would have sent certain persons for evaluation, how many, thus far, have been sent? And how many are still waiting evaluations?

Madam Chairman: Well, that depends on a time period, what kind of time period you are talking about?

Mrs. Gayadeen-Gopeesingh: From 2016 to 2017.

Dr. Nwokolo: Dr. Ramtahal, I guess, would be in a better position, but people who come from Magistrates' Court are usually processed within two weeks. They are processed and returned to the Remand Yard, or prisons, as the case may be, and that goes on. Where we have a backlog is persons who come from the High Court, and, as he said, who need more extensive psychological testing, you know, and in that area we have really suffered a lot of backlog. And, hence, now there is a backlog list that we are aiming to attend to in a systematic manner. So I do not know if he has any information to give concerning this.

Dr. Ramtahal: Well about the same, we get patients from the Magistrates' Courts and from the High Courts, so right now we have about 36 male patients there and two female patients today. With the resignation of a forensic psychiatrist recently we had a little bit of a backlog, but Dr. Nwokolo is taking up that mantle for now.

Madam Chairman: If I may, we have been discussing at length this issue of mental health and the enquiry really deals with mental health, which is very important, as well as the issue of family life concerns. So I would like us to spend a little time now—I know time is far spent, but just a little bit longer, and I want to engage Vision on a Mission. The remandees who spend many years, we have one of the questionnaires coming in speaking to quite a number of persons in the sample spending between five and 10 years in the remand section at the prisons, what is the effect of

this on their families? And what is happening to bolster that?—because one of the enquiries we would have done early in our tenure as a Committee is looking at the effects on the children of perpetrators of violent crimes, and so on, and how they are effected. And we would want to know what is happening for the families, and with specific reference to the children, because many of the remandees are in the age where they have young children between the ages of one and 10. When we looked at the statistics presented from the questionnaires we gave out we, realized that there are quite a number of children who would be effected by their parent being incarcerated in remand. What is in place for those families, and especially the children?

Mr. Chance: I know Mr. Husbands would like to have an input so I would just allow him, and after he completes I would definitely want to have an input as well. So, thank you very much.

12.30 p.m.

Mr. Husbands: Madam Chair, first I must identify there is not a clear policy on what you call family life and incarcerated persons as is done abroad where they do a complete assessment in terms of the number of children, where the children are, the ages of inmates who are on remand or convicted. And they have what you call an intervention, a family life intervention at two levels, one, inside the prison where it deals with family life to see how it is impacting on the individual in the prison in terms of the social impact, in terms of isolation, in terms of his mental health and the like, but particularly towards the children.

There is a lot of research, not locally again, but internationally in where the impact is very, very grievous, it is negative, it is impacted in terms of, one, social impact. A lot of those children are grieving, going through grief and loss and they are trying to be secretive because they do not want people to know where either their mother or their father is at the moment. Right? They also suffer a lot of, what we call, disorders from the trauma in terms of not having their mother or their father there.

More than that, the research suggests that they are the ones who get involved in bullying in the schools; they are the ones who become prime targets for domestic abuse, for human trafficking. There is also the impact in terms of children in terms of running away because some of them have to go to caregivers. Sometimes the mother and the father, if the mother is there, the mother is unable to provide adequately because the father may have been the breadwinner, so there is that aspect of that economic impact as well. But having said all of this, there is the whole sense in terms of they are at the highest risk of becoming delinquent or in also becoming adult perpetrators. So that is the critical areas in terms of how it will impact on the family life, because family life has a lot to do in terms of what are the activities that a family would be involved in, and the fact that the father or the mother is not there, there is not that kind of bonding, adequate bonding, and those children develop what we call in corrections, they suffer strain. There are no adequate bonds to the family, there is no adequate bond to education, no adequate bond to work and valuing life and they become very estranged. And more than that down the road there is that sense in terms of no adequate bonds to law, order, morality and justice.

So they are the ones exposed to all those risk factors when they have a parent incarcerated, and without proper intervention from the social services, right?—there is going to be that kind of detrimental effect, and as I said earlier you will find that they are more represented in the adult institution when they become adults or young adults.

Madam Chairman: Mr. Chance, just before you weigh in, let me just indicate that what was said there came out in

our deliberations. At that enquiry we looked at the children of offenders, and it was established at that point in time that there is no research being done to identify these children and to make any type of intervention to assist them so that they do not undergo and become, as you say, over-represented. And again, there is no data either that would, except international data, give us some factors that contribute, but in Trinidad and Tobago we do not have that data available to us; there is no tracking done of children whose parents have been incarcerated and how they proceed along the journey. So I just wanted to put that into the conversation. Mr. Chance.

Mr. Chance: Thank you. You answered the question there as well. I want to just go back a bit to Mrs. Jennings-Smith when she was engaging the Commissioner as it relates to the remand preparation while remanded to reduce the incidence of recidivism or reoffending as VOM works with the Trinidad and Tobago Prison Service to provide resettlement service or reintegration service. We do not work, and I am not privy to all of the different programmes that exist in the prison, I know of a lot. I am not privy, have knowledge of what exists to a great extent within the remand. However, I know we provide a great degree of service for persons expecting to go home, but that is more within the convicted division.

I would want to know if persons remanded are not expected to return back to society, and therefore, why not a preparation for release?—even though there is uncertainty, why is there not a preparation for release for remand inmates? Because the challenges faced by persons convicted are also faced by persons who have spent a lengthy time within the remand prison. And most of those persons who come out on bail or after being acquitted and so forth within the court system, do approach the step of Vision on Mission, but we would not have any kind of interaction, prior interaction of their criminal history or what would have taken place within the prison, and that creates a setback for reintegrating them and making recommendations for places of employment, et cetera.

So, I would like to make a recommendation in respect to the question that Mrs. Jennings-Smith has put and to this panel in respect of inmates attending via convicted or remand, programme by choice—attending programme by choice, but attending programmes based on compulsory. Because when inmates come into the prison and they are criminalized and they are involved in certain circles, the likelihood of that person coming and saying, "officer I want to change", is very, very small. Right? They would try their utmost to remain within their circle. So the onus is upon the officers to be the motivator, to encourage those persons to access programmes. So if you leave it up to them they would spend the whole five years, whatever period of time, just within the circles, et cetera.

So I would like to see and make recommendation that the Committee also look at passing legislation for the prison to have a greater hold in terms of those who come in the system, to participate in programmes by compulsory, and mainly as it relates to the preparation for release, because that is a whole regime, that is a whole module in terms of best practice within the criminal justice system. It is the last end of the criminal justice system. How do you take or usher back that person within the community? What is the practice? What are the procedures and steps?

So, I would like to see that take place, and that kind of preparation will allow us to engage their families, because at the "convicted" division we would engage families with the welfare division of the prison service prior to the inmate's release so we could see what is happening there and make whatever adjustment for the return of the person. If the person does not have the wherewithal to return, then we provide a transitional housing programme for that person, as opposed to that person being released abruptly and have to face, that in itself–sometimes a man walks

into a home where he is no longer welcomed; he meets new people in the home and this could have certain triggers, even mental health triggers, and the possibility of reoffending, and we deal with that on a quite frequent basis.

So preparation for release alleviates and reduces those kinds of incidents. So I would like the Committee to take into account, if possible, as far as possible recommendations to empower the prison to make programmes mandatory in certain aspects particularly too as it relates to the remand persons in terms of coming out of the prison, so that they could have the same opportunities as convicted persons upon being released from prison.

Madam Chairman: Mr. Bruce.

Mr. Bruce: Thank you very much, good afternoon. I would just focus on the first question that was asked in terms of the family. The Trinidad and Tobago Prison Service has recognized the importance of family, as Mr. Chance has said, the importance that the family plays in reoffending. We have developed programmes specifically suited for the remanded that would deal with issues like Fathers' Day where the Prison Welfare Department when they see the need either through the family or through the offender, where they would bring families together to deal with issues.

To focus on what Mr. Chance has just said, a remanded person, managing a remanded person is different to managing a convicted individual. Every time a remanded man goes to court he is of the belief he may be going home that day. Preparing someone for reintegration at that point, you cannot prepare someone for reintegration from there because if he does not go home how do you measure what is happening? What comes up is the length of time an individual spends at the remand. The length of time that an individual spends at remand it is really long. And I hear the ease we say 10 years, 15 years, that in itself is too long. A remanded person is innocent until proven guilty; they come with rights. Forcing someone into a programme, I am innocent, I did not commit the crime. Am I going into the programme, am I admitting that I am guilty? All these things are taken into consideration by the inmate.

And we must recognize that managing a convicted inmate with a planned intervention in case management done through the LSCMI is different to managing someone when every time he goes to court he is of the belief he is going home. Whilst he has hope, he has hope that he may go home, but a convicted inmate knows he is going home, he knows the time, he knows how to plan, he plans with his family and that support system is developed.

And the work of the officers is there to ensure especially the Prison Welfare Department, the programmes department, the officers who work on the lines with the inmates they are trained on issues of motivational interviewing, so they would encourage inmates to be a part of the programmes. And the separation of inmates is also important where we have the classification to reduce harm to themselves and to others, and that continues within the service.

Mr. Alexander: Just one continuation on that—

Madam Chairman: On this same issue here—

Mr. Alexander: Yes.

Madam Chairman:—that we just ventilated for a little while?—a short intervention.

Mr. Alexander: Yeah. Yeah. Here is where your probation department earlier I talked about a policy. Right?—and the aspect of community corrections. There is something in corrections called pre-trial resettlement where you prepare the person for the eventuality in terms of how long they may be there, but more than that how you bridge the gap between the family who is outside and the individual. The person may still have housing, the person may still have business and the like, so that is the preparation in terms of pre-trial preparation. It is something that is now invoked

in corrections, because of the length of time that people are spending on remand.

Madam Chairman: All right. So we take that point as well. If I remember correctly, Commissioner, you would have referred to the fact that the prison has taken a decision to increase the visitation above and beyond what is provided for in the Prisons Rules that have existed since, I think, the 1940s. Not so?

Mr. Alexander: Yeah.

Madam Chairman: Yeah. Okay. Could you give us a little more idea about that, and why this decision was taken, whether it was with the family in mind and that type of situation? And if you would indicate, is there any consideration given for extra visitation for remandees with families or is it a standard thing across the board whether you have a family or you do not have family?

Mr. Alexander: Well, the first thing I want to indicate, we have to disabuse our minds of the notion of what is family. There are challenges that we face that you would not understand it until we sit down for about five weeks or so to talk about it. We have this concept of a family being a man, a women, a car, a house and a dog. There are all kinds of permutations of relationships outside there.

Madam Chairman: Okay. Let me just step in to clarify exactly what we are speaking about here.

Mr. Alexander: "Um hmm."

Madam Chairman: We are speaking specifically to the spouse or a common-law spouse or—

Mr. Alexander: Girlfriend?

Madam Chairman:—and dependants. Whether it is common law or a long-standing girlfriend. What I am asking is, is there any differentiation made if you have a girlfriend alone or if you have a wife or if you have a wife and children or children alone? Is there any differentiation made? So I am "kinda" trying to narrow down the family which I understand could be very broad.

Mr. Alexander: Well we get difficulty in narrowing it down because Mr. Bruce spoke about, say for example, the children's day when we try—we have noticed children have a way of touching men's heart. They may have problems with the wife, they "doh" want to see the wife. The wife may be with somebody else, but she would bring the child on that day and that will do something in terms of changing that individual's behaviour, so we focus more on the children.

When the welfare officers goes out to investigate this family because the prisoner John Smith will tell you, I have two children or I have three children, two with Jane and one with Mary. You have to make sure Jane and Mary does not fight when they come in the same space. It is a whole lot of background work you have to do, but we focus on what the prisoner tells us because you do not want to create friction and possibly when the inmate is released he goes outside there and murders the wife or spouse or whatever you choose to call them. It is not as easy as just—there is a lot of background work that you have to do.

Madam Chairman: You know, what I am asking is, you said you all will increase the visitation—

Mr. Alexander: Yes.

Madam Chairman:—I am just asking, what is the basis for that increase? And I am just asking, is the visitation standard for every remandee or are there any considerations given for somebody who may have children or a wife or that kind of thing?

Mr. Alexander: Yes. Consideration is given. What are you asking, the genesis for it; the reason behind it?

Madam Chairman: Yes. I am asking, how come you all increased the visits?

Mr. Alexander: Ah ha.

Madam Chairman: Right? And I am also asking, every remandee gets the same visitation time and period whether they have children or not or is there any differentiation made?

Mr. Alexander: The standard visit, all remanded inmates are given the same 15-minute twice a week visitation, but what I am talking about is the additional visit, what we call special visit. The rules provide for us to give special visits dependent on what the issue may be, familial, business or what have you, but in addition to that we have created days for children where the children are brought in and we have an activity; whether we have music, we have treats, we have bouncy castles for the children. We have also what we call a superintendent weekend visit for persons of good behaviour, and that could be utilized also to influence persons' participation in programmes. When we were talking about whether compulsory or voluntary, well we know the law restricts you in terms of compulsory, but we could create incentives and we do that.

Dr. Mahabir: Mr. Commissioner, I am not clear with respect to the amount of visits. If I am a remandee and I have a five-year-old daughter, how often in the year could I expect the prison authorities to arrange for me see the child?

Mr. Alexander: That would not be standard; that would be dependent on a request. Any inmate who—and there are stipulations whether the child was born within one year of him—that is the rule. He could make a request to see his child, the Welfare will investigate to see how plausible it is, and it is sent up to the seniors, and they okay it and the visit takes place.

Dr. Mahabir: Right? But from your experience is it possible that someone with a 10 year old can see that child after he has gone through the channels maybe six times for the year, is that possible?

Mr. Alexander: That is possible.

Dr. Mahabir: Okay. Very well.

Mr. Alexander: Let me remind persons, the old rule—no, I should not say the old rule—the rule is, persons under 16 years are not allowed in the prison. I came into the prison and met that and that is still on the books, because there is a school of thought that says, those minors will be affected, psychologically affected.

Dr. Mahabir: Right. But like a follow up on that, you see, I understand that that may be a constraint. In fact, I spoke to many prisoners who have indicated that they did not wish their children to see them in prison. And so, I am simply wondering, prisoners are transported on a monthly basis, once every 28 days, remandees, to go to court, so you have a process where prisoners are transported. Is it at all possible that prisoners may be transported to some neutral place where they can meet their child outside the prison setting in a secured area to have a box of chicken and chips and to spend two hours?—something that fathers and mothers do on a regular basis.

Mr. Alexander: Well I do not think that is necessary because where we cause the children to meet the fathers is not in the cell areas, you know, it is either in the gymnasium or that kind of broad setting.

Dr. Mahabir: But, Commissioner, I went to prison and you should see the amount of gates I had to go through. And whenever you go—and I went as a visitor. Right?

Mr. Alexander: Ah ha.

Dr. Mahabir: So the children and they know that their father or mother is behind four or five gates and has to come through there escorted. What I am asking is, to avoid any notion of incarceration, is it at all possible that you can meet in a neutral setting outside the prison system where the children know that their parents are behind bars, but they are seeing them in as normal an environment as possible so that some level of normalcy can be retained over the course of the visit.

Mr. Alexander: That would pose certain security risks. I will prefer that—I went to a prison in Colombia and there is something like a park on the prison compound. So there is open air, trees, there are benches and, you know, you almost fraternize in a—that would be a more manageable situation.

Madam Chairman: In the refurbishment plans that are proffered, the $54 million plans that would be toilets and so on, any spaces like that are envisaged for the development of any of those?

Mr. Alexander: Well we have not done the design as yet. In terms of the question you asked, we have not done the designs, but when I said just now purpose-built remand prison, these are some of the things that we would want to do. Environment influences behaviour, ambiance affects your psychology, so these are some of the things.

We have partnered with the Correctional Institute of Canada. We have sent 14 officers to understudy their system. They have come to Trinidad and have seen our system and we intend to remodel and modernize. We liked what we saw in Canada so we are getting some assistance from them.

Madam Chairman: Let me just ask a question here. I know we are looking at the conditions for the prisoners, the remandees especially because they have not been convicted and so on. We may not have the data here, but does data suggest that the recidivism rate and so on is reduced when all these conditions are made right and they have access to their family and so on. Is there data that suggest that is what happens and therefore, that is why we are making all these suggestions to move towards that because we want to see a reduction in our recidivism rate that matches that kind of investment?

Mr. Alexander: Well two things, internationally there is data. The University of Pennsylvania, I think, in 2011 did something. We have anecdotal information. We are in process of computerizing so that we can do some manipulations and make some projections and things like that. But from anecdotal and academia would suggest, because it is something that you can reason yourself, you know. The more you treat somebody like an animal, do not be amazed when they behave like an animal, it is like a self-fulfilling prophecy. Why it is violent crimes are mostly centered in improvised areas, and none-violent crimes are created by a different echelon of persons?

Madam Chairman: But you know there is a view, I am not saying it is a popular view nor is it the right view that, you know, these persons may have committed wrong and if they did not put themselves in these situations then they would not have to go through this, and the society is, you know, spending so much time considering their rights and ensuring that they are well taken care of and some people, you know, tend to feel as though that is too much to be offered to that sector of the population. So that is why I was asking that because if you are doing it, we are doing it with a purpose in mind which is to reduce, generally to reduce crime, you know, and to reduce—

Mr. Alexander: You are quite correct, and the public must see that because there is always this competition for resources. And while some of them are of the view, why do you spend all these resources on people who have killed and raped and do people—and there are persons who have done nothing, but because of circumstances of life they

have no access to anything. This is why that I have said up front, without love and understanding the concept of love we cannot have a properly ordered society, you know, we could do what we want.

Mrs. Jennings-Smith: And so we are staying on the premise that the persons we are referring to are persons awaiting trial, right?—and they have certain rights. I want to know how robust is your programme of intervention with respect to other Ministries?—Ministry of Labour and Small and Micro Enterprise Development, social services and Housing and Urban Development, because and I want to refer particularly to the mothers out there who when these men are incarcerated, they depend on them for their livelihood, taking care of the children out there. I want to know what programmes you have or what programmes you intend to have or what are the present arrangements and how robust are the arrangements undertaken with the Social Welfare Department?

Mr. Alexander: I will briefly answer you and then I will put it on to Mr. Bruce, please. Recently, we had two officers that were killed and the sword cuts both ways, and they have children. And as a prison family we came together in order to meet certain financial obligations. I "doh" know if you catch me? There are gaps in the system that do not provide for certain things in an appropriate and sufficient manner, but there are things that we can do, and I will hand you over to Mr. Bruce to answer that question.

Mr. Bruce: Thank you, Sir. We have to understand that the prison service has adopted the philosophy of restorative justice. No one is there to stay in prison and they would come out. The recognition that the family support system is a strong system to keep somebody from reoffending, as Mr. Husbands would say, that is best practice. That study has been done throughout although it has not been here, we could safely understand that in a family system if somebody feels a sense of belonging, a sense of value towards that system, they would not likely reoffend.

Mrs. Jennings-Smith: [*Inaudible*] I particularly ask you the question of the family support whilst we have remandees and the whole health, the mental health issue that when a person is incarcerated and as Dr. Dominic had pointed out, he spoke about a person feeling that every day they go to court the matter would be heard and they would not be coming back. But what we have to think about is that person is innocent until proven guilty. But he is the head of a family, and whilst he is incarcerated what is happening to that family out there? Just the thought that he knows that family is out there with no support, it could impact on his mental capacity. And I am asking you, how robust is the intervention by the prison department utilizing all the non-governmental agencies, as well as government departments like the social services, Ministry of Labour and Small and Micro Enterprise Development and things like that?

Mr. Bruce: We are very robust in that aspect, Ma'am. Public assistance for the families that will assist the families to take care of the children. We also on discharge, we have a simple incidence of licensing officers where the person has to renew their driving permit and we have received assistance from the Licensing Department in this, like keeping jobs within government agencies because somebody would have been remanded for quite some time and that job is important for them to continue living on release, so that system, that interaction, that co-operation does exist. Also with stakeholders, Vision on a Mission, other halfway houses even through COPCAM they have assisted us, Rebirth House they have provided resources to us to ensure that when an inmate comes out or whilst that inmate is there they provide the support system to ensure that the family system stays intact as much as possible.

Madam Chairman: And is all of this available for the remandee?

Mr. Bruce: Yes, it is, Ma'am.

Madam Chairman: Because if I—yes. It is?

Mr. Bruce: Yes, Ma'am.

Madam Chairman: Okay. Because if I look at that in comparison with what was said by Mr. Chance, he was indicating that there are some things that are available for those who are already convicted and are going to be released and they are not available necessarily to the remandees who have been there for a long time, and so therefore, the remandees who have spent a long time come out almost with no type of support or less support than those who would have been convicted when they are actually released.

Mr. Bruce: Convicted inmate planning is different because there is an end. Remanded, the planning would be short term and quick. Whilst Mr. Chance may talk about they come to his door and now he has limited information. Yes. Because sometimes an inmate comes out of remand, he goes to court he does not come back, he is released, he comes and he gets bail tomorrow by someone. Those things they are not always planned, so the planning time is short and it is sudden.

Madam Chairman: Right. We understand that, I mean, it is uncertain and that is what we are talking about, its uncertainty. I just wanted to look at what, even in that prevailing circumstance, those who have been there for a long, you know, how they take that sudden release because, I mean, every time they go to court we understand they expect to be released, but if after 10 years, you know, it has been going on and on if they are released then, you know, I understand the difficulty because you would not know that they would be released at that time.

Mr. Bruce: What happens is that those same facilities are available. Someone may be released, he says, "Sir, my driving permit has expired", he is given a document that he could to Licensing Office he would not have to pay the fees for the length of period that he has not been driving, and that comes in handy because for some people they depend on driving as a livelihood. So we make that available through the prison welfare department where inmates are referred to different departments for different levels of assistance. It may not be planned before as convicted, but at the short term, on release, the system is always available for an inmate.

1.00 p.m.

Madam Chairman: All right, now I want to thank everyone really for their contributions, and I want to invite—if there are any last questions for members—the members who are here to give very brief closing comments, and we would take it in the order that we took the opening comments. So, Mr. Vel Lewis; Mr. William Alexander, Commissioner of Prisons; then we will take Mr. Richard Madray; Mr. Wayne Chance and Dr. Nwokolo.

Mr. Lewis: Thank you very much, Madam Chairman, and members of the Joint Select Committee. I think all of us have been very enlightened today, and therefore we want to thank you for this opportunity. I would also want to thank other members here for sharing and for the contributions made. I certainly want to thank the Prison Commissioner and members of the prison service, not only for the contributions here today, but for the work that they continue to do in the prison service. I would think that for remandees, our deliberations here today will only serve to improve their health and quality of life. We at the Ministry of National Security and indeed the prison service would want to concur with the World Health Organization's position, that, and I want to quote:

> Addressing the needs of people with mental disorder improves the probability that upon leaving prison they will be able to adjust to community life which may in turn reduce the likelihood that they will return to prison.

And with those words, I want to again thank you members of the Committee and we look forward to your report and certainly to the recommendations as we in the Ministry strive to improve on all aspects of our operations. Thank you very much.

Madam Chairman: Thank you so much. Mr. Alexander.

Mr. Alexander: Madam Chairman, members of the Committee, all those present, and all those that are listening to us. We have a golden opportunity to make a difference in the lives of our citizens, and we must take that as an oath. We have to change the conditions and circumstances of some dispossessed persons in our community, otherwise the quality of life would never change for most of us. In fact, it carries a risk, because as their numbers grow our comfort, our ability to live freely will be comprised. I value the opportunity to sit and discuss with persons from different disciplines. Some things that were said here today caused me to have a different perspective. I want us to never despair. But, we are a talented people. Some of us may be underutilized, but I think if we come together there is nothing that we cannot do. We could make a difference.

I want to state publicly, on behalf of my prison officers, we are going through a very risky period now, but the majority of them are holding fast to their oath. They are coming out to work, they are dedicated to the service to their countrymen, to their country. Whatever hurt that they are feeling now, we will overcome. We would prevail. God is on our side. Thank you.

Madam Chairman: Thank you so much. Mr. Madray.

Mr. Madray: We at the Ministry of Health, particularly take note of the discussions on the subject of training, and whether such training could improve the likelihood that mental issues could be more readily identified for further investigation by specialists. We therefore commit to discussing with the relevant agencies and the specialists the viability and the validity of introducing such training programmes. We also commit to working with UWI to determine whether it is possible to incorporate into the research agenda the issues of mental health within the prison population and, of course, specifically within the remand facilities.

Madam Chairman: Thank you. Mr. Chance.

Mr. Chance: Thanks, Madam Chairman and all the members of the head Table there. And I want to also say thanks to the Parliament for their continuous looking at the risks and needs of the prison practitioners and the customers of the prison service, to create a more humane and transformational system. I still want to leave on the record that the remand inmates definitely need a programme to look at how they adjust and readjust in going back into the society. I thank all of you, and I send my condolences to the family of those who would have suffered demise recently within the prison system. Thank you.

Madam Chairman: Thank you. And Dr. Nwokolo.

Dr. Nwokolo: Thank you, Madam Chairman, and the members of the Joint Select Committee for having given me the opportunity under the ambience of the AP, Association of Psychiatrists of Trinidad and Tobago. We at the association believe that mental health is a community affair, and a psychiatrist sits like a cherry atop that pie, but the rest of the pie, which is the rest of us, the prison officers and members of the community, we all have a role to play in helping to attain the end of mental health for all as soon as possible. So, we will continue to play our roles and try our best to assist any organization that may need such assistance from us. Thank you.

Madam Chairman: Thank you, and I just beg your indulgence to just summarize some of the findings that we have discussed here, and some of the recommendations that would have come forward. Some of the findings are:

- That no routine psychiatrist screening of remandees takes place at this time.
- No baseline data regarding the remandees who have mental illnesses on entering the prison in Trinidad and Tobago is collected.
- No research is being done to determine the incidence rate of mental illness in the prison versus the general population of Trinidad and Tobago.
- The determination of mental degradation in remandees is left to prison officers mainly and reports of inmates and this may be insufficient to accurately institute preventative treatment because problems may be picked up at advanced stages.
- Budgetary concerns and logistics may prevent routine psychiatric examination, which may be desirable for every remandee.
- The treatment of remandees is a difficult process due to the behavioural patterns of remandees which may reduce the effectiveness of any screening processes as well as possible treatment.
- There is not adequate facilities or space for provision of programmes for remandees.
- Infirmary officers are trained at COSTAATT to assist in detecting signs of mental illness.
- Many NGOs support the rehabilitation work of prisons for remandees and have a positive effect on the attitudes of prisoners.
- No formal family life intervention mechanisms to treat with the family and children of remandees exist though international studies confirm that they are at high risk of becoming offenders themselves due to the mental strain and grief of having incarcerated parents.
- Preparation for release programmes are not formally extended to remandees though they have access to some of them, and especially longstanding ones, due to the uncertainty of their release times, and that there are some programmes instituted at Remand Yard, including Fathers' Day programmes, special days for children and families at the prison and there are also opportunities for extra visits where possible.

Some of the recommendations that have been advanced are:

- That standard procedures to determine deteriorating mental health in remandees over their detention time are necessary.
- Support may be required to assist ex-remandees who have developed mental illnesses while detained, and partnerships and information sharing systems may have to be put in place.
- Psychiatric evaluation should be a routine part of the admission criteria or testing on entrance of remandees to detention spaces or prisons.
- Research must be done to determine if the conditions and length of time spent at Remand Yard, in fact, lead to the development of mental illnesses and disorders in Trinidad and Tobago.
- Funding has been approved for the refurbishment of remand prison which would allow for more programmes in different areas to be provided for the engagement of remandees, which may assist in

preventing the development of mental disorders.

- More officers can be trained to detect basic mental illness, and both infirmary officers as well as those who interact with the general remandee population can be included.
- Training modules at COSTAATT can be reviewed with inputs from the department of psychiatry at UWI, the Association of Psychiatrists of Trinidad and Tobago, as well as the Ministry of Health.
- NGOs have to be encouraged to continue interacting with the Trinidad and Tobago Prison Service.
- Children of remandees should be connected to social services to provide them with support both financial and psychological, et cetera, to mitigate the effects of mental strain which results from having incarcerated parents.
- Preparation for release programmes to be opened to remandees, particularly the longstanding ones, not necessarily compulsory, but available to them, and recommended.
- Rules which prevent minors from entering the prisons need to be reviewed and the data must be collected to determine the effects of improvements in the physical infrastructure and programming of Remand Yard on the mental health and family life of remandees.

Quite a mouthful.

And I want to thank the representatives who were here for contributing in such a substantial way to our investigation, and I am certain that our report will bear recommendations that can both be fleshed out in the short term as well as the long term to improve the conditions for remandees with regard to their mental health and their family life.

So, I want to thank the members of the viewing public who were here with us. I want to thank representatives and the members of the Committee, and we have had really an extended session, but I think a very good one, and I want to declare this meeting now, adjourned.

1.11 p.m.: *Meeting adjourned*.

Appendix III
Questionnaire

Questionnaire FOR PERSONS ON REMAND

Background Information

1. How old are you?

- ☐ 18-25 years
- ☐ 26-33 years
- ☐ 34-40 years
- ☐ 41-48 years
- ☐ 49-56 years
- ☐ Over 56 years

2. How long have you been at Remand Prison?

- ☐ Less than 1 year
- ☐ 1 year
- ☐ 2-3 years
- ☐ 3-4 years
- ☐ 4-5 years
- ☐ 5-6 years
- ☐ 6-7 years
- ☐ 7-8 years
- ☐ 8-9 years
- ☐ 9-10 years
- ☐ More than 10 years

3. What are you accused of?

- ☐ Murder
- ☐ Kidnapping
- ☐ Rape
- ☐ Robbery
- ☐ Assault
- ☐ Possession of Drugs
- ☐ Possession of Fire arms
- ☐ Illegal trafficking of Drugs
- ☐ Gang-related activities

Other Offence please state: _____

4. Are you on remand because you were unable to afford bail?

☐ Yes ☐ No

5. Has the proceedings for your trial commenced?

☐ Yes ☐ No

If, yes how many times has the trial been postponed?

6. In what area of Trinidad and Tobago do you reside?

☐ North ☐ South ☐ East
☐ Central ☐ West ☐ Tobago

Family Life Information

7. Do you have children?

☐ Yes ☐ No

Please state how many and the age(s) of the child/children? _____

8. Please indicate your marital status.

☐ Single ☐ Married ☐ Common-Law ☐ Separated
☐ Divorced

9. What effect(s) has your incarceration had on your relationship with your children?

10. What effect(s) has your incarceration had on your relationship with your family (exclusive of children)?

11. What effect(s) has your incarceration had with your partner/significant other?

12. How often has your family/friends visited you at Remand Prison?

Mental Health Information

13. Have you ever been physically or verbally abused by either the prison officers/other staff at Remand Yard Prison or other inmates?

☐ Yes ☐ No

If yes, please provide details:

_____

_____

14. Have you witnessed other remandees being verbally or physically abused by the prison officers/other staff at remand yard or other inmates?

☐ Yes ☐ No

15. Are there any procedures to submit concerns/complaints regarding abuse?

☐ Yes ☐ No

16. Were you examined by a mental health practitioner upon entry to the Remand Prison?

☐ Yes ☐ No

If yes, please state how often:

☐ Twice per week ☐ Fortnightly
☐ Weekly ☐ Monthly

17. What types of behaviours have you observed by other persons on remand?

☐ Violence (fighting) ☐ Restlessness
☐ Rebellious (disobedience to rules/authority) ☐ Depression
☐ Anxiety ☐ Suicidal

Other Behaviours: _____

18. How has your time at Remand Yard Prison affected your mental state?

_____

_____

Programmes and Services

19. Do you have access to any programmes or services to support your mental health and family life?

☐ Yes ☐ No

If yes, please indicate how often and state the name of the programme _____

☐ Upon entering
☐ Weekly
☐ Monthly
☐ Every 3 Months
☐ Every 6 Months
☐ Yearly

Other time please state: _____

20. At the Remand Prison, have you observed other persons on remand displaying abnormal behaviour?

☐ Yes ☐ No

If yes, what treatment if any is given to these persons?

_____

_____

_____

21. Any other comments and or observations on the impact on your mental health and family life ☐ of Remand Yard:

_____

Appendix IV
Statistical Report

JOINT SELECT COMMITTEE ON HUMAN RIGHTS, EQUALITY AND DIVERSITY

Statistical Report for the questionnaires distributed to the Ministry of National Security on the Impact on the Mental Health and Family Life of Remandees at Remand Prison.

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1. INTRODUCTION 87

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Remandees - Ministry of National Security 88

3. SUMMARY OF FINDINGS 98

1. INTRODUCTION

1.1. On May 19, 2017 the Committee agreed to pursue an inquiry into the impact on the mental health and family of remandees at remand prison. In order to gain a comprehensive understanding of the mental health and family life of the remandees the committee agreed to conduct a survey on remandees and post-remand prisoners.

1.2. On June 07, 2017 the Committee sent correspondence to the Ministry of National Security and Vision on Mission requesting questionnaires provided by the Committee be distributed amongst the remandees and post- remand prisoners respectively.

1.3. The questionnaires provided to the Ministry of National Security were distributed to the Remand Prison, Golden Grove, the Remand Yard in Port-of-Spain Prison, the Remand Section of the Women's Prison and the Maximum Security Prison, Golden Grove.

1.4. Questionnaires from the Ministry of National Security were received on June 09, 2017 and June 16, 2017. However, the Committee did not received the questionnaires from Vision on Mission.

1.5. The Committee would like to inform that there are questions which were left unanswered by the remandees and as such the representation of the number of remandees may not be accurate.

2. STATISTICAL ANALYSIS

Remandees - Ministry of National Security

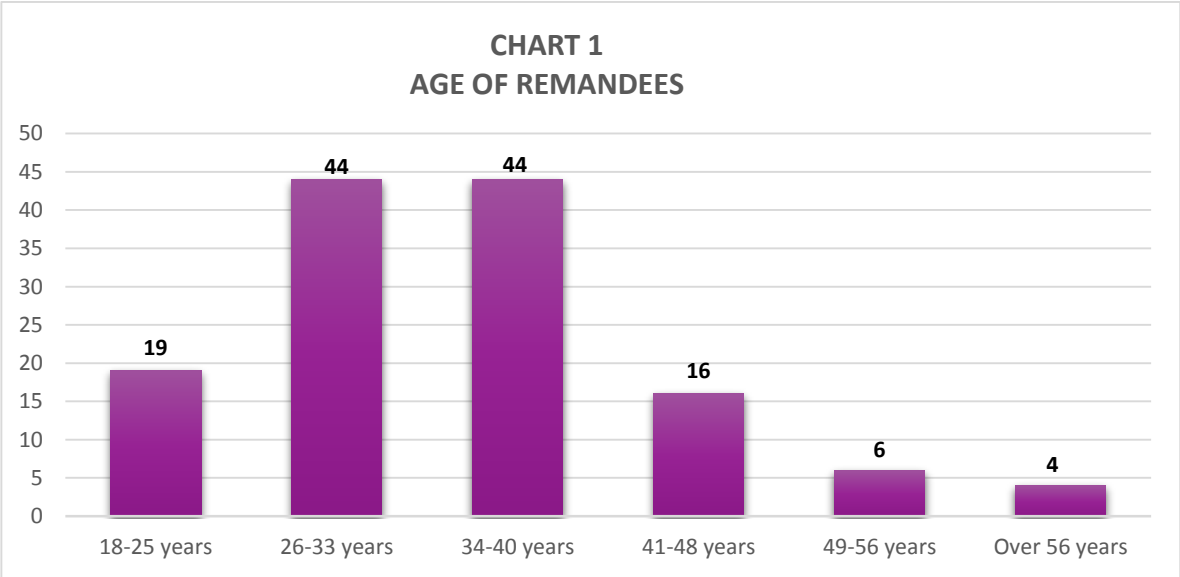
General

2.1. A total of 133 questionnaires were completed from the following Prison Facilities of the Ministry of National Security:

- Remand Prison[19], Golden Grove – 15 responses
- Remand Yard, Port-of- Spain Prison – 53 responses
- Remand Section of the Women's Prison – 15 responses
- Remand Section of the Maximum Security Prison – 50 responses

2.2. The statistical analysis shown on the following charts and/or tables reflects the answers to the questionnaires received from the 133 remandees of the various prison facilities mentioned in **2.1** above.

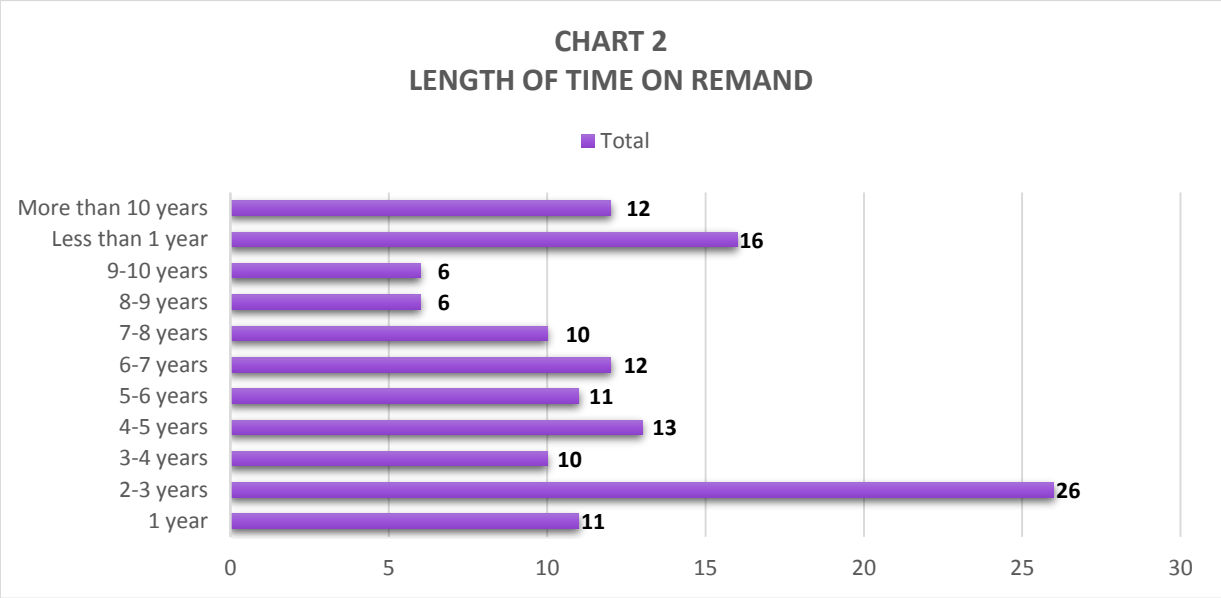
2.3. Chart 1 shows the average age of the remandees at the four (4) prisons listed above. The greatest number of remandees at the facilities is between the ages 26 to 33 and 34 to 40 with 44 remandees for each age range.



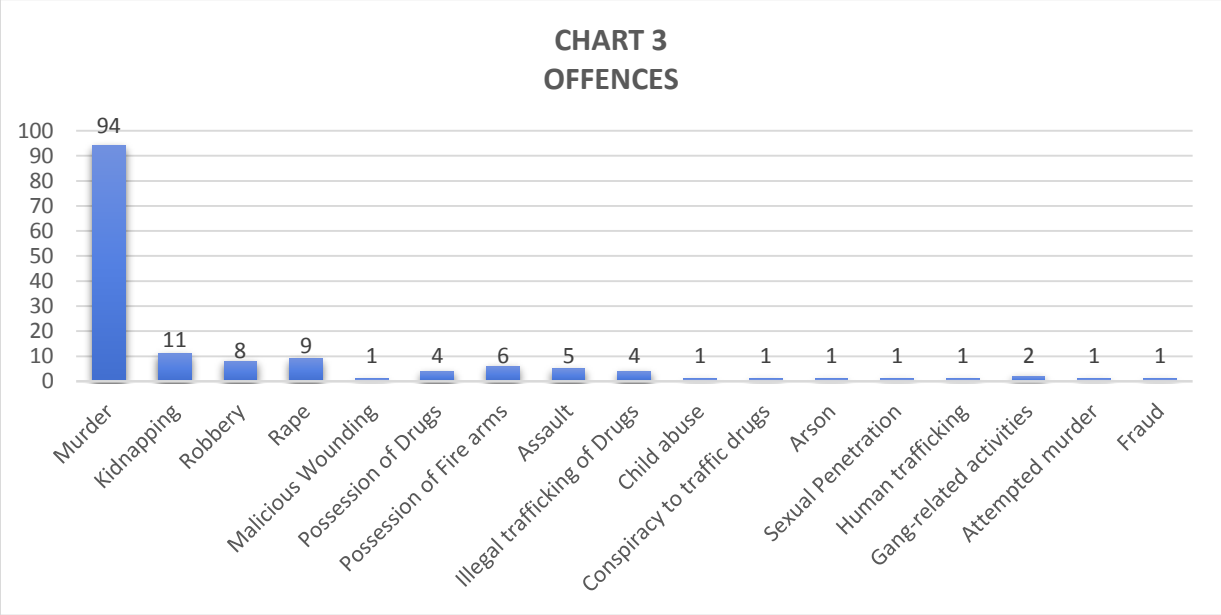
2.4. Chart 2 indicates the length of time the 133 remandees spent on remand. The majority of the remandees have spent '2-3 years' on remand with the smallest numbers spending '8-9 years' and

[19] According to the Fifth Report of the JSC Human Rights, Equality and Diversity on the Human Rights of Remandees at Remand Prisons, the number of remandees at the Remand Prison, Golden Grove as at January 2017 was 1074. [page 24] http://www.ttparliament.org/reports/p11-s3-J-20170929-HRED-r5-REMA.pdf

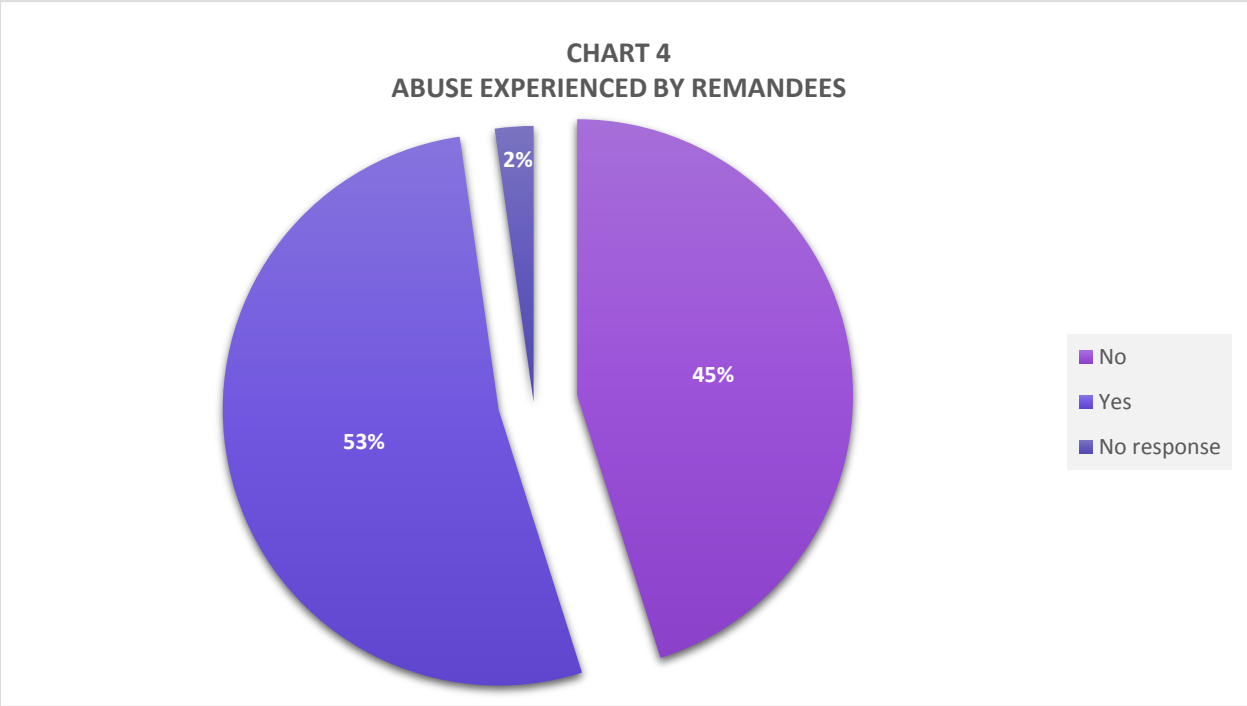
'9-10 years' on remand. 12 of the remandees indicated that they spent 'more than 10 years' on remand.



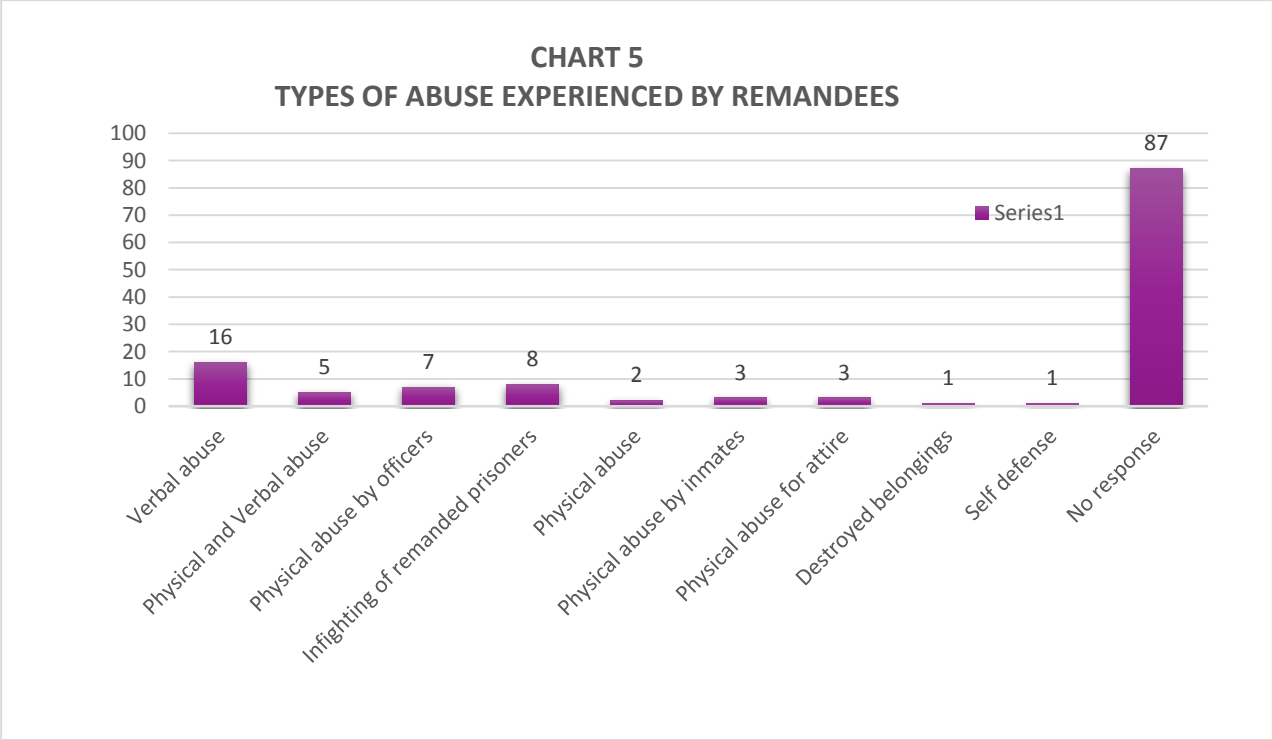
2.5. Chart 3 highlights the most popular offences committed by remandees at the facilities. The most popular offences are those of murder (94) and kidnapping (11). Remandees were allowed to choose more than one response for this question.



2.6. Charts 4 shows the number of remandees who have experienced abuse by the staff at the remand prisons or by other remandees at the prisons.

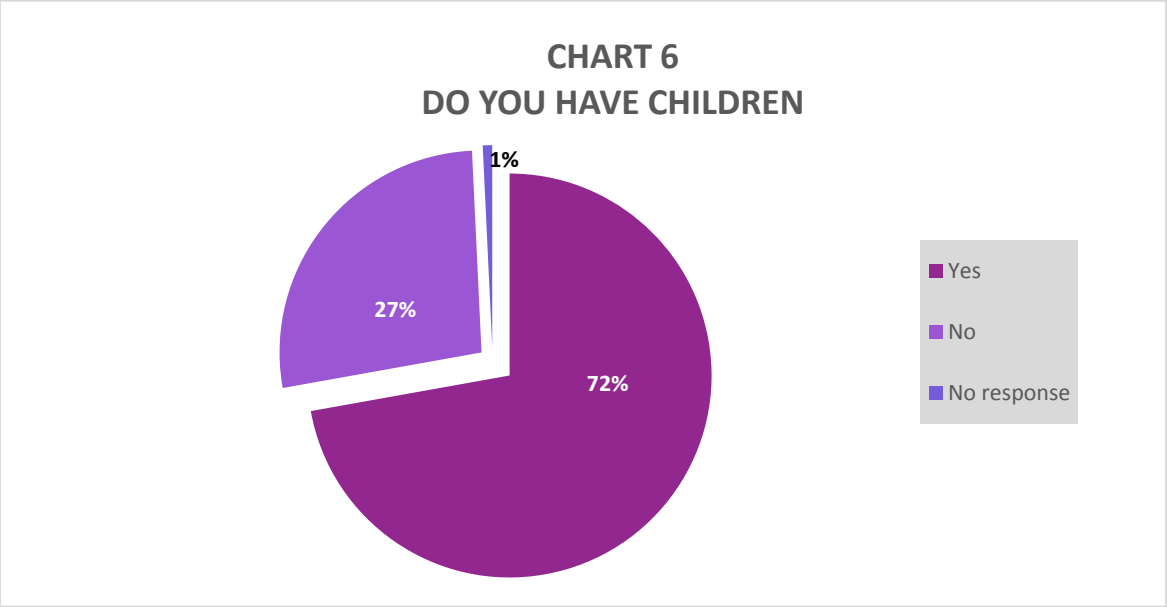


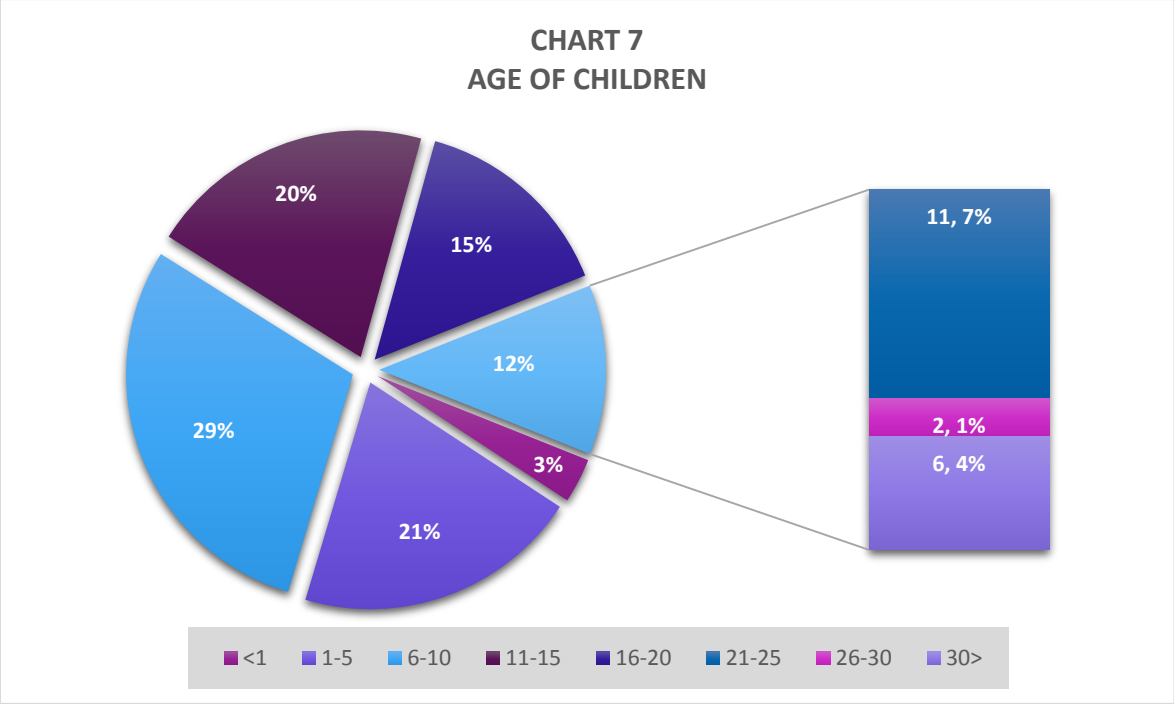
2.7. Chart 5 shows the most popular types of abuse that the remandees in Chart 4 experienced.



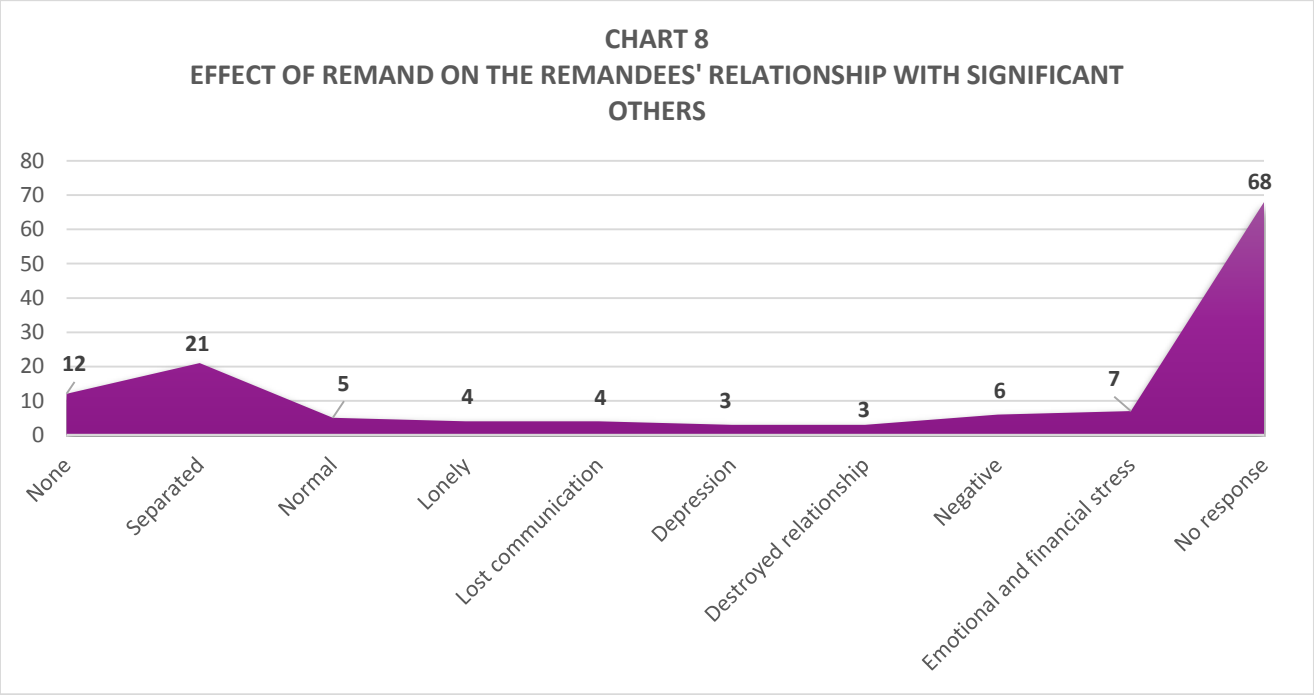
Family Life

2.8. Chart 6 indicates the percentage of remandees who have children. Chart 7 indicates the most popular age ranges of the children of the remandees who indicated "Yes" in Chart 6.

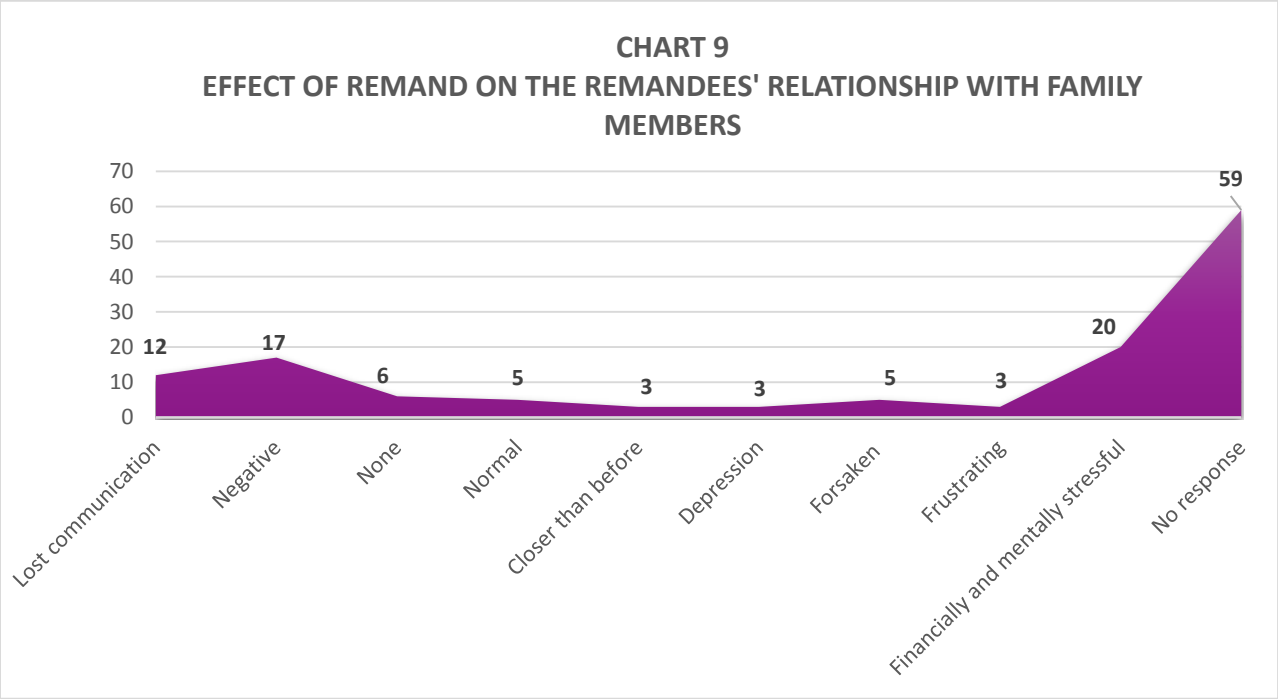




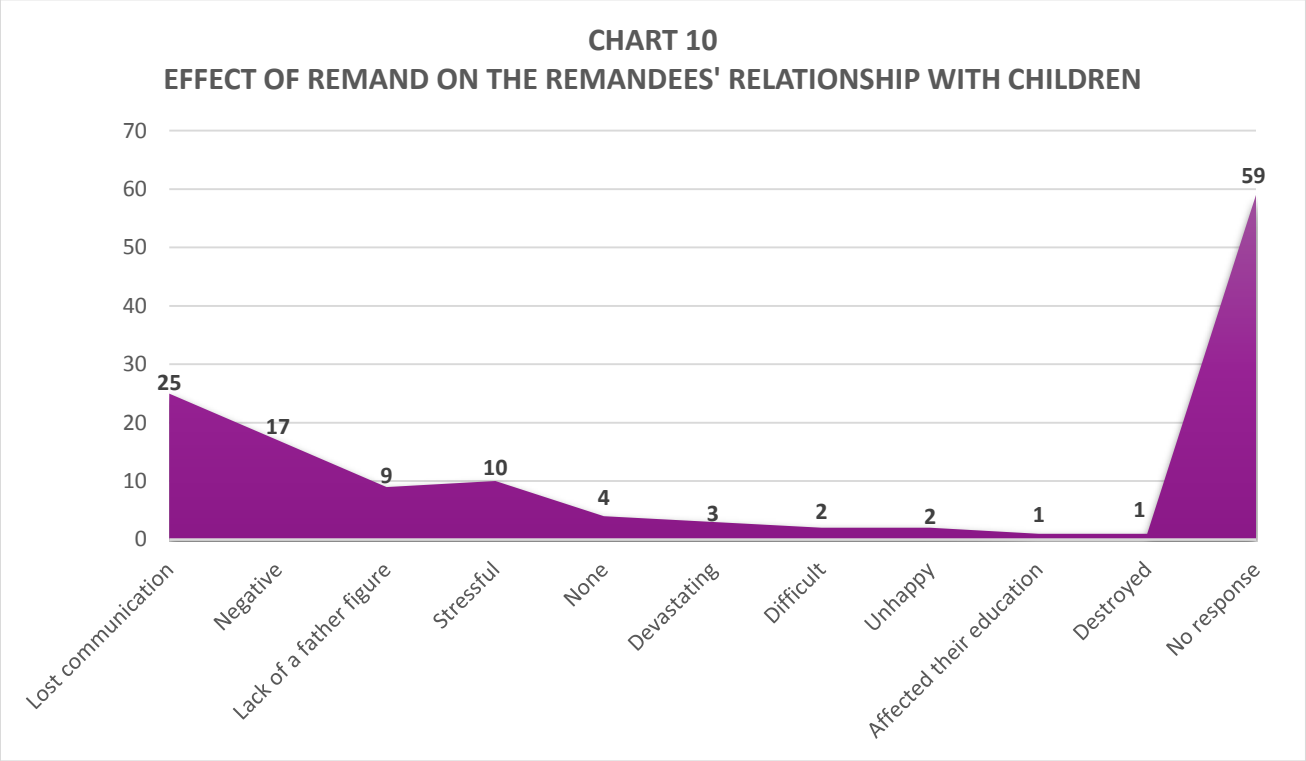
2.9. Chart 8 indicates the most frequent effects of remand on the relationship of the remandees with their significant others.



2.10. Chart 9 indicates most frequent the effects of remand on the relationship of the remandees with their family members.

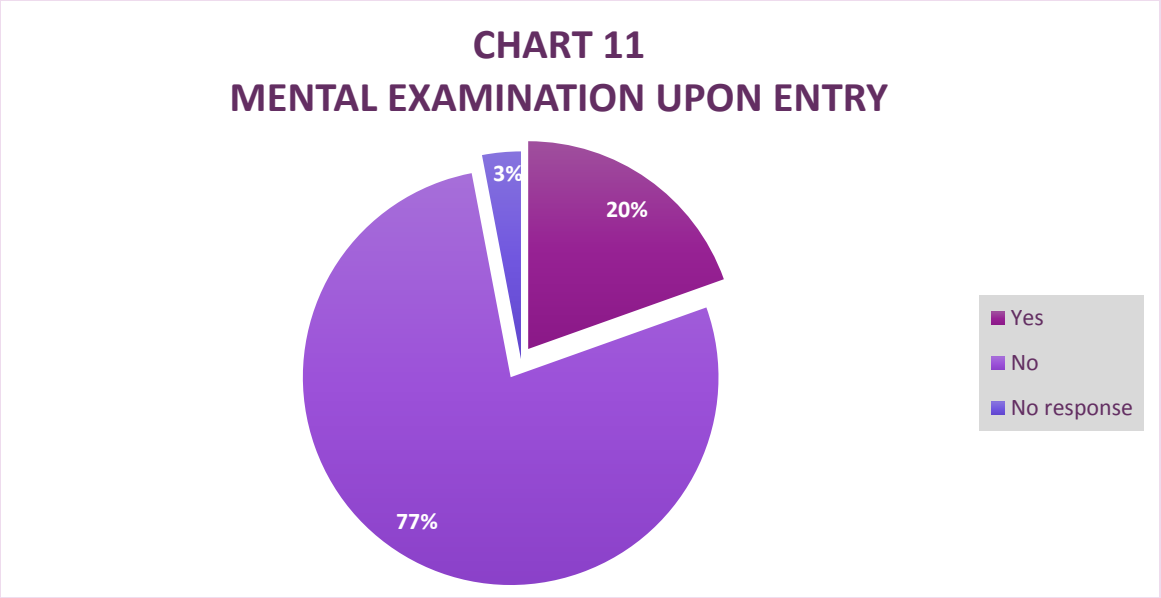


2.11. Chart 10 indicates most frequent the effects of remand on the relationship of the remandees with their children. The figures in Chart 10 correspond with the number of remandees who indicated they had children **(See Chart 6 page 92).**

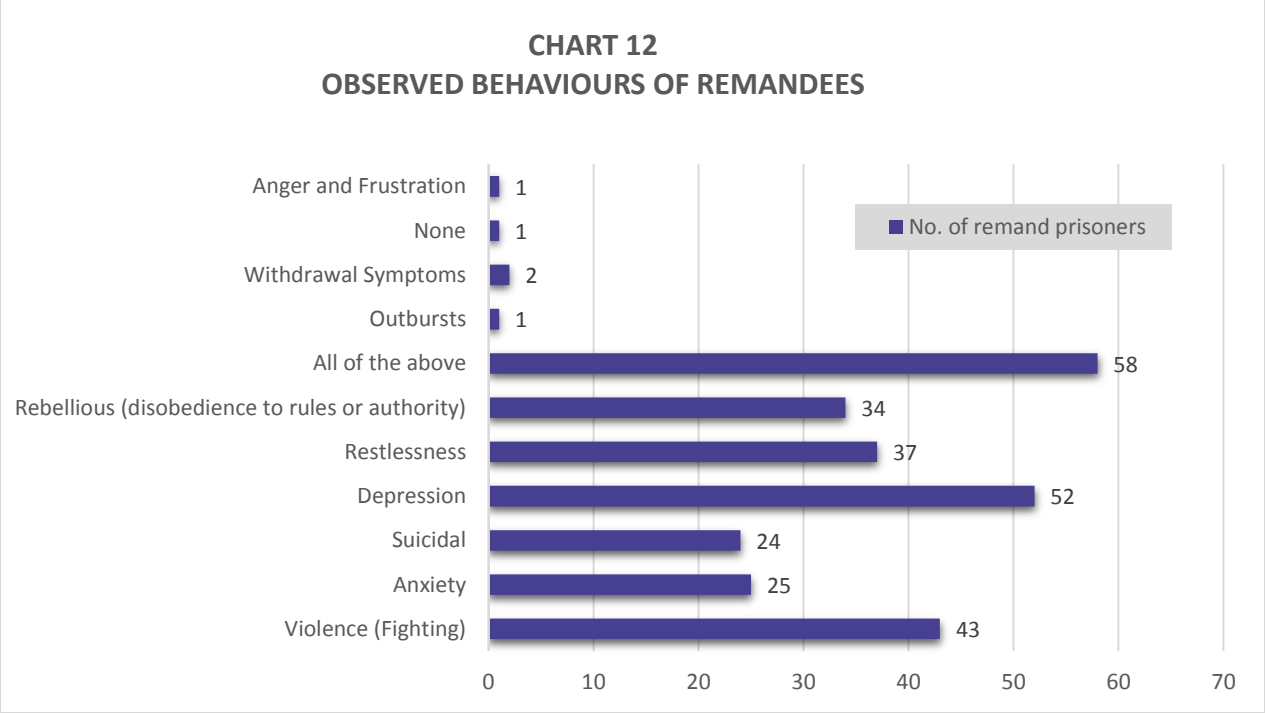


Mental Health

2.12. Chart 11 indicates the percentage of remandees who were subjected to a mental health examination upon entry into the remand prisons.



2.13. Chart 12 indicates the popular behaviours of remandees observed by other remandees. Remandees were allowed to choose more than one answer for this question. Remandees were allowed to choose more than one response for this question.



2.14. Chart 13 indicates the mental health effects the remandees experience while in the remand prisons.

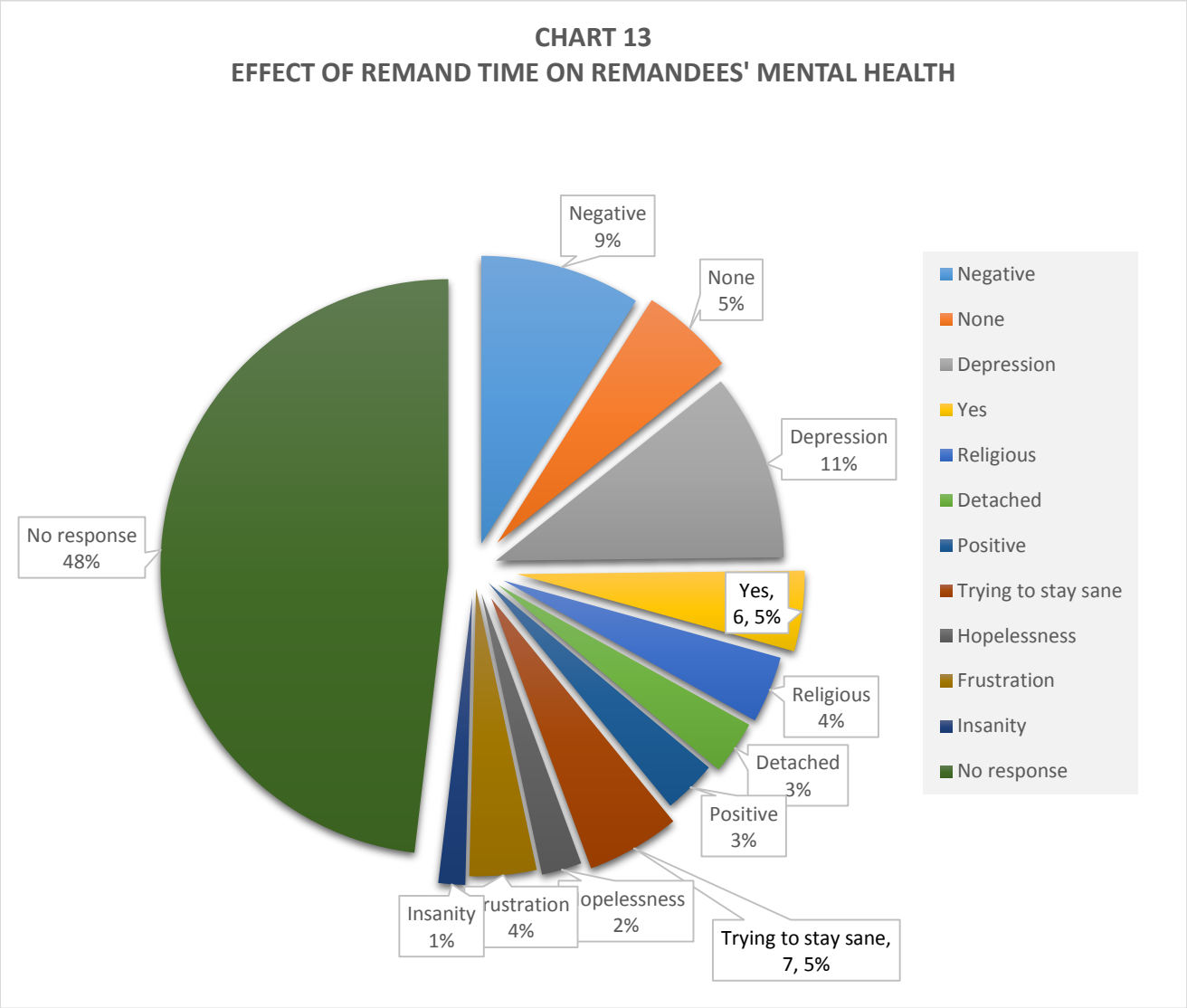
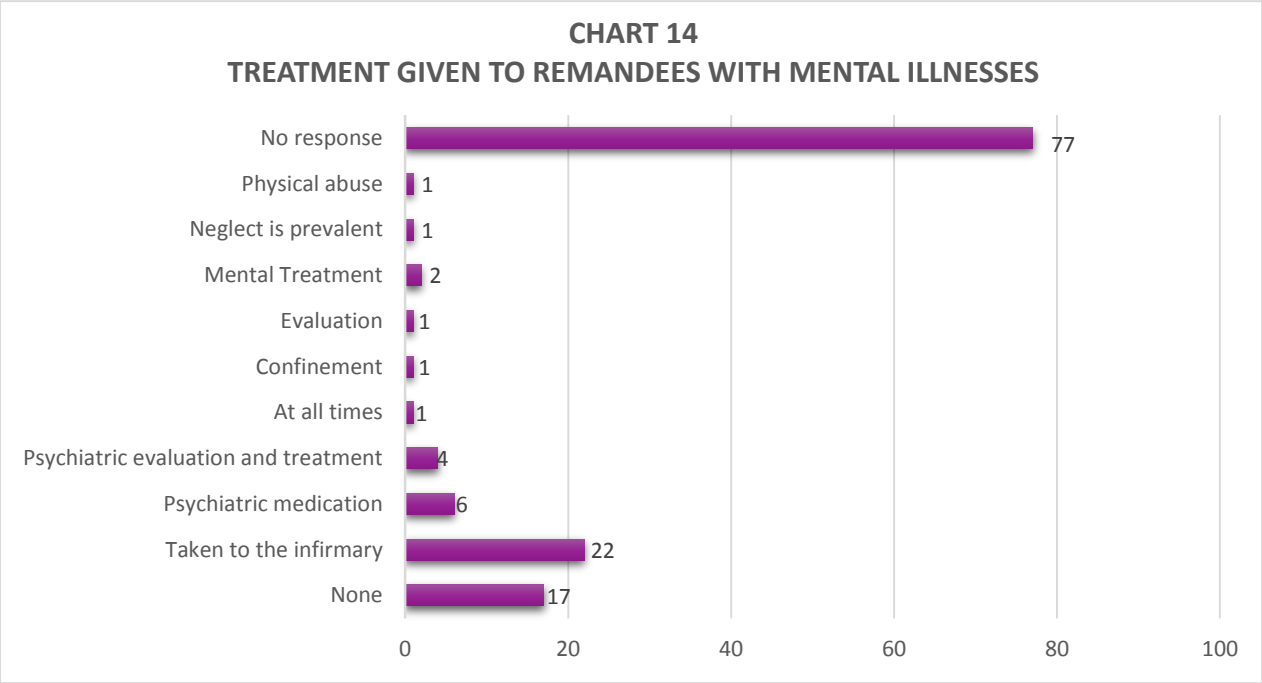
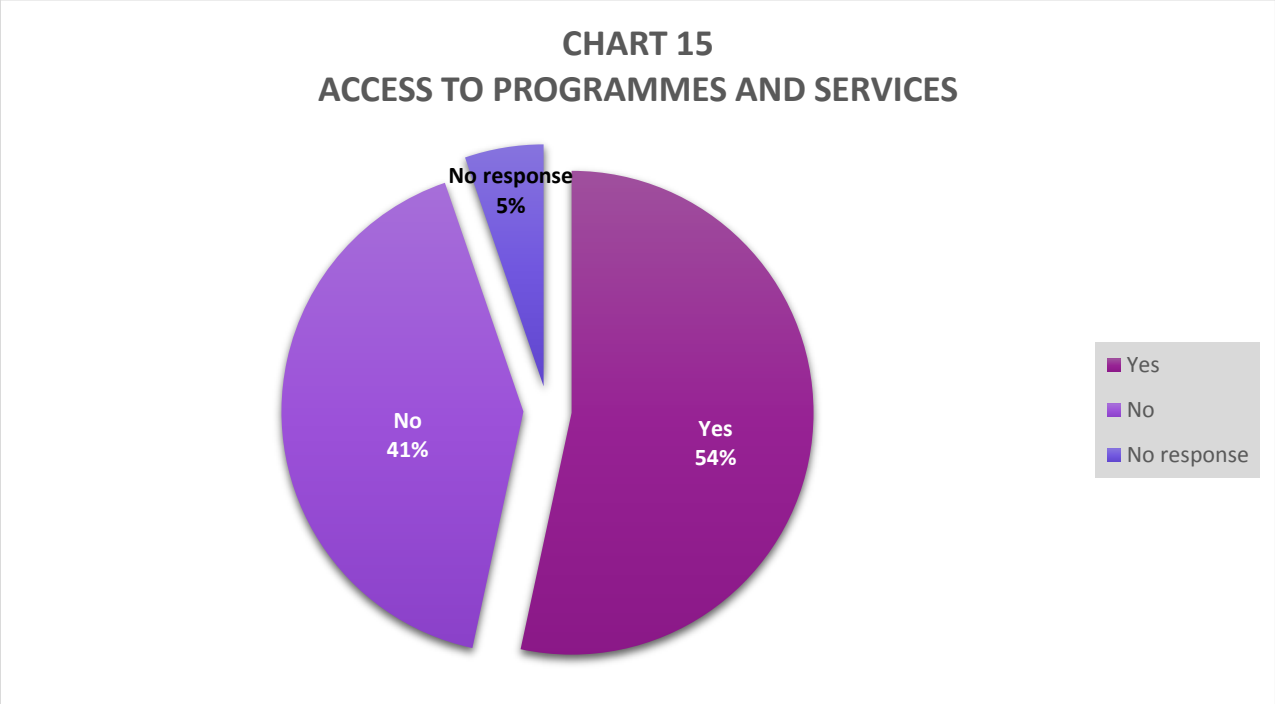


CHART 13
EFFECT OF REMAND TIME ON REMANDEES' MENTAL HEALTH
Negative 9%
None 5%
Depression 11%
Yes, 6, 5%
Religious 4%
Detached 3%
Positive 3%
Trying to stay sane, 7, 5%
opelessness 2%
rustration 4%
Insanity 1%
No response 48%
Negative
None
Depression
Yes
Religious
Detached
Positive
Trying to stay sane
Hopelessness
Frustration
Insanity
No response

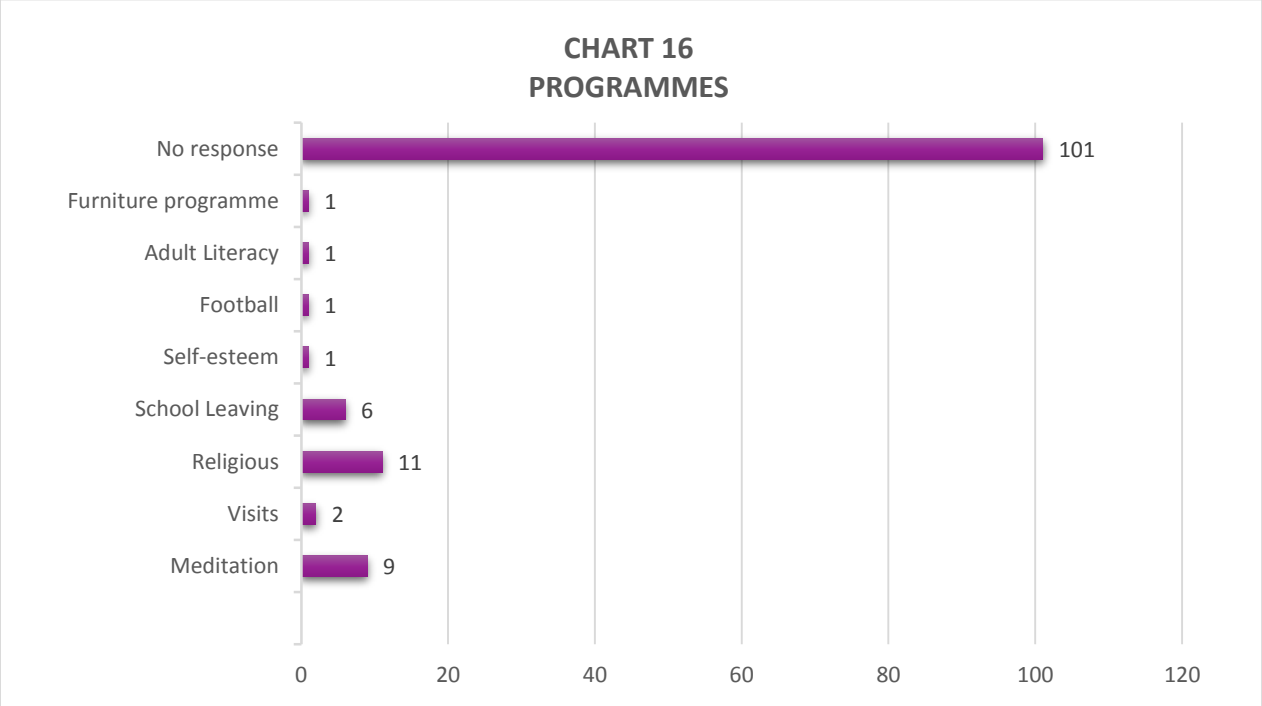
2.15. Chart 14 indicates the treatment given to remandees who have exhibited signs of possible mental illnesses.



2.16. Chart 15 highlights the percentage of remandees who indicated they have access to the programmes offered at the remand facility.



2.17. Chart 16 highlights the programmes which remandees indicated they attend frequently.



3. SUMMARY OF FINDINGS

Family Life

3.1. According to Charts 6 and 7, 72% of the remandees indicated they were parents of children. The majority these remandees have children who are between the ages of one to five (28%) and six to ten (21%).

3.2. In Chart 8, 21 of the remandees indicated that they were "separated" from their significant other while they were in remand facilities. In contrast, 12 of the remandees indicated that their remand time had no effect on their relationship with their significant other.

3.3. In Chart 9, 12 remandees indicated they "Lost communication" with their family while in the remand facilities, 17 indicated their remand time had a "Negative" effect on the relationships and 20 stated that it was "Financially and mentally stressful."

3.4. According to Chart 10, 25 remandees indicated they "Lost communication" with their children while in remand, 17 indicated their remand time had a "Negative" effect on the relationships while only four (4) indicated their remand time had no effect on the relationship with their children.

Mental Health

3.5. According to Chart 11, 77% of the remandees who answered the questionnaire did not receive a mental health examination upon entering the remand facility.

3.6. In Chart 12, 58 remandees indicated that they have observed all of the behaviors (anxiety, depression, rebellious, suicide, restlessness, violence) in other remandees while in the remand facilities. The most observed behaviour however, is depression, which was observed by 52 remandees.

3.7. According to Chart 13, 11% of the remandees indicated that "Depression" was the effect of their time in remand prison, 9% indicated that remand prison has "Negative" effects on their mental health, while 48% of the remandees did not respond to the question.

3.8. In Chart 14, 22 remandees indicated that remandees exhibiting signs of mental health illnesses were "Taken to the infirmary". However, 17 remandees indicated that "no treatment" was given to mentally ill remandees, while 77% of the remandees did not respond to the question.

3.9. According to Chart 15, 54% of the remandees indicated that "Yes" they hve access to programmes while in the remand facilities.

3.10. In Chart 16, the most popular programme amongst the remandees is the "Religious" programmes with 11 of the remandees, however 101 remandees did not respond to this question.

September 26, 2017

Appendix V
List of NGOs

Table 1
List of Non-Governmental Organisations Operational at TTPrS in 2015

Organisation	Programmes	Station Operational
Prim Rawat Foundation	Peace Education Programme	Eastern Correctional Rehabilitation Centre (ECRC)
Vision on Mission	Vision on Mission Resettlement and Counselling Programme	ERCR, Golden Grove Prison (GGP)
Teen Challenge of Trinidad and Tobago	Drug Rehabilitation	ECRC
New Hope Ministries	Orientation	ECRC, GGP, Maximum Security Prison (MSP), Remand
SERVOL	SERVOL Adolescent Development Programmes	Youth Training Centre (YTC)
Caribbean Umbrella Body for Restorative Behaviour (CURB)	Alpha	YTC
Neal and Massy Foundation	Life Skills	YTC
Sibling Partnership Programme	Life Skills	YTC
British Gas	Music	MSP
H.I. Jeffers and Associates	Boys to Men	YTC
Ministry of Tertiary Education and Skills Training	Prisons Retraining Programme (YTEPP)- Construction industry trades, Information Technology, Life Skills	GGP, MSP
Ministry of Justice	Music Therapy	GGP, Women's Prison (WP)
Ministry of Tertiary Education and Skills Training	YTEPP Information Technology, Barbering, Radio Broadcasting, Food Preparation	YTC
Ministry of Education	Youth Apprenticeship Programme in Agriculture	YTC

Table 2

Ministry of Arts and Multiculturalism	Music in the Classroom	YTC
Ministry of Community Development (Export Centres TT)	Woodburning, Decorating for events	YTC, WP

List of Faith-Based Organisations Operational at Prisons in 2015

Organisation	Station Operational
Agape Ministry	ECRC
Hindu Service	ECRC
Raja Yoga	ECRC
Aglow Ministry	ECRC
Roman Catholic Ministry	ECRC, GGP, MSP, WP, Remand, Port-of-Spain Prison (POSP), YTC
New Hope Ministry (Seventh Day Adventists)	POSP, CCP, MSP, GGP
Alpha and Omega	ECRC, GGP
Jehovah Witness	ECRC, GGP
Evans Vision and Sound	ECRC, MSP, WP, GGP, YTC, Remand
Prison Fellowship of Trinidad and Tobago	GGP, WP, MSP
Anglican Mothers Union	GGP
Full Gospel Ministry	GGP
Transform Life Ministries	ECRC
Spiritual Baptist	YTC, GGP, ECRC, WP, POSP, Remand
Apart House Ministries	YTC
Church of the Naraene	YTC
Curepe Pentecostal Church	YTC
Fundamental Baptist	YTC
House of Judah	YTC
Jesus is the answer	YTC
St. Vincent de Paul	YTC
Urban Ministries	YTC

Appendix VI Recommendations from VOM

Vision on Mission's Recommendations -:

To mitigate against the effects of detention on Remandees at the Remand Prison, VOM wishes to recommend the following -:

1. The TTPS must establish standards and guidelines for the provision of services and programmes for remandees. The TTPS Statement of Principles should include -:
    - Identification and assessment shall focus on offender risk, need, responsivity / treatability and management of risk.
    - The timing, duration, focus and intensity of services shall be based on a remandees' level of risk, needs, responsivity, treatability, motivation and other relevant factors.
    - Participation in services shall be based on informed consent. Remandees should accept full accountability for their own behaviours throughout the provision of services.
    - Services and programmes provided must be an integral part of the offender management carried out by a multidisciplinary team with active participation of the remandee.
    - The remandees' plan shall include a continuum of intervention strategies, which may extend beyond the end of incarceration.
    - Remandee programmes shall be founded on sound theory and research. Intervention offered to remandees must incorporate Restorative Justice Approaches. All interventions will focus on reducing the likelihood of reoffending, even for remandees.
    - Development of innovative methods in the assessment, treatment and management of remandees shall be encouraged in order to improve programme delivery, in accordance with the TTPS's policy on research.
    - Service providers and multidisciplinary team members shall be qualified and trained in accordance with their duties.
    - Service providers shall be reviewed and evaluated on a regular basis to ensure they meet professional, ethical and correctional standards.
    - To ensure public protection, the TTPS must work towards partnerships with the community agencies to develop joint interventions and maintenance programmes and services.

2. TTPS must develop a policy to ensure the provision of psychological services to remandees in order to assist them with resolution of mental health problems and behavioural disorders; and to help them learn and adapt socially acceptable behaviour patterns and to prevent or attenuate their relapse following intervention.
    - Services shall include, but are not limited to:
        - Assessment
        - Therapeutic and Socio-Centre Intervention

- Crisis Intervention
- Programme Development, Monitoring and Evaluation.
- Pharmotherapy
- Occupational Therapy
- Psychiatric Services and Counseling
- Mental Health and Wellness Therapy
- Family life Reality Intervention
- Re-Entry Pre-Release Programming
- Referral and Consultation Services
- Reconation Therapy
- Recreational Therapy (Sports)
- Relapse Prevention Programme

  - All mental health services provided for essential and mental health needs shall be comparable to those available in the community.
  - All psychological services shall focus on the needs of the remandees, specifically the behaviours that contributed to criminal activity and the assessment risks posed by the remandee and on strategies to reduce and / or manage risk.

3. Importance of Assessment for Re-Entry -:
   - Assessment shall focus on offender risk, need and responsivity and on the management of risk, utilizing a variety of successfully validated assessment methodologies in an integrated process.
   - As an integral part of the Intake Assessment process, all remandees shall be screened on admission by appropriate personnel to determine which amongst them, require more in-depth assessment; remandees shall be re-assessed during and following treatment and following any significant crisis situation. Certain offenders will require pre-release assessments.
   - The referral and completion of pre-release assessments shall be such that they are available in time to be incorporated in reports to decision-makers at time of eligibility regarding bail, compassionate, leave, etc.
   - The pre-release assessment report must provide an evaluation of the level of risk posed by the remandee, provide options for the management of risk and identification of problems which might be encountered that would increase the risk. If the offender is being considered for release, the report shall also include specific recommendations concerning the continuing need for interventions in the community, including but not limited to psychological services.
   - Assessments and interventions shall be both culturally and gender sensitive.

4. Approach for the Therapeutic Intervention:
   - Intervention shall be provided in priority to those remandees who require it most with higher risk / higher needs remandees receiving more intensive treatment. Problem behaviour directly related to criminality and essential mental health needs shall be primary treatment targets.
   - Psychologists will identify treatment targets in keeping with applicable research literature (e.g.: sexual deviation, substance abuse, anger/aggressive behaviour, criminal attitudes, values and beliefs, poor social skills, interpersonal problem-solving, empathy deficits and impulsivity).
   - The delivery of treatment should be matched to methods proven to be effective with remandees, subject to ongoing programme development and innovation.
   - Interventions shall be theoretically and empirically based. Programmes require clearly articulated admission criteria and individual participants require specific treatment objectives, methods for attaining goals and a strategy for measuring treatment gains. Issues of treatability, frequency of contact and likely consequences of relapse must be addressed.
   - Treatment shall be aimed at symptoms reduction, skill acquisition, the identification of highrisk situations, visible coping strategies for remandees and relapse prevention.
   - Documentation must be maintained relating to treatment activities. In addition, psychologists shall submit treatment programme reports and/or treatment summaries as appropriate in consultation with case management staff.
   - Professional staffing needed to manage psychological and mental health, and wellness intervention programme in Prison -:
     - Psychologist
     - Psychiatrist
     - Mental Health Specialist
     - Counselor
     - Social Worker
     - Occupational Therapist
     - Family Life Specialist
     - Resettlement Specialist
     - Research Specialist
     - Intake Assessment Specialist
     - Case Management Worker
     - Psychiatric, Mental Health Nurse

Appendix VII Circular dated February 23, 1987 "Visit of Inmates by Children"

PS(1/1/79)
c d:

64.

Prisons Headquarters,
Port of Spain Prison.

February 23, 1987.

Deputy Commissioner of Prisons,
Asst. Commissioner of Prisons 'A',
Asst. Commissioner of Prisons 'O',
Superintendent of Prisons - Admin.,
-do- P.O.S.P.,
-do- G.G.P.,
-do- Y.T.C.,
-do- C.C.P.,
Chief Welfare Officer,
Prison Supervisor - Women's Prison

VISIT OF INMATES BY CHILDREN

As a consequence of the many requests from all categories of prisoners to be visted by their children, it becomes expedient to convey formal approval for this facility subject to the undermentioned conditions:-

(a) An inmate, convicted or remanded, who has been in Prison custody for a continuous period of at least one (1) year will be allowed such visits:-

(i) to see child/children born during his incarceration;

(ii) to see child/children about to migrate before the inmate is due for release;

(iii) in the event of serious illness of the inmate or in situations necessitating special considerations;

(b) An inmate under Sentence of Death shall be permitted a visit subject to condition as at (a);

(c) Visits will normally be conducted on Saturday mornings between 8.30 a.m. and 12.00 noon except otherwise directed under the following conditions:-

(i) a request shall be made to the Superintendent of Prisons by the inmate requiring such visit in the prescribed manner;

(ii) before the request is granted, the Welfare Officer shall be instructed to investigate the circumstances and report as to the merits or demerits of the specific case;

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(d) (i) such visits shall normally be of fifteen (15) minutes duration;

(ii) a visit can be extended only if prior approval has been obtained;

(iii) the visit shall be in the sight and hearing of a Prison Officer;

(e) Where there is any doubt or need for clarification in connection with these arrangements, the matter shall be discussed with the Assistant Commissioner of Prisons, 'Operations'.

Circular No. 3 of 1986, is hereby rescinded.

Commissioner of Prisons.

Appendix VIII Psychiatric form/ Data sheet

Prison
INFIRMARY

Psychiatric Doctor,
St. Ann's Hospital,
St. Ann's.

PSYCHIATRIC QUESTIONS

This patient who is referred to you, by the Medical Officer, is acting strangely. I shall be grateful for a Report on your assessment please.

Prisoner's Name .....

Age .....

Address .....

Next of Kin .....

Offence .....

Court ..... Sentence .....

Behaviour: Normal ..... Acting Strange .....

Violent ..... Or quiet .....

.....

Conversation: Normal ..... Sub-normal .....

Abusive ..... Quiet .....

Clothing ..... Wears clothing .....

Damage ..... Naked .....

Are you a previous psychiatric case? .....

Are you attending a unit? .....

Do you know what medicine you are given? .....

Do you know the doctor? .....

Do you take hard drugs, weed or alcohol and for how long? .....

.....

Did you grow up with your parents? ..... Are you living with them? .....

Did you grow up with grandparents? .....

Were you ever sent to an institution? .....

How many times did you get into trouble with the police? .....

.....

How do you get along in your area? .....

.....
Infirmary Officer

G.P., Ts./To.—P 2564—5,000— /99